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# Business Insurance®

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## Updates

### 1994 catastrophe loss propels 48% plunge in insurer profits

NEW YORK—Battered by catastrophes, U.S. property/casualty insurers' 1994 net income fell 47.7% to $10.1 billion from $19.3 billion in 1993, according to figures from the Insurance Services Office Inc. and the National Assn. of Independent Insurers.

The largest commercial property/casualty companies, though, fared far better in 1994. Twenty-one companies surveyed by *Business Insurance* posted a 29.1% increase in net income to $7.73 billion in 1994 (*BI*, March 20). The *BI* figures, though, do not

*See* **Updates** *on next page*

**Spotlight on The Managed Care Market Page 3**

**Directory of Prescription Benefit Managers Page 18**

# Home deal's critics speak out

## Regulators to hear arguments to block Zurich plan

**By GAVIN SOUTER**

CONCORD, N.H.—Policyholders, bondholders and competitors of Home Holdings Inc. will use public hearings here this week to slam the proposed takeover of Home Holdings' prime business by Zurich Insurance Group.

At a hearing that opens today and is scheduled through Wednesday, opponents of the deal will urge regulators to block the takeover under its current terms.

Home Holdings' primary operating unit, The Home Insurance Co., is domiciled in New Hampshire, and the other six states where units are domiciled are expected to send representatives to this hearing.

Opponents are expected to argue that Zurich should not be allowed to take over the good business of The Home without standing behind all its other liabilities, and that the Zurich deal will not sufficiently cover future claims.

Competing insurers are also expected to argue that if Zurich does not cover all the claims, other insurers will have to pay policyholder claims that should have been paid by The Home.

Among those scheduled to testify against the plan is Richard E. Stewart, a former president of the National Assn. of Insurance Commissioners who will be speaking on behalf of both a Home competitor, American International Group Inc., and a policyholder, Atlantic Richfield Co.

Also at the hearings, a group of Home bondholders will be urging regulators to adopt an alternative deal under which some Home units would remain ongoing insurers—with a rating high enough to provide policyholders some comfort—and others would be run off.

Home Holdings rejected that proposal last week, saying shareholders would be better off with the Zurich deal, and rating agencies give the bondholders' plan little chance of success.

Under the Zurich offer, Zurich would buy all the publicly traded shares of Home Holdings and many of those held by its parent, Trygg Hansa SPP Holding A.B.

Zurich American Insurance Group would assume about $1 billion of The Home's $2.2 billion written premiums. The Home would then cease underwriting and be placed in runoff, and Zurich would cover the run-off busi-

*See* **The Home** *on page 41*

# Claimants try to tap MTA policy

**By JOANNE WOJCIK**

LOS ANGELES—In an unusual move, some Hollywood-area property owners plan to attempt to tap the Los Angeles subway project's general liability coverage and file claims as both first-party policyholders and third-party beneficiaries to the policies.

As part of their suits, the property owners will allege that subway contractors used a preconstruction risk assessment as a cost-benefit analysis to decide not to reinforce structures that could potentially be damaged when a subway tunnel was dug under Hollywood Boulevard.

Since tunneling began in January 1993, portions of the famed Hollywood Boulevard have sunk as much as 10 inches, causing the curbs and foundations of buildings to crack (*BI*, Nov. 21, 1994).

"You rarely have a case where you can pursue somebody as a first party and as a third party at the same time," says Steven Zelig, the Los Angeles attorney representing 685 Hollywood business owners, which are seeking more than $1 billion in damages from the Los Angeles Metropolitan Transportation Authority. The plaintiffs have formed Hollywood Damage Control & Recovery Inc. solely to seek recovery from the Los Angeles MTA.

"We feel that we have a good-

*See* **Hollywood** *on page 34*

GRAPHIC BY JERRY PARKS

# Employers unsure that they benefit from HMO deals

**By CHRISTINE WOOLSEY and JOANNE WOJCIK**

LOS ANGELES—Corporate benefit executives are asking a tough question as the flurry of HMO mergers and acquisitions continues: What's in it for us?

Some fear the answer may be: very little.

The recent spate of deals—including WellPoint Health Networks Inc.'s proposed acquisition of Health Systems International Inc.—is fueled in part by the formidable profits generated by some leading managed care companies.

But benefit executives are asking why such HMOs are using their huge cash stores to fund mergers rather than cut premiums or fund the improved prevention programs and health care data and outcomes systems that their clients want.

"They're taking their eye off the ball," said Tanya Bednarski, health care plans adviser at Chevron Corp. of San Francisco. "When do they have the time and money to spend on prevention and outcomes programs when they are so busy dealing with the fallout from a merger?"

"GTE and other major corporations have really sent a lot of members to HMOs, which has resulted in a huge amount of capital for them," pointed out Dwight McNeill, health care information manager

*See* **HMOs** *on page 43*

# Cost savings by all accounts

## MSAs slashing employer's health care expenses

**By JERRY GEISEL**

INDIANAPOLIS—The numbers are striking.

Since Golden Rule Insurance Co. launched a new medical savings account program for its employees nearly two years ago:

- Employees have received more than $1.2 million in MSA refunds, including $468,549 in 1993 and $734,037 last year. The average refund was $603 per employee in 1993 and $1,002 in 1994.
- Just 6% of MSA participants had medical expenses that equaled or exceeded their MSA account balances in 1993, while last year 10% of participants had medical expenses that reached or exceeded the amounts contributed to their MSAs.
- Participation in the MSA program has increased to 91% of eligible employees, up from 80% when the program began. Golden Rule, which has about 1,300 employees, also offers a traditional indemnity plan with a $500 per person deductible and 20% coinsurance on the first $5,000 of expenses above the deductible.
- Total MSA plan costs—including contributions to the MSA and insurance premiums paid by Golden Rule and employees—have held steady since the program began.

**Golden Rule Chairman J. Patrick Rooney is not the only booster of the company's medical savings accounts.**

**Many other employees favor them, too. See story on page 32.**

In fact, at an average cost of $1,404 per em-

*See* **MSAs** *on page 32*

## Updates

### Cats blamed for P/C profit slide

*Continued from preceding page*
include results of State Farm Group, Farmers Group Inc. and other primarily personal lines companies hit hard by catastrophe losses.

The January 1994 Northridge, Calif., earthquake cost insurers an estimated $11.4 billion. State Farm alone, for example, reported quake losses of $2.53 billion (*BI*, Dec. 19, 1994). Altogether, U.S. insurers' 1994 catastrophe losses amounted to $15.7 billion, second only to 1992's toll of $23 billion.

The ISO and NAII figures are consolidated estimates for the industry based on reports from insurers that account for 96% of the nation's property/casualty business.

The survey showed the industry's combined ratio deteriorated to 108.5% last year from 106.9% in 1993. Insurers' underwriting losses ballooned 25.8% last year to $22.4 billion from $17.8 billion in 1993. Net written premiums rose 3.4% to $249.8 billion from $241.7 billion.

Net investment income was nearly unchanged at $33 billion, compared with $32.6 billion in 1993. Policyholder surplus increased 4.6% to $190.6 billion from $182.3 billion.

### House would extend surcharge

WASHINGTON—An amendment passed by the House last week would extend through the end of the year a 1993 law that effectively requires employers providing health care benefits to employees in New York to pay a 13% surcharge on hospital bills.

The 1993 law, which expires on May 12, bars employers from deducting their health care costs as a business expense unless they pay New York's 13% surcharge on inpatient hospital bills. The surcharge applies to patients who are covered under self-funded plans or health plans sold by commercial insurers. The surcharge is not added on bills incurred by employees covered under Blue Cross/Blue Shield plans.

The 1993 law was a short-term congressional response to a court decision that found the New York law imposing the 13% surcharge was pre-empted by the Employee Retirement Income Security Act. The U.S. Supreme Court is reviewing the decision (*BI*, Jan. 23).

The amendment effectively continuing the 13% surcharge is part of a broader bill, H.R. 831, that would retroactively restore the partial tax deduction the self-employed can take on their health insurance premiums. The tax deduction, which expired in 1993, would be 25% in 1994 and then would be permanently set at 30%.

The Senate is expected to act on the measure this week.

### Suits over AT&T satellite loss

ALEXANDRIA, Va.—AT&T Corp. and satellite manufacturer Martin Marietta Corp. are suing each other over the loss last year of AT&T's Telstar 402 satellite.

AT&T filed suit March 6 in federal court in Alexandria over Martin Marietta's alleged failure to correct known defects in Telstar's propulsion system and delays in delivery and launch of a replacement satellite. The suit seeks more than $250 million in damages, including lost business opportunities but not the loss of the satellite itself.

Martin Marietta, meanwhile, is charging in a breach of contract suit filed last month in federal court in Trenton, N.J., that AT&T failed to pay for Telstar 402.

The September 1994 loss of Telstar 402 cost satellite insurers about $187 million (*BI*, Oct. 24, 1994).

Underwriters said last week they were "considering their position" in regard to the suits between AT&T and Martin Marietta.

### MEWA ruling not required

NORFOLK, Va.—The U.S. Department of Labor has no obligation to determine whether a self-funded health plan is operating pursuant to a valid collective bargaining agreement that would exempt it from state oversight, a federal judge has ruled.

Trustees of Centurion Health & Welfare Benefit Plan of Virginia Beach, Va., sought to force the department to issue an advisory opinion on the validity of a collective bargaining agreement covering its members. In the absence of such an opinion, the Virginia Insurance Department barred Centurion from soliciting new participants in the state (*BI*, March 27).

U.S. District Judge Rebecca Beach Smith ruled last month, however, that the Employee Retirement Income Security Act does not require the department to issue such opinions and that the department is within its discretionary authority in refusing to do so.

### Antitrust settlement approved

SAN FRANCISCO—Final approval of the settlement in the massive insurer antitrust case will clear the way for restructuring of the Insurance Services Office Inc. and formation of a national risk database.

In a long-awaited move, U.S. District Court Judge Charles A. Legge gave final approval last week to the settlement between 20 state attorneys general and insurance industry defendants, thus ending litigation that began in 1988.

The settlement calls for the industry to pay $21 million to finance the Public Entity Risk Institute, $5.2 million to create a national risk database and $9.8 million in legal costs incurred by the states.

The agreement also calls for a restructuring that will give insurance companies less control over New York-based ISO (*BI*, Oct. 10, 1994).

*See* **Updates** *on page 42*

### Errors & Omissions

• A table in the Feb. 20 issue illustrating the 1994 results of U.S. publicly held brokers carried an incorrect label. The figures in the chart are in millions of dollars, not thousands.

# Deal to bolster Value Health

## Diagnostek is considered a good fit

**By CHRISTINE WOOLSEY**

AVON, Conn.—The latest megamerger in the prescription benefits marketplace is good medicine for both the industry and employee benefit plans.

Consultants say Value Health Inc.'s acquisition of Diagnostek Inc. is a logical and solid merger that will create a stronger and more efficient firm.

"Both companies have good products and will now be in a position to provide better discounts to customers," said Jim Norton, a practice leader in Toronto with The Wyatt Co.

And, unlike previous deals that involved pharmaceutical manufacturers, this deal is unlikely to draw resistance from the Federal Trade Commission.

The two companies signed an agreement last week whereby Value Health will acquire Diagnostek in a stock swap. Based on Thursday prices, the deal would be valued at $547 million. The transaction, which will be accounted for as a pooling-of-inter-

*See* **Mergers** *on page 37*

GRAPHIC BY MIKE GARVEY

# Pension plan rule change

## Plans must report underfunding yearly

**By JERRY GEISEL**

WASHINGTON—Employers with underfunded pension plans will have to provide a new annual disclosure statement to participants explaining the funding level of their pension plans and the limits of federal benefit guarantees if the plans are terminated.

The disclosure statement, which must be distributed by employers that have pension plans that are less than 90% funded, was mandated as part of sweeping legislation Congress passed last year that also tightens pension funding rules.

The details of the disclosure statements were unveiled last week by the Pension Benefit Guaranty Corp. and published in the March 28 Federal Register.

Prior to last year's law, employers with underfunded plans—then defined as those that were less than 70% funded—had to disclose limited financial information about their plans.

The new disclosure statement rule goes into effect for about 1,500 employers with more than 100 plan participants this year, and about 4,000 smaller employers next year.

It will require a big increase in

*See* **Pensions** *on page 42*

**Senate expected to debate reform bills this month**

# Reviewing product liability

**By MARK A. HOFMANN**

WASHINGTON—The Senate Commerce Committee is expected to vote on a product liability reform bill this week, opening the way for full Senate debate later this month.

Sen. Slade Gorton, R-Wash., said last week that Senate Majority Leader Robert Dole, R-Kan., has promised to bring S. 565—the Product Liability Fairness Act of 1995—to the floor on April 24, the day the Senate returns from its Easter recess.

Sen. Gorton, the chief Republican sponsor of S. 565, said that once the bill reaches the floor, it will have to survive several attempts to talk it to death before a final vote.

Attempts to bring product liability bills to a Senate vote in previous years have died because proponents have lacked the 60 votes necessary to end debate. The most recent attempt came last year (*BI*, July 4, 1994). But the House already has passed a much more comprehensive product liability and tort reform bill (*BI*, March 13). Although S. 565 deals solely with product liability, Sen. Gorton said, "I will welcome the proposition that the bill be expanded on the floor of the Senate."

Sen. Gorton made his remarks during a briefing sponsored by the National Assn. of Manufacturers.

Among other things, provisions

*See* **Products** *on page 40*

# APIW names Hutter Woman of the Year

**By SALLY ROBERTS**

NEW YORK—Never say never.

That's one thing Heidi E. Hutter has learned in her 16-year career in the insurance industry.

In addition to never thinking she would enter a career in insurance, Ms. Hutter said she never had any thoughts of working for Lloyd's of London.

Nevertheless, when given the opportunity for a two-year appointment to head up Equitas Ltd., the reinsurer designed to run off Lloyd's syndicates' pre-1986 liabilities, the 37-year-old New York native jumped at the chance.

This daunting task was part of what prompted the Assn. of Professional Insurance Women Inc. to honor Ms. Hutter as the 1995 Insurance Woman of the Year.

*See* **Hutter** *on page 42*

## Inside

• Zurich should offer The Home's policyholders more security, this week's editorial says. **PAGE 8**

• Government intervention will be needed to help insurers handle rising natural catastrophe costs, some industry executives say. **PAGE 35**

• A good benefit program can actually help an employer's bottom line. **PAGE 37**

• Workers comp insurers can help cut claims costs, an executive says. **PAGE 39**

### Departments

**Advertiser Index** ..... 34
**Classifieds** ..... 38
**Directory of Prescription Benefit Managers** ..... 18
**Insurance Services Guide** ..... 39
**International** ..... 35
**Letters** ..... 8
**London** ..... 35
**Opinions** ..... 8
**Perspectives** ..... 25
**Reader Reply Service** ..... 34

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# New cure for high treatment costs?

*Prescription firms tout drug therapies for chronic ailments*

By CHRISTINE WOOLSEY

There is a good chance that most employers have encountered the latest catch phrase to hit the managed health care scene: disease state management.

There is an even better chance that many employers have yet to figure out exactly what it means and whether they should buy into it.

Like all new terms, disease management means different things to different people and, depending on who is marketing a program, the program can have very different intentions.

A growing number of pharmaceutical manufacturers, prescription benefit management firms and specialty drug suppliers are now selling disease management programs, most of which are built around promoting certain drug-based therapies for specific chronic illnesses.

Disease management strategies also are being developed by health maintenance organizations and tend to focus on establishing optimal therapies to treat a broader category of illnesses and conditions.

Other health care management companies, ranging from those specializing in health care information systems to those marketing employee assistance programs, also are entering the field.

All of the vendors tout disease management as the definitive way to control chronic illness costs and improve the quality of patient care.

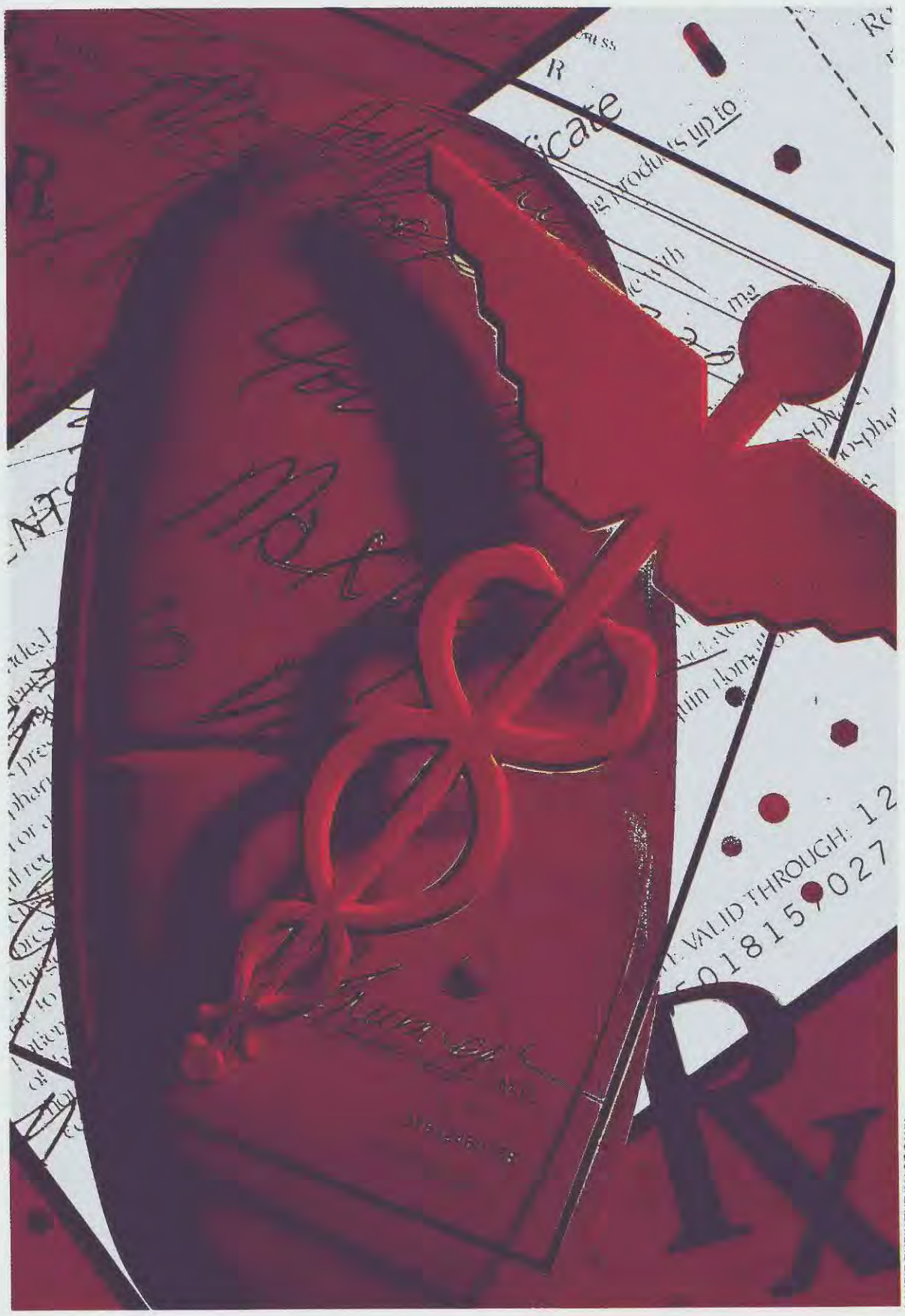
But, consultants and other observers say disease state management is still in its infancy. And, they say, because the programs are so new, hard data showing cost and quality improvement is very hard to come by.

"Disease management varies from a concept on paper to processes and procedures in place but with minimal results back yet," commented Kimberly Babbin, a consultant in the Houston office of Towers Perrin.

Generally, though, disease management programs promise to produce the best—and most cost-effective—outcomes for patients with serious chronic illnesses by carefully coordinating their care and focusing on state-of-the-art drug and lifestyle therapies.

The programs focus heavily on patient education and compliance. Disease management programs are designed to make sure patients with chronic conditions like diabetes, asthma and hypertension follow a proven treatment

*See* **Disease** *on page 14*



LAURIE RUBIN/THE IMAGE BANK

# Managed Care Market Report

**Most favored nation clauses are less favored in provider deals**
**PAGE 10**

**Should you believe the hype about mail-order drug services?**
**PAGE 16**

# PHOs try 'direct' approach to client

*Physician-owned managed care firms flourishing*

By JOANNE WOJCIK

Physician-hospital organizations are continuing to make inroads into the health care delivery market by eliminating insurance company and HMO middlemen and contracting directly with employers.

While PHOs are more prevalent in regions where managed care is firmly entrenched, they are popping up throughout the United States as medical providers respond to employers' cost-cutting demands.

But some observers view the phenomenon of physician-owned and -operated managed care companies as merely a transition vehicle in the drive toward integrated medical delivery systems.

"It's a whole new world and it's moving ahead at such a rapid rate that it's even hard for us in the business to keep up with it," said Rebecca McQueen, president of PROMINA Northwest Health Network, a PHO based in Austell, Ga.

"In Texas, if a hospital wasn't established as a PHO by the first of this year, then it's missed the boat," observed Dennis Baker, a principal in Buck Consultants' Houston office who has helped form about 20 physician-hospital organizations in the state over the last 18 months.

"All the providers want to be insurance carriers and all the carriers want to be providers, and we stand in the middle and direct traffic," quipped Christopher Kane, a principal in the Atlanta office of benefit consultant A. Foster Higgins & Co. Inc.

Even the American Medical Assn. is hopping on the PHO bandwagon, having recently launched Physicians Capital Source, a program designed to help physicians build and lead health care delivery networks.

PHOs are being formed by the physicians and the hospitals with which they are affiliated in response to increasing pressure from employers, insurers and health maintenance organizations to discount their fees or accept capitated payments—both of which shift more of the risk of bearing the cost of medical care to the provider.

Started just 1½ years ago, the American Assn. of Physician-Hospital Organizations in Richmond, Va., already has nearly 800 members representing some 230 PHOs, said Daniel Friend, its executive director.

Depending on their state of de-

*See* **PHO** *on next page*

# PHO

*Continued from previous page*
velopment, PHOs operate at three levels:

- As a marketing vehicle for physicians and hospitals seeking contracts with health insurers and HMOs.
- As a provider of medical services to self-insured employers, insurers and HMOs on a discounted fee-for-service basis.
- As a fully capitated organization that can provide medical services, claims administration and other ancillary managed care services directly to employers.

So far, PHO development has been concentrated in regions where managed care has been long established and in those states where regulators permit providers to accept risk.

"Each state has different requirements for reserving if PHOs take full risk," Mr. Friend said.

Since only a few states have established solvency requirements for PHOs, the National Assn. of Insurance Commissioners is beginning to develop a model law for regulating these entities, which some regulators have characterized as "stealth HMOs" (*BI*, Aug. 22, 1994).

But it may be only natural for medical providers—having been forced by health insurers and HMOs to adhere to strict cost-containment criteria—to eventually begin providing the services directly to employers.

"The hospitals have been getting beat up, and the doctors are getting beat up separately. This is their way of circling the wagon train," explained Roy S. Lyons, a vp in Johnson & Higgins' Los Angeles office. "They hope that by banding together they can negotiate from a position of strength."

However, many health insurers and HMOs view the emergence of PHOs as unwelcome competition.

"Many PHOs annoy insurers," observed Foster Higgins' Mr. Kane, who cited as an example one Southeastern PHO under contract with an insurer that offered to provide services directly to one of the insurer's employer clients.

"It was a classic no-lose situation. If they didn't win the contract, they'd still be the provider," he said.

Indeed, "the long-term objective of all PHOs will be direct contracting with employers," Mr. Lyons predicts. "If everybody went this way, you'd eliminate the middleman."

And this new player can be a boon for employers—the ultimate health care payers—many health care industry experts believe.

"It's easier to do direct contracting with PHOs," insists Buck's Mr. Baker. "They've already discussed pricing, steerage and exclusivity parameters, so you can get right to brass tacks quickly."

PHO contracts also eliminate the need for purchasing ancillary services, such as precertification, case management and utilization review. "All the bells and whistles used to control the medical community can be eliminated as soon as you shift the risk back to the provider," Mr. Baker explained.

Indeed, because integration helps streamline the medical care delivery process, "we have been able to provide all the administrative services employers are used to for 8% of the capitated premium, much less than the administrative services offered by insurance companies," PROMINA's Ms. McQueen pointed out.

In addition to providing access to network physicians, PROMINA can assist its self-insured employer clients with claims administration, prescription drug and other ancillary services, as well as out-of-area and out-of-network care, she said.

Such extras can add as much as 25% to the cost of an employee benefit plan, according to some industry estimates.

Some PHOs, such as PROMINA, even are willing to enter into risk-sharing arrangements—another insurer cost-containment innovation.

"We've set a risk corridor of 10% on either side of the rate paid per member per month, with PROMINA and the employer sharing 50/50 any amount over or under the capitated premium," Ms. McQueen explained.

The employer self-insures above that amount, purchasing the necessary stop-loss coverage on its own, she added.

This is similar to the risk-sharing contract that CIGNA Corp. forged with Allied Signal Inc. when it introduced its first point-of-service plan in 1988 (*BI*, Feb. 22, 1988).

Daniel Provencher, chief executive officer of Tour Med Inc. in Deerfield, Fla., likes to contract with PHOs to provide health care services to retired Canadian "snowbirds" who live part-time in the southern United States because "they are easier to work with than insurers and HMOs."

"Other systems work on percentage discounts and the wave of the future is capitation," he said.

Tour Med's PHO contracts generally contain a catastrophic cap so that medical costs that exceed a fixed amount revert to a different method of payment, such as stop-loss coverage underwritten by a capitation reinsurer, Mr. Provencher explained.

"So the provider is never at risk," he said.

PHO contracting also can help employers with geographically dispersed workforces—such as those with employees in rural areas—to gain managed care access.

When insurers told Blue Bell Creameries USA Inc., an ice cream manufacturer based in Houston, that a substantial number of its employees would not have access to network providers because they were scattered over a large geographical area, the employer decided to contract directly with providers, including several Texas PHOs.

"The No. 1 complaint employers have about insurance companies is that they don't offer customized services," said Mr. Baker of Buck, who helped the ice cream maker establish the Blue Bell Medical Network. "(Insurers) think one national network will respond to the needs of all employers."

While after Bill Clinton was elected president, PHO growth skyrocketed—in response to the threat of health care reform, some say—formations have slowed somewhat since the midterm elections.

"Now that the GOP has control in Congress, the urgency has subsided," said Don Gasparro, managing director of Apex Management Group Inc., a health and actuarial consulting firm in Princeton, N.J.

But over the long term, PHO development will likely continue, he predicted.

"It may have peaked in its level

*See* **PHO** *on page 6*

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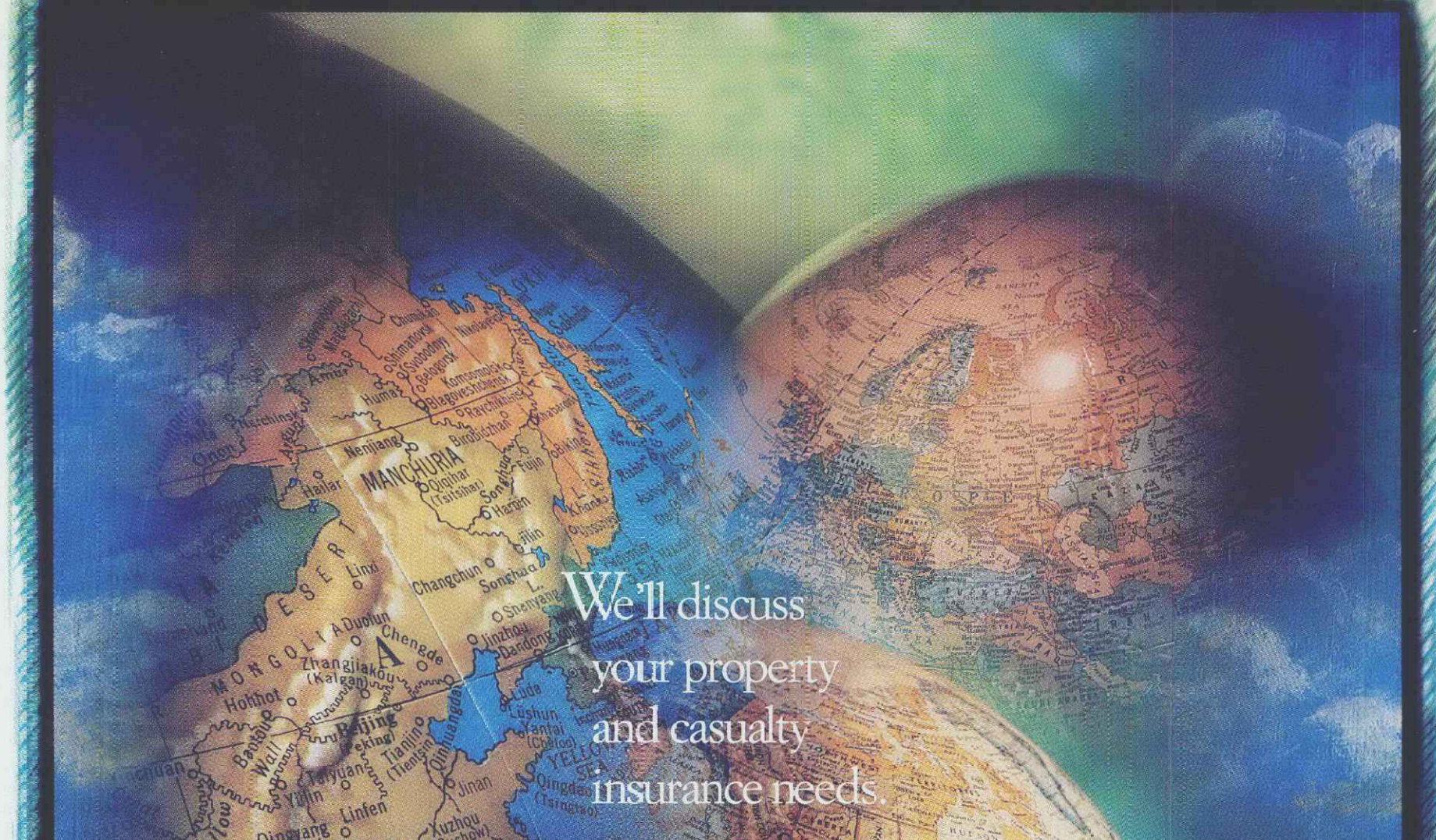


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# PHO

*Continued from page 4*

of interest," agreed Foster Higgins' Mr. Kane. "It's been a trendy strategy and it's served its purpose."

But, "PHOs may be transitional," he suggested.

Indeed, even PROMINA's CEO acknowledges that the PHO is only one step in the constantly evolving managed care continuum.

PROMINA was formed by six hospitals and 650 physicians in 1993 "to enable this system to become a vertically integrated delivery system," Ms. McQueen explained.

When the plan is fully integrated, its physician owners will be employed by the organization, much like physicians in a staff-model HMO, she explained.

But before achieving integrated delivery system status, the most likely next step in the development of PHOs will be setting capitated rates for their services.

While PROMINA is "experimenting" with capitation in "a couple" of its employer contracts, Ms. McQueen said, most PHO contracts with employers have involved discounted fee-for-service arrangements, per diem hospital charges, diagnostic related groups and global case rates.

For example, Primrose Health Care Services in Springfield, Mo., contracts with employers on a discounted fee-for-service basis, providing its network to self-insured employers, said Mary Ann Beranek, acting president of the PHO.

But consulting firms like Apex are already conducting quantitative analyses of medical services to help PHOs formulate capitated rates.

"You don't want to take on too much risk until you know what that risk is," Mr. Gasparro said. Unfortunately, medical providers—like most professionals—aren't used to pricing their services as products. "Doctors don't know how much it costs to provide medical services."

And stop-loss insurers that had been marketing products to self-insured employers have begun to target the PHOs (see related story).

PHOs also are not yet equipped to provide the outcome data that many employers are now demanding, J&H's Mr. Lyons said. "They're not yet sophisticated enough."

According to a recent survey by New York-based Ernst & Young L.L.P., few PHOs at this stage are consolidating services, integrating information systems, using global billing systems or managing utilization (*BI*, Feb. 13).

But it probably won't take long for PHOs to catch up.

Having been painted into a corner by health insurers, HMOs and employers, the physicians and hospitals may have little choice but to compete.

"Providers see a clear path between the provider of services and the ultimate payer," says Mr. Baker. "The bottom line is, they want to do business directly with their customer."

And, if obtaining large employers' business means providing measurements of quality, "let Hospital A compete with Hospital B and you'll see how fast they quantify quality," predicts Mr. Baker. BI

# Capitation exposure for PHOs

Many stop-loss insurers and capitation reinsurers view the PHO phenomenon as a market ripe for the picking.

"It's ballooned into a very competitive market," says Scott Walker, assistant vp for Southeastern Risk Specialists in Atlanta, which underwrites provider stop-loss insurance on behalf of Lexington Insurance Co., a unit of American International Group Inc.

"In the last six months, I've heard of 30 companies (selling) specific stop-loss. That's more than double from a year ago," he said

One example of such sales is provided by SCPIE Insurance Services Inc., a unit of the Southern California Physicians Insurance Exchange.

Last year SCPIE added a managed care stop-loss insurance program through a new business agreement with Jardine Managed Care, a unit of JIB Group Inc. in San Francisco.

"The risk exposure posed to many of our insureds in their various contractual obligations to health plans has grown immensely," said Donald J. Zuk, SCPIE president and chief executive officer.

"This unique program affords those in integrated delivery systems greater security and increased flexibility in operating under these provider contracts," he said.

Some underwriters that specialize in providing stop-loss coverage to self-insured employers are getting into the provider excess business, realizing that they face many of the same kinds of exposures.

Providers who enter into capitation contracts face three primary risks:

- Indemnifying out-of-area providers for care delivered to enrollees on vacation, etc.
- Paying for referrals to out-of-network providers and specialists.
- Paying for overutilization and/or catastrophic cases.

"Just about anybody who was writing employer stop-loss has tried to develop a product for this," said Don Gasparro, managing director of Apex Management Group Inc., a health and actuarial consulting firm in Princeton, N.J.

He predicts that as more PHOs enter into capitation contracts, "you'll see stop-loss shift from the employer to the providers," who will become the ultimate risk-takers.

However, many PHOs "don't understand how capitation is taking on risk" and aren't seeking out the necessary stop-loss coverage, observed Craig Kelbel, senior vp of Costa Mesa, Calif.-based U.S. Benefits, which is an MGA for Continental Insurance Co. of New York.

In order for PHOs to continue as viable organizations over the long term "capitation has to be done the right way, so the providers can make enough to pay their overhead and still make a profit," Mr. Kelbel said.

*—By Joanne Wojcik*

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# Opinions

## More security for The Home

THE FATE OF Home Holdings Inc. still hangs in the balance—almost four months after Zurich Insurance Group's initial offer for the company was made and accepted.

State insurance regulators are starting public hearings this week on Zurich's offer for The Home, which has already been revised to address the concerns of regulators, policyholders and bondholders (*BI*, Feb. 13).

Home bondholders have also advanced a counterproposal that would require The Home's business to be separated into two pools according to its risk characteristics. This would enable the company potentially to obtain a higher rating and remain a going concern.

Given the unique characteristics of Zurich's bid, though, the outcome of these developments already may be moot.

Zurich has been allowed to review The Home's existing book of business and will renew or provide cut-throughs to the most attractive risks, leaving the remainder of the risks—much of which is long-tail liability business—to be run off. If the deal were scuttled today, Zurich hardly would walk away a loser, having already captured some of The Home's best business.

Regardless of that fact, we think that allowing this deal to proceed without seeking additional protection for policyholders could cause problems down the road.

That is because the deal, in which the "bad" risks are separated from the "good" risks, essentially allows The Home and its new owner to cherry-pick the best of the insurer's book of business. The rest would be run off.

As with many other insurers, there are no assurances that The Home's reserves will prove adequate down the road. And while Zurich amended its plan to provide a $1 billion reinsurance program to cover reserve shortfalls, there is no certainty it will be enough, either.

With no reserve guarantee or requirement that a new owner stand behind all of an insurer's long-tail business, policyholders could be left holding the bag.

Despite our reservations, we think Zurich's offer should not be flat out rejected; it probably would be difficult to keep The Home a going concern at this late stage.

Instead, we would like to see the offer modified again so that Zurich—or perhaps Trygg-Hansa SPP Holding A.B., which is The Home's current parent—provides greater security for the policyholders of the business that will be run off.

"YOU AREN'T REALLY GOING TO JUST LEAVE HIM OUT THERE?"

From the perspective of Zurich's shareholders, this was a smart offer and is one that some of its more vocal critics probably wish they had thought of first.

As Oppenheimer & Co. analyst Myron Picoult put it recently (*BI*, Feb. 27), Zurich "may actually disprove the adage that there's no such thing as a free lunch."

But given what Zurich and Trygg-Hansa would receive in the bargain, we think greater backing of The Home's reserves would only be fair.

Besides, while under its current offer Zurich is not willing to provide a larger guarantee, we cannot imagine that one of the world's largest insurers would walk away from its perceived—if not contractual—obligations years down the road. It's an insurance company with an interest in protecting its name and good will, not a corporate raider looking to bleed the company dry.

If that's so, we think Zurich and Trygg-Hansa should simply pledge now to do more to meet those obligations. That will most likely appease regulators and policyholders and allow the companies to move forward—without neglecting the obligations of the past.

# Letters

## Barings captive clients stand by asset manager

To the editor: In regard to your March 6 article, "Captive Owners Feel Repercussions from Barings Mess," I can further report the acquisition of Barings P.L.C. by Internationale Nederlanden Groep N.V. has resulted in a positive outcome for Barings' offshore insurance company clients.

The acquisition of Baring Asset Management Holdings Ltd. and its subsidiaries by ING, whose capitalization is $13.8 billion, has resulted in all client deposits being secured and honored. Furthermore, back interest is being paid on deposits so no clients lost money during the short period of administration.

Contrary to the predictions of some of our competitors in the offshore insurance market, the Barings offshore insurance team has received a tremendous amount of support from our longstanding clients and their service providers in the banking and insurance management community. We cannot thank our supporters enough for their patience and understanding. While our clients were justifiably concerned during the period of administration, there was no "flight of assets." Clients have renewed their commitment to Barings and commenced our team on the level of dedication we maintained over the last several weeks, which they found reassuring.

My colleagues and I believe that the new structure under which we operate will be positive for the interests of our clients. With ING, we have a considerable financial base with a great deal of potential. ING fully supports our efforts and does not wish to make any fundamental changes to the environment in which Baring Asset Management units operate.

It gives our clients comfort to know that the philosophy, people and process that helped Baring Asset Management to build its successes in the past will now lead the organization and its clients into the future.

**Mary Joaquin**
Vp
Baring Asset Management
Washington

*Business Insurance welcomes letters to the editor from its readers. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Please send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590.*

## Praise for challenging German status quo

To the editor: As a result of your Feb. 27 article on German insurance companies, "German Insurers Respond to Buyers: More Individual Rating of Property Risks," I would like to compliment the resourcefulness of the Sun Alliance Group P.L.C. and Karl-Heinz Jaeger of BASF A.G. for challenging the cartel-like stranglehold the German rate-setting group has on its domestic policyholders.

Policyholders like BASF have a management that has consistently demonstrated its willingness to reduce the probability of loss through a strong engineering program.

If the German insurance companies do not recognize this, it is obvious that other global insurers like Sun Alliance will.

**Lawrence C. Vitale**
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# 'Most favored nation' clauses falling out of favor

By MICHAEL BRADFORD

A controversial contract clause that guarantees a health insurer or managed care plan receives a provider's lowest fees is coming under heavy fire.

The so-called "most favored nation" clause has been challenged as anti-competitive by the U.S. Justice Department and singled out by some as a contributor to high health care costs.

Taking its name from the world of international trade, the clause is designed to ensure that a provider charges the insurer the lowest fee that it charges any other health care payer. Such arrangements could stifle competition because providers will be less likely to offer selective discounts, discounts that outside insurers often need to break into a new market.

"(Most favored nation clauses) are being scrutinized by antitrust regulators," said Alice Gosfield, a health care attorney who heads the firm of Alice G. Gosfield & Associates P.C. in Philadelphia. Regulators view the clauses as "creating an incentive not to lower prices," she noted.

Costs may be kept "artificially high" if a provider won't give a low price to a new entrant in the marketplace because the provider would have to extend the discount to an insurer with most favored nation status, said Erling Hansen, an attorney specializing in managed care with the Washington firm of King, Pagano & Harrison. "So you're not getting the price competition you might otherwise get."

The legal battles and attacks by the Justice Department have led some insurers to drop the clauses from their contracts. But opinion is divided on whether the controversial arrangements will remain a part of the benefits landscape.

"My sense is that they are beginning to decrease in number," said Michael Taylor, a health care consultant with Towers Perrin in Boston.

The clauses first appeared in Blue Cross & Blue Shield contracts in the early 1980s or even earlier, he said. "They had the market leverage to say, 'Nobody gets a better deal than I do.' But as the leverage of the Blues decreased over the years, providers would not agree to these contracts."

In a market where one large player dominates so that "everyone else pays more, it could increase the costs to others," said Mr. Taylor. But he believes that overall, the impact is slight. "My sense is that because people are steering away from (the contracts), I would be surprised if it has a measurable impact."

Most favored nation clauses probably are here to stay in many cases, said Robert E. Bloch, a partner specializing in antitrust law at Mayer, Brown & Platt in Washington. "The people who use them will have to be more careful in assessing the competitive implications. They have to be evaluated in the context they are using them."

Some experts, though, say that the clauses may prevent competing networks from developing.

"My personal view is that they are anti-competitive," said Mr. Hansen of King, Pagano & Harrison. "But they are all so varied, you have to look at the market share of all the participants to really analyze these things."

The managed care attorney explained how the clauses could work to stifle new competition. "A well-established company can tell (providers) that 'You can't give anyone a better price than you give us.' For a local company to start up against a well-established company, it has to give a better price to compete. The most-favored nation clause stifles that competition."

When a provider signs away most favored nation status to a large insurer, the resulting disincentive to offer discounts can hurt both the provider and competing insurers, said Gary Brantz, a principal with Coopers & Lybrand in Dallas.

Even though a health care provider might be willing to negotiate a discounted fee with a smaller insurer, the provider "won't want to expand it to the large insurer that is 50% of its revenue," Mr. Brantz explained.

Several health insurers have abandoned the clauses in settling antitrust lawsuits brought by the Justice Department.

Delta Dental Plan of Arizona last year settled a lawsuit filed by the Justice Department and the Arizona attorney general by agreeing not to enforce its most favored nation clause (*BI*, Sept. 5, 1994). The contract called for dentists to offer all patients covered by the plan the same discounts they offered to any patients.

Delta Dental, which neither admitted nor denied wrongdoing, said at the time of the settlement that the clauses were a key way the company controlled dental care costs.

Since then, though, prices have not risen, a spokeswoman con-

*See* **Clauses** *on page 14*

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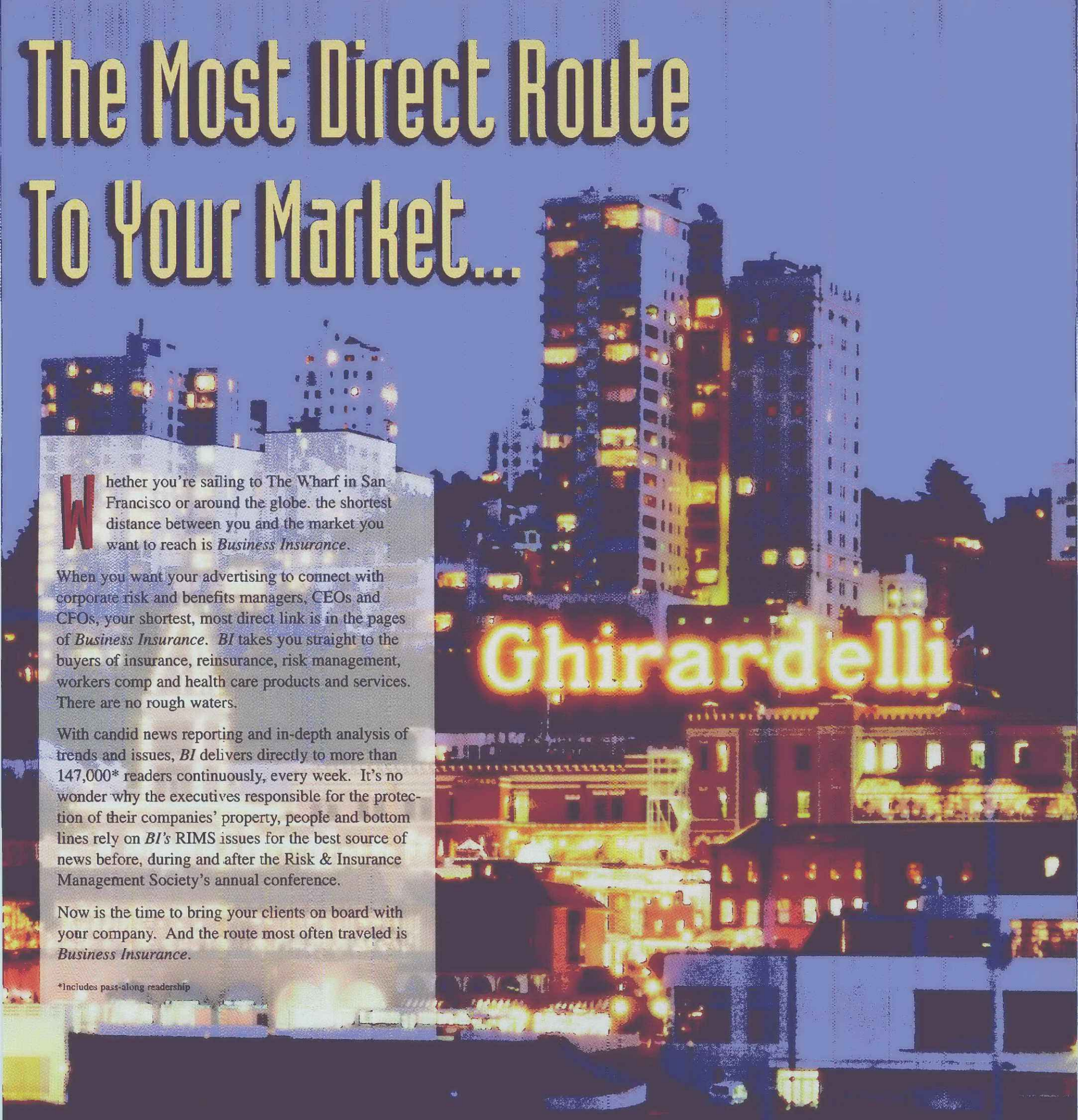


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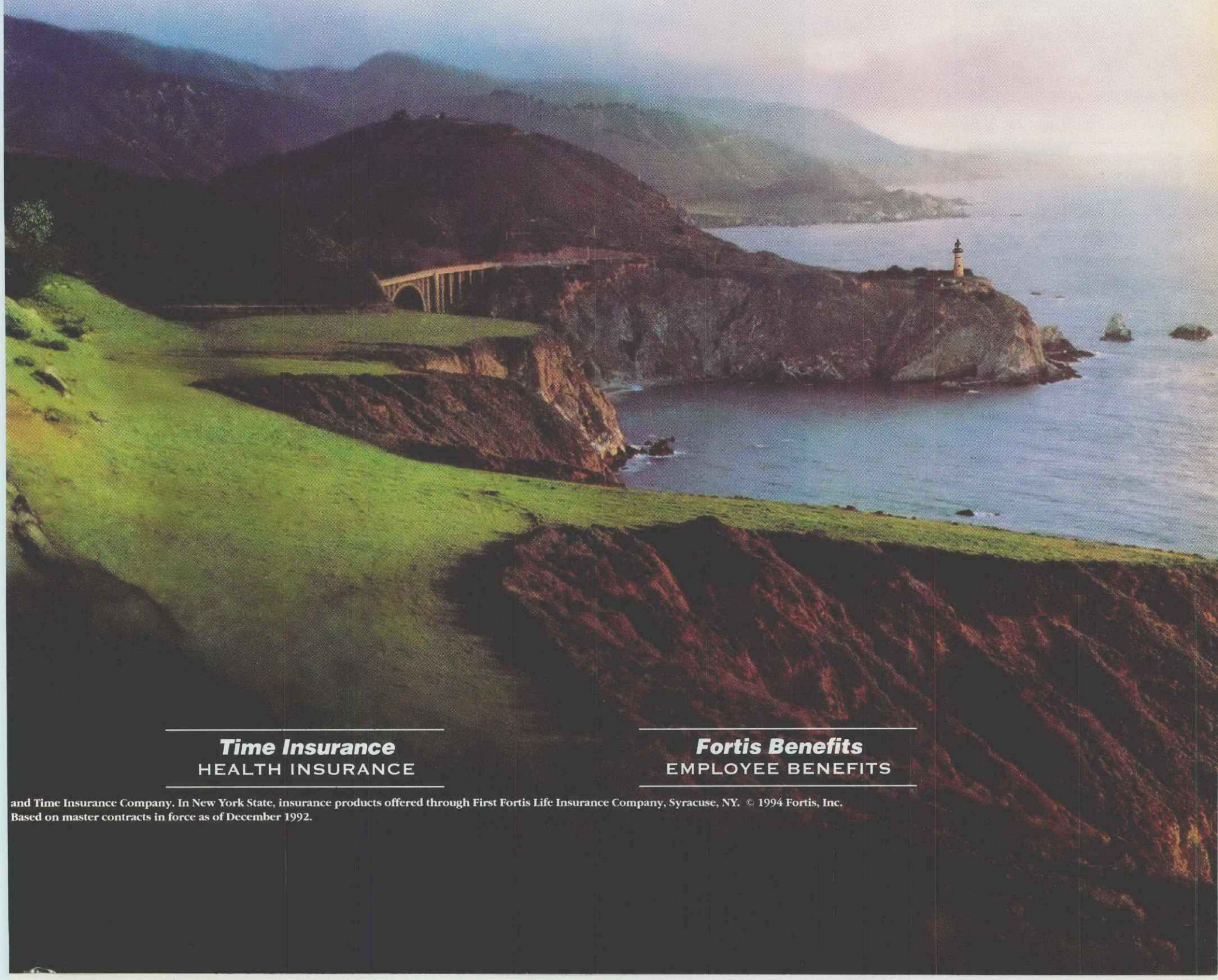

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# Disease

*Continued from previous page*
addicts in the country."

Because Black & Decker's former prescription drug card vendor did not adequately address these problems, in 1994 the company introduced the Diabetes Supply Program, marketed by Universal Self Care Inc., a pharmacy benefits management firm in Roanoke, Va.

Universal Self Care administers Black & Decker's diabetes program as a carve-out from its other pharmacy benefit programs. The program:

- Customizes diabetic supplies based on the needs of each participant.
- Operates as a mail-order program.
- Monitors usage to ensure compliance with the prescribed insulin regimen.
- Offers discounted prices to Black & Decker.
- Has the ability to interface with Black & Decker's medical claims administrator for claims processing.

It's too early to measure results of the program, but Black & Decker is in the process of implementing a new claims analysis system that will help establish a baseline from which results can be measured, Mr. Brusca said.

Consultants say disease management programs have the potential to cut employers' health care costs and improve the quality of care for patients suffering from chronic illnesses. And, they say, the fees associated with these programs are not prohibitive.

HMOs tend to build the cost of disease management services into their per member/per month charges. Pharmaceutical companies and PBMs offer varying fee arrangements depending on the level of services they provide.

Some vendors may be willing to enter into some type of risk-sharing agreement with employers, based on a targeted level of savings that can be achieved, consultants add.

But, experts say employers that are considering purchasing disease management services should take a careful look at the various vendors' true motivations for offering these services.

Altruism does not guide vendors to market disease management programs, Ms. Babbin pointed out. "They are in this to sell their product, whether it's through a PBM, an HMO or whatever."

"Employers view these programs cynically. Not many employers will go with a pharmaceutical manufacturer to do disease management because most recognize they are in it only to sell their products," said Wyatt's Mr. Norton. "PBMs that get into disease management just to push certain products will fall flat on their face," he added.

Employers should not make a decision to buy these services without scrutinizing their own claims data, Mr. Norton said. "Don't make a decision based on a PBM's or drug company's book of business data. And, use a vendor capable of dealing with all diagnostic situations, not just the drugs they sell."

Mr. Brusca said employers that cannot find a disease management program that fits their needs should not give up. "Be creative. Find someone that is even doing a small portion of what you need and try to partner with them." BI

# Shop mail-order drug services for best deal, experts advise

## *Right fit can bring cost savings*

By ROBERTO CENICEROS

It's not a Victoria's Secret catalog with lingerie-clad models arranged on glossy pages.

But benefit managers say improved mail-order pharmaceutical services are increasingly capturing their attention as a cost-saving benefit plan addition that is also a source of convenience for employees.

And just as Victoria's Secret transformed "unmentionables" into respected fashion, many companies offering mail-order prescription drugs have evolved considerably, implementing automated systems that enhance their case management and utilization management services. In addition, the industry's move to high-tech packaging and delivery systems is eliminating some of the problems that drew criticism from competitors on the retail pharmacy side.

Employers like the improvements, which have been driven in part by tough competition for their dollars. Yet employers also advise caution when contracting for mail-order services from the growing array of prescription benefit managers.

It's a benefit area where sales promises are as thick as the pricing complexities, experienced benefit managers say.

"Not all vendors are created equal," said Diana Murray, senior manager of group insurance for Sara Lee Co. in Chicago. "Unless you understand the process and how they compare, you are bound to be misled."

Ms. Murray compares finding the right mail-order program to shopping for a new car. Just as understanding the nuances of automobile sticker pricing is vital for consumers, employers need to understand the array of discounts, rebates, data collection and customer services that prescription benefit managers offer.

In early 1994, Sara Lee implemented a managed prescription benefit program—including the integration of mail and retail pharmacy services—for 60,000 employees working in several divisions scattered nationwide.

"You need to make sure you get the best deal because these are drugs your employees will be on for a long time," Ms. Murray said, reflecting the conventional wisdom that mail-order prescription drug plans work best for retirees and others who will be using the same "maintenance" medications over long periods.

Mail-order companies typically offer 90-day prescription refills. For shorter-term drug treatments, retail networks are typically the preferred distribution method. Competent integration of retail and mail-order drug dispensing can be crucial to a good benefit plan.

Ms. Murray tells of employees who bought antibiotics from a retail pharmacy outlet to treat short-term problems. The same employees simultaneously obtained birth control medication from a mail-order drug distributor without anyone advising them that antibiotics can neutralize birth control pills.

Those incidents occurred when Sara Lee had a stand-alone mail order program with little managed care. Under Sara Lee's current program, network retail pharmacies and the company's mail-order supplier feed information into a common database the moment an employee buys a new prescription or refills an old one.

Such industry changes have come rapidly with a decline in the number of stand-alone mail-order prescription companies. Through mergers, acquisitions and alliances, many former stand-alone mail-order vendors have changed from merely selling pharmaceutical drugs to offering several of the managed care services provided by full-service PBMs.

At the same time, several phar-

*Continued on next page*

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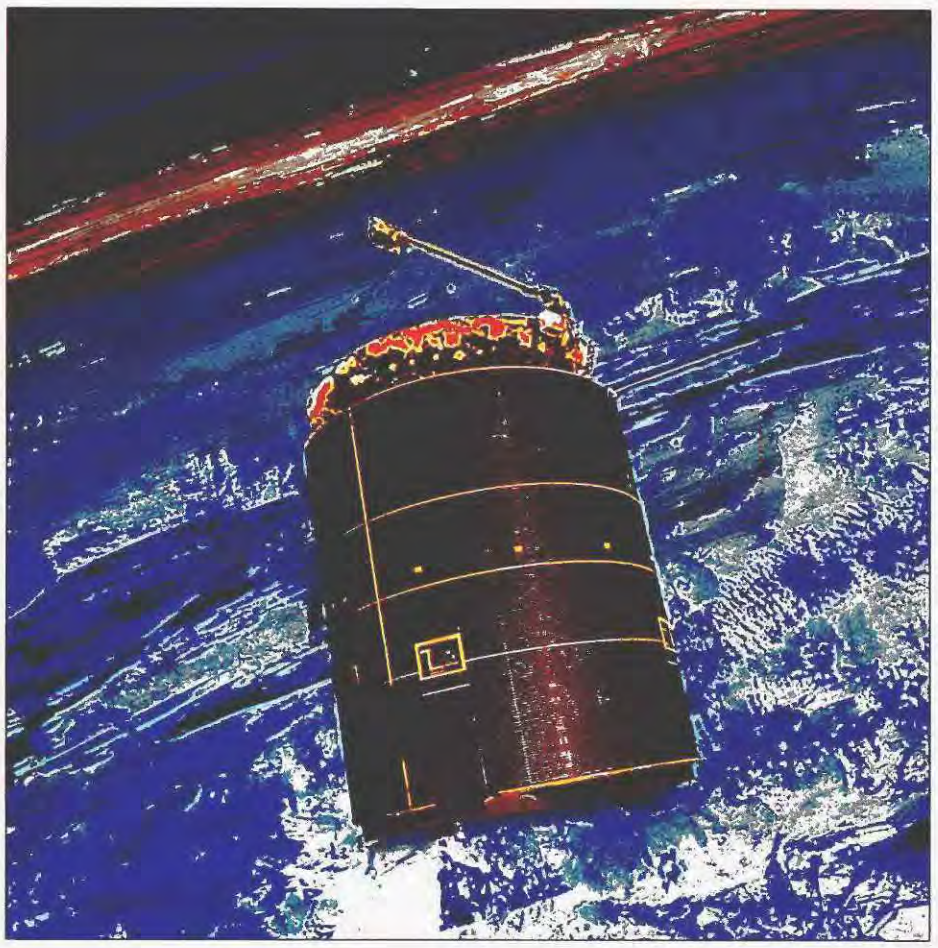

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*Continued from previous page*

maceutical manufacturers have entered the PBM business—such as Eli Lilly & Co.'s 1994 purchase of PCS, among other such combinations—while retail drug companies have begun jumping into the mail-order business.

The PBMs offer employers a range of information services and prescription drug monitoring and screening, tracking the drugs employees use and suggesting alternative formularies when appropriate—even profiling providers according to the prescriptions they write.

Because of industry changes and rapid changes in drug prices, employers might want to review their prescription drug benefits if their plan is more than 3 years old, advised Kimberly Babbin, a pharmacy consultant with Towers Perrin in Houston.

Fierce industry competition also has prompted companies offering mail-order prescriptions to install state-of-the-art technology, on both the data collection and distribution sides, in order to be competitive.

The automation has helped reduce many of the complaints about mail-order plans leveled by independent pharmacists, such as the potential for an employee to mix antibiotics and birth-control pills.

When shopping for PBM for mail-order and other services, experienced benefit managers recommend scrutinizing the vendor's data collection and customer service capabilities.

For example, is there a potential problem with lag time in adding a newly eligible employee to the system?

Many PBMs offer 24-hour, toll-free hot lines for employees who need prescription advice. Observers say some companies do a better job than others when tracking the customer telephone calls and the helpfulness of the advice.

Benefit managers recommend calling a potential PBM's hot line at various hours to judge the quality.

Employers should also determine if a PBM has staff members with specialty expertise for populations who have specific needs, such as seniors.

Benefit managers and industry consultants all stress checking vendors' references. Because of the rapid industry growth, many PBM employees have not received the training necessary to match the claims that PBM companies make about their services, said Ms. Babbin of Towers Perrin.

"Ask a lot of questions," Ms. Babbin advises. "It's pretty basic due diligence. Just take the time to do it."

Facility visits are important to scrutinize PBM employee attitudes and to look for signs of potential service problems. For example, is there clutter that might mean order forms or memorandum might be lost?

Facility visits might seem like common enough advice, but it's also advice that can get overlooked.

"It amazes me how many of my peers have made decisions without going to visit," said Neil Austin, director of health and welfare plans administration for Pacific Telesis Group. In 1994, the San Francisco telecommunications company upgraded its 7-year-old stand-alone mail-order pharmaceutical service to a managed prescription drug plan that includes a mail-order and retail program.

Many mail-order facilities offer prospective customers satisfaction surveys, said John Jones, director of contracting and compliance for Prescription Solutions, a PBM in Cypress, Calif. But for additional assurances, employers can insist that a contract they sign allows them to participate in future surveys.

Performance penalties can also be demanded, Mr. Jones said.

"It's all part of the negotiation process and if you are a big client and they want you badly, that would be something to discuss," he said.

But long before signing a contract or even soliciting specific services, employers should ask themselves what they want to accomplish with a pharmaceutical benefit plan, says Beth Bird, Hewitt Associates L.L.C.'s national practice leader for prescription benefit programs in Bedminster, N.J.

Some employers may want bottom-line savings. Others may want a carve-out plan that helps them transition into other managed health care programs.

Ms. Bird also notes that many employers have more active employees rather than populations who would need steady supplies of maintenance drugs. Meanwhile, many retail drug companies are fighting to compete with mail-order vendors by slashing retail prices.

**Facility visits are important to scrutinize PBM employee attitudes and to look for signs of potential service problems. Is there clutter that might mean order forms might be lost?**

"The retailers have put up a real competitive fight to keep their business," Ms. Bird said. "The majority of drugs are still placed in retail, so if you want to get your arms around the claims you have to understand retail."

But mail-order does offer employers cost-savings potential. Suppliers can cut costs because of their lower administration costs and their emphasis on refills.

Turning that potential into real savings for employers depends on the discounts, the use of generics vs. brand name drugs and the structure of the benefit plan, Ms. Bird said.

"Absent other controls, mail order does not provide any savings for you," said Beverly King, director of human resources for the Los Angeles Department of Water & Power.

Ms. King said she is in the process of searching for a PBM to help reduce the prescription drug component of the $70 million her organization spent on health care in 1994. Like other benefit managers, she believes pharmaceutical costs are well worth understanding.

"I think today, more than ever before, you need to be a graduate of Pharmacy 101," according to Ms. King. BI

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**Spotlight report**

# Directory of prescription benefit management companies

## A

### APB America

4015 W. Lake Creek Drive, P.O. Box 27000, Jackson Hole, Wyo. 83001; 307-733-9470; fax: 307-733-4211

| Retail Network | |
|---|---|
| Pharmacies under direct contract | 18,000 |
| **Staff** | |
| Total | 12 |
| Professionals | 1 |

**PBM services since:** 1994.

**Parent:** Spur Road Investments Inc.; primary business: managed health care investments.

**Services:** Retail pharmacy network, claims processing*, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review*, patient/physician education.

* *Subcontracted.*

**Formularies offered:** Open, restricted/customized.

**Pharmacies contracted:** Independently owned.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs.

**Officers:** Chris Osmers, president/CEO; Karen Curro, executive vp-sales/marketing; George Newcomb, director-national operations; David Turquie, director-national accounts; George Cowen, secretary.

### Aetna Pharmacy Management

151 Farmington Ave., Hartford, Conn. 06457; 203-636-7050; fax: 203-636-4875

| Lives Covered | |
|---|---|
| **Group Health:** | |
| Total | 4,663,417 |
| **Retail Network** | |
| Pharmacies under direct contract | 3,800 |
| **Mail-order services** | |
| Percent of prescription volume | 75% |
| **Generics** | |
| Percent of prescription volume | 28% |
| **Staff** | |
| Total | 566 |
| Professionals | 30 |

**PBM services since:** 1985.

**Parent:** Aetna Health Plans; primary business: HMO/PPO, insurer.

**Services:** Retail pharmacy network, mail-order distribution, claims processing*, concurrent utilization review*, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, prospective review, disease management, cognitive services, integrated medical management.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, cost/cost savings, customized reporting.

**Service area:** Nationwide and Puerto Rico.

**Billing methods:** Fee per claim, negotiated rates for drugs. Volume discounts to employers with 2,000 employees.

**Contact:** Nancy Baba, director-sales/marketing.

### Allscrips Pharmaceuticals Inc.

1033 Butterfield Road, Vernon Hills, Ill. 60061-1360; 800-654-0889; fax: 800-743-4231

| 1994 Revenues | |
|---|---|
| Total gross revenue | $58,900,000 |
| PBM gross revenue | $26,200,000 |
| **PBM Clients** | |
| Total | 200 |
| Employer/group plans with direct service | 10 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 400,000 |
| Active enrollees | 53,000 |
| through employers | 80% |
| through third-party vendors | 10% |
| through Medicare/Medicaid | 10% |
| **Retail Network** | |
| Pharmacies under direct contract | 35,000 |
| **Mail-order services** | |
| Percent of prescription volume | 15% |
| **Generics** | |
| Percent of prescription volume | 50% |
| **Staff** | |
| Total | 150 |
| Professionals | 10 |

**PBM services since:** 1986.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, integration of prescriptions dispensed from physician offices.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, customer specific.

**Service area:** Continental United States and Hawaii.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs.

**Officers:** Michael Cahr, president/CEO/chairman; James Zilka, CFO.

## C

### Caremark Prescription Service Division

111 Barclay Blvd., Lincolnshire, Ill. 60069; 708-634-7600; fax; 708-634-7914

| PBM Clients | |
|---|---|
| Total | 1,250 |
| Employer/group plans with direct service | 774 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 14,000,000 |
| Active enrollees | 9,800,000 |
| through employers | 60% |
| through third-party vendors | 37% |
| through Medicare/Medicaid | 3% |
| **Retail Network** | |
| Pharmacies under direct contract | 53,750 |
| **Staff** | |
| Total | 1,576 |
| Professionals | 295 |

**PBM services since:** 1985.

**Parent:** Caremark International.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, disease state management.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns; generic vs. name brands dispensed analysis; employee utilization; program savings; integrated, concurrent and retrospective intervention outcomes.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs, risk sharing arrangement. Volume discounts to employers.

**Officers:** C.A. Lance Piccolo, chairman/CEO; James G. Connelly III, president/COO; Thomas W. Hodson, senior vp/CFO; Donna C.E. Williamson, senior vp-integrated services; Kent J. DeLucenay, Kris Gibney, vps-managed care; Michele J. Hooper, vp-international business; Diane L. Munson, vp-physician services; Dennis R. Owczarski, treasurer; John M. Pellettiere Jr., vp/controller;

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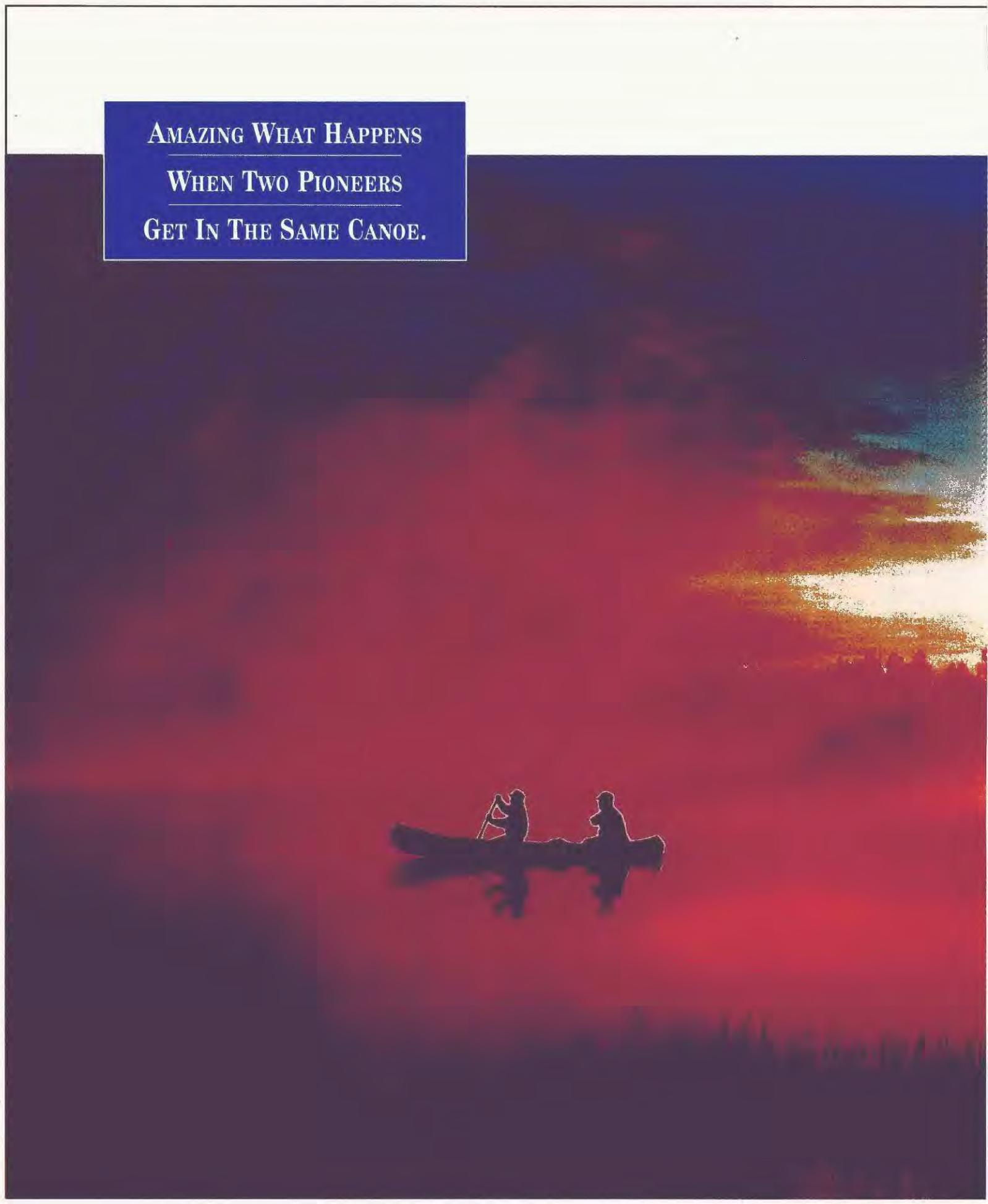

*Continued from previous page*
Thomas R. Schuman, vp/secretary/general counsel.
**Contact:** Todd Martin, vp-sales.

## Certifax Pharmacy Services

P.O. Box 188, Bearendon, Ore. 97075; 800-635-3070; fax: 503-526-0580

| 1994 Revenues | |
|---|---|
| Total gross revenue | $15,000,000 |
| PBM gross revenue | $15,000,000 |
| **PBM Clients** | |
| Total | 300 |
| Employer/group plans with direct service | 290 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 450,000 |
| Active enrollees | 55,000 |
| through employers | 50% |
| through third-party vendors | 50% |
| **Workers Compensation:** | |
| Active enrollees | 1,500 |
| through employers | 100% |
| **Mail-order services** | |
| Percent of prescription volume | 100% |
| **Generics** | |
| Percent of prescription volume | 30% |
| **Staff** | |
| Total | 35 |
| Professionals | 7 |

**PBM services since:** 1989.
**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, patient/physician education.
**Formularies offered:** Open.
**Reports provided:** Generic vs. name brands dispensed analysis, employee utilization, drug utilization.
**Service area:** Pacific Northwest and Mountain states.
**Billing methods:** Negotiated rates for drugs. Volume discounts to employers.
**Officers:** H. Russell Brown Jr., president; E. Faye Stumpf, president-CARE RX.
**Contact:** H. Russell Brown Jr.

## Choice Drug Systems of Maryland Inc.

2930 Washington Blvd., Baltimore, Md., 21230; 410-646-7373; fax: 410-525-3691

| 1994 Revenues | |
|---|---|
| Total gross revenue | $50,000,000 |
| PBM gross revenue | $50,000,000 |
| **PBM Clients** | |
| Total | 80 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 250,000 |
| Active enrollees | 180,000 |
| through third-party vendors | 80% |
| through Medicare/Medicaid | 20% |
| **Retail Network** | |
| Pharmacies under direct contract | 11 |
| **Mail-order services** | |
| Percent of prescription volume | 40% |
| **Generics** | |
| Percent of prescription volume | 65% |
| **Staff** | |
| Total | 200 |
| Professionals | 12 |

**PBM services since:** 1984.
**Parent:** Choice Drug Systems Inc.; primary business: institutional pharmacy.
**Services:** Mail-order distribution, concurrent utilization review, retrospective utilization review, formulary management/review, monitoring of physician prescribing practices, patient/physician education.
**Formularies offered:** Closed, restricted/customized.
**Pharmacies contracted:** Independently owned.
**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis.
**Service area:** 22 states.
**Billing methods:** Capitated rate.
**Officers:** Allan Silber, chairman; Morris Perlis, president/CEO; Charlie Lathrop, COO; Mike Susnowik, executive vp-operations.

*Continued on next page*

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# *Explanation of directory terms*

The first annual *Business Insurance* directory of prescription benefit managers (PBMs) lists organizations that provide general prescription benefit management services, defined as an integrated package of services designed to control the types and distribution methods of prescriptions used by plan participants. The package of services must include at least several of the following elements: claims processing, formulary management, negotiated pharmacy network, mail-order drug plan, pharmaceutical benefit plan design consulting, prescription educational services for users and/or physicians and utilization review.

The PBM services must be provided on an unbundled basis (i.e. offered separately from other products and services the PBM may offer) and must be available to corporate and institutional clients other than third-party vendors.

Listings begin with the company name, address, phone and fax numbers. **1994 revenues** includes total gross revenues and gross revenues generated from PBM services. The **PBM clients** section specifies total clients for which the listed company provided prescription benefit management services and the number of employer/group plans who contract directly with the company (rather than accessing the plan through a third-party vendor) in 1994.

**Lives covered** lists total **group health** plan lives (both eligible and active), active group health enrollees and active **workers compensation** enrollees in 1994. Along with the number of active group health enrollees is a break out indicating the percent enrolled via direct contract with employers, through third-party vendors and through Medicare/Medicaid. The percent of active workers compensation lives enrolled through direct contract with employers is also given. Please note, active enrollees include only those participants who actually received prescriptions through the plan.

**Retail network** information includes the number of pharmacies who participate in the company's network via direct contract and the number of pharmacies participating in the network through leasing arrangements with other PBMs. The percent of prescriptions filled through **mail-order services** and the percent of prescriptions filled with **generic** equivalents is listed next.

**Staff** information is given in full-time equivalents for 1994 and details the listed company's total number of staff members as well as the total number of professionals assigned to prescription benefit management services (not including sales, marketing or clerical staff).

PBM **services** offered by the company are identified next. Services that are provided through a subcontracted organization are indicated with a footnote.

**Network design** specifies the type of formularies offered by the PBM. Open formularies allow patients to receive prescriptions from a relatively unrestricted list of drugs, whereas a closed formulary specifies the brand names/generic drugs which must be dispensed to receive coverage through the plan. Restricted/customized formularies fall in the middle and usually provide coverage for drugs not specified in the formulary, but at a reduced rate and may allow the client to have some input in the design of the formulary.

The sections that follow indicate the types and names, if provided, of **pharmacies** participating in the network; the types of **reports** provided to the client; **service area**; and **billing methods** offered. If volume discounts are given to employer clients, it is noted under billing method and the minimum size required to receive the discount is noted.

Principal **officers** and a **contact** person for those seeking more information complete the listings.

Listings are 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.

*Continued from previous page*

## Claimspro Health Claims Services Inc.

24370 Northwestern Highway, Southfield, Mich. 48075; 810-352-2852; fax: 810-352-3714

| 1994 Revenues | |
|---|---|
| Total gross revenue | $59,235,000 |
| PBM gross revenue | $58,985,000 |
| **PBM Clients** | |
| Total | 430 |
| Employer/group plans with direct service | 130 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 350,000 |
| Active enrollees | 280,000 |
| through employers | 30% |
| through third-party vendors | 54% |
| through Medicare/Medicaid | 16% |
| **Retail Network** | |
| Pharmacies under direct contract | 37,000 |
| **Mail-order services** | |
| Percent of prescription volume | 2% |
| **Generics** | |
| Percent of prescription volume | 40% |
| **Staff** | |
| Total | 21 |
| Professionals | 10 |

**PBM services since:** 1987.

**Services:** Retail pharmacy network, mail-order distribution*, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education*.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including Albertson's, American Drug, Arbor, Big B, Dominicks, Eckerd, Farmer Jack, F&M, Giant Eagle, K&B, K-Mart, Kroger, Medicine Shoppe, Meijer, Pathmark, Perry, Phar-Mor, Revco, Rite-Aid, Shopko, Target, Thrift, Wal-Mart, Walgreen.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, standard management reports.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim.

**Officers:** Bruce Liebowitz, president; Ronald Klein, executive vp.

**Contact:** Ron Klein.

D

## Diagnostek Inc.

4500 Alexander Blvd. N.E., Albuquerque, N.M. 87107; 505-345-8080; fax: 505-761-6174

| 1994 Revenues | |
|---|---|
| Total gross revenue | $485,700,000 |
| PBM gross revenue | $326,400,000 |
| **PBM Clients** | |
| Total | 1,600 |
| Employer/group plans with direct service | 1,400 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 14,000,000 |
| Active enrollees | 7,000,000 |
| through employers | 31% |
| through third-party vendors | 65% |
| through Medicare/Medicaid | 4% |
| **Workers Compensation:** | |
| Active enrollees | 100,000 |
| through employers | 3% |
| **Retail Network** | |
| Pharmacies under direct contract | 49,972 |
| **Mail-order services** | |
| Percent of prescription volume | 7% |
| **Generics** | |
| Percent of prescription volume | 34% |
| **Staff** | |
| Total | 1,700 |
| Professionals | 250 |

**PBM services since:** 1970.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, disease state management, home infusion, case management, outcomes management.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including Albertson's, Big B, CVS, Eckerd, Fay's, Healthmart, K&B, K-Mart, Kroger, Longs, Medicine Shope, Osco, Pathmark, Phar-Mor, Revco, Rite Aid, Safeway, Thrift, Thrifty PayLess, Von's, Walgreen, Wal-Mart.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, executive summary, early warning, pharmacy and physician profiling, patient profiling, exceptional activity.

**Service area:** Nationwide.

**Billing methods:** Fee per claim, risk sharing/partnership. Volume discounts to employers.

**Officers:** Nunzio DeSantis, CEO/chairman; William A. Barron, president; Arthur Solomon, executive vp/managed care officer; Andrew Masetti, CFO/executive vp; Courtland Miller, executive vp/counsel.

**Contact:** David Jones.

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## Diversified Pharmaceutical Services Inc.

7760 France Ave. S., Suite 500, Edina, Minn. 55435; 800-344-3405; fax: 612-896-6941

| 1994 Revenues | |
|---|---|
| Total gross revenue | $171,000,000 |
| **PBM Clients** | |
| Total | 205 |
| Employer/group plans with direct service | 53 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 14,000,000 |
| Active enrollees | NA |
| through employers | 12% |
| through third-party vendors | 87% |
| through Medicare/Medicaid | 1% |
| **Retail Network** | |
| Pharmacies under direct contract | 43,000 |
| **Generics** | |
| Percent of prescription volume | 42% |
| **Staff** | |
| Total | 665 |
| Professionals | 570 |

**PBM services since:** 1976.

**Parent:** SmithKline Beecham; primary business: drug manufacturer.

**Services:** Retail pharmacy network, mail-order distribution*, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, generic drug program, disease management, call center, reporting, account management.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, claims cost, drug utilization, network and formulary compliance, comparison of plan performance, provider profiling, demographic, pharmacy performance in HEDIS/NCQA format.

**Service area:** Nationwide and international.

**Billing methods:** Capitated rate, fee per claim, manufacturer's rebate. Volume discounts to employers.

**Officers:** Travers Wills, CEO; Dave Moules, president-self funded division; Joe Schiesl, president-wholesale/public sector division; Carol Schneeweis, vp-client services; Shawn Patterson, senior vp-marketing.

**Contact:** Kirsten Stewart Cradit, sales manager, 800-344-3405 ext. 7167.

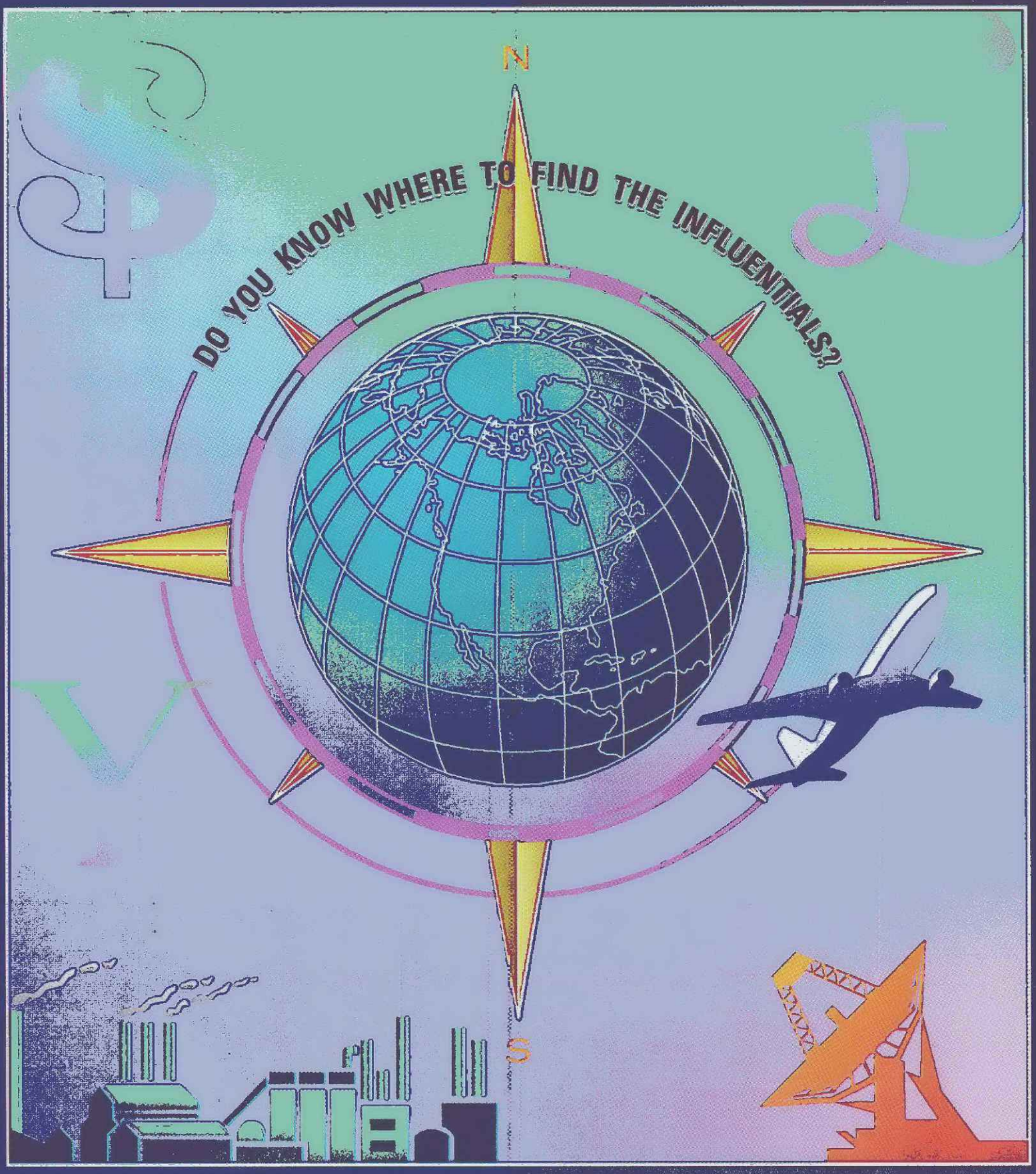
E

## Eckerd Health Services

8333 Bryan Dairy Road, Largo, Fla. 34647; 813-399-6000; fax: 813-399-6438

| Retail Network | |
|---|---|
| Pharmacies under direct contract | 34,000 |

*Continued on page 22*

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*Continued from page 20*

**Staff**

Total ..... 60
Professionals ..... 30

**PBM services since:** 1995.

**Parent:** Eckerd Corp.; primary business: retail drug stores.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, disease state management (pilot programs).

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization.

**Service area:** Primarily southeast.

**Billing methods:** Capitated rate, fee per claim. Volume discounts to employers with 500 employees.

**Officers:** Joseph F. Kearney, Frederick Howe, general partners.

**Contact:** Joseph Kearney, 813-399-6448.

## Express Scripts Inc.

14000 Riverport Drive, St. Louis, Mo. 63043; 314-770-1666; fax: 314-770-2367

**1994 Revenues**

Total gross revenue ..... $385,000,000
PBM gross revenue ..... $385,000,000

**PBM Clients**

Total ..... 2,600

**Lives Covered**

**Group Health:**
Total ..... 6,200
**Workers Compensation:**
Active enrollees ..... 35,664

**Retail Network**

Pharmacies under direct contract ..... 37,000

**Mail-order services**

Percent of prescription volume ..... 9%

**Generics**

Percent of prescription volume ..... 29%

**Staff**

Total ..... 900
Professionals ..... 400

**PBM services since:** 1986.

**Parent:** New York Life Management Inc.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization.

**Service area:** Nationwide.

**Billing methods:** Fee per claim, negotiated rates for drugs.

**Officers:** Barrett Toan, CEO; Stuart Bascomb, CFO/executive vp; Thomas Boudreau, senior vp/general counsel; Richard Calvert, vp-operations; Ken Evelyn, senior vp-sales/marketing.

**Contact:** Sandra Russell, vp-sales.

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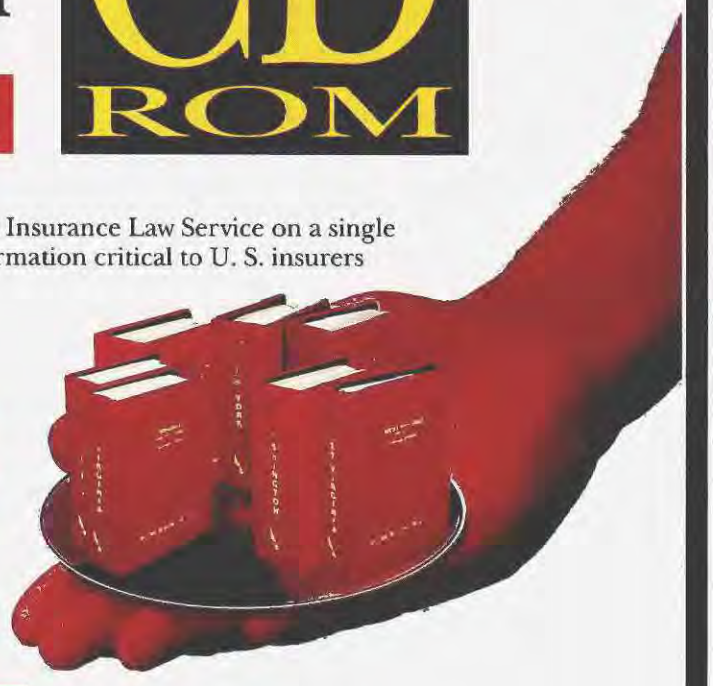

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*Continued on next page*

A complete explanation of terms can be found on page 19.

# Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

## Agents continue fight for level playing field

### Banks should be subject to state laws, agents contend

**By MICHAEL SCHACHNER**

Insurance agents are engaged in several court battles with banks over whether provisions of the federal National Bank Act pre-empt state laws that bar banks from selling insurance.

Agents have had some success arguing that the state statutes are not pre-empted by the federal banking law, but the issue is likely to go all the way to the U.S. Supreme Court before it is resolved.

Although willing to fight this issue with banks on a case-by-case basis, agent trade groups would prefer federal legislation that would define once and for all the circumstances under which banks could sell and write insurance.

Ideally, agents would like Congress to enact federal legislation clarifying that any entity selling insurance products of any kind, including annuities, would be subject to state insurance regulation, as well as licensing and unfair trade practices laws.

*Legislative Issues*

And, if banks are going to sell insurance, agents insist that states should require them to disclose in no uncertain terms that the coverage they offer is not federally insured like bank deposits.

Groups like the National Assn. of Professional Insurance Agents, the Independent Insurance Agents of America, the Council of Insurance Agents & Brokers and the National Assn. of Life Underwriters have been meeting regularly in recent months to plot a strategy on how to get their view heard.

They feel they may have an ally in the new Republican-led Congress, which has repeatedly espoused states' rights, and more specifically in Rep. Thomas Bliley, R-Va.

Legislation introduced by Rep. Bliley, the new House Commerce Committee chairman, would resurrect certain provisions of a failed insurer solvency bill championed by former Committee Chairman John Dingell, D-Mich. The Bliley bill contains a provision that would declare states are responsible for regulating banks' insurance activities, not the Comptroller of the Currency.

Agents say that if individual states want to permit banks to get into the insurance industry, that is a state's prerogative and they will accept banks as added competition. But, agents add, if states want to keep banks out of insurance because they feel banks would gain a competitive advantage over agents or for other reasons, the states' wishes should override any element of the National Bank Act.

Currently, 34 states have some sort of restrictive laws pertaining to banks selling or writing insurance. Only 16 states permit banks to sell various forms of insurance without restriction.

Since 1986, the Comptroller of the Currency has held that Section 92 of the National Bank Act permits federally chartered banks to sell insurance nationwide from offices located in towns with fewer than 5,000 people.

For example, if the Bank of America were to open a branch in Haverhill, Fla., population approximately 1,500, the branch theoretically would be able to sell property/casualty coverage throughout the country despite the fact that Florida laws forbid banks from engaging in the business of insurance.

Agents successfully challenged this exact scenario when it arose with another bank in Florida. Last December, a federal judge ruled that the "Comptroller's loophole" doesn't allow Barnett Banks Inc. to sell auto, life and homeowners insurance through a small town agency it acquired. On appeal, the 11th U.S. Circuit Court of Appeals affirmed that decision.

Last month, a state appellate court in Louisiana ruled in a case involving First National Bank of Denham Springs that Section 92 of the federal banking law doesn't pre-empt state laws forbidding banks in the

*See* **Banks** *on next page*

# Banks

*Continued from previous page*
in the state from selling insurance.

However, agents have not fared as well in Kentucky, where the 6th U.S. Circuit Court of Appeals recently affirmed a trial court's 1992 decision that Section 92 pre-empts restrictive Kentucky laws, thus allowing banks to sell insurance out of towns with fewer than 5,000 residents.

Two weeks ago that court refused to rehear the case, which creates a conflict in the 6th and 11th Circuits, appearing to pave the way for the Supreme Court to decide the issue.

Earlier this year, the nation's highest court struck a blow to insurance agents when it ruled that banks could sell annuities because they were investment devices, not true insurance products. But agents aren't as upset with that ruling as they are with the Section 92 situation, because they sell far fewer annuities than property/casualty policies.

Yet another case over Section 92 pre-emption is pending in Connecticut, but hasn't yet gone to trial.

With all these court battles centered on this provision of the National Bank Act, agents say federal legislation is needed that would resolve the issue once and for all.

What irks agents most about banks being allowed to sell insurance are the subtle and explicit competitive advantages that banks may have over insurance agents. Government affairs officials with the big agent associations all have expressed concern about banks' ability to tacitly or overtly coerce borrowers into accepting insurance from them. The association officials say this is possible since banks write the majority of home and car loans, which generally require insurance for a set period of time.

**What irks agents most about banks being allowed to sell insurance are the subtle and explicit competitive advantages that banks may have over insurance agents.**

"We simply think it's unfair for there to be linkage between a credit provider and an insurer. There's an undeniable perception among customers that credit worthiness is improved by doing business with one entity. That's what's worrisome to our group, not that banks will write insurance better," said Joel Wood, vp-government affairs with the Council of Insurance Agents & Brokers in Washington.

"We're very sensitive to the argument that we're complaining only because we don't want the competition," he added.

Robert Rusbuldt, vp-federal affairs with the Independent Insurance Agents of America in Washington, insisted that agents aren't afraid of increased competition, but unfair competition.

"By allowing federally chartered banks to write insurance, we'd be up against a seller that has many advantages over us, specifically the perception that they are FDIC-insured and the fact that they fall under the too-big-to-fail doctrine," he said.

"The public just doesn't understand the fact that bank insurance isn't FDIC-insured whether there's disclosure or not," agreed Chuck Wells, owner of the Wells Insurance Agency in Palmyra, N.Y.

The issue of banks writing insurance comes at a time when both President Clinton and Senate Banking Chairman Alfonse D'Amato, R-N.Y., are pushing to give banks more freedom to enter into other financial services areas, such as insurance and securities sales.

House Banking Chairman Jim Leach, R-Iowa, also is sponsoring a bill that would offer banks more freedom to enter into the securities industry, though his bill doesn't address insurance.

The D'Amato bill, known as the Depository Institution Affiliation Act, would allow the formation of financial services holding companies.

Commercial banks, securities brokerages, insurance companies and other commercial firms would be permitted to own one another and to engage in an expanded range of cross marketing and other activities. Rep. Richard Baker, R-La., has introduced similar legislation in the House.

President Clinton also has proposed changes to federal banking laws that would allow banks to get into insurance. All such proposals would overhaul the longstanding Glass-Steagal Act, which primarily prevents banks from marketing securities.

"We oppose D'Amato, Baker and Clinton because they go too far in reforming Glass-Steagal. We know there's a push for something to happen. The bank lobby has been at it for some time. But we don't need wholesale changes to the financial services laws. That's why we like the Bliley bill. In simple terms, it reaffirms states' rights," said Dean Sackett, assistant vp-government affairs with the National Assn. of Professional Insurance Agents in Alexandria, Va.

Mr. Sackett added that the congressional debate over Glass-Steagal should focus on the Leach bill, which would only address banking and securities overlap.

But other agent/broker advocates would just as soon concentrate on legislation that will ensure that states set all the rules for insurance.

"For us, it's down to one issue, and that's states' rights. Banks at every turn want into insurance because they see it as an easy profit center. But who will regulate them?" questioned the Council's Mr. Wood.

"I think it's inevitable that bank powers will be expanded," summed up Mr. Wells of Wells Insurance Agency. "My point of view is that if banks are going to come in and write insurance, I want to be able to offer car loans and mortgages. Let's play fair across the board." BI

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# IIAA legislative hot line rings up interest

By GAVIN SOUTER

For insurance agents who want to keep up to date on the latest progress of legislative issues, information is just a phone call away.

And the better informed that agents are, the more effectively they can influence the legislators who represent their interests on Capitol Hill, the Independent Insurance Agents of America says.

To get its members more involved in grass-roots lobbying, the insurance industry trade association last November launched a toll-free hot line: 800-51-ROOTS (800-517-6687). Agents can access it 24 hours a day, seven days a week.

So far, agents are dialing up the hot line at a rate of 2,000 calls a month to hear the latest information on federal legislative issues like health care and pollution liability reform.

"I've used it and I think it has great potential as it provides information on issues that are interesting. You need to be informed on issues when you are lobbying within the community," said Jim Klagholz, secretary and treasurer at Clayton N. Sterling Associates in Seaside Park, N.J.

The hot line is the brainchild of Robert R. Hoopes, the IIAA's grass-roots coordinator, who is also the recorded voice on the other end of the line.

Agents who called the hot line last week heard a brief introduction on the makeup of Congress and the political leaders of both the Democratic and Republican parties. Outlines of four issues affecting agents also were given: health care reform; Superfund; natural disaster legislation; and an update on the grass-roots efforts of the IIAA.

On health care, the hot line tells callers that health care reform legislation will be enacted but it will be small and incremental rather than a wholesale rethinking of the health care system.

"President Clinton has continued to make it a top priority. . . .It's expected that Bob Dole, as a member of the Senate Finance Committee, may push for some incremental reforms," the hot line tells agents.

On Superfund, callers hear that there is a good chance that the current Congress will eliminate retroactive liability. The IIAA has yet to take a position on the new Superfund reform efforts but it will determine which line to take at the IIAA's next board meeting, the hot line says.

Passage of the Natural Disaster Act is a major issue for the IIAA, but members need to increase their lobbying efforts, the recording says.

In 1994, the IIAA concentrated its lobbying efforts on informing Democratic committee staffers about the need for the disaster legislation, but now that the Republicans control the House and Senate, their staffers will have to be targeted by the IIAA, the hot line said.

"We will have a major educational effort for Republican staffers bringing them up to speed. We can't let the opponents of the bill drive this debate," the hot line said.

The fourth recording advises agents that there are 73 new members of Congress whom IIAA members need to reach. The IIAA invites agents who know members of Congress and all agents who wish to become more involved in legislative issues to contact the trade group.

The hot line is designed to keep IIAA members well versed in issues that affect them when they are talking to any politicians or business associates, said Mr. Hoopes.

"The problem we had was that we have agents who are members of Rotary. PTAs and other organizations, but they don't have time to talk to lobbyists," he said.

By calling the hot line, IIAA members can get a quick briefing on subjects before they meet with influential people, Mr. Hoopes said.

Other features of the IIAA's grass-roots program include broadcast faxes on important legislative activity, he said.

The hot line currently is updated about once a month, but will likely be updated more often as it is used more frequently, Mr. Hoopes said. "We will probably update it every two to three days," he said.

IIAA members who have used the grass-roots hot line sing its praises.

"I used to be involved in government affairs with the association and I'm still interested in it, so I use it to keep myself updated," said Thomas J. Dietz, president of Medical Professional Liability Agency Ltd. in Bedford Hills, N.Y.

For example, Mr. Dietz recently went to a reception where his local congresswoman was present and he called the hot line to get an update before he left.

"I have a good rapport with our congresswoman and state senators and they look to me for advice on insurance issues. The hot line reminded me of the issues and it gave me the IIAA's position on them," he said.

The hot line gives good basic information, and if agents need more information they can follow it up with a call to an IIAA official or lobbyist, Mr. Dietz said.

"It's one of the best things that they have done in a long time because it gives a member who is interested in issues and in transmitting them to legislation the ability to learn about them very easily," he said.

The ease of using the hot line is one of its main values, said George Stancil, commercial agent at Cornell Agency Inc. in Grayling, Mich., and an IIAA national director.

"Our focus in all our grass-roots efforts has been to make things as quick and easy and user friendly as possible, so I'm encouraged by the hot line," he said.

The hot line will enable agents who attend IIAA meeting to be informed on the issues discussed beforehand and allow them to have more productive meetings and keep the grass-roots efforts going, Mr. Stancil said.

"The big challenge of grass roots is to keep people motivated and informed," he said. BI

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*Agent/Broker Topics*

# Farm insurance reforms do not yield bumper crop of business for agents

By SALLY ROBERTS

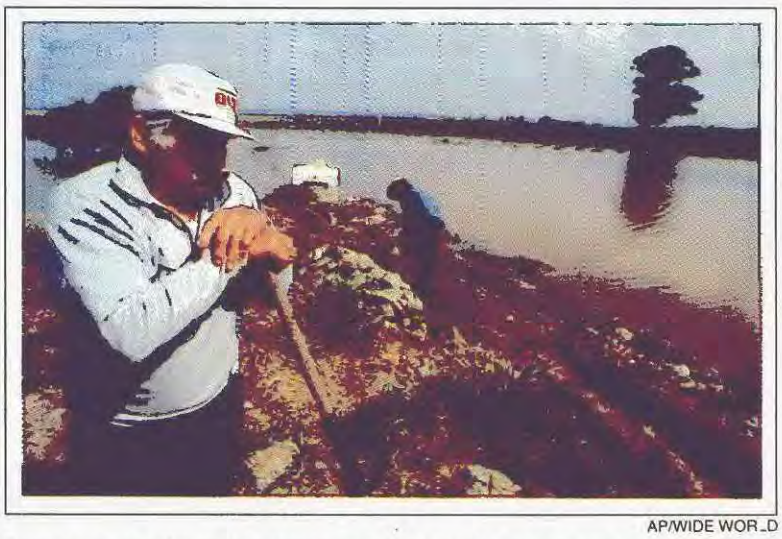
Legislative Issues

For many, the term "March Madness" means college basketball tournaments, but for independent insurance agents this year, it could only mean crop insurance reform.

The Consolidated Farm Service Agency says it is too early to tell how many new crop insurance policies were written by March 15—the deadline for farmers to sign up for coverage under the new Federal Crop Insurance Reform Act, which became law last October. However, a spokesman for the government agency said an estimated 2.9 million potential crop insurance policies could be written under the reformed program, increasing covered acreage to 80% from just over 30% in years past.

The new law repeals the government's ad hoc crop disaster relief program, which offered farmers compensation for damage only if crop loss was widespread in an area. Under that program, the government compensated farmers for their crop losses whether they had bought crop insurance or not, but there were no guarantees that a loss would be covered. The new program requires farmers to purchase at least minimal catastrophic coverage—or to "buy up" to some form of federally subsidized multi-peril coverage—to participate in certain government agricultural programs.

The new program is expected to cost $8.1 billion for fiscal years 1995 through 1999, saving the government $750 million over the five-year period.



AP/WIDE WORLD

**Farmers could recoup crop losses like this field of ruined zucchini and artichokes in California by buying coverage under a new crop insurance program.**

Despite some concerns over what they consider inadequate catastrophic coverage, crop agents are generally supportive of the government's reform efforts and report new business growth.

Insurance agency associations also favor crop insurance reform, but they would like to see the government leave sales of the coverage to the private sector.

'Overall, we're pleased," said Ruth Gerdes, crop insurance specialist at the Auburn Agency in Auburn, Neb. "Our (crop) policy count was up well over 15%," she said.

'We picked up about $100,000 in new premium," concurred Dave Overman, a marketing agent for the Merritt Hall Insurance Agency in Indianapolis. However, "it's nowhere near what we thought we'd get."

Bob Fulwider, an agent with Wuestenberg Agency Inc. in West Liberty, Iowa, said it was too early to tell how much new business the agency picked up. "We're cautiously optimistic but not overly optimistic," he said, adding, "we didn't have a real opportunity to sell the buy-up coverage that we could have if we had more time."

Indeed, many agents said there simply was not enough time between the passage of the bill in October until the March 15 purchase deadline to educate farmers about the coverage's limitations. As a result, agents say, many farmers are now underinsured.

'I applaud (the government's) efforts but, on the other hand, it came much too fast and it crippled us on the back end," Mr. Fulwider said.

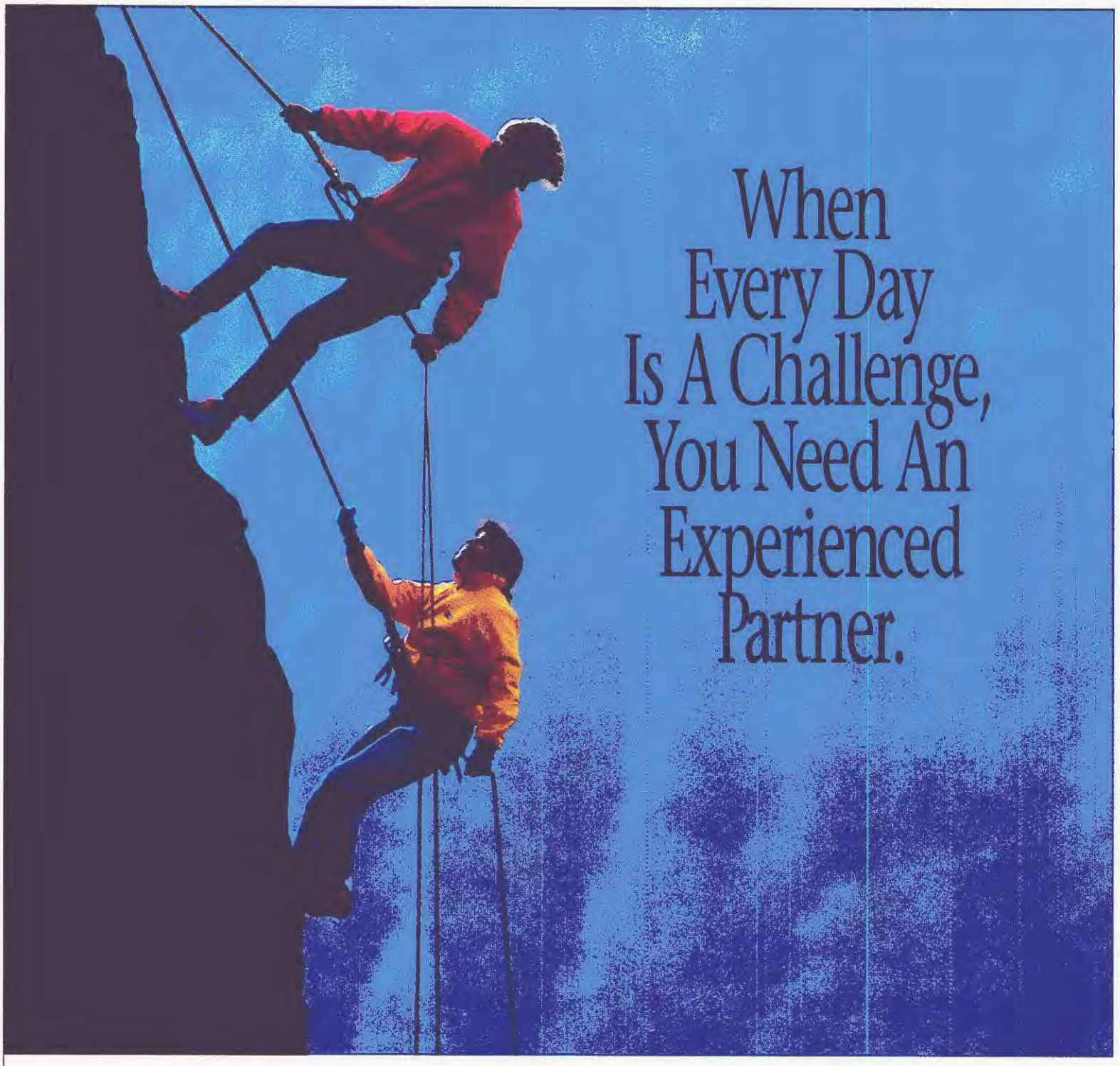
The minimum catastrophic coverage required under the act compensates farmers for 60% of the expected market price of a crop after at least 50% of the crop is destroyed. Farmers can purchase this coverage through CFSA agencies or through independent agents and pay only $50 per insured crop per county, up to a maximum of $200 per farmer per county and $600 per farmer aggregate.

A spokesman for the CFSA acknowledged that depending on where the farmer is located and what crop he or she is growing, the cat coverage may be less comprehensive than what a farmer could have recovered from the government under the ad hoc program.

Under the ad hoc program, however, there was no guarantee a farmer would receive any aid, the spokesman added.

Farmers are required to buy at least this minimum catastrophic coverage in order to participate in

*See* **Crops** *on page 22F*

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# Rep. Kingston draws on insurance roots

## Agent-turned-legislator advocates agents' political involvement

By MARK A. HOFMANN

There's no doubt in U.S. Rep. Jack Kingston's mind that a career as an independent insurance agent provides an enviable stepping stone into the political arena.

"Politics is networking, and independent agents do it better than any profession," said Rep. Kingston, a Republican from Georgia.

And he makes no secret of the fact that he would like to see other agents and small-business people follow in his footsteps. The way to do it, Rep. Kingston says, is to bear in mind what he calls the "three C's of politics: contributing, campaigning and being a candidate."

Rep. Kingston was an agent with Palmer & Cay/Carswell Inc. in Savannah when he was elected to the Georgia House of Representatives in 1985. After eight years as a state legislator, he sought to represent Georgia's 1st congressional district in Washington. That district covers a large portion of southeastern Georgia, stretching from Savannah west and south to Brunswick and Waycross.

Rep. Kingston

He won 58% of the vote in the 1992 general election and 76% of the vote in his 1994 re-election bid. Those victories made the 39-year-old second-term U.S. representative the only Republican to represent Georgia's 1st District in at least a century.

Rep. Kingston makes clear, though, that his interest in politics goes back much further than his first shot at a big-league political prize.

"I have always liked it," he says. Although he jokes that his interest in politics was caused by his mother dropping him on his head as a baby, Rep. Kingston says that running for class officer in junior high school really hooked him. He says that just as some people become fanatics about golf or fishing, he's become hooked on politics.

Which brings him to the first "C": serving as a candidate.

"If an independent agent wants to be effective, he should consider running," said Rep. Kingston. He added, though, that no one will make as much money in politics as in insurance.

But if an agent doesn't personally want to seek office, he or she should instead campaign for somebody, he said. This means putting up yard signs, putting some brochures in the office and "even going down to headquarters and stuffing envelopes," he said.

Rep. Kingston also advocates agents calling clients and recommending the candidate, citing for example the candidate's positions on workers compensation, tort reform or other issues of interest to businesses.

The third "C"—contributing—is facilitated through political action committees, said Rep. Kingston. In addition to contributing money directly to PACs, Rep. Kingston recommends that agents contact agent association and insurer PACs and recommend that those PACs make financial contributions to the candidates whom the agents support.

It's not enough for agents to show up on a congressional representative's doorstep when an issue in which they're interested reaches the boiling point, he said. Instead, agents must have "staying power," he said.

"Agents need to know that they need to come by frequently and let their faces be seen. Then, when the crisis does emerge, you've got the rapport, you're through with introductions and you can walk in and say, 'This is our position. We hope you'll consider it.' The time to introduce yourself is not at the peak of the storm," he said.

When asked how his experiences as an independent agent affect the way he does business as a member of Congress, Rep. Kingston laughed and said, "Well, it made me a conservative."

More seriously, he said his experience as an agent gave him the opportunity to see what entrepreneurs and business people do and how government impacts them.

Being an agent also helped in campaigning, he said. As both agent and candidate, Rep. Kingston had to do a lot of door-to-door work and he knew that not every call would result in a close.

"Sometimes they'd support you and sometimes they'd say, 'Keep walking, I'm with the other person,' " he said.

The agent's life taught him lessons beyond how to deal with disappointment in campaigning, said Rep. Kingston. On Capitol Hill, "you're not going to get anything done unless people like working with you," he said.

"You have to be professional, you have to be intelligent, you have to be thorough. You've got to know what's in the bill just as you have to know what's in the policy before you can sell somebody on your position."

Then comes persuading the other person to back your position, said Rep. Kingston. In doing this, he recalls advice from an Aetna sales school: lead with questions.

"You can't push a string; you have to pull it," he said.

Rep. Kingston also credited his participation in the Young Agents' Committee of the Georgia Independent Insurance Agents and the local agents' group in Savannah with helping his political career.

*See* **Kingston** *on page 22F*


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# Crops

*Continued from page 22D*

other government programs, including price support and production adjustment programs, certain Farmers Home Administration loans and the Conservation Reserve Program.

Many farmers bought the catastrophic coverage without an understanding of exactly what they will receive if a disaster occurs, agents say.

The cat coverage offered under the new program "is not insurance," agreed Phil Anderson, senior Washington representative for the Independent Insurance Agents of America Inc. in Alexandria, Va. The cat coverage is simply a link to get to other government programs.

"It will take the first major disaster year to happen before farmers completely understand the new program," said Ms. Gerdes of the Auburn Agency.

"In my opinion, the cat policy is not beneficial to farmers," said Mr. Overman of Merritt Hall.

The "buy-up" multiperil coverage, only available through the private sector, would be more beneficial to farmers, but the government failed to effectively communicate that to farmers, Mr. Overman said.

Under the new law, the government provides greater subsidies for the buy-up coverage, therefore reducing farmers' premiums by 8% to 16%.

The so-called buy-up coverage, while more expensive than the basic cat cover, provides greater protection. For example, farmers could purchase additional coverage to protect up to 75% of a crop at 100% of the expected market price.

Since not all kinds of crops are insurable under the new program, the government also provides farmers a separate Non-Insured Assistance Program.

The NAP program will pay 60% of the expected market price of that crop but is only triggered by a 35% crop loss.

**The government built in incentives for farmers to buy up additional coverage, but it did not give them enough information beyond that, says Dave Overman.**

Agents say farmers' attitudes toward the new insurance program ran the gamut: some did not buy any coverage, some bought only the catastrophic coverage in order to remain in other government programs, while others bought the highest layer of multiperil insurance available.

However, agents feel too many farmers bought the cat coverage without fully understanding its limitations.

"The government fell short on getting the word out that farmers needed to get the buy-up coverage," IIAA's Mr. Anderson contends.

Although the government built in incentives for farmers to buy up additional insurance coverage, it did not give farmers enough information beyond that, Mr. Overman agreed.

To protect the Wuestenberg Agency from potential errors and omissions claims, farmers buying catastrophic coverage had to sign a disclaimer stating they understood they had bought limited coverage, Mr. Fulwider said. "The government should have made the cat coverage less dollar signs and more of a coverage."

Sharon K. Heaton, owner of The Heaton Agency in Pontiac, Ill., said agents need a full year to educate the farmers about their insurance options.

"We had an overwhelming job interpreting the law" within the short time frame. "We need another year to educate the public so they understand the buy-up coverage," said Ms. Heaton, who is also a vp with the Alexandria, Va.-based National Assn. of Professional Insurance Agents.

Both the PIA and the IIAA have actively supported the crop reform legislation, but they advocate 100% delivery from the private sector.

"We don't think it is a good idea to still have the CSFA involved in the sale of cat coverage," said Lydia Astorga, assistant director of industry affairs for the PIA.

County offices are already involved in other programs for farmers, and history shows "it never worked" to have the government delivering insurance, said Ms. Astorga.

"The IIAA's No. 1 priority is to support the reform bill but to eliminate the government in the delivery of crop insurance," Mr. Anderson said.

"We have every reason to say it was a Herculean task to put a new program into the field," but the government's inconsistencies with its communications and its delay in regulations "are beyond expectation," Mr. Anderson said.

And, for the crop insurance reform program to work better, there should be less administration involved in selling the product, he said.

Crop insurance is "already the most complicated, labor-intensive insurance program in the world," according to Mr. Anderson. In addition to readjusting crop yields and visiting the farms, insurance agents must deal with a morass of paperwork.

"The deal with the Legislature was that we'll except less money on the product if you make reductions on the paperwork. So far the government has been on track in the completely opposite direction and has not lived up to the spirit of the bill," he said. BI

# Kingston

*Continued from page 22E*

The congressman, who is a graduate of the University of Georgia, also holds the Chartered Property & Casualty Underwriter designation.

"As a rule, independent agents are people who know lots of people, who are well thought of and they're well respected. They're well connected," he said.

Participation in church and synagogue activities, a prominent profile in the civic and charity arena, and business ties that mark a successful agent all help with politics, he said.

Looking ahead, Rep. Kingston sees the threat of banks getting into the business of insurance as one of the major agent-related issues facing the 104th Congress (see story, page 22A).

He noted the following example from a recent conversation with an agent who had attended the National Assn. of Professional Insurance Agents' federal legislative conference. The agent explained how increased niche marketing and specialization among independent agents can make them more vulnerable to bank marketing strategies if the banks happen to be zeroing in on the same market segment targeted by that agent.

Rep. Kingston, who sits on the Appropriations Committee, has joined Commerce Committee Chairman Thomas Bliley, R-Va., and ranking minority member Rep. John Dingell, D-Mich., in cosponsoring a measure to address this issue. The measure is designed to assure that banks' insurance activities are regulated by state insurance authorities and that banks are not permitted to engage in activities prohibited by state regulators.

**Participation in community activities and business ties help agents with politics, says Rep. Kingston.**

In addition, "repeal of McCarran-Ferguson is always on the burner in one form or another," said Rep. Kingston.

He praised the House's success in passing sweeping tort reform legislation, which he said was necessary to "get our culture to move away from this wheel-of-fortune mentality." But, he doubts the Senate will follow suit with tough legislation (*BI*, March 20).

Rep. Kingston has refused to move his family to Washington and tries to get back to his district every week. "I'm only up here to work," he says.

He freely admits that the grueling pace of enacting the legislation promised by Speaker Newt Gingrich, R-Ga., is taking its toll on Capitol Hill, as members of Congress and their staff work well into the night to deal with the ambitious agenda.

"You're walking around seeing the naked and the dead," the congressman said.

But, to people who share Rep. Kingston's conviction that the 104th Congress can enact a probusiness agenda, the price is one they're more than willing to pay.

"Most people have a sense of 'Seize the day, let's get this done while we have the chance,'" he said. BI


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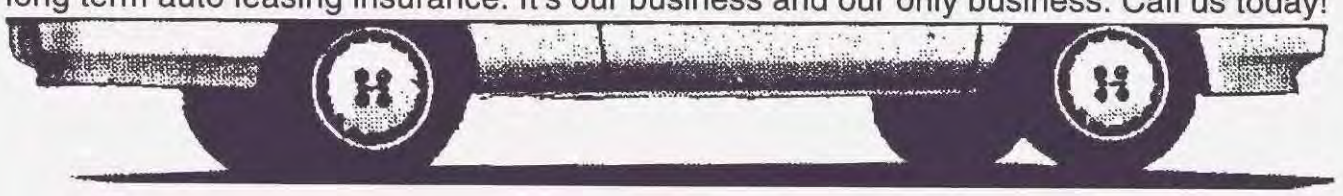

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# Agents' annual pilgrimage to Washington pays off

## Legislative conferences help keep agents and brokers up to date

**By MARK A. HOFMANN**

Every city has its seasonal rituals, and for Washington, late winter and spring means the return of insurance agents and brokers to the halls of Congress as their trade associations hold their annual federal legislative conferences.

The legislative conference season—which this year stretches well into May—began with the Council of Insurance Agents and Brokers' 14th annual legislative conference during the first week of February.

The meeting's focus was on one of last year's most contentious legislative issues—the reauthorization of the Comprehensive Environmental Recovery, Compensation and Liability Act, better known as Superfund.

Last year's Superfund battle split the insurance industry into warring camps, a situation the industry has attempted to head off this year by agreeing upon a set of common principles (*BI*, Jan. 23).

Executives gathered at the Council meeting heard two presentations that took the issue from different perspectives. A panel discussed various aspects of the reauthorization issue only a few hours before the chief House architect of Superfund legislation—Rep. Michael G. Oxley, R-Ohio—delivered the luncheon address.

During the panel discussion, George Baker, who is executive director of a new business/insurer group called Superfund Reform '95, pointed to bills introduced by Sen. Robert Smith, R-N.H., and Rep. Bill Zeliff, R-N.H., as the starting points for this year's debate.

Both bills would repeal Superfund's imposition of retroactive liability for polluting dump sites before 1987, the effective date of the last major Superfund reauthorization. Sen. Smith is working closely with Rep. Oxley—who is chairman of the House Commerce Committee's Subcommittee on Trade and Hazardous Materials—to craft a bill that can win the approval of both houses.

"If we do our job right this year, the (Superfund reform) product we come up with will be totally alien to what we have now," Rep. Oxley said.

"Our goals will be to maximize the Superfund dollars going to actual cleanup, move the program to the states if possible, dramatically cut the cost of cleanups and make the program fair," he said.

Superfund was also on the agenda at the National Assn. of Professional Insurance Agents' federal legislative conference in Arlington, Va.

Francis D. Bouchard, federal affairs representative of the Reinsurance Assn. of America in Washington, told the PIA's audience that insurance industry representatives have been meeting regularly "to avoid what happened last year." Mr. Bouchard said that he expects a bill to be introduced in June or July.

PIA members heard a former insurance agent—Rep. Jerry Solomon, R-N.Y.—kick off their gathering by saying that the balanced budget amendment isn't dead despite its narrow defeat in the Senate. Rep. Solomon, who is chairman of the House Rules Committee, introduced his first balanced budget bill more than 15 years ago.

Rep. Solomon praised the 104th Congress for passing "revolutionary measures." One was a wide-reaching tort reform bill, including product liability reform, which passed the House on March 10. Another was sweeping regulatory reform, including a temporary moratorium on many new federal regulations and a bill that would subject new regulations to cost-benefit analysis.

"We are making the bureaucrats jump through the hoops instead of the local businesses," he told an appreciative audience.

Another change wrought by the 104th Congress is the lineup of insurance-related issues likely to receive attention, said Dean Sackett, PIA's assistant vp-government. Reform or repeal of the McCarran-Ferguson Act, a project near and dear to the heart of former House Judiciary Chairman Jack Brooks, D-Texas, is "a dead issue at the federal level" for at least two years, said Mr. Sackett.

Health care reform in the form of "the utopian, socialist system President Clinton and his wife pushed" is also off the screen, said Mr. Sackett. Instead, Congress is likely to consider a market-based health care reform package, he said.

A third item of concern to agents in the 103rd Congress—bills designed to end insurer redlining, illegal denial of coverage on the basis of the applicant's race or place of residence—won't emerge during this Congress, he said. But the Department of Housing and Urban Development may try to address alleged redlining in inner cities through regulations. Those regulations, however, could be stymied by the regulatory moratorium if it becomes law, he said.

Another area of concern to agents and insurer alike—financial protection against natural disasters—was addressed by Sante Esposito, chief counsel for the House Transportation and Infrastructure Committee. Mr. Esposito said that a natural disaster protection bill was likely to be introduced within a few weeks of the PIA conference. The bill, which he said he hoped would have bipartisan support, would encourage the purchase of

*See* **Conventions** *on next page*

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Agent/Broker Topics

# Some states' damage awards punishing to insurers

## Alabama agents worried about underwriters leaving market

By SARA MARLEY

Move over, California and Texas. Juries in Alabama are now awarding some of the highest punitive damages in the land, a fact that has insurers pulling out of the state and agents and brokers worried about availability.

"If you file a lawsuit with a frivolous claim, you have a better chance of winning than if you buy a lottery ticket" in Alabama, said D. Gaines Lanier, president and chief operating officer of J. Smith Lanier & Co. Inc., a West Point, Ga.-based agency with offices in Huntsville, Lafayette and Opelika, Ala.

"No matter whether a case has merit or not, the insurance carrier is not going to win," Mr. Lanier contended. "There's a wave of settlements, which in turn creates a flurry of new claims."

Forty percent of cases settled in Alabama were settled for higher than the amount demanded, according to Jury Verdict Research of Horsham, Pa., which publishes data on awards and settlements.

The median settlement was $20,000, while the highest reported from 1988 to 1993 was $10 million.

In cases that go all the way through trial, the median punitive award in personal injury suits in Alabama was $250,000, more than eight times what juries in the state typically award to compensate directly for personal injuries.

That median—which excludes wrongful death claims—is also three times higher than the national median of $82,561, $100,000 higher than the median award in Texas and equal to California's median.

Defendants that lose in Alabama can expect to pay $5,000 to $200,000 for the personal injury portion of the award, while the range of probable punitive damages stretches from $50,000 to $1 million, according to Jury Verdict Research.

The largest punitive damages award given during the five-year period ending in 1993 was a whopping $33 million, more than twenty times greater than the largest compensatory award.

Several of those multimillion-dollar punitive damages verdicts have been directly against insurance companies. In all, Alabama juries have awarded more than $130 million in punitive damages against insurers since 1991, most for fraud, bad faith, misrepresentation and other illegal sales practices.

Many of the cases involve the sale of life and health insurance policies, including Medicare supplement policies.

A judge upheld $25 million in punitive damages against Prudential Insurance Co. of America after its agent fraudulently sold whole life policies, but the judge called for 40% of the award to go to the state's general fund (*A/BT*, Nov. 7, 1994). He further recommended that the money be earmarked for the Department of Insurance to hire someone to investigate and monitor insurance agents.

Prudential later settled for an undisclosed amount.

In December 1991, a jury awarded $25 million in punitive damages against Northwestern Mutual Insurance Co. and one of its agents after the agent allegedly stole about $9,000 in premiums and disappeared.

Southern Life & Health Insurance Co. was ordered to pay $5 million for bad faith and fraud over a dispute involving a $1,000 death benefit in 1991. The award was reduced to $500,000 and was later settled after the U.S. Supreme Court remanded the case to the Alabama Supreme Court.

Continental Casualty Co. was ordered to pay $750,000 for late payment of workers compensation benefits in 1990.

More than 20% of the injuries reported in Alabama were for emotional distress, more than for any other category, including back and neck strains and wrongful death.

The Alabama legal system is taking its toll on the insurance market. At least 10 insurers have pulled out of the state or stopped writing new business due to the legal climate, estimates the Alabama Department of Insurance. Insurers are not required to notify the department when pulling out.

"We are hearing from agents that companies are cutting staff and cutting back" writings, said Michael Bownes, general counsel for the Alabama Department of Insurance. "At this point we are not hearing consumer complaints about availability. But our fear is that by the time we hear there is an availability problem, it's too late."

Premium tax paid was steady in the fourth quarter of 1994, an in-

*See* **Alabama** *on next page*

# Conventions

*Continued from previous page*

insurance against quakes and other disasters by homeowners.

The third major property/casualty producer legislative conference will begin on May 15. House Speaker Newt Gingrich, R-Ga., is slated to deliver the keynote address to the Alexandria, Va.-based Independent Insurance Agents of America.

A fourth major insurance producer group, the National Assn. of Insurance Brokers, gathered in Washington in February to discuss international market matters in the first World Brokers Conference.

The meeting drew representatives from broker groups in Australia, Canada, Europe, New Zealand and the United Kingdom as well as the United States.

"There are major world markets—China, India, Japan—where brokers are restricted or banned," said NAIB Chairman Lucien P. Laborde Jr., managing director-risk management services for Willis Corroon Corp. in Nashville, Tenn.

"We want to get ourselves organized to open new markets to our skills and services. We are here to forge a working alliance between our association and our members to break down the barriers to our industry, country by country, continent by continent," said Mr. Laborde.

Among the actions NAIB and its fellow brokerage associations plan to undertake are to appoint liaison contacts for each of the groups, to coordinate the NAIB and the London Insurance Brokerage Committee's positions on Japan, to share policy positions on India and to have the Brussels, Belgium-based Bureau International des Producteurs d'Assurance et de Reassurances take the lead on coordinating efforts in Eastern Europe, where markets are chaotic.

The associations also agreed to convene another international meeting sometime within the next two years.

Other speakers included Sen. Richard Lugar, R-Ind., who announced his intention to seek the Republican presidential nomination shortly after appearing at the conference, and U.S. Commerce Secretary Ronald H. Brown. BI

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Tom Moore (l) and "Barney" Runcie at the 19th Hole at Southward Ho Country Club

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# Alabama

*Continued from previous page*

dicator that the amount of insurance sold was the same as in previous quarters, Mr. Bownes said.

Life Insurance Co. of Georgia stopped writing new policies in Alabama after a jury ordered the company to pay $15 million in punitive damages to a woman who was fraudulently sold a Medicare supplement policy. The award was later reduced to $12.5 million. Life of Georgia is appealing.

"We believe that punitive damages are out of control in Alabama," President James C. Brooks said when announcing the insurer's decision last June. Despite the Atlanta-based company's 103-year history in Alabama, "we simply cannot continue to do business in a climate where arbitrary and excessive penalties are imposed."

While many agents and brokers said there isn't a coverage availability crisis in the state yet, they fear one is brewing if the gargantuan awards aren't brought under control.

"Without question, if it continues on the course it's on now unchecked, it will be more difficult to get insurance and the price will be higher over time," said Bruce C. Dunbar Jr., chairman and chief executive officer of agency McGriff, Seibels & Williams Inc. in Birmingham.

However, there are some hopeful signs the trend is slowing. Some insurers have only restricted their writings in the handful of Alabama counties producing the majority of the huge awards. And judges seem to be more willing to reduce the awards in post-trial proceedings.

"We're seeing the light at the end of the tunnel finally," said John R. Pacholick, chairman and chief executive officer of Palomar Insurance Corp., a Montgomery, Ala.-based agency. "The election in November brought more pro-business people into the state Legislature and Senate."

Agents also agree the situation could be far worse if it weren't for the generally soft insurance market.

"The insurance market is real competitive now," making insurers less likely to walk away from potential policyholders, Mr. Dunbar said.

"There isn't a shortage of market here," Mr. Pacholick said. "The regional carriers are still very aggressively writing business. National carriers are taking a cool attitude and only writing the best risks."

Commercial lines insurers are scrutinizing all risks in Alabama more closely, particularly professional liability. In fact, some agents have had difficulty renewing their own errors and omissions coverage.

Employers Reinsurance Co., according to Mr. Dunbar, threatened to non-renew agents errors and omissions coverage held by McGriff, Seibels, which is the 17th largest broker of U.S. business in the country. Employers Re officials were not available for comment.

Agents and brokers are encouraged that Alabama's newly elected governor, Republican Fob James Jr., has made tort reform a priority.

They also perceive the state Legislature as more pro-business. In the past, though, the Legislature has passed tort reform measures only to have them struck down by the state's Supreme Court (*BI*, July 26, 1993).

And that elected body remains a wild card in any 1995 efforts.

Held last November, the race for chief justice still remains too close to call while a dispute over absentee ballots is settled. That race pitted the current chief justice, Sonny Hornsby, who has repeatedly voted to strike down pro-business tort laws, against Perry Hooper, who is considered a backer of tort reform.

Regardless of the outcome of the chief justice race, "the message to the Supreme Court is clear," Mr. Pacholick said. "The state will no longer tolerate the kind of pro-trial lawyer attitude they have had."

In addition to tort reform, the state must also reform some aspects of its Insurance Department, Mr. Bownes said.

The department needs more authority and more staff to address consumer complaints, Mr. Bownes said. "We are woefully understaffed," with just four employees to handle consumer complaints, giving Alabama one of the lowest staff-to-premiums-written ratios in the country.

The Insurance Department is seeking to implement some basic consumer protection laws to "bring the department into the 21st century," Mr. Bownes said.

The department has already passed a regulation requiring continuing education for agents, although the rule has not yet been implemented.

Gov. James has yet to appoint a permanent insurance commissioner, making it difficult to formulate a legislative agenda, Mr. Bownes said.

"The industry has been very supportive of our efforts to obtain additional staff and funding," he noted.

Some in the state fear the punitive damages problem is worsened because the department has limited authority to fine companies or agents for misconduct. So, juries mete out their own justice.

"Most industries find any regulation distasteful, but (insurers) find regulation by the insurance department preferable to regulation by the plaintiffs bar," Mr. Bownes said. BI

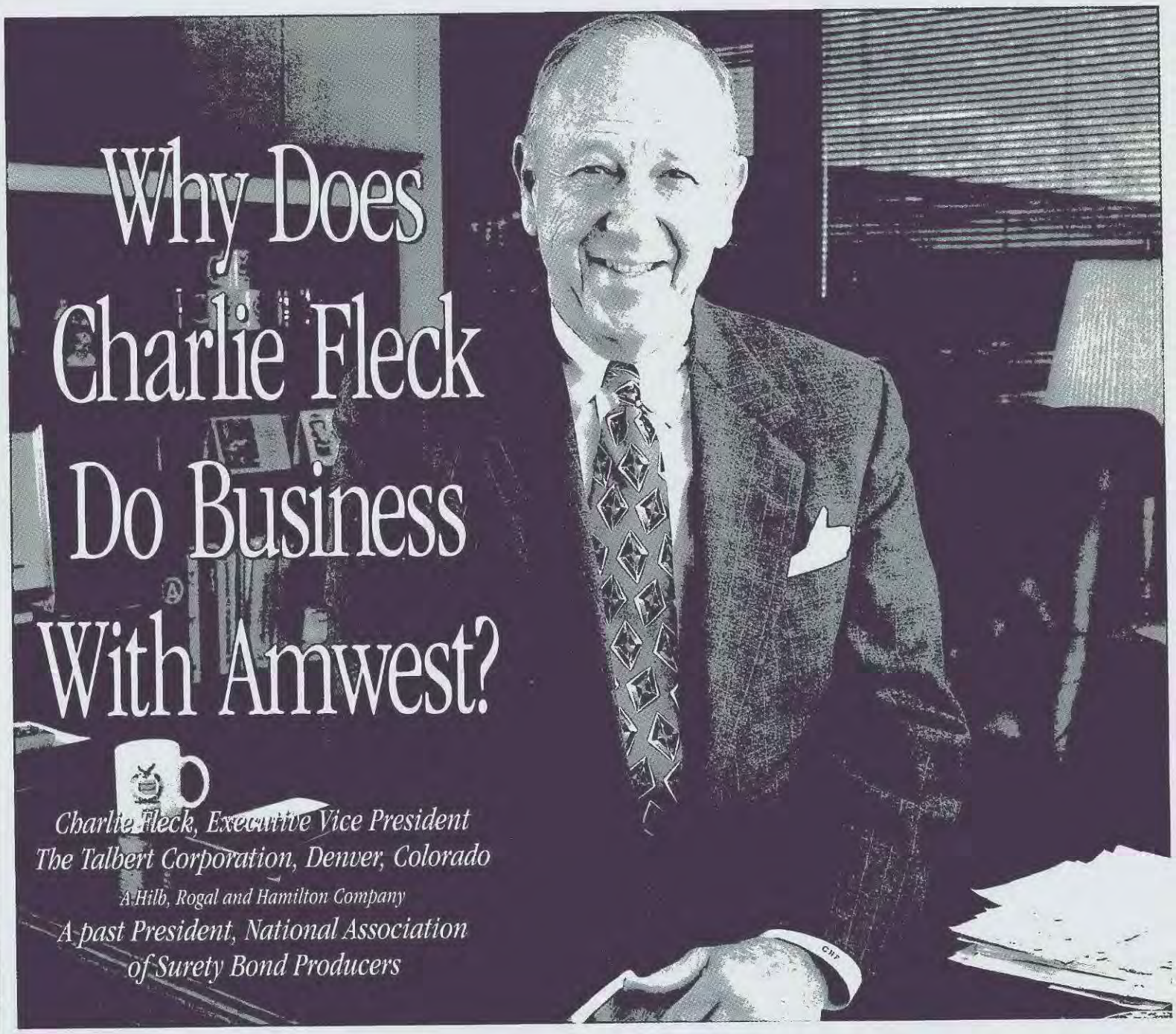
## Where the juries see green

Median punitive award in personal injury claims (excluding wrongful death) in selected states 1988–1993

| | |
|---|---|
| Alabama | $250,000 |
| California | 250,000 |
| Texas | 155,000 |
| Florida | 125,000 |
| New York | 120,000 |
| National average | 83,000 |
| Pennsylvania | 60,000 |
| Georgia | 23,000 |
| New Jersey | 20,000 |

Source: Jury Verdict Research

GRAPHIC BY KIM ROME



# Legislative changes may help insurance industry

**By Gerald D. Stephens**

## A/BT Perspective

The revolution that brought the Republican Party into power in Congress and statehouses last November has had an amazing effect.

Suddenly, off-limits, politically protected laws and regulations are open for debate. The new breed of politician is challenging sacred institutions and government fiefdoms that were untouchable under prior regimes. War has been declared on red tape and useless regulation.

This is the time for the insurance industry to stand up, wave our hands and shout: "Don't forget us!" Many insurance laws and regulations, if examined in daylight, make no sense and only add cost to our products and confusion to the marketplace.

For example, a bill in the Illinois Legislature would abolish the historically misguided countersignature law. For brokers and agents in Illinois, passage of this bill would eliminate the retaliation of five states. To anyone handling an interstate insurance account, six new states with no countersignature law will come into being. Sharing commissions with politically connected agents in other states smacks of backroom politics from the dark ages. Fresh air! Sunshine! The demise of a law that did nothing but increase policyholders' costs is finally imminent.

We are on a roll. Now let's get rid of the remaining anti-competitive price and form control laws. It still takes up to a year to get a new insurance product filed and approved through the bureaucratic maze in states with price laws.

If all states were as sophisticated as Illinois—with no insurance price-fixing laws—there would be no experience calls. Sending policy coding and report submissions to the Insurance Services Office and ISO's subsequent reports to the individual states involved costs the industry a fortune. I'm convinced that all this data goes on a shelf somewhere in the insurance department involved and is never referred to again.

What do we get for this expense? Price and form controls are leftovers, legalized by the McCarran-Ferguson Act. Some may remember that regulating insurance rates was thought necessary to protect insurers from competition. Rates were regulated to keep them high so companies would not go broke.

Times change. In reality, states do a lousy job of regulating price. Commercial rate filings are riddled with so many deviations and experience credits that almost any premium can be quoted for any risk. What irony. We suffer from ineffective price controls supported by a nightmare of regulation and resulting paperwork and companies can still go broke.

Misguided arguments to justify the existing system have been made to the effect that one company is not large enough to develop its own rates. Especially small, regional insurers. We have all heard stories that the little company can't compete without the availability of industry experience. Rubbish. In the real world, property and casualty rates are not cost-driven, they are market-driven. If a small company wants to compete in a given line of business, it looks at the price other companies are charging in the region and goes from there. Independent actuaries are more than happy to consult if help is needed.

No conceivable argument can demonstrate the need for price controls in this highly competitive industry. If you are a consumerist and you want premiums to go down, get rid of bureaucracy and regulation. Make the industry compete in a free market. It works in Illinois and it will work in other states. Price fixing is a relic and should be consigned to the Republican-driven junk heap.

### It's coming from feds

The sweet era of tort reform is upon us. It's overdue. The initiatives on product liability and punitive damages are indeed a breath of fresh air.

The granddaddy of them all unfortunately is not part of the "Contract with America." Without doubt, the most expensive and misguided legislation from the past is Superfund. That 1980 law was "politically correct" Washington's finest hour. Superfund is to the plaintiffs bar as candy is to a baby.

The most onerous part of this bill was its retroactive provisions. What used to be perfectly legal and even required by older laws is now retroactively against the law. Not only is the law retroactive, but it provides for joint and several liability. This raises the hackles of most of us more than anything the government has done to redistribute wealth, not to the poor, but to the attorneys.

Suppose 10 years ago you drove through a small town in your state. Today you would get 60,000 summonses because it is alleged you ran a red light that had just been installed in the town. You say: "But the light wasn't even there 10 years ago!" They say, tough luck, the law is retroactive. You say: "But I am only one, why the other 59,999 tickets?" They say you're the only one they could find and since the law provides for joint and several liability you have to pay for all of them.

The companies involved did not break the law. They, in fact, complied with then-current laws and standards in waste disposal. Now they have to pay if they are responsible or even if an unrelated party was responsible if they occupy or own the land involved.

Because companies will defend themselves against such unfair laws, the only people benefiting from this litigation are the attorneys. Attempts to pass the costs onto insurers have succeeded in about 50% of the states and the law will continue to be litigated for the next century unless Congress does something about this ridiculous situation.

The solution? Repeal it. There is no place for retrospective penalties and joint and several liability. They don't work.

Cleaning up polluted sites entails moving dirt. A lot of it. It could put a lot of able-bodied welfare recipients to work. Divert some welfare funds and human resources to this goal. Some additional funds will be needed. A trust fund could be established from fees levied on the industries involved on a no-fault basis. The important thing is to get the job started.

### A job for the feds

After deep thought, I have reluctantly concluded there is one place the federal government can do something useful that the states or free enterprise cannot.

A long time ago, somebody defined insurance as placing a light burden on the many to pay for the losses of the few. It follows that if we could somehow get most property owners to contribute a small amount to a nationwide trust, we could take care of the unfortunate who would suffer mightily if their place of employment and their home were destroyed by a catastrophe. Simply put, the P/C industry lacks the resources to pay the losses it would be face, for example, in a force 5 hurricane that struck 30 miles north of where Hurricane Andrew hit.

Not even all of the world's insurers could handle the potential $100 billion-plus earthquake loss that scientists say can happen in the Midwest, California or, by the way, did you know Manhattan lies on a fault line?

Plainly put, most insurers of any size would be bankrupt. Portfolio stocks and bonds would have to be dumped to pay losses. Financial markets would be in shambles. Debts would not be paid. Banking

*See* **Legislators** *on next page*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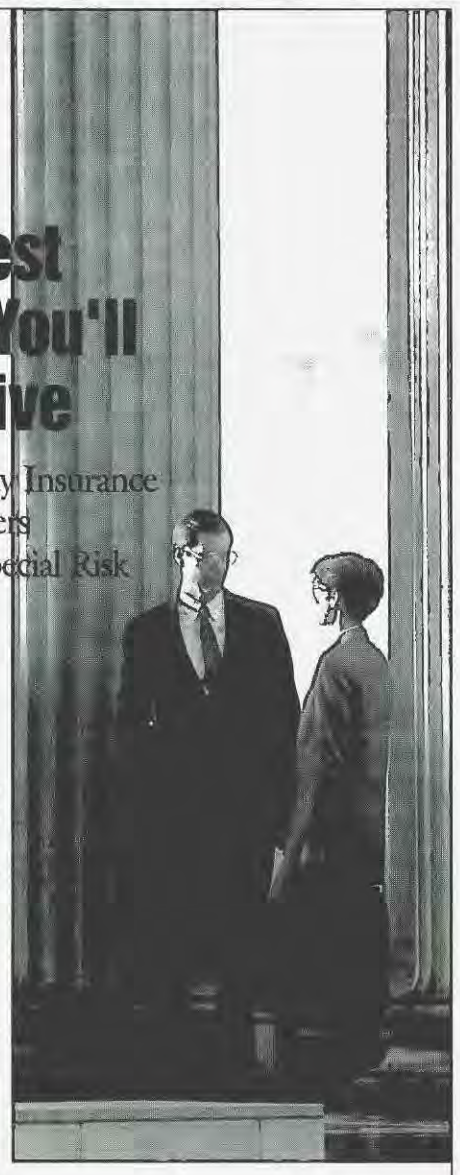

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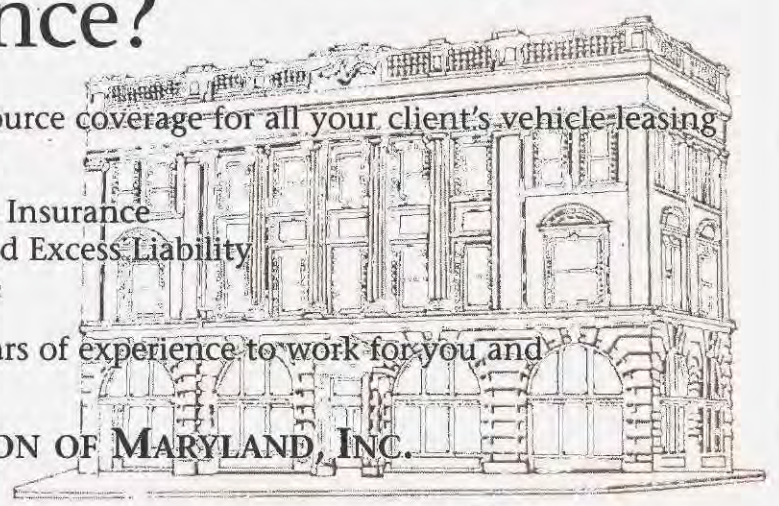

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## A/BT Briefs

### Ethics institute

MALVERN, Pa.—The American Institute for Chartered Property Casualty Underwriters and the Insurance Institute of America recently established an Institute for Applied Ethics in Insurance.

Coming on the heels of Ethics Awareness Month, sponsored by the AICPCU and IIA each March, the Ethics Institute—with initial funding of $1 million from the AICPCU and IIA—will support independent ethics research and publish the findings. It will also distribute videotapes and other informational material and conduct seminars to educate members of the insurance industry as well as the public on ethics in insurance.

Staff members of the Malvern, Pa.-based AICPCU and IIA will operate the Ethics Institute, which will cooperate with other ethics organizations to produce pamphlets, newsletters and workshops.

The Ethics Institute will fund research helpful to agents, adjusters, underwriters, risk managers, insurance regulators and consumers.

"The objective of the new Ethics Institute's activities will be to raise the consciousness of all of these groups about ethics in insurance and to help those involved in insurance to make better ethical decisions on the job," said Frederick England Jr., AICPCU/IIAA chairman and chief executive officer of Hastings-Tapley Insurance Agency in Cambridge, Mass.

The institute is currently accepting research proposals. For more information, contact Norman A. Baglini, Institute for Applied Ethics in Insurance, P.O. Box 3016, Malvern, Pa. 19355-0716.

### IIS moves

NEW YORK—The International Insurance Society Inc. has a new home: The College of Insurance in New York.

Formerly based at Georgia State University in Atlanta, the IIS will now operate from The College of Insurance's campus in New York City's financial district.

The IIS, a non-profit organization founded in 1965 and managed by leading insurance executives and scholars, fosters the development of insurance and communication of ideas internationally. It offers annual seminars on global insurance issues.

The College of Insurance offers undergraduate degrees in business administration, finance, insurance and actuarial science, and graduate degrees in finance, insurance, risk management and actuarial science.

### Producer defined

A subgroup of the **National Assn. of Insurance Commissioners** has given interim approval to expanding the definition of "producer" in the Producer Controlled Property/Casualty Insurer Act.

The change allows for the act to apply to agents as well as brokers if they control insurers, as defined in the act. BI

# Legislators

*Continued from previous page*

would be disrupted. A loss this large would affect everything from food to building supplies. Thousands of people would be displaced and thousands more killed. The damage to Kobe, Japan, in the recent quake would pale in comparison.

What happens to the folks in Ohio, Iowa or Minnesota if the Big One happens in New York or California? Unless we come together to solve this problem as a nation, all of our people will be affected one way or another.

Fortunately, there is a solution. It is called the Natural Disaster Act. Unlike most potential legislation that affects our industry, this proposal has the industry's unanimous support. It makes sense, so much that I'm worried about its chances in Washington.

It makes sense because it's not only a reinsurance program of last resort but more importantly it will bring affordable protection to all American families. The proposal would provide coverage for private dwellings for earthquake and wind disasters and provide excess-of-loss reinsurance for commercial and industrial risks.

Each insurer would cede reinsurance premiums to the central pool. Since we all have a stake in catastrophes, it makes sense that everyone should contribute, in proportion to exposure. The cost of this valuable protection would be very economical.

Thus a major fund accumulates to pay for the Big One when it occurs.

If it comes before there is enough money in the pool to pay for it, the pool would have to borrow from the federal government or possibly issue government-guaranteed bonds to pay the losses. The loan or bonds or both would then be paid back from future reinsurance receipts from the industry.

The act would enable the industry to immediately put its substantial adjusting force in an affected area and get people housed by making "additional living expense" payments, instead of Federal Emergency Management Agency loans that probably won't be collected anyway.

The bill would not require new taxes. In fact, it reduces government emergency expenditures in major catastrophes.

Many of us were energized by what happened last November. There is hope and optimism that our views will finally receive a fair hearing. Price fixing, Superfund and the Natural Disaster Act are in my opinion the most important issues to address this year.

Fairness and logic are breaking out. You can feel it. BI

*Gerald D. Stephens is president and chief executive officer of RLI Insurance Co., a property/casualty insurer based in Peoria, Ill.*


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Agent/Broker Topics

# Turmoil postpones rewards of Mexico insurance ventures

## Insurers adjust business strategies to reap future gains

By GAVIN SOUTER

What a difference a year makes.

At the beginning of 1994, optimism about business prospects in Mexico was rampant among U.S. insurance companies.

The North American Free Trade Agreement, which was signed in November 1993, made many U.S.-based insurers eager to take advantage of the developing economy in Mexico.

U.S. insurers had visions of new demand created quickly by huge infrastructure projects, the privatization of Mexican industry, increased presence of U.S. companies there and the growing Mexican middle class.

No more. In only a year, the value of the peso collapsed; foreign governments and companies had to step in to avert a financial crisis; and the Mexican government is combating rising inflation and interest rates with a severe austerity program.

So far, U.S. insurers have not suffered long-term setbacks in the Mexican crisis, said Norman Rosenthal, managing director of equity research at Morgan Stanley & Co. Inc. in New York. "All of the U.S. insurers have said that the problems in Mexico are not going to have a material effect on their results."

But their high expectations for short-term growth have been dampened, Mr. Rosenthal added.

The problems have made insurers less enthusiastic about trumpeting their Mexican interests, said David Seifer, vp at Donaldson, Lufkin & Jenrette Securities Inc. in New York.

"After NAFTA they all talked about being in Mexico, but after the peso they shut up or said that they were really small there," Mr. Seifer said.

During the past year, U.S. insurers involved in Mexico posted impressive sales figures, but the increased profits from those sales were offset by the devaluation of the peso, Mr. Seifer said.

U.S. insurers see the economic crisis as only a temporary setback.

"I think the problems will be short lived," said Joseph Graziano, executive vp of the international division of Reliance National Insurance Co. in New York.

Mexico's economy should return to normal within two years, he said. "During that period there will be a lot of management efforts to deal with the problem. We'll go back to fundamentals and look at things like expenses, rates and the commissions we pay," Mr. Graziano said.

Reliance National—which became the full owner of Seguros Renamex S.A. in November 1994 after buying a 30% stake in 1993—already has adjusted its underwriting strategies in Mexico.

For example, to lessen the effects of inflation, it sometimes offers only six-month policy periods for some coverages rather than the customary one year. In addition, it is shying away from writing coverage on older automobiles, he said.

"Older cars usually have more expensive replacement parts than new cars. . . .We are trying to deemphasize any business that is susceptible to inflation on the claims side," Mr. Graziano said.

During the crisis itself, companies and individuals probably will buy less coverage, said Ernest Auerbach, head of the insurance practice at Andersen Consulting in Mexico City. "For many companies, insurance will be one of the things they spend less money on so that they can pay for things that have a higher priority."

Overall, the economic woes have pushed Mexico's economic development back by two years, he said earlier this month at a roundtable discussion sponsored by the International Insurance Council.

However, most U.S. insurers still view Mexico as a market with many opportunities that is going through a difficult period of its economic cycle, he said.

"Inflation will restrict demand but it does not affect our basic program in Mexico," said Jorge Suzan, president of Liberty Veracruzana Compania Seguros S.A. in Mexico City, which is owned partly by Liberty Mutual Insurance Co.

Boston-based Liberty Mutual purchased 35% of the company in December 1994 under the terms of NAFTA. It plans to purchase 100% of the company in 1999, Mr. Suzan said.

Under NAFTA, foreign insurers normally cannot assume full ownership of Mexican companies until 1999, in order to give Mexican insurers time to grow sufficiently to compete with U.S. insurers. But, Mexico does permit foreign companies to acquire 100% stakes in Mexican entities by going through a relicensing process, as Reliance National did with Seguros Renamex.

The company plans to focus on marine insurance and personal lines auto and property business in regional areas, he said. "We think that there is a large proportion of the middle class in Mexico that has not been accessed by insurance companies."

The financial turmoil in Mexico is a reminder that all of the nations in Latin America are on "the road to modernization," said Gary C. Petrosino, senior vp in the Latin American Zone office of Chubb Corp. in Miami.

"Doing business in Latin America is clearly not without risk," he said at the roundtable discussion. "I believe, however, that this is a risk worth taking and that the future of Latin America and its insurance industry is bright."

The signing of NAFTA resulted in a 20% increase last year in trade by U.S. industrial and commercial companies in Mexico, Mr. Petrosino said. And U.S. insurers in Mexico are already taking a more active role.

"In October of last year, the Mexican government approved the entrance into Mexico of 47 new financial groups. Included in the group were 12 American or American subsidiaries of foreign insurance companies," he said.

This is in addition to the several other U.S. and foreign insurers that already had operations in Mexico.

"All of this additional capacity flowing into the Mexican market, when added to the capacity of the large Mexican insurers, has made this market very competitive," Mr. Petrosino said.

While this is good news for policyholders looking for the lowest rates, they should also be concerned about the security of their insurers as the competition may be strong enough to push some weaker insurance companies out of the market, he said.

Earlier this month, Chubb changed names and increased its shareholdings in its Mexican investments.

It now owns 100% of Chubb de Mexico Compania Aflanzadora, a surety and fidelity bond company formerly known as Central de Fianzas. Full ownership of Mexican surety companies is permitted under NAFTA.

And it increased its stake in Chubb de Mexico Compania de Seguros to 30% from 27%. The property/casualty insurer was previously known as Seguros Equitativa.

With NAFTA in place, U.S. insurers are projecting growth in commercial coverages that are not yet widely bought in Mexico, such as directors and officers liability and errors and omissions, said Reliance National's Mr. Graziano. "The insurance requirements in Mexico will change as investments there take hold," he said.

Increased trade with the United States should stimulate interest in D&O and product liability insurance, said Steve Schleisman, president of American International Underwriters North America, a unit of American International Group Inc. in New York.

"It's driven by the fact that a lot of companies in Mexico are looking to U.S. capital markets. Also, the increase in exports to the U.S. means that they have product liability exposures here," Mr. Schleisman said.

One benefit of the peso's devaluation is that it makes Mexican exports cheaper, said Hamilton Dasilva, president of the Latin American division of AIU.

"We are already seeing a better flow of Mexican exports, not only to the U.S. but also to other Latin American countries," he said.

Increased insurance opportunities also may result from the Mexican and foreign companies that are taking advantage of the economic slowdown to make bargain investments in Mexico, Mr. Dasilva said.

AIU is currently setting up a NAFTA business unit to take advantage of the medium- and long-term increase in trade among Mexico, the United States and Canada, Mr. Schleisman said.

"We feel optimistic about the future and we are going ahead with our plans for the new unit despite the problems in Mexico," he said.

AIU units in North America will have NAFTA business desks that will do business with AIG's affiliate in Mexico, Mr. Schleisman said.

AIG owns 49% of Seguros Interamericana S.A. in Mexico City.

The only Mexican insurer to venture into the U.S. market is Aseguradora Mexicana S.A., or Asemex, which opened a branch office in Austin, Texas, in May 1994 to write coverage for trucking business between the United States and Mexico.

The company has not yet written any premiums and earlier this month the Mexican government took control of Asemex in Mexico due to financial problems at its parent, Grupo Financiero Asemex Banpais S.A. de C.V. (*BI*, March 13). BI


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| 101 | Brownyard Group | 22H |
| — | Business Insurance | 22K |
| 102 | EBP Health Plans | 22D |
| — | Greater NY Insurance Co. | 22H |
| 103 | Jamison Special Risk Inc. | 22J |
| — | Lee & Mason | 22J |
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Continued from previous page

## G

### General Computer Corp.

2045 Midway Drive, Twinsburg, Ohio 44087; 216-425-3241; fax: 216-963-7726

**PBM Clients**

Total ..... 50
Employer/group plans with direct service ..... 4

**Lives Covered**

**Group Health:**
Total ..... 3,703,828
Active enrollees ..... 2,777,871
through employers ..... 10%
through third-party vendors ..... 82%
through Medicare/Medicaid ..... 8%
**Workers Compensation:**
Active enrollees ..... 48,000

**Retail Network**

Pharmacies under direct contract ..... 40,000
Pharmacies in leased networks ..... 5,000

**Mail-order services**

Percent of prescription volume ..... 5%

**Generics**

Percent of prescription volume ..... 22%

**Staff**

Total ..... 186
Professionals ..... 55

**PBM services since:** 1989.

**Parent:** Welsh, Carson, Anderson & Stowe; primary business: investment firm.

**Services:** Retail pharmacy network, mail-order distribution*, claims processing, concurrent utilization review, retrospective utilization review*, benefit design consulting*, formulary management/review*, monitoring of physician prescribing practices*, patient/physician education*, decision support*.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Generic vs. name brands dispensed analysis, employee utilization, provider pharmacies statistics.

**Service area:** Nationwide.

**Billing methods:** Fee per claim.

**Officers:** Carol A. Dragan, president/CEO; Thomas Stanek, executive vp-operations; Robert M. Phillips, senior vp-sales/marketing; Timothy Loerch, vp-third party services; David Shields, vp-administration; Sidney Huling, vp.

**Contact:** Robert M. Phillips.

## H

### Home Pharmacy

820 W. Jackson Blvd., Chicago, Ill. 60607; 312-258-5200; fax: 312-258-5357

**1994 Revenues**

Total gross revenue ..... $65,000,000
PBM gross revenue ..... $65,000,000

**PBM Clients**

Total ..... 430
Employer/group plans with direct service ..... 250

**Lives Covered**

**Group Health:**
Total ..... 2,000,000
Active enrollees ..... 1,200,000
through employers ..... 60%
through third-party vendors ..... 35%
through Medicare/Medicaid ..... 5%
**Workers Compensation:**
Active enrollees ..... 200
through employers ..... 100%

**Retail Network**

Pharmacies under direct contract ..... 37,000

**Mail-order services**

Percent of prescription volume ..... 20%

**Generics**

Percent of prescription volume ..... 25%-30%

**Staff**

Total ..... 115
Professionals ..... 50

**PBM services since:** 1983.

**Parent:** ArcVentures Inc.; primary business: hospital.

**Services:** Retail pharmacy network, mail-order distribution, claims processing*, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review*, monitoring of physician prescribing practices, patient/physician education.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patters, generic vs. name brands dispensed analysis, employee utilization.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers.

**Officers:** Marie Sinioris, president; Tony Davis, CFO; Ed Fischer, senior vp; Tony Chan-Sew, pharmacist-in-charge.

**Contact:** Eirik Olsen, sales manager, 312-258-5251.

## I

### Independent Pharmaceutical Consultants Inc.

7 Regatta Bay Court, Lake St. Louis, Mo. 63367; 314-561-3656; fax: 314-561-1498

**PBM Clients**

Total ..... 20
Employer/group plans with direct service ..... 12

**Lives Covered**

**Group Health:**
Total ..... 900,000
Active enrollees ..... 900,000
through employers ..... 70%
through third-party vendors ..... 30%

**Staff**

Total ..... 3
Professionals ..... 2

**PBM services since:** 1991.

**Services:** Retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, independent prescription benefit consulting and management.

**Formularies offered:** Open, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization.

**Service area:** East and Midwest.

**Billing methods:** Payer based reimbursement, true consulting.

**Officers:** Kenneth W. Anderson.

### Infocare Rx Services

14800 Quorum Drive, Suite 390, Dallas, Texas 75240; 800-631-2807 or 214-386-2922; fax: 214-404-8431

**1994 Revenues**

Total gross revenue ..... $300,000,000
PBM gross revenue ..... $125,000,000

**PBM Clients**

Total ..... 194
Employer/group plans with direct service ..... 57

**Lives Covered**

**Group Health:**
Total ..... 1,500,000
Active enrollees ..... 400,000
through employers ..... 10%
through third-party vendors ..... 85%
through Medicare/Medicaid ..... 5%

**Retail Network**

Pharmacies under direct contract ..... 285
Pharmacies in leased networks ..... 20,000

**Mail-order services**

Percent of prescription volume ..... 12%

**Generics**

Percent of prescription volume ..... 34%

**Staff**

Total ..... 20
Professionals ..... 5

**PBM services since:** 1986.

**Parent:** Texas Pharmacy Co-op.

**Services:** Retail pharmacy network, mail-order distribution, claims processing*, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education.

* *Subcontracted.*

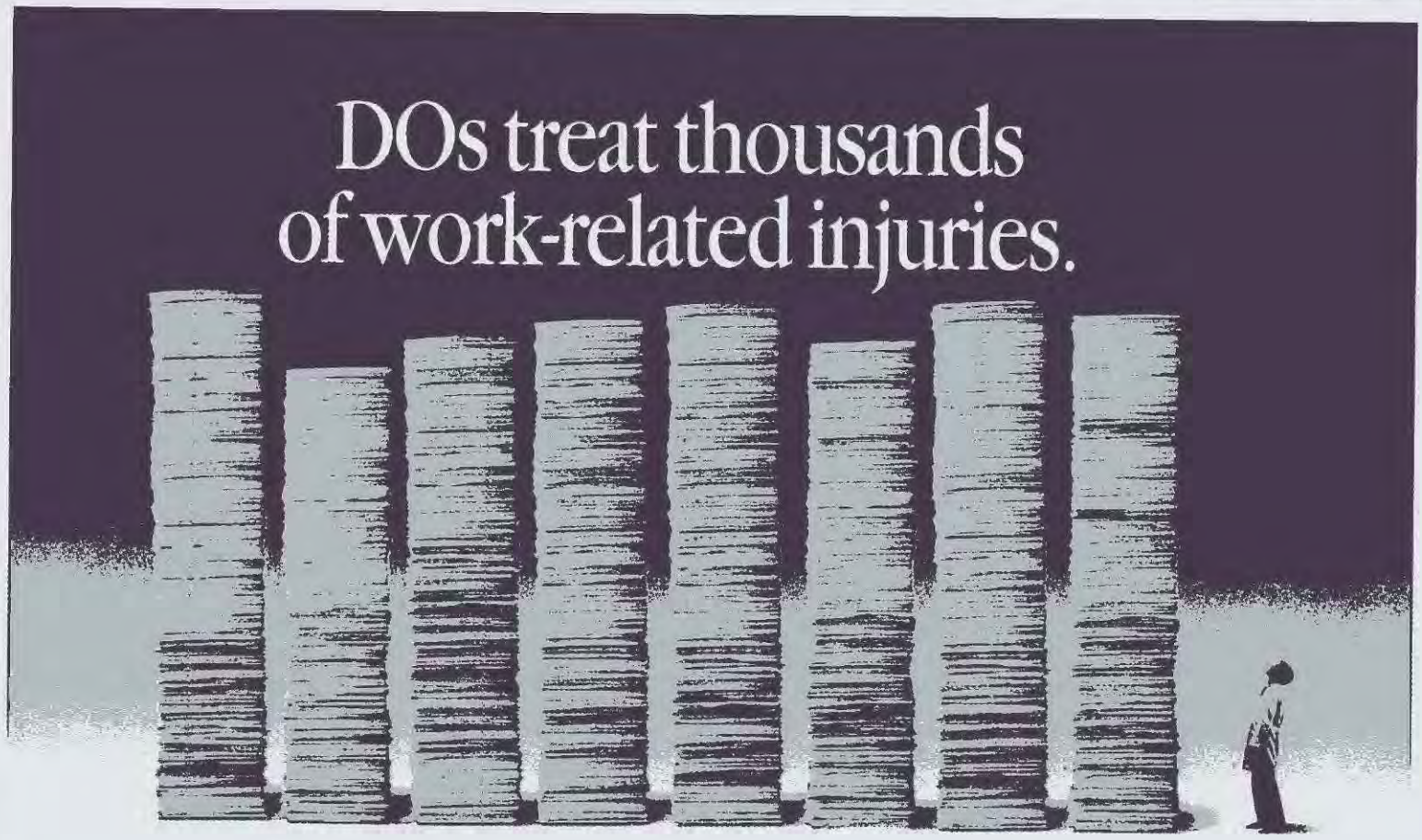
**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, client specific.

**Service area:** Nationwide.

Continued on page 27

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# Getting back to the basics

## Don't let technology drive your strategy for communication

By Ronald D. Hurt

FOR BENEFITS PROFESSIONALS today, few issues are hotter than defined contribution plans, especially 401(k) plans and their communication to employees. There are three primary reasons for this rising interest:

- Choice. The employee choice of investment options and deferral rates required by most defined contribution plans mandates at least some level of employee communication. At its most basic, this could mean nothing more than a plan document, an enrollment form and an annual statement.
- Change. The well-documented shift from defined benefit to defined contribution plans, coupled with increased job mobility, has meant that defined contribution plans are becoming the primary income replacement vehicle for many employees. As a result, an entirely different level of communication is required, and employers and plan-providers are scrambling to fill that need.
- Congress. The new guidelines for Internal Revenue Code Section 404(c) offer employers safe-harbor protection from employees who—through the exercise of choice—make bad investment decisions and look to the employer to relief. At the least, this requires significant "disclosure" (read "communication") about a plan and its investment options. Many employers, however, are choosing to interpret the law even more broadly to mean that an employer must "educate" employees so they can "exercise control" over their accounts in a reasonable, intelligent way.

As a result, much attention is being paid to the development of the "latest" communications tools for 401(k) plans, including such things as:

- Annual employee meetings, with emphasis on understanding investment basics and retirement planning.
- Multipiece enrollment packages, often with sophisticated financial-planning tools.
- Personalized print communications that integrate and project a company's defined benefit and defined contribution benefits with Social Security.
- Video teleconferencing with financial experts and retirement planners.
- Daily valuation of accounts, including daily investment transactions, via touch-tone 800 numbers.
- Financial planning software.
- Individual sessions with a "financial planner."

Whoa! Financial planning? Software? Teleconferencing? What is going on here? What started a few years ago with a simple flyer to explain how a 401(k) plan worked has exploded into a communications "gold rush," with consultants and plan providers rushing to offer "the latest" tool to make even the least-educated employee as savvy as Peter Lynch.

In fact, the rush has reached such a feverish pitch that a communication vendor announced to me recently that his company had developed a product that was so sophisticated that it was "beyond state-of-the-art!"

Given the intensity of the scramble for such sophistication, it is easy to understand why some 401(k) communications programs are flawed: they have lost sight of the basics of communications. Even the latest communications tools won't work if you let the cart get too far in front of the horse.

In fact, sticking to some communications basics can help not only those benefit professionals who are working simply to develop new 401(k) communications materials but also those who see themselves as leading the way "beyond" state of the art.

In my experience, the more complex and expansive a program, the more likely it is that its developers have failed to step back and consider the basics of communication. So, in the hopes of restoring some professionalism to the rush to communicate, here are five basics that can help you ensure that the communications you introduce are appropriate and effective:

- **No. 1: Decide Where You Want to Go!**

Communications goals for a 401(k) plan often seem obvious: increase participation, diversification and savings. And it is not uncommon for all the stakeholders in a 401(k) plan to know exactly what they want the plan's communications to do. Unfortunately, perhaps because the goals seem so obvious, stakeholders often don't realize that their own communications goals differ from their colleagues'!

For example, the head of pension benefits wants everyone to appreciate the plan's latest enhancements. The head of human resources, however, wants the plan to be seen as an important part of a broader range of company-sponsored benefits. The chief financial officer wants to see more intelligent investing. And the president wants everyone to participate at the maximum level so no more money gets returned because the non-discrimination tests were failed.

In fact, there can be a myriad of potential—and often different—goals for a 401(k) communications plan. Even the best communications plan, however, can only achieve one or two primary goals at a time. To ensure your program's success, you must emphasize and repeat your primary messages in every medium you use.

*See* **Basics** *on next page*

# Centering sights on quality

## Technology advances lack meaning without useful data

By Richard F. Denning

THE 1992 CAMPAIGN for president brought in vogue a new expression for an old concept. "It's the economy, stupid," served as strong advice to focus on issues truly central to the voters. The phrase has potential application in countless areas.

In information management, too, there are distractions to confuse us from recognizing such pivotal issues. One such peril is that users become too focused on advancements in technology and new bells and whistles at the expense of data quality.

Obviously the information highway is not completely paved yet, and traffic jams—even bridge collapses—are commonplace. Nevertheless, this technology is moving in the right direction and becoming ever more "user friendly." Five years ago, for example, you needed a computer science degree simply to install a software program. Today, the only requirement is the ability to read, move a mouse and faith that the computer knows what it is doing.

Walk into a modern computer superstore and you are bombarded by the best and newest of the big three—hardware, software and communications. In risk management, we have experienced an explosion of information services in each of these areas. There are literally hundreds of firms offering various information products for the risk manager today.

As technology has expanded, the systems used in risk management have become lower priced, more consistent in their features and even similar in the way they operate. Indeed, they are becoming commodities.

Using the annual Risk & Insurance Management Society Inc. convention as a guide, in 1980 an exhibitor's use of a computer was a big draw ("Wow, you can do that?!") but, by 1990, a mere yawn ("Ah, when did you say lunch was?").

Despite the advance of technology, that is not what will differentiate the service providers of the future. Rather, the scope and quality of their data will be the critical issue.

Insurers and third-party claims administrators have accepted the once radical notion that the information they provide is as valuable as any of their operations, such as claims handling. The content, accuracy and accessibility of that data are the critical battlefronts for those who are using information as a component of their services.

Given the importance of data quality, how do you measure it?

Although benchmarking—comparing your performance to that of another, similar organization—is much in vogue, I believe the most reliable benchmarking source for any organization is its own experience. Competing with yourself (continuous quality improvement) was strongly endorsed by W.E. Deming—an American statistician who pioneered the quality revolution and introduced it to Japan following World War II—as the most reliable and objective for monitoring performance. Trends showing improvements year to year are the best measure of quality available.

The flow of data from the source to the computer database can have a significant impact on quality.

The problem of coding errors, for example, usually starts with the original documents from the field. Unclear, unfamiliar and bureaucratic forms and procedures, in particular, can create errors and delays and start a claim down the expensive path to lawyer involvement.

An increasingly popular alternative is telephone hot lines for claims reporting. A phone call replaces a form and all the frustrating procedures surrounding paper systems. But the key benefit of telephonic systems is their ability to get the right people in contact with the claimant quickly.

Kemper National Insurance Cos. and Travelers Corp. have published their results on the savings in average claim settlements when even a few days are cut in contacting claimants. Today, 50% of workers comp claims are initiated through such telephonic services.

Data quality must be considered in light of the value of the resulting information.

Claims data collected but never used is irrelevant. Indeed, there is a positive correlation between use of data and its accuracy. The more data is relied upon, the more its errors become obvious and are corrected.

*See* **Data** *on next page*

# Basics

*Continued from previous page*

Otherwise, they will get lost in the "noise" of everyday life.

What to do? Before you even begin to think about specifics, make sure you decide as a company what you want to achieve. My advice is to get all the stakeholders in a room and agree on no more than one or two key objectives. You can always come back next year and work on other objectives. But if you don't focus on one or two, you may end up accomplishing nothing.

- **No. 2: Know Your Audience!**

Many of our clients are surprised to hear me suggest that talking to—and listening to—employees is critical to the success of any 401(k) communications program. Don't we all have the same need to save? Perhaps, but it is not exactly that simple.

For example, what we say when a 5-year-old plan is being enhanced is very different from what we say to employees under a new plan.

Other differences are also critical. Employees with a strong defined benefit plan should get different information from employees whose 401(k) will be their primary source of retirement income. Employers with younger employees may want different communications than those with primarily older employees. Employees with less formal education may need different communication than employees with college degrees (though this one can surprise you!).

In fact, the differences among employee groups and their needs for information vary so greatly that any communication program taken "off the shelf" runs the risk of missing the mark widely.

What to do? It's simple: talk to your employees. We often use either focus groups or employee surveys. Ask how well they understand how the plan works and how well they understand investment basics. Find out whether they appreciate the need for saving. Probe their understanding of tax issues, Social Security, retirement planning and estimating retirement income and its sources.

And don't forget to ask how they would like to learn about what they don't know. Sometimes they would like a video, and sometimes it will appear unnecessary and exorbitant. Maybe they want a nice color brochure, but maybe they would prefer a detailed memo with a live Q&A session.

The point is that you're not going to know what will work or what you really need unless you do your homework. If you don't, your carefully crafted words could be ignored.

- **No. 3: Develop a Specific Plan and Stick to It!**

Once you've set one or two goals for your communications and gotten some data about your audience's needs, the most important thing to do is to lay out a road map for how to get where you've decided you want to go.

In other words, you need to develop a strategic plan to meet your goals.

Generally, there are two obstacles to developing such a plan. The first is that you have too many goals for any single plan to achieve. If this happens, go back to Basic #1.

The second problem is developing a document that is not specific enough to serve as a detailed action plan once the communications campaign begins. If this happens, you need to work harder. The best plans are detailed. They list every item to be developed, assign a purpose to each of them, and identify key dates in each item's development and who is responsible for them.

Many of today's 401(k) communications plans are complex. It's not uncommon to see 10-12 separate pieces developed in two or three different media (print, audio/visual, live presentation, etc.) And enrolling hundreds or thousands of employees in two or three shifts in eight or nine locations can get dicey. The best advice is to develop a specific action plan, get agreement on it, and then use it to manage the entire process. Persistence pays off!

- **No. 4: Don't Be Afraid to Sell It!**

We all know how important it is for employees to save for their retirements. We all know how important it is that they make the right personal investment decisions. Unfortunately, when we get to the point of writing materials, we often get timid and fall back on "benefits-speak" and "legalese."

Of course, we need to protect ourselves. But equally problematic is the fact that employees just won't "get it" if our materials are lengthy, boring or confusing. Then, you'd miss the point of having these plans in the first place; people will not enroll, will not contribute as much as they should, or will make all the wrong investment decisions.

What to do? Remember that these plans are voluntary and, as such, they have to be sold. In a real sense, the plan is competing for disposable income against all the powers of Madison Avenue. Should I join the plan. . .or take a nice vacation? Should we increase our 401(k) contribution. . .or get a new car? How many times have you heard employees say they can't afford to save? What they're saying is that the advertisers of consumable products have just done a better job of getting their money than you have!

So, when you communicate your plan, use advertising's own basics to your advantage: focus on benefits, not features; keep your language simple and your "sales" literature brief; repeat your primary message as often as possible; use different media to reach the widest audience; and make sure your "ads" are colorful and compelling.

- **No. 5: Measure Your Results!**

This is the one that almost everyone misses. You've set your goals. You've talked to your employees. You've developed a strategic plan, and you've sold the heck out of the program and why it's important to save. And you finally make it through the enrollment period unscathed! Usually, the relief of having completed a communications campaign is so great that most people just want to walk away and work on something easy, like managed health care or workers compensation!

Unfortunately, you're not going to know how well you've done unless you can put a number to it. So you've got to measure results. Of course, the results will also have a tremendous impact on next year's communications, too, so they can serve a double purpose.

To sum up, you may want to consider shifting your focus away from the latest communications tools and get back to the communications basics.

Certainly, 401(k) plans and financial planning are complex topics, and many employees are ill-equipped to make the best judgments about them. But, it's also not productive if you spend money, time and energy working on communications that are misdirected, poorly conceived or inappropriate for your employees.

Put another way, you can lead an employee to financial planning, but you can't get him to use your software if he doesn't like computers. BI

*Ronald D. Hurt is national director-employee communications for the defined contribution group at Metropolitan Life Insurance Co. in New York.*

# Data

*Continued from previous page*

In the ideal, claims data should be collected as an auxiliary process to a person's routine processing responsibilities.

For example, consider an automobile adjuster who after inspecting a damaged vehicle can directly transfer photo images of the damage to the computer-based claim file. Authorized users, even thousands of miles away, have near immediate access to these photo images.

On the other hand, a risk manager can improve data quality by not collecting data at all. How? Simply by building a link to the best source of such data (for example, employee personnel information) when it is available more accurately elsewhere.

In summary, risk managers can improve data quality in three ways:

- Use it.
- Collect it in the normal course of someone's responsibilities.
- Find the best source available for data; avoid redundancy.

The Holy Grail of Risk Management in the 1990s is saving money. Risk management is no more exempt from cost containment pressures than any other corporate department. The attention on cutting cost of risk via lower expense and smaller risk financing charges has squeezed these areas to a point of diminishing returns. Improved data quality can lead to dollars-and-cents payoffs.

For example:

✓ Retrospectively rated premiums often are manually calculated, even by some of the largest insurers. Having an accurate and flexible database of claims gives the risk manager the opportunity to verify all the calculations used to compute a retro-premium. Mistakes corrected in the policyholder's favor may prove so cost effective that the savings pay for the cost of the RMIS.

✓ Defining coverage seems a simple enough task. No one would confuse an automobile case with a workers compensation claim. But there are practical pricing considerations. What happens when a workers comp medical-only claim is mislabeled as an indemnity case or occupational disease?

If you answered "higher expense," you're right! Another example: Are the number of closed, no-payment cases reasonable and in line with historical trends? Since fees are often based on the coverage type, consider how you can test your data to confirm claim characteristics match the indicated coverage. It is an exercise in expert systems to test this logical connection between coverage and claim characteristics. This type of checking has broader applications. It also can be used to test the reasonableness of outstanding reserves or the appropriateness of risk control codes.

Reducing the cost of risk means cutting losses. Effective risk control must be in the plan for every risk manager. Unfortunately, risk control represents the most severe data challenges. The claims administrator usually is assigned the foot soldier's role in collecting this data. Yet many TPAs or insurers do not consider data collection as their critical mission. The mediocre quality of their efforts becomes a hindrance to down-stream analysis.

The problem is compounded by the lack of communication between the risk control/ergonomic specialists and the claims administrators. The challenge is also reflected in the fact that claims data alone is not enough to study the opportunity for reduced claims. One needs access to the demographics of an entire work force to monitor characteristics of workers with claims and those characteristics associated with claim-free workers. We have the statistical analysis methods; we just need the data to run them.

From a distance, objects have a look of perfection that is lost as one approaches closer and closer. Data has the same character. Its apparent accuracy and completeness break down under the scrutiny of use. We have no need for data we do not use. Conversely, use of inaccurate or incomplete data can lead to embarrassment, errors and sometimes disaster.

The starting point for improvement is to determine your risk data requirements. Then you can measure the quality of your current providers in meeting these standards. That baseline, in turn, tells you whether or not to set higher future standards for your providers or can form the basis for new specifications if you look to new providers. Remember, Mr. Deming believed that long-term partnerships based on continual improvement were the right way to do business. When trying to achieve high data quality, his advice seems particularly sound. BI

*Richard F. Denning is president of Shelter Island Risk Exchange of Shelter Island, N.Y., a risk management consulting firm specializing in analytical studies and information technologies.*

*Continued from page 23*

**Billing methods:** Fee per claim. Volume discounts to employers with 500 employees.

**Officers:** Donald P. Hollis Sr., president; L. Glenn Hall, vp.

## The INTEQ Group Inc.

1100 Centennial Blvd., Suite 180; Richardson, Texas 75081; 800-324-7799 or 214-437-2121; fax: 214-437-2736

| 1994 Revenues | |
|---|---|
| Total gross revenue | $12,500,000 |
| PBM gross revenue | $12,500,000 |
| **PBM Clients** | |
| Total | 400 |
| Employer/group plans with direct service | 150 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 400,000 |
| Active enrollees | 85,000 |
| through employers | 38% |
| through third-party vendors | 62% |
| **Workers Compensation:** | |
| Active enrollees | 1,000 |
| **Retail Network** | |
| Pharmacies under direct contract | 28,937 |
| Pharmacies in leased networks | 5,000 |
| **Mail-order services** | |
| Percent of prescription volume | 19% |
| **Generics** | |
| Percent of prescription volume | 37.5% |
| **Staff** | |
| Total | 22 |
| Professionals | 3 |

**PBM services since:** 1992.

**Services:** Retail pharmacy network, mail-order distribution*, claims processing, concurrent utilization review, retrospective utilization review*, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, disease state management*.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, clinical.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers.

**Officers:** Andrew P. Fisk, president; Jerry M. Hosler, treasurer/CFO; G. John Teichgraeber, vp-sales/marketing.

## K

## Kroger Managed Prescription Drug Program

1014 Vine St., Cincinnati, Ohio 45202; 513-762-4968; fax: 513-762-1547

| 1994 Revenues | |
|---|---|
| Total gross revenue | $10,000,000 |
| **PBM Clients** | |
| Total | 500 |
| Employer/group plans with direct service | 50 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 150,000 |
| Active enrollees | 150,000 |
| through employers | 40% |
| through third-party vendors | 60% |
| **Retail Network** | |
| Pharmacies under direct contract | 38,000 |
| Pharmacies in leased networks | 150 |
| **Mail-order services** | |
| Percent of prescription volume | 7% |
| **Generics** | |
| Percent of prescription volume | 42% |
| **Staff** | |
| Total | 15 |
| Professionals | 8 |

**PBM services since:** 1992.

**Parent:** The Kroger Co.; primary business: grocery retailer.

**Services*:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education.

* *All services subcontracted.*

**Formularies offered:** Closed.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Generic vs. name brands dispensed analysis, detailed utilization reporting.

**Service area:** Nationwide.

**Billing methods:** Fee per claim. Volume discounts to employers with 25 employees.

**Officers:** Joseph A. Pichler, chairman/CEO; Richard L. Bere, president/COO; William J. Sinkula, executive vp/CFO; David Dillon, executive vp; Patrick Kenney, senior vp.

**Contact:** Marc Weiss.

A complete listing of terms for the first annual *Business Insurance* prescription benefit managers directory can be found on page 19.

If your organization provides PBM services and you would like to be listed in next year's directory, contact Kathy Welyki at 312-649-5279.

## M

## Managed Prescription Network

404 Berkshire Center, Greensburg, Pa. 15601; 412-838-9669; fax: 412-838-9686

| PBM Clients | |
|---|---|
| Total | 3,000 |
| Employer/group plans with direct service | 100 |
| **Lives Covered** | |
| **Group Health:** | |
| Active enrollees | NA |
| through employers | 30% |
| through third-party vendors | 70% |
| **Retail Network** | |
| Pharmacies under direct contract | 32,000 |
| **Mail-order services** | |
| Percent of prescription volume | 25% |
| **Generics** | |
| Percent of prescription volume | 38% |
| **Staff** | |
| Total | 350 |
| Professionals | 325 |

**PBM services since:** 1988.

**Parent:** Columbia/HCA Healthcare Corp.; primary business: health care provider.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, disease state management, employee compliance programs, capitated programs, pharmacist education programs, integration with hospital providers.

**Formularies offered:** Restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers.

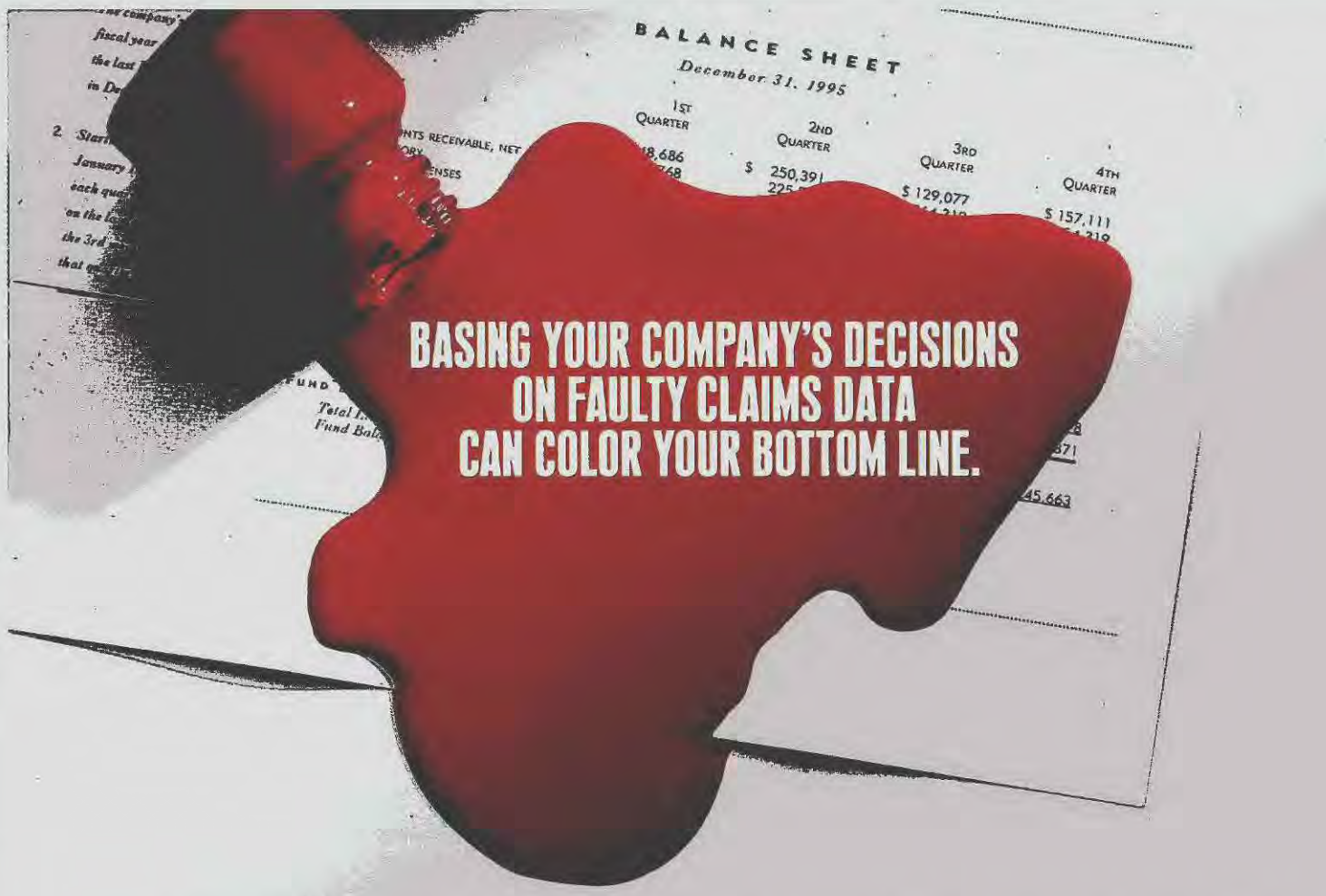
**Officers:** Dom A. Meffe Sr., CEO; Dom A. Meffe Jr., president; George Merchant, vp-sales; Kevin DeStefino, vp-operations.

## Managed Prescription Services

515 N. 6th St., Suite 1100, St. Louis, Mo. 63101; 800-372-5706 or 314-259-4200; fax: 314-259-4201

| PBM Clients | |
|---|---|
| Total | 155 |
| Employer/group plans with direct service | 110 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 3,500,000 |
| Active enrollees | 2,400,000 |
| through employers | 1% |
| through third-party vendors | 99% |
| **Workers Compensation:** | |
| Active enrollees | 11,000 |
| **Retail Network** | |
| Pharmacies under direct contract | 33,000 |

*Continued on next page*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*Continued from previous page*

**Mail-order services**

Percent of prescription volume ..... 2.8%

**Generics**

Percent of prescription volume ..... 35%

**Staff**

Total ..... 61
Professionals ..... 44

**PBM services since:** 1984.

**Parent:** Humana Inc.; primary business: HMO/PPO.

**Services:** Retail pharmacy network, mail-order distribution*, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, client specific.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers.

**Officers:** Dan R. Scott, CEO; Arthur F. Shinn, vp/general manager-clinical services; John D. Tobin, vp-sales/marketing.

**Contact:** John D. Tobin.

## Medco Containment Services

100 Summit Ave., Montvale, N.J. 07645; 201-358-5400; fax: 201-358-5783

**1994 Revenues**

Total gross revenue ..... $5,300,000,000
PBM gross revenue ..... $5,300,000,000

**PBM Clients**

Total ..... 47,000

**Lives Covered**

**Group Health:**
Total ..... 41,000,000

**Retail Network**

Pharmacies under direct contract ..... 52,000

**Staff**

Total ..... 11,500

**PBM services since:** 1965.

**Parent:** Merck; primary business: drug manufacturer.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, outcomes management, seniors care.

**Formularies offered:** Open, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, ad hoc, on-line access.

**Service area:** Nationwide and Puerto Rico.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers.

## N

## National Pharmaceutical Services

713 N. 132nd St., Omaha, Neb. 68154; 800-546-5677 or 402-896-3660; fax: 800-458-1646

**1994 Revenues**

Total gross revenue ..... $15,000,000
PBM gross revenue ..... $15,000,000

**PBM Clients**

Total ..... 100
Employer/group plans with direct service ..... 3

**Lives Covered**

**Group Health:**
Total ..... 110,000
Active enrollees ..... 73,000
through employers ..... 15%
through third-party vendors ..... 85%

**Retail Network**

Pharmacies under direct contract ..... 20,000

**Mail-order services**

Percent of prescription volume ..... 15%

**Generics**

Percent of prescription volume ..... 42%

**Staff**

Total ..... 12
Professionals ..... 6

**PBM services since:** 1990.

**Parent:** Pharmaceutical Technologies Inc.; primary business: software vendor.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, coordination of benefits.

**Formularies offered:** Closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including Albertsons, American Drug, Eckerd, Revco, Shopko, Smitty's, Walgreens, Wal-Mart.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, client specific.

**Service area:** Midwest.

**Billing methods:** Fee per claim, negotiated rates for drugs. Volume discounts to employers.

**Officers:** Mike Makoid, president; Douglas M. Pick, vp; Daniel G. Billerbeck, secretary/treasurer; Melissa Shreifels, director-mail order; Judy Petty, claims adminstrator.

## National Prescription Administrators Inc. (NPA)

711 Ridgedale Ave., E. Hanover, N.J. 07936; 201-503-1000; fax: 201-503-1084

**PBM Clients**

Total ..... 917
Employer/group plans with direct service ..... 905

**Lives Covered**

**Group Health:**
Total ..... 6,500,000

**Retail Network**

Pharmacies under direct contract ..... 51,000

**Staff**

Total ..... 510

**PBM services since:** 1978.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, on-line eligibility systems, data services, pharmacy claims audit, plastic card production, pharmacy credit cards, fully insured programs.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including Arbor, Big B, CVS, Dominick's, Drug Emporium, Eckerd, Fay's, F&M, Genovese, H.E.B., K-Mart, Long's, Osco, PayLess/Thrifty, People's, Phar-Mor, Revco, Rite-Aid, Safeway, Shop-Rite, Smith's, Thrift, Von's, Wal-Mart.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, ad hoc.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers.

**Officers:** Richard O. Ullman, president; David Karlin, executive vp; Art Ullman, Steve Nicoletos, Stacey Tabor, vps.

## P

## PCS Health Systems Inc.

9501 E. Shae Blvd. Scottsdale, AZ 85260; 602-391-4600; fax: 602-661-2420

**1994 Revenues**

Total gross revenue ..... $6,000,000,000
PBM gross revenue ..... $6,000,000,000

**PBM Clients**

Total ..... 186,000
Employer/group plans with direct service ..... 1,500

**Lives Covered**

**Group Health:**
Total ..... 56,000,000
**Workers Compensation:**
Active enrollees ..... 5,000
through employers ..... 75%

*Continued on next page*


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*The Better Health Care Alternative.*

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*Continued from previous page*

**Retail Network**

Pharmacies under direct contract ..... 54,000

**Generics**

Percent of prescription volume ..... 34%

**Staff**

Total ..... 1,646
Professionals ..... 463

**Parent:** Eli Lilly & Co.; primary business: drug manufacturer.

**Services:** Retail pharmacy network, mail-order distribution*, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Generic vs. name brands dispensed analysis, employee utilization, claims history, drug utilization review information, ad hoc (customized), network performance.

**Service area:** Nationwide and Puerto Rico.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers.

**Officers:** Steve Geringer, president; Thomas Garrity, executive vp/CFO; Robert Ashworth, executive chief information officer; Elizabeth Dichter, executive vp-strategic marketing; Kevin Moley, senior vp-product/business development.

## PDN (Pharmacy Direct Network)

909 N. Washington St., Suite 500, Alexandria, Va. 22314; 703-549-9600; fax: 703-549-7700

**Retail Network**

Pharmacies under direct contract ..... 32,000

**PBM services since:** 1995.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, prospective drug utilization review, prescription cards, national pharmaceutical and therapeutics committee, retail maintenance.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including American Stores, CVS, Drug Emporium, Eckerd, Genovese, Giant Food, Harco, K-Mart, Kroger, Longs, May's, Medicine Shoppe, Osco, Pathmark, Revco, Rite-Aid, Safeway, Thrift, Thrifty PayLess.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, online.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs, risk sharing. Volume discounts to employers.

**Officers:** Robert P. Pfotenhauer, president/CEO; Eric Sorkin, senior vp-marketing/product development; Douglas Pinnell, vp-sales; Mark Rubino, vp-clinical programs; Lowell Sterler, vp-operations.

**Contact:** Doug Pinnell.

## Pequot Pharmaceutical Network

1 Annie George Drive, Mashantucket, Ledyard, Conn. 06339; 800-342-5779; fax: 203-536-9462

**PBM Clients**

Total ..... 50
Employer/group plans with direct service ..... 20

**Lives Covered**

**Group Health:**
Total ..... 750,000
Active enrollees ..... NA
through employers ..... 59%
through third-party vendors ..... 40%
through Medicare/Medicaid ..... 1%
**Workers Compensation:**
Active enrollees ..... NA
through employers ..... 50%

**Retail Network**

Pharmacies under direct contract ..... 15,000

**Mail-order services**

Percent of prescription volume ..... 50%

**Generics**

Percent of prescription volume ..... 69%

**Staff**

Total ..... 50
Professionals ..... 20

**PBM services since:** 1992.

**Parent:** Mashantucket Pequot Tribal Nation.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilizatior. review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including Brooks, CVS, Walgreens.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, client specific.

**Service area:** Nationwide.

**Billing methods:** Fee per claim. Volume discounts to employers.

**Officers:** William A. Miller II, president/CEO; JoAnn Zingoni, vp-pharmacy; Darryl L. Percival, senior vp; Larry Holder, vp-MIS.

**Contact:** Darryl Percival, 800-342-5779 ext. 6472.

## Pharmacy Gold Inc.

P.O. Box 64812, St. Paul, Minn. 55164; 800-858-0723; fax: 612-456-6990

**Lives Covered**

**Group Health:**
Total ..... 18,000,000
Active enrollees ..... 16,700,000

**Retail Network**

Pharmacies under direct contract ..... 35,000

**Generics**

Percent of prescription volume ..... 41%

**Staff**

Total ..... 50
Professionals ..... 43

**PBM services since:** 1986.

**Parent:** Blue Cross Blue Shield of Minnesota; primary business: HMO/PPO, insurer.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, clinical programs, carve-out plans.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including Albertsons, American Drug, CVS, Dillon, Drug Emporium, Eckerd, Fay's, Genovese, Hook-Superx, K-Mart, Longs, Medicine Shoppe, Perry, Revco, Safeway, Shopko, Target, Thrift, Thrifty Corp. Thrifty PayLess, Wal-Mart, Walgreens.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, client specific.

**Service area:** Nationwide, Canada and Puerto Rico.

**Billing methods:** Volume discounts to employers.

**Officers:** John Anderson, president/CEO; Richard Bruzek, vp-marketing/product development; Debra Dullinger, vp-pharmacy programs; James Linden, vp-network management; Jack Yarbrough, vp/COO.

**Contact:** Brad Bream.

## Prescription Delivery Systems Inc.

206 Welsh Road, Horsham, Pa. 19044; 800-441-8976; fax: 215-830-9418

**PBM Clients**

Total ..... 38
Employer/group plans with direct service ..... 38

**Lives Covered**

**Group Health:**
Total ..... 315,136
through employers ..... 100%

**Retail Network**

Pharmacies under direct contract ..... 32,000

**Mail-order services**

Percent of prescription volume ..... 96%

**Generics**

Percent of prescription volume ..... 38%

**Staff**

Total ..... 115
Professionals ..... 23

**PBM services since:** 1963.

*Continued on next page*

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## Spotlight report

*Continued from previous page*

**Services:** Retail pharmacy network, mail-order distribution, claims processing*, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including CVS, Fays, Hooks, K-Mart, SupeRX, Thrift Drug, Walgreens.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, ad hoc.

**Service area:** Nationwide.

**Billing methods:** Fee per claim, negotiated rates for drugs. Volume discounts to employers with 50 employees.

**Officers:** Leon Weissberger, vp-operations; Ira Pastor, vp-managed care; Jeff Alexander, director-MIS; Tom Kim, director-pharmacy operations; Kara N. Gremminger, director-marketing.

**Contact:** Kara N. Gremminger, 800-441-8976 ext. 1407.

### Prescription Solutions

5701 Katella Ave., P.O. Box 6446, Cypress, Calif. 90630; 800-479-7658; fax: 714-236-5803

| PBM Clients | |
|---|---|
| Total | 45 |
| Employer/group plans with direct service | 32 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 3,200,000 |
| Active enrollees | 2,800,000 |
| through employers | 60% |
| through third-party vendors | 30% |
| through Medicare/Medicaid | 10% |
| **Retail Network** | |
| Pharmacies under direct contract | 30,000 |
| **Mail-order services** | |
| Percent of prescription volume | 12% |
| **Generics** | |
| Percent of prescription volume | 45% |
| **Staff** | |
| Total | 135 |
| Professionals | 115 |

**PBM services since:** 1989.

**Parent:** PacifiCare Health Services; primary business: managed care organization.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including Albertsons, Arrow, Bi-Mart, Clark, CVS, Drug Barn, Drug Emporium, Eckerd, Fedco, Gemmel, H.E. Butt, Hook, SuperRx, Horton & Converse, K-Mart, Kroger, Longs, Med-Rx, Med Express, Merrill's, Osco, PayLess, Perry, Price Less, Raley's, Randall, Rite Aid, Safeway, Sav-On, Save Mart, Sharp Rees-Stealy, Smith's, Thrifty, Vons, Wal-Mart, Walgreens.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, financials, benefit performance analysis.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers with 1,200 employees.

**Officers:** Debi Reissman, president; Jeff Herzfeld, Ed Feaver, Harry Soza, vps.

**Contact:** Jeff Herzfeld.

### RESTAT

724 Elm St., P.O. Box 758, West Bend, Wis. 53095-0758; 800-926-5858; fax: 414-338-5791

| PBM Clients | |
|---|---|
| Total | 2,000 |
| Employer/group plans with direct service | 25 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 5,000,000 |
| Active enrollees | 1,000,000 |
| through employers | 30% |
| through third-party vendors | 70% |
| **Workers Compensation:** | |
| Active enrollees | 100 |
| through employers | 50% |
| **Retail Network** | |
| Pharmacies under direct contract | 45,000 |
| **Mail-order services** | |
| Percent of prescription volume | 20% |
| **Generics** | |
| Percent of prescription volume | 42% |
| **Staff** | |
| Total | 55 |
| Professionals | 50 |

**PBM services since:** 1985.

**Parent:** The F. Dohmen Co.; primary business: wholesale distributor/data management.

**Services:** Retail pharmacy network, claims processing, concurrent utilization review, retrospective utilization review*, benefit design consulting, formulary management/review*, monitoring of physician prescribing practices, patient/physician education, integrated mail service programs with a variety of vendors*, integrated case management services, risk financing*.

* *Subcontracted.*

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including American Drug, Arbor, Big B, CVS, Drug Emporium, Eckerd, F&M, Fays, Genovese, Harco, K&B, K-Mart, Longs, Medicap, Medicine Shoppe, Perry, Phar-Mor, Revco, Rite Aid, Super Drug, Thrift, Thrifty PayLess, Walgreens.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, trend reporting, finance reporting, case management, outcomes management.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs, risk financing. Volume discounts to employers with 20,000 employees.

**Officers:** Jim Martin, president; Prati Agarwal, director-professional services; Peggy Schindhelm, director-operations; Barbara O'Donahue, director-sales/marketing; Lew Snyder, director-MIS.

**Contact:** Barbara O'Donahue.

### RxAmerica

369 Billy Mitchell Road, Salt Lake City, Utah 84116; 800-770-8014; fax: 801-238-6008

| Lives Covered | |
|---|---|
| **Group Health:** | |
| Active enrollees | 800,000 |
| through employers | 52% |
| through third-party vendors | 48% |
| **Workers Compensation:** | |
| Active enrollees | NA |
| through employers | 82% |
| **Retail Network** | |
| Pharmacies under direct contract | 33,000 |
| **Mail-order services** | |
| Percent of prescription volume | 50% |
| **Generics** | |
| Percent of prescription volume | 52% |
| **Staff** | |
| Total | 35 |
| Professionals | 20 |

**PBM services since:** 1994.

**Parent:** American Stores; primary business: food and drug chain.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, outcomes management.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, drug interaction, same drug/same class reports, rebate reports.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers with 50 employees.

**Officers:** John Dyer, general manager; Allan Kellogg, vp-sales/marketing; Mark deBruin, vp-operations/administration.

*Continued on next page*


# RxChoice Makes Cost

*Continued from previous page*

## S

### Systemed Pharmacy Inc.

500 Park Blvd., Suite 985, Itasca, Ill. 60143; 708-875-8040; fax: 708-875-8050

| 1994 Revenues | |
|---|---|
| Total gross revenue | $526,000,000 |
| PBM gross revenue | $516,000,000 |
| **PBM Clients** | |
| Total | 206,000 |
| Employer/group plans with direct service | 1,659 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 11,500,000 |
| Active enrollees | 6,900,000 |
| through employers | 86% |
| through third-party vendors | 11% |
| through Medicare/Medicaid | 3% |
| **Retail Network** | |
| Pharmacies under direct contract | 31,000 |
| **Mail-order services** | |
| Percent of prescription volume | 10% |
| **Generics** | |
| Percent of prescription volume | 34% |
| **Staff** | |
| Total | 500 |
| Professionals | 460 |

**Parent:** Systemed Inc.; primary business: pharmaceutical benefit manager.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including Eckerds, Kroger, Phar-Mor, Revco, Safeway, Walgreens, Wal-Mart.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, drug utilization, financial reports for top 100 drugs.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs. Volume discounts to employers with 5,000 employees.

**Officers:** Sam Westover, president/CEO; Perry Cohen, Mark Hanrahan, senior vps-marketing business unit; Steve Konsin, senior vp-mail service operation; Ken Kay, senior vp-finance/administration.

## T

### TDI Managed Care Services Inc.

620 Epsilon Drive, Pittsburgh, Pa. 15230; 412-963-1975; fax: 412-967-2334

| PBM Clients | |
|---|---|
| Total | 100 |
| Employer/group plans with direct service | 1,000 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 11,500,000 |
| Active enrollees | 4,200,000 |
| through employers | 50% |
| through third-party vendors | 50% |
| **Retail Network** | |
| Pharmacies under direct contract | 40,000 |
| **Mail-order services** | |
| Percent of prescription volume | 15% |
| **Generics** | |
| Percent of prescription volume | 38% |
| **Staff** | |
| Total | 1,200 |
| Professionals | 300 |

**PBM services since:** 1982.

**Parent:** J.C. Penney Co.-Thrift Drug; primary business: Retail chain drug store.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, disease state management, case management activities, prospective prescription drug utilization review, specialized pharmacy services including dispensing of Biotech products.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization.

**Service area:** Nationwide.

**Billing methods:** Capitated rate, fee per claim, negotiated rates for drugs, risk sharing. Volume discounts to employers.

**Officers:** F.A. Marksco, president; David Halpern, vp-managed care; Lloyd McDonald, vp-sales/marketing; Dennis Santo, vp-pharmacy services; James Smith, vp-pharmacy operations.

**Contact:** William C. Jardine, national sales director.


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JACK STEINBERG

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RCHOICE

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4500 Alexander Boulevard NE, Albuquerque, NM 87107


## V

### ValueRx Pharmacy Program Inc.*

1825 S. Woodward Ave., Suite 200, Bloomfield Hills, Mich. 48032; 810-338-4466; fax: 810-253-6510

| 1994 Revenues | |
|---|---|
| Total gross revenue | $1,000,000,000 |
| PBM gross revenue | $1,000,000,000 |
| **PBM Clients** | |
| Total | 1,500 |
| Employer/group plans with direct service | 126 |
| **Lives Covered** | |
| **Group Health:** | |
| Total | 16,000,000 |
| **Retail Network** | |
| Pharmacies under direct contract | 42,000 |
| **Mail-order services** | |
| Percent of prescription volume | 80% |
| **Generics** | |
| Percent of prescription volume | 38% |
| **Staff** | |
| Total | 380 |
| Professionals | 13 |

**PBM services since:** 1985.

**Parent:** Value Health Inc.; primary business: HMO/PPO, insurer, drug manufacturer.

**Services:** Retail pharmacy network, mail-order distribution, claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient/physician education, disease management, member services, generic substitution.

**Formularies offered:** Open, closed, restricted/customized.

**Pharmacies contracted:** Independently owned; retail chains, including Albertson's, Arbor, Big B, Big Bear, City Markets, Dominick's, Drug Emporium, Duane Reade, Eckerd, Farm Fresh, Fay's, Fred Meyer, F&M, Genovese, Giant Eagle, Giant Food, Grand Union, Happy Harry's, Harco, H.E.B., HY-Vee/Drug Town, K&B, Kinny Drugs, King Soopers, Kerr Drug, Kmart, Kroger, Longs, Meijers, Osco-Savon, Pathmark, Pay-Less, Phar-Mor, Perry, Publix, Rite-Aid, Revco, Shopko, ShopRite, Stop N' Shop, Smith's Food & Drug, Super-D, Snyder, Vons, Walgreens, Wal-Mart, Winn-Dixie.

**Reports provided:** Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization.

**Service area:** Nationwide and Puerto Rico.

**Billing methods:** Fee per claim. Volume discounts to employers.

**Officers:** Barry Smith, president/CEO; Steve Wylie, senior vp-finance/CFO; Sheila Black, senior vp-operations/COO; Robert Chan, senior vp-information systems; Earl Hurst, senior vp-sales.

**Contact:** 810-253-6509.

** Listing does not include figures from Diagnostek Inc., which was acquired on March 27, 1995. See separate listing for Diagnostek Inc.*

81

For information on listings in next year's Directory of Prescription Benefit Managers, call 312-649-5279.

# MSAs

*Continued from page 1*

ployee for individual coverage and $3,862 for family coverage, total MSA plan costs are about 11% less than Golden Rule's traditional indemnity plan, in which employees can't get cash refunds.

Golden Rule launched the MSA in May 1993 as part of a restructuring of its health care benefit program.

Employees choosing the MSA option are responsible for paying the first $2,000 of medical expenses for individual coverage and $3,000 for family coverage.

Golden Rule kicks in $1,000 to a special account—the MSA—for those with individual coverage and $2,000 to accounts for those with family coverage.

Employees can take money out of the accounts during the year to pay for health care expenses. At the end of the year, employees are free to take in cash any funds remaining in their MSAs or roll over the funds into a special annuity.

Is Golden Rule's experience with this plan too good to be true?

J. Patrick Rooney, chairman of Golden Rule, an Illinois-domiciled insurer founded in 1940 with administrative offices in Indianapolis, and the architect of the MSA program, doesn't think so.

By giving employees a stake in how they use medical services—the possibility of cashing in an MSA account balance—they become better consumers, Mr. Rooney contends. "When you bring the financial interest of employees into the picture, they will change their consumption pattern of medical services. The empirical evidence is quite clear."

Employees look for lower-cost alternatives, like seeking care in outpatient settings rather than in

*Continued on next page*

# Golden Rule workers praise MSA

## Accounts let them take 'responsibility'

**By JERRY GEISEL**

INDIANAPOLIS—Shelli Johnson thought the $800 quote she received from a hospital for medical tests she needed sounded too high.

So, the 30-year-old Golden Rule Insurance Co. lobbyist let, as she put it, her fingers do the walking.

Using the Yellow Pages as a guide, Ms. Johnson called several hospitals and asked how much they charged for the tests. Her search ended when one hospital she called said it would charge $114 for the tests.

"That sounded right to me," Ms. Johnson said.

Ms. Johnson, who has participated in Golden Rule's medical savings account program since it was launched in 1993, says her experience shows how individuals can receive better value for their health care dollars.

"You don't have to be a medical expert, nor do you have to be in an HMO," she says. "You do have to take responsibility. You can and should shop around," she says, adding that even her physician was surprised at the wide variation in charges that the hospitals quoted.

Ms. Johnson isn't the only Golden Rule employee doing more shopping around.

Others agree that the ability to take as cash unused account balances gives them a powerful incentive to be better consumers of medical services.

"With MSAs, you become a lot more involved," said John Falk, a 35-year-old financial services manager in Golden Rule's Milwaukee office.

Mr. Falk has several examples of his own increased involvement since he and his family opted for the MSA program.

Once he and his wife, Beth, spotted a $190 hospital physician's charge for a newborn baby examination that was not conducted. After the Falks brought it to their attention, hospital officials removed the charge.

Similarly, the Falks were skeptical about certain ultrasound tests their doctor suggested while Beth was pregnant with their son, Luke. Such tests had been done during an earlier pregnancy—when the baby was not positioned properly in the womb—to help determine if a Caesarean section delivery would be necessary.

The Falks asked the physician if the ultrasound tests really were necessary for a normal pregnancy. When the physician said, "Not really," the Falks requested that the tests not be performed.

Before the MSA, "we really were docile patients," said Mr. Falk. "We never questioned."

But now, "we've become much more involved." he said. "We are getting more appropriate, better quality care. I would not have had the same kind of involvement in the old health care plan."

For other Golden Rule employees, involvement seems less important than the freedom of choice of providers that the program allows.

Sue Stein, a 28-year-old rate analyst in the Indianapolis office, especially valued that unlimited choice of providers when she gave birth to twins last year.

One child was stillborn and the surviving twin, Andy, was born six weeks premature. He needed to be put on a respirator and to have blood transfusions, because his lungs were not properly developed.

Ms. Stein's pediatrician recommended that Andy be transferred to Riley University Hospital in Indianapolis, which the Steins were familiar with through volunteer work her husband had done for the facility.

Ms. Stein says Andy received outstanding care and Riley personnel kept her well-informed of Andy's medical progress.

Being able to select the hospital—rather than having the decision being made by an HMO—meant everything to the Steins.

"Andy got the very best care available. I was much more comfortable because I could decide where" he would receive treatment, she says.

In all, the medical bills from Ms. Stein's pregnancy, delivery and Andy's 10-day hospitalization came to about $40,000.

That exhausted the $2,000 Golden Rule contributed to the Steins' MSA, leaving the Steins with $1,000 of bills they had to pay. For family coverage, Golden Rule provides 100% coverage after the first $3,000 of expenses. Ms. Stein considers her family's actual out-of-pocket expense to be $400, because they had saved $600 of Golden Rule's 1993 MSA contribution.

While financially—at least in 1994—the Steins may have been better off in an HMO or another low-cost sharing plan, Ms. Stein said the freedom to choose providers was paramount.

"I want to be the one to select the care (provider), not an HMO or an insurance company," she says.

Freedom of choice also is important to Melody Taggart, a 34-year-old secretary in Indianapolis. When at a previous job, she recalls the cold, uncaring treatment she received in an HMO.

**When Golden Rule unveiled its MSA program, Melody Taggart was suspicious. She thought 'there had to be a catch. It sounded too good to be true.'**

"I will never go back to an HMO. I wanted that freedom of choice," she says.

When Golden Rule unveiled its MSA program, Ms. Taggart acknowledged that she was suspicious. She said she thought that "there had to be a catch. It sounded too good to be true."

Any initial skepticism has long since faded. Aside from being able to choose her own doctor, Ms. Taggart said she has benefited financially. In 1993, she collected $1,000 from her MSA and last year received about $1,800. However, she paid certain expenses, including prescription drugs for her son, out of her pocket and did not request reimbursement.

"For me and for my family, the MSA could not be better. If I ever left Golden Rule, the MSA is what I would miss the most," she says.

Marilyn Wagner, a 44-year-old assistant manager in Golden Rule's home office in Lawrenceville, Ill., describes the MSA as a "win-win situation."

The MSA means the Wagners get first-dollar coverage for health care services without having to meet a deductible, she notes.

And since her family has been fairly healthy, the Wagners have had account balances remaining in the MSA at end of the year. In 1993, they collected about $700, while $900 was left last year. The account balances were transferred to a savings account, Ms. Wagner said. BI

**IN THE MATTER OF THE COMPANIES ACT, 1981 IN THE MATTER OF RAPPORT INSURANCE LTD (IN VOLUNTARY LIQUIDATION)**

Notice in hereby given that the Creditors of the above-named Company are required on or before 1st May, 1995 to send by registered mail their names and address and the particulars of their debts or claims to the Liquidator of the said Company, John Milligan-Whyte, P. O. Box HM 1223 Hamilton, HM FX, Bermuda and to fax copies to the Liquidator at 1-809-295-1348 and if so required by Notice in Writing from the said Liquidator to come in and prove their said debts or claims at such time and place as shall be specified in each notice or in default thereof they will be excluded from the benefit of any distribution made before such debts are proved.

Dated this 14th March 1995.

John Milligan-Whyte
Liquidator

*Continued from previous page*
higher-cost hospitals, he said.

"The $7,000 hospital admission may end up being a $300 outpatient service," he said.

And Golden Rule employees themselves say participation in the MSA has made them better medical care consumers. They say they are more likely to scrutinize medical bills for services that never were performed, while they do more price comparisons before selecting a hospital or physician (see story, page 32).

From Mr. Rooney's perspective—as both an employer and a leading seller of these plans—MSAs are winners.

"I see them as a marvelous opportunity to control medical costs, without depriving people of needed care. Individuals can go to any doctor they want and have first-dollar coverage. I thought they would be a gain for everyone," he said.

And, as a company that has been aggressively pushing MSAs to potential customers, Golden Rule has a lot to gain by promoting its own program.

Indeed, since it began marketing MSAs last year, Golden Rule has sold MSA programs to about 600 employers, mostly smaller companies with fewer than 100 employees.

Some employers switching over from traditional indemnity plans to MSA plans sold by Golden Rule are delighted.

"We like it because our employees are happy. And if they are happy, they become much better employees," said Randy Velting, a partner with Concord Management, a property manager in Grand Rapids, Mich., with seven employees.

Employees are happy, Mr. Velting said, because they have collected on average 75% of their MSA account balances—Concord contributes $1,500 for employees with single coverage and $2,000 for family coverage—while Concord's costs are roughly comparable if it had continued its old indemnity plan.

MSA programs have yet to make significant inroads among larger employers, though interest has picked up lately.

The increased interest is due at least partly to the publicity Golden Rule's and other MSA-type programs have generated and the increased likelihood that Congress could enact legislation this session that would give new tax breaks to MSAs.

However, some benefit consultants say it is much too soon to draw any conclusions about whether MSAs can help employers hold down health plan cost increases while giving employees hefty cash bonuses.

"We need a lot more cost data and a lot more experience. It is questionable to tout something based on such short, limited experience," said Regina Barb, a consultant in the New York office of Hewitt Associates L.L.C.

**MSAs are a 'marvelous' way to control medical costs without depriving people of care, says J. Patrick Rooney.**

Issues that need to be examined in depth, she said, include whether employees delay seeking medical care in order to collect big MSA account balances.

At the same time, Ms. Barb questions how MSAs can save employers money if companies funnel most of their premium savings from boosting deductibles into employees' MSAs. That could result in healthy employees, whose medical care costs previously were negligible, receiving big MSA contributions, while costs for heavy users of medical services remain about the same, she said.

Mr. Rooney rejects the suggestion that employees in MSAs delay seeking medical services as a way of ensuring they will have the maximum amount of funds available at the end of the year.

He notes that, in an MSA program, employees essentially have first-dollar coverage to pay for services, unlike traditional plans where employees have to take money out of their own pockets to cover expenses that fall under a deductible. Even managed care plans, like HMOs, typically have copayment requirements, Mr. Rooney pointed out.

"If a woman needs a mammogram, the money is there to pay for it," Mr. Rooney says, adding that MSA participants don't have to worry, as they might in a traditional plan, about a tradeoff in which money spent for medical services could mean the "kids won't get pizza."

Some Golden Rule employees bristle at the suggestion that they would delay seeking medical care so as to have a big account balance at the end of the year.

"I would never neglect my family's health" to get the cash at year end, says Melody Taggart, a 34-year-old Golden Rule secretary in Indianapolis.

Indeed, a telephone survey of Golden Rule employees—conducted by The Luntz Research Cos., an Arlington, Va.-based pollster—found that 27% of MSA participants used medical services that they hadn't before joining the plan. BI

## How employers use MSAs

Medical savings accounts are employer-funded accounts linked to high-deductible medical indemnity plans.

When setting up such accounts, an employer typically hikes—often by 300% to 400%—its medical plan deductible and thereby slashes its insurance premiums. A portion of that premium savings is returned to employees as contributions to the accounts.

Employees can use the contributions to pay for uncovered health care expenses, such as claims beneath the deductible, or for benefits, such as dental or vision care, that the employer does not offer.

Typically, employers will only reimburse employees with account funds after employees show evidence of a health care-related expense, such as a prescription drug receipt.

During the year, employees can only use MSA contributions to pay health care bills. At the end of the year, though, employees may take in cash whatever remains in the account.

One employer has taken it a step further. At Golden Rule Insurance Co., employees can roll over those unused contributions into an annuity the insurer designed. Currently, contributions invested in the annuity earn 7% interest. Still, most employees take the cash instead.

Employees leaving a company can withdraw accumulated account balances as cash. In some cases, departing employees have used the cash to pay for COBRA health care continuation premiums.

Unlike employer contributions to conventional health plans, MSA contributions are not eligible for tax-favored treatment. While employers can fully deduct contributions as a business expense, those contributions are added to employees' taxable income.

That may change. Last week, House Speaker Newt Gingrich, R-Ga., said he expected Congress to pass legislation this session giving favorable tax status to MSA contributions. Aside from Rep. Gingrich, others who support MSAs include House Ways and Means Chairman Bill Archer, R-Texas, Senate Majority Leader Bob Dole, R-Kan., and Sen. Bob Packwood, R-Ore., chairman of the Finance Committee.

*—By Jerry Geisel*

## Robinson foundation raffle results

The annual Angus Robinson Jr. Memorial Foundation St. Patrick's Day raffle raised $27,200 for the educational foundation.

The winning raffle tickets were drawn at the annual Aon Corp. St. Patrick's Day party held in Chicago.

Kurt Meyer, executive vp of Sutherland Page & Co. Claim Consulting in Rosemont, Ill., won the $4,000 first prize.

Second prize, use of an apartment in London, went to Steve Nunn, a director of Ballantyne, McKean & Sullivan in London. The third prize, Irish crystal, was given to Daniel McDonnell, president of Bryson Associates Inc. in Jenkintown, Pa., and fourth prize—assorted Irish gifts—went to Joseph Nicosia, chief executive officer of First Oak Brook Corp. Syndicate on the Illinois Insurance Exchange in Chicago.

The Angus Robinson Jr. Memorial Foundation, with more than $300,000 in assets, awards scholarships to qualified students of insurance and reinsurance needing financial aid to complete their education. This year, the foundation awarded scholarships totaling $22,500 to 15 students.

The St. Patrick's Day raffle is first of three fund-raising events sponsored by the foundation this year. The next will be a golf tournament on May 30 in Bermuda in conjunction with the Bermuda Insurance Symposium II. The other will be the 5th Annual Angus Robinson Jr. Memorial Foundation Golf Tournament at Burning Tree Country Club in Greenwich, Conn., on Sept. 14.

For more information, please write the Angus Robinson Jr. Memorial Foundation at 1690 Fairfield Beach Road, Fairfield, Conn. 06432. BI

**IN THE MATTER OF THE COMPANIES ACT, 1981**
**IN THE MATTER OF RAPPORT INSURANCE LTD (IN VOLUNTARY LIQUIDATION)**

NOTICE IN HEREBY GIVEN that the Final General Meetings Members of the above-named Company will be held at 1st Floor, Bermuda Commerical Bank Building, 44 Church Street Hamilton, HM 12 Bermuda on the 29th of May 1995 at 10a.m. for the purpose of having an account laid before them showing the manner in which the winding-up has been conducted and the property of the company, disposed of, and of hearing any explanation that may be given by the Liquidator, and also of determining by resolution the manner in which the books, accounts and documents of the Company and of the Liquidator thereof, shall be disposed.

John Milligan-Whyte
Liquidator

Dated this 14th March 1995.


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# Hollywood

*Continued from page 1*

faith interpretation that the property owners are insured by definition under the policy," Mr. Zelig said.

And, as policyholders, "we do intend to include a bad faith cause of action against Argonaut (Insurance Co.) as well as the individual contractors," he added.

The MTA has a total of $100 million in commercial general liability coverage above a $500,000 per-occurrence deductible. Primary limits of $2.5 million are underwritten by Menlo Park, Calif.-based Argonaut and $98 million in excess coverage is provided by Lloyd's of London underwriters and other London insurers.

The new allegations are the latest salvo in an escalating war between the MTA and property owners along the subway route.

Since the inception of the project more than 10 years ago, the MTA has resolved 208 lawsuits filed by business and property owners, according to MTA Risk Manager Abdoul Sesay.

At least nine others are pending, including suits filed by Texaco Refining & Marketing Inc., the Wiltern Theatre, the Radisson Wilshire Plaza Hotel, Mid-Wilshire Associates and Wilshire Partnership.

In addition, numerous governmental tort claims filed by individual property owners remain unresolved.

As a quasi-governmental entity, the MTA has 45 days to respond to the claims under state law. After that, the property owners have six months to file a lawsuit.

Since its administrative tort claim seeking more than $1 billion was rejected, Hollywood Damage Control & Recovery has assembled a team of 12 researchers to develop numerous grounds for its lawsuit.

For example, in one draft of the as-yet-unfiled suit, the property owners are alleging that they were made "partners" in the project when they were asked to contribute a one-time "benefit assessment tax" to help finance it.

The property owners "paid a percentage of the premiums" when they were asked to contribute $66.75 million, or 3% of the total construction costs, Mr. Zelig contends. And since the MTA's CGL policy extends coverage to all "partners," the property owners argue, they should be able to file first-party damage claims.

Mr. Sesay counters that the Hollywood property owners have misinterpreted their involvement in the project, as well as the MTA's CGL coverage.

"They are partners in the sense that there should be a team effort and common objectives between the MTA and the private sector in revitalizing the economy of this region," he said. "Great urban areas around the world have great mass transit systems. Los Angeles is a major urban center."

When voters approved the project in the early 1980s "inherent in their approval was the recognition of side-effects like dust, noise, settlement, traffic and limited access," Mr. Sesay continued. "Knowing that, we put together a public relations program that explains what we're doing to minimize some of the inconveniences."

It is a brochure from the PR program that Hollywood Damage Control & Recovery is citing in its suit.

The brochure talks about the Metrorail project, the funding sources for the project and the benefits of the project after completion to property owners as well as businesses along the subway route.

Even if the property owners are successful in obtaining policyholder status through litigation, "what about the owned-property exclusion?" asked Mr. Sesay.

"The policy does not cover any property in our care, custody or control. The owned-property exclusion will void coverage for the policyholders' own property," he pointed out.

**As a quasi-governmental entity, the MTA has 45 days to respond to the claims under state law.**

In the most recent draft of their suit, the property owners assert: "Said policies were issued. . .for the benefit of plaintiffs herein as parties to the contract. Further, the premiums for said policies were paid for out of the funds charged and assessed to the plaintiff partners. Accordingly, the plaintiffs herein are insured under various policies issued by defendants Argonaut among other insurers according to proof."

The master CGL policy issued by Argonaut defines "insured" as "any partner, director, executive officer, stockholder, administrator or supervisory employee of the named insured, or any member of any joint venture or any political subdivision, authority, board or agency."

However, an additional interest endorsement dated June 30, 1994, limits the definition of "partner" as five entities, which consist mostly of building contractors or engineering firms:

- Metro Rail Transit Consultants, a joint venture of Parsons, Brinckerhoff, Quade & Douglas Inc.; Daniel, Mann, Johnson & Mendenhall; ICF Kaiser Engineers Inc.; and Harry Weese & Associates Ltd.
- PDCD, A Joint Venture of the Ralph M. Parsons Co.; Dillingham Construction Co. and DeLew, Cather & Co.
- Parsons-Dillingham, A Joint Venture of Parsons, Dillingham and DeLew.
- The city of Los Angeles Department of Water & Power.
- The county of Los Angeles.

Even if they are not deemed additional insureds under the Argonaut policy, the property owners will seek damages as third-party beneficiaries to the policy, according to Jerry Schneiderman, the Hollywood businessman who is leading the effort.

The property owners may also allege that MTA claims representatives misled the property owners into believing that filing an insurance claim was all that was needed to file an administrative tort claim as well.

As a result of these alleged misrepresentations, the statute of limitations may have passed for some property owners to file administrative tort claims, according to Mr. Zelig.

That's why the suit will seek to annul any settlements that property owners believe may have been fraudulently induced, he said.

So far 116 claims totaling $439,828 have been paid by the MTA in connection with the Hollywood occurrence, according to Mr. Sesay. Another 91 claims being investigated.

Mr. Schneiderman added that the lawsuit also will cite a 1991 geotechnical design summary conducted by The Earth Technology Corp. as evidence that MTA contractors used cost-benefit analysis to decide not to try to prevent damage to buildings.

According to the report, "The damage potential to the buildings is probably greatest along Hollywood Boulevard, where the tunnels are located in the alluvial soils and the street is relatively narrow. . . .Considering the value of the buildings along this portion of the alignment, it does not appear economical to undertake building protection measures prior to tunneling to counter the risk associated with runs," the report advised.

"This is the Pinto case all over again," Mr. Schneiderman said.

"They did a cost-benefit analysis and decided they could afford to demolish Hollywood and rebuild it on change orders."

Not so, insists Mr. Sesay.

The Hollywood property owners "have completely misstated the intent of the report," said the risk manager.

"The report was a thorough risk analysis intended to guide prospective bidders. It's a risk assessment that outlines the best and worst-case scenarios," Mr. Sesay said.

The building protection that was recommended in the report was a process called "underpinning" in which structures are reinforced with braces installed under their foundations, Mr. Sesay explained.

"But if we would have done that it would have been so expensive for us and it would have caused a lot more inconvenience for those businesses," he said. BI

**IN THE MATTER OF:**
**The Companies Act, 1981**
**MEMBERS' VOLUNTARY WINDING-UP NOTICE OF APPOINTMENT OF LIQUIDATOR**
**RAPPORT INSURANCE LTD.**

**TO:**
**The Registrar of Companies:**
**I, John Milligan-Whyte of P. O. Box HM 1223 Hamilton, HM FX Bermuda hereby give you notice that I have been appointed liquidator of RAPPORT INSURANCE LTD by a Resolution of the Company dated 14th March 1995.**

**John Milligan-Whyte**
**Liquidator**


# READER REPLY SERVICE

## PRODUCTS & SERVICES LISTING

### Issue of April 3

| Reader Service # | Advertiser | Page # |
|---|---|---|
| 1 | Alexander & Alexander | 6 |
| 2 | Ameritas Life Insurance Co. | 29 |
| — | Aux. Amer. Osteopathic Assoc. | 23 |
| — | Business Insurance | 11,21,40 |
| 3 | Claims Overload Systems | 22 |
| — | Consumer Health Network | 32 |
| 4 | Cover X | 33 |
| 5 | Diagnostek Inc./RX Choice | 30-31 |
| 6 | EBP Health Plans | 28 |
| 7 | Fortis Inc. | 12-13 |
| — | Health Net | 21CA |
| 8 | HIAA/Health Ins. Assoc. | 32 |
| 9 | Int'l Found. of Empl. Benefits | 17 |
| — | LeBlanc De Nicolay Reassurance | 16 |
| 10 | Liberty Mutual | 20 |
| 11 | Medicode | 27 |
| 17 | Met DisAbility | 18-19 |
| — | John Milligan-Whyte | 32,33,34 |
| — | National Insurance Partners | 36 |
| 12 | NILS Publishing Company | 22 |
| 13 | Olsten Kimberly Qualitycare | 7 |
| — | Pharmacy Direct Network | 24 |
| 14 | Prudential DMO Benefits Div. | 10 |
| — | Prudential Re/California | 16A/16B |
| 15 | Reliance National | 44 |
| 16 | Reliastar | 14-15 |
| — | Risk Management Solutions | 37 |
| — | Wausau Insurance Company | 5 |
| 18 | Willis Faber N. America | 9 |
| — | The Wyatt Company | 4 |

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| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 |
| 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 |
| 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 |
| 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 |
| 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | 101 | 102 | 103 | 104 | 105 |
| 106 | 107 | 108 | 109 | 110 | 111 | 112 | 113 | 114 | 115 | 116 | 117 | 118 | 119 | 120 |
| 121 | 122 | 123 | 124 | 125 | 126 | 127 | 128 | 129 | 130 | 131 | 132 | 133 | 134 | 135 |
| 136 | 137 | 138 | 139 | 140 | 141 | 142 | 143 | 144 | 145 | 146 | 147 | 148 | 149 | 150 |

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## LONDON

# Heinz Ulrich von Eicken, reinsurance exec, is dead

By STACY SHAPIRO

LONDON—Heinz Ulrich von Eicken, a former executive of Munich Reinsurance Co. and one of the London market's great personalities, died last month after a short illness.

Mr. von Eicken, 66, was employed by Munich Re for 35 years and established the German reinsurer's London office in 1967. He served as executive manager and managing director of Munich Re's London office and of the company's U.K. branch in Munich.

Until his retirement in 1990, Mr. von Eicken spent the majority of each working week in London before returning to Munich.

Though he always looked forward to retirement and spending more time with his family and hobbies, when he finally left Munich Re he developed a second working life as a consultant and expert witness. Mr. von Eicken spent five weeks giving testimony as the main expert witness for the members of Lloyd's of London underwriter Richard Outhwaite's syndicate, who were suing 81 members agencies over run-off contracts written by the Outhwaite syndicate (*BI*, Dec. 16, 1991). It is believed his testimony, which questioned Mr. Outhwaite's competence, led the agents to make an out-of-court settlement.

Mr. von Eicken last year was called again as an expert witness for the 3,095 members of the Gooda Walker Action Group, who successfully sued 71 underwriting agents for negligent underwriting (*BI*, Oct. 10, 1994).

His other recent interests included serving as non-executive chairman of Lowndes Lambert Deutschland, which is the German arm of U.K. broker Lowndes Lambert Group Holdings P.L.C.

Though a man of great insurance knowledge, friends will remember him more for his charm, and joie de vivre.

As Richard Shaw, chairman of Lowndes Lambert, summed up, "He was a friend of mine in this business who I always looked forward to seeing."

Mr. von Eicken is survived by six children and wife Angelica.

## Gooda damages

Gooda Walker Action Group members are back in court seeking £435 million ($694.3 million) in damages from 71 underwriting agencies and their errors and omissions underwriters.

The agencies, though, argue that they owe the 3,095 members as little as £185 million ($295.3 million) after a court ruled last year that Gooda Walker underwriters were negligent in accepting excess-of-loss reinsurance programs for major catastrophes (*BI*, Oct. 10, 1994).

Both sides were once again in front of Justice Phillips in the High Court last week in a "quantum" hearing to determine the amount of damages the Gooda Walker members are due.

Although the Gooda Walker Action Group expected members would receive a total of £504 million ($804.4 million) after they won their negligence suit, the total damage sum has slowly been reduced as Justice Phillips' original judgment has been interpreted over time. The group now is seeking around £348 million ($555.4 million) for losses they have suffered, plus interest and additional damages for syndicate run-off costs bringing the total to around £435 million.

The agency defendants, however, dispute the sums, including various payments by Lloyd's Central Fund on behalf of the members to policyholders, which the defendants say should be deducted from the total.

The Gooda Walker Action Group already has been awarded

*See* **London** *on next page*

# Global warming warning

## Government aid will be needed if climate changes: Insurers

By DON LEWIS KIRK

BERLIN—Government intervention will be needed to help insurers cope with the increasing threat of natural disasters caused by climate changes, several insurance company executives say.

Some insurers could be bankrupted if global warming increases the severity of extreme events, Franklin S. Nutter, president of the Reinsurance Assn. of America, said at a March 26 global warming conference in Berlin sponsored by Greenpeace. The conference was held in conjunction with the March 28 to April 7 United Nations conference in Berlin on climate change.

"After two decades of complacency, insurers are looking at risk in a different light," said Mr. Nutter. Based on data from the Property Claims Services division of the American Insurance Services Group, natural catastrophes are becoming more frequent and their severity is a "wake-up" call, he said.

"Of the 25 largest insured catastrophes in the United States, 21 have occurred in the last decade and 16 have involved a combination of wind and water," said Mr. Nutter.

If insurers are unprepared, a series of extreme events could produce major insolvencies, and a single "mega" storm might jeopardize the whole U.S. insurance industry, he said.

A Category 5 hurricane like Andrew would cause $26 billion in insured losses in New Orleans or $50 billion in the Northeast, he said. "That's nearly one-third of the $180 billion capital base of the entire U.S. insurance industry," he said.

Government intervention might be needed to ensure that claims on that scale were met, said Mr. Nutter.

One possibility would be government-sponsored reinsurance, or a "safety net," to cover losses exceeding 15% of insurance industry surplus, Mr. Nutter said.

"Should a truly catastrophic event occur, government could provide excess catastrophe reinsurance to insurers or to a national pool of insurers," he said. Claims of $50 billion in an area like Miami or the Northeastern seaboard would wipe out some insurance companies, Mr. Nutter

*See* **Warming** *on next page*

GRAPHIC BY JERRY PARKS

# U.K. area codes change this month

**Beginning April 16, callers to the United Kingdom will need to dial a 1 before all area codes.**

**For example, the new area code for all London callers will be 171 for inner London and 181 for outer London (see map).**

**The additional 1 also applies to all area codes outside London in the United Kingdom.**

# QBE's sale of U.S. insurer to boost reinsurer unit

SYDNEY, Australia—QBE Insurance Group Ltd. plans to put the $31 million in proceeds from the sale of its Sequoia Insurance Co. unit into its Syndey Reinsurance corp. unit.

Sequoia, primarily a commercial multiperil and auto insurer based in Pleasanton, Calif., was purchased by Physicians Insurance Co. of Ohio in Pinkerton. PICO is a holding company for two insurers that write professional liability insurance for physicians, dentists, nurses and other health care professionals. The sale is subject to regulatory approval.

The New York-based reinsurance unit writes property, casualty, accident and health insurance on a facultative and treaty basis through intermediaries.

"We're not thrilled with reinsurance rates in the U.S. at the moment," but they may improve next year, explained E. John Cloney, managing director of QBE.

QBE did not want to be in the primary insurance market in the United States, particularly in California, said Mr. Cloney, who called U.S. regulation of primary markets a "shambles."

QBE's main markets for primary insurance are in the Asia Pacific region. The company has announced it will open an office in India as a joint venture with India's Modi Group. QBE was forced to exit the Indian market in 1971 when the non-life insurance industry in that country was fully nationalized.

*—By Kate Tilley*

S.T.P. PHOTOGRAPHY

# Forging a safety program

## U.K. steelmaker says effort is worthwhile

By CAROLYN ALDRED

LONDON—Implementing a workplace safety and accident prevention program can take years, but the struggle is worth it, says a risk manager who's been there.

Cardiff, Wales-based Allied Steel & Wire P.L.C., as it is known today, was formed in 1981 through a 50/50 venture between British engineering firm GKN and the former nationalized company British Steel to process steel scrap to make wire rods, reinforcing bars, wire and nails.

Since then, the company has expanded steadily, launching an initial public offering in 1988 and recently receiving French government approval of a planned takeover of French steel company Societe des Aciers d'Armature pour le Beton of Montereau.

**Workplace safety programs help steel firms and other manufacturers cut costs.**

The enlarged ASW group will have a market capitalization of £165 million ($263.3 million) with annual revenues of £575 million ($917.7 million). It will employ 4,300 people in plants in South Wales and Yorkshire, England, and Belgium, France, Germany, the Netherlands and Italy.

Employee injuries are typical of a manufacturing company, according to George Bartlett, director of risk management for Wales-based ASW. According to company statistics, 23% of accidents at ASW are caused in the course of employees moving materials around the plant; 14% by hot metal; 17% from falls, slips and trips; 14% are eye injuries; 11% by strains and 8% from falling objects. The remaining 13% of injuries were from numerous other causes.

One of Mr. Bartlett's first tasks in implementing an effective employee-centered safety program in 1981, when the company was formed, was changing attitudes and awareness throughout the company.

"We needed to persuade individuals to take individual responsibility for health and safety," he said during a recent seminar in London sponsored by the Assn. of Insurance & Risk Managers in Industry & Commerce.

Although Mr. Bartlett said he received "a commitment from the board (of directors) that is second to none" with the availability of cash being no obstacle, he noted that "it has taken 13 years and we are not halfway through the journey."

Mr. Bartlett began that journey by appointing London-based broker Minet Holdings P.L.C. to review the company's risk management arrangements.

Minet's recommended 470 measures in its report, including the formation of a risk management committee, and the implementation of evacuation

*See* **Safety** *on next page*

## INTERNATIONAL

# Warming

*Continued from previous page*
said. The government would have to cooperate with insurers to meet those claims, he said.

For years, the U.S. insurance industry has been seeking such government-sponsored protection, but to little avail (*BI*, Feb. 1, 1993).

Similarly, in Britain, sudden claims of £5 billion to £10 billion ($8 billion to $16 billion) would be mark a critical turning point for insurance industry solvency, said Andrew Dlugolecki, chief manager of operations for British General Accident Insurance, a subsidiary of General Accident Fire & Life Assurance Corp. P.L.C. of Scotland.

"Weather patterns are changing and even small changes have a big effect," he said. "These are compounded by changes in the market. We believe climate change will speed up, and that has major consequences for insurers."

Although scientists disagree on whether increased levels of greenhouse gases like carbon dioxide hurt the atmosphere and how they may affect weather, insurance executives say the impact is clear and that climate-related natural catastrophes are increasing.

Two other factors increasing insured losses are shifts in population and a rise in the value of property in endangered zones.

"Fifty percent of the U.S. mainland population lives within 50 miles of one of our coasts," said Mr. Nutter. And, tourism compounds the problem because the number of people in those areas can rise tenfold during warm weather, when most hurricanes occur.

The potential loss in high-risk areas has become staggering, said Mr. Nutter, who estimates the insured value in U.S. coastal communities increased 64% since 1980 to more than $2 trillion.

In response, insurers are modifying underwriting practices by, for example, reducing coverage limits and raising deductibles or coinsurance payments.

After Hurricane Andrew in 1992, for instance, insurers sharply hiked property rates and reduced capacity for exposures in the affected regions (*BI*, April 19, 1993).

"Many insurers would have liked to have withdrawn from the market altogether," said Mr. Nutter.

**'We believe climate change will speed up, and that has major consequences for insurers,' says Andrew Dlugolecki of British General Accident Insurance.**

But some had little choice. Florida and other states have taken action to keep insurers from pulling out of those markets.

At the same time, a joint underwriting association for apartment buildings and condominiums set up by the state of Florida has underwritten a good deal of the property coverage coming up for renewal (*BI*, July 4, 1994).

Insurers could close the gap in uninsured exposures by increasing disaster reserves and taking loss control measures, but it will also require government and policyholders to bear part of the burden, Mr. Dlugolecki said.

"Government cooperation is needed to improve physical risks, build up reserves and provide essential coverage," he said. Governments can reduce risks by building dikes or flood walls like, for example, the Thames flood barrier in London, he said.

While it is difficult to quantify the impact of global warming on claims, insurers know they have a problem on their hands, says Gerhard Berz, head of technical research at Munich Reinsurance Co. in Munich, Germany.

"There can be no doubt that the growing number and intensity of windstorms, thunderstorms and floods all over the world are attributable to the rapid increase in air and sea temperatures," said Mr. Berz.

The result is a growing fear of what many believe is a certainty: more extreme events.

"We can expect governments to use insurance markets to handle financial impact," Mr. Dlugolecki said. France, for example, uses a government-mandated plan to help control the impact of flood losses (*BI*, Feb. 6).

"Government is a financial partner in the cost of recovery. . .and a culprit in increasing losses" from natural phenomena, the RAA's Mr. Nutter contends.

In the last 25 years, the U.S. government has spent more than $140 billion in disaster assistance for a variety of hurricanes, floods and earthquakes.

However, state and local governments must do a better job of providing and enforcing responsible building codes that require the construction of homes and offices more able to withstand the effect of natural catastrophes, Mr. Nutter said.

He estimates that 30% of the costs related to Hurricane Andrew could have been avoided had building codes been enforced.

Rolf Gerling, chairman of Gerling-Konzern Versicherungs-Beteiligungs A.G. of Cologne, Germany, says it's no surprise that environmentalists and insurance companies should be allies on questions of global warming.

"The time is over when we could draw a division between us. Now we should march together," he said. BI

# Safety

*Continued from previous page*
plans for all company plants. ASW implemented both measures in 1982.

Changing the culture required placing greater emphasis on safety committees, safety administrators and safety training, Mr. Bartlett said.

ASW replaced the external doctors retained by the company with an in-house occupational health manager and eight nurses trained in occupational medicine.

The steel company also commissioned the making of in-house safety videos that re-enacted past accidents at the company's plants.

The videos were very explicit—causing several employees to faint on viewing them, Mr. Bartlett said, observing that they were an effective form of "shock treatment."

The company also set up safety seminars for all employees. Meanwhile, employee safety awards, sponsored by Minet, proved very popular and effective for five years, Mr. Bartlett said. After that period, the awards were canceled because their effectiveness reduced with time.

In 1991, 10 years after its original report, Minet returned to the company to review its progress. The consultants determined that the company's safety philosophy and policies were well founded, but suggested the need for new initiatives, Mr. Bartlett said.

In particular, Minet advised that the employees had not received sufficient safety training, the risk management committee should be restructured and junior and middle-management participation in safety initiatives needed improvement.

As a result of Minet's suggestions, ASW broadened the role and membership of the risk management committee to include line managers throughout the production area. A corporate slogan, "Health, safety and the environment are equal to production and quality," was adopted.

And, at a "significant cost" to the company, a risk management team was formed, including Mr. Bartlett as director; two full-time engineers; two part-time consultants and an occupational health manager.

The risk management team monitors health and safety throughout the company; reviews health and safety plans and an annual audit; ensures safety training meets a minimum standard and offers advice in the event of serious accidents, Mr. Bartlett said.

In 1993, the company introduced minimum health and safety training standards for every employee. These include a five-day "managing safely" course for general managers; a 10-day safety course for safety administrators; and a three-day "working safely" course for all other employees.

So far, 350 managers have completed their course and half of the remaining workforce has successfully completed the three-day course, Mr. Bartlett said.

Despite more than a decade of adopting positive new risk management initiatives, Mr. Bartlett claims the company still has a long way to go before it can claim "world's best practice" in health and safety.

Current initiatives include:

**The workplace safety program's success was apparent in ASW's last employers liability insurance renewal.**

- Implementing "self-inspection."

"We have had enormous problems changing the culture so people will inspect themselves" and implement changes in their work areas, he said.

- Continuing health and safety seminars every two months.
- A major drive to ensure that similar safety standards are adopted by subcontractors.
- Learning lessons from competitors.
- Implementing refresher training.
- Improving accident investigations and documentation.

And while Mr. Bartlett believes that he still is only halfway through changing the culture of safety throughout the company, he points to a sure sign that his efforts are already paying off: For the first time in 12 years, ASW renewed its employers liability insurance policy at Lloyd's of London on the same terms as its last renewal.

"That gave us heart that our programs are being recognized," he said. BI


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## LONDON

*Continued from previous page*
a £210 million ($335.2 million) interim payment by Justice Phillips, but as of last week had only seen £3 million ($4.8 million) in cash.

Another £107 million ($170.8 million)—from the underwriting agents' E&O underwriters—stands in a trust account held by the E&O underwriters' law firm, Clyde & Co. The interim payment has been frozen until at least the end of April, when an appeal will be heard on whether members who are "first past the post" in litigation battle should recover damages before the other members action groups have their days in court (*BI*, Feb. 20).

### Aviation rate hikes seen

Though competition is increasing in the aviation insurance market, London underwriters expect airline and airport insurance premiums to rise this year.

With airline hull and liability losses totaling $2.2 billion in 1994, underwriters should increase rates this year, said Jeff Weston, retiring chairman of the Aviation Insurance Offices' Assn. in London last week.

"Premiums will go up to some degree," predicted Mr. Weston, who is aviation underwriter and manager of Zurich Re (U.K.) Ltd., though he didn't say by how much.

Although there haven't been many airlines renewing this year, "so far (rates) are increasing," he said.

Underwriters are putting rates up for airport liability coverages, too, said Mr. Weston, particularly if refueling liability is included. Last year, underwriters suffered a $100 million refueling liability claim when 2,000 aircraft engines were refueled improperly, causing damage to the engines.

Mr. Weston was speaking the day before the AIOA's annual general meeting, at which Barry Wilkes, aviation underwriter of Generali (U.K.B.) S.p.A., took over as association chairman.

The AIOA consists of nine London-based aviation underwriting groups, including British Aviation Insurance Group, Westminster Aviation Insurance Group, and Insurance Co. of North America (U.K.) Ltd.

The London market, including Lloyd's of London, accounts for roughly 45% of the world's airline insurance and reinsurance capacity and leads coverage for all but a half a dozen non-U.S. airlines.

In the past two years, though, major airlines have gone elsewhere. Air France, Aer Lingus, South African Airways and Qantas, for instance, have all moved their lead to France. BI

# Top notch benefits strategies reflect 'big picture'

**By MICHAEL SCHACHNER**

BOSTON—An employee benefits program can help a company's bottom line as well as serve its employees if the benefits staff is in touch with the company's overall business strategy, says an employee benefits manager with a large multinational corporation.

Benefits professionals must be knowledgeable about the business or industry in which their company participates, interact with management to understand corporate goals and identify key business drivers before designing and implementing benefit plans, he said.

"Although it sounds obvious, learning about one's business is vital. But I'm not sure we spend as much time as we should understanding the business we're in. It's difficult to link benefits into the mainstream of business if you don't understand what drives the business. For every company, the imperatives are different. We have to be aware of the grand scheme first," said David Brandies, vp-compensation, benefits, mobility and human resources information systems with Rhone-Poulenc Rorer Inc.'s U.S. headquarters in Collegeville, Pa.

The type of benefits program a corporation should have is influenced by business commitments like customer satisfaction, product innovation, operational excellence and market share growth, Mr. Brandies said at a recent Boston meeting of the New England Employee Benefits Council.

"Benefits can help you achieve these goals. They increase employee satisfaction and enhance employee security, thus giving companies a competitive advantage. Benefits can also (give employees an incentive)to use the company's products and services and walk the talk of the business," said Mr. Brandies. Once benefits professionals are ready to implement a benefits program founded on the company's overall business strategy, they must make sure the benefits strategy is appropriate for the needs of management and employees, he suggested. And, the benefits professionals must make sure the benefits program will be used and appreciated, he said.

"The true benchmark for a benefits strategy isn't so much what the chief human resources or benefits people feel, but what managers and employees feel. It's their program, and at the end of the day, it's only successful if they buy into it and support it," said Mr. Brandies.

Once a decision to implement has been made, communication and marketing become the next tasks.

"Communication and marketing must occur again and again. You have to stay focused, and then try to validate results based on data analysis and input from management and employees," such as satisfaction surveys, he said.

Measurements of the new benefits plan's impact allow benefit managers to know the success of what they have designed and instituted, he said. And, such measurements are a way to get recognized by upper management.

"We spend a tremendous amount of time and energy putting together strategies. It is, therefore, important to assess and measure how they are working. Then we can fix it if it's not working," Mr. Brandies said.

To determine whether benefits are making a difference within the company, benefits professionals can do several things: measure employee participation levels; measure business results for any noticeable link to when the benefits were implemented; survey employee perceptions; and get feedback from external partners, including third-party administrators.

"For example, your claims TPA or 401(k) administrator knows what's going on. They're the ones hearing what people are complaining about," said Mr. Brandies.

Employee benefits managers and their staffs should strive for ongoing improvement of current programs. "There is always a fair amount of change going on within an organization, so we shouldn't put our strategies in a desk drawer and forget about them. It may be necessary to realign and redesign plans," he said.

When strategizing, benefit managers should keep in mind that to be the best, you don't have to be the biggest, Mr. Brandies insisted. Instead, he said, being the best means:

- Having the best overall strategic design and getting the best value out of money spent through effective financial structures and flexible approaches.
- Providing a flexible benefits package which meets a diverse population's current and future needs.
- Making the most out of opportunities that arise from tax rules, the economy, the workforce, and other factors, and by being responsive and willing to change.
- Providing excellent administrative service that is high in quality and timely in delivery.
- Having the most effective overall benefits programs, which are fully communicated, clearly understood and perceived as competitive internally and externally. BI

# Mergers

*Continued from page 2*

ests, is likely to be completed by the third quarter.

Value Health of Avon, Conn., which provides speciality managed care and health care data management services, is the parent company of ValueRx, a prescription benefit management firm headquartered in Scottsdale, Ariz.

ValueRx currently provides services to 16 million group health plan members and reported 1994 revenues of $660 million.

Diagnostek of Albuquerque, N.M., was founded in 1983 as a provider of free-standing diagnostic imaging centers. The company entered the prescription benefit management business in 1988 and currently employs 1,400 workers. Its 1994 revenues totaled $656 million.

Combined, the new company will become the largest prescription benefits management firm not owned by a drug manufacturer. It will offer mail order, retail and other prescription benefit management services to more than 30 million group health plan lives.

The proposed merger follows a flurry of vertical integration in the pharmaceutical industry that started with Whitehouse Station, N.Y.-based Merck & Co.'s $6 billion buyout of Medco Containment Services Inc. (*BI*, Aug. 9 1993). Medco, based in Montvale, N.J., presently covers about 41 million group health plan lives.

Less than one year later, in May 1994, SmithKline Beecham P.L.C. of Philadelphia purchased Diversified Pharmaceutical Services Inc., a unit of United HealthCare Corp. in Minneapolis, for $2.3 billion (*BI*, May 16, 1993). DPS provides prescription benefit management services to 14 million lives.

Then, Indianapolis-based Eli Lilly & Co. entered the prescription benefit management business by acquiring PCS Health Systems Inc. for $4 billion (*BI*, July 18, 1994). PCS of Scottsdale, Ariz., is the largest of the drug maker/prescription benefit management alliances, covering 56 million group health plan lives.

Health care analysts have reacted favorably to the Value Health/Diagnostek announcement. The two firms are well-suited for a merger, they say, citing Diagnostek's strong mail-order business and ValueRx's strong retail pharmacy network.

And, consultants say, the FTC will likely approve the deal.

"I wouldn't imagine the FTC would be too concerned because this is simply two entities within the same industry merging to become a first-tier player. It's not really vertical integration, it's more horizontal integration," said Todd Swim, a practice leader in the Chicago office of Buck Consultants Inc.

"Given the fact that there are so many other players out there, I doubt the FTC would find a problem with this merger," Mr. Norton added.

Late last year, the FTC scrutinized Eli Lilly's purchase of PCS, looking for potential anti-competitive practices. The two parties eventually reached a consent agreement that, among other things, requires PCS to accept all discounts and rebates offered by other drug makers and to make open formularies available to all customers (*BI*, Nov. 7, 1994; Oct. 31, 1994).

Robert Patricelli, chairman and chief executive officer of Value Health, said these regulatory issues played a part in Value Health's decision to drop its plan to sell ValueRx, which had been on the block for about three months late last year.

"FTC scrutiny was a factor in chilling interest by drug companies, but it wasn't the principal factor. The drug manufacturers that wanted to acquire PBMs had done so and the others, for a variety of financial, strategic and regulatory reasons, had determined it wasn't the right strategy," he said.

A merger with another independent PBM made sense as vertical integration in the industry slowed and it became clear drug manufacturers would be willing to work with all PBMs, not just those they owned, Mr. Patricelli added. "Once we made the judgment to keep ValueRx, it made sense to make it the largest independent."

Other large independents remaining include the prescription benefit management unit of Caremark International Inc. in Northbrook, Ill., which covers 14 million group health plan lives, and Maryland Heights, Mo.-based Express Scripts Inc., with 6.2 million group health plan lives.

PBM acquisitions will continue over the next few years, probably resulting in four or five major players, Wyatt's Mr. Norton predicted.

Some observers have speculated that the newly merged ValueRx itself will become ripe for a takeover by a pharmaceutical manufacturer.

"That's quite unlikely and is not our intention," Mr. Patricelli said. "But it is our desire to be bigger and it may be a beneficial consequence if there is a change in strategy."

Barry M. Smith, chairman and chief executive officer of ValueRx, will be in charge of the merged company, which will operate under the name ValueRx. Nunzio DeSantis, Diagnostek's founder, chairman and CEO, is leaving the company but will serve as a consultant to Value Health.

The merger is not expected to cause any disruption to either Diagnostek or ValueRx pharmacy program enrollees. BI

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# Construction defect claim threat lurks ahead: Insurer

SAN FRANCISCO—Construction defect litigation is likely to become as big of a thorn in the side of the insurance industry in the next decade as toxic tort claims have been over the past 10 years, one specialty insurer predicts.

"It's going to ruin some balance sheets; it is certainly taking its toll on mine," Insurance Co. of the West President Bernard Feldman told those attending the recent National Insurance Symposium Leadership Conference sponsored by Russell Miller Inc. of San Francisco.

The San Diego-based insurer, which wrote about $20 million in premiums in liability coverage in the late 1980s and early 1990s for so-called "safe" subcontractors—such as heating and air conditioning—already has paid out more than $35 million in claims on their behalf, he said.

The litigation generally is spawned by industrious plaintiffs lawyers who approach disgruntled homeowners associations about defects or other flaws in their homes, he explained.

Since construction defect claims have a 10-year statute of limitations in most jurisdictions, the tail on building projects can be much longer than many contractors—or their insurers—anticipated, Mr. Feldman pointed out.

The first entity at risk is the first-party property insurer, he said, which is sued under a legal theory known as "concurrent causation" which effectively bypasses most property policy exclusions through semantic differences in descriptions of causation, he said. For example, under an earthquake damage exclusion, a lawyer may claim the damage was caused by "a shift in the Tectonic plates of the United States," which is not specifically excluded, he said.

Then the plaintiffs lawyer usually goes after the developer and/or general contractor, who generally turn around and sue all the subcontractors involved in the project.

"That's called the shotgun approach to litigation, and that's where my company comes in. We have some of the subs, who quite often have named that general contractor as an additional insured under our policy," Mr. Feldman said.

"It used to be that early in these litigated issues you could find out what your contractor did. But today, it takes longer to determine causation" because more parties are being drawn into the litigation, he said.

And even after causation is established, a new precedent set by a California courts in a pollution case involving Montrose Chemical Co. (*BI*, March 8, 1993; March 9, 1992) often is used to persuade the judge to apply a continuous coverage trigger so that the insurance is stacked horizontally, rather than vertically, Mr. Feldman said.

"Instead of tying this to one policy period, you're maybe taking four or five policies and you take the combined limits of those policies and you stack them, and then you go vertically and get an excess policy or something of that sort," he explained.

On top of the policyholder-insurer litigation, insurers are often suing other insurers so that they aren't saddled with the claims, he added.

"So you have this endless litigation. You have each insurance company hiring a lawyer, you have each subcontractor hiring a lawyer, and the practical application is you get in a room like this with a magistrate that goes from table to table and asks your claims person or your lawyer, 'Do you have the stomach for this?' It is truly like that," he said.

In some cases, the litigation process deteriorates into a form of blackmail, he said.

"They will ask how many dollars you have in your policy limit, and then they tell you how many tracks of depositions they can make you attend a day, and they tell you what it will take to buy your way out of this," he said.

"I believe that this problem is as pervasive and as dangerous as toxic tort and environmental litigation, and I think it will end up costing any company that writes commercial liability, any company that even writes personal lines, as much as some of these other issues," Mr. Feldman warned.

*—By Joanne Wojcik*

# Small group health care reform forges ahead in South Dakota

PIERRE, S.D.—South Dakota Gov. Bill Janklow has signed small-employer health care reforms into law.

But separate bills that threatened managed care in the state and could have created a medical provider tax have died.

The small-employer health care reforms are based on a National Assn. of Insurance Commissioners model health reform law.

Similar small-employer health care reforms have been enacted in 42 states, said Shannon Anderson, a consultant with the Health Insurance Assn. of America in Lincoln, Neb.

The law requires health insurers to issue standard health insurance policies to small employers that want to buy the coverage. The law covers businesses with two to 50 employees.

However, health insurers may stop writing small group coverage once that segment of their business exceeds 5% of earned premium.

A 3-to-1 age rate ban in the law prevents insurers from charging the oldest plan participants more than three times the rate that the youngest plan participants are charged.

The Legislature, meanwhile, repealed a 1994 law that created a risk pool for residents who have been rejected by two or more health care insurers.

Legislation that the HIAA feared would kill managed care in South Dakota died in the Senate, which tabled it and other bills shortly before its March 4 adjournment.

The bill, H.B. 1187, would have limited the additional costs that health plan participants would have had to pay for obtaining care from out-of-network providers to 10% more than the cost of care from in-network providers.

In addition, those out-of-network charges would have been capped at $250.

Ms. Anderson said that insurers, providers and employers probably still will attempt to work out the problem that prompted the legislation: Providers that are left out of networks fear they will lose a sizable portion of their client base.

The governor signed but then asked the Legislature to kill a law that could have created a 4% tax on medical providers' revenues. The $40 million that the law could have generated annually would have been used to partially finance a $120 million reduction in property taxes statewide.

Signing and killing the law was easier administratively for the Legislature than if the governor had vetoed it originally because of how the law was interwoven with other tax legislation, a spokesman for the governor explained.

Even if the law hadn't been killed, South Dakota voters would have decided in a special election on July 11 whether they wanted the medical provider tax or a 0.5% increase in the general retail sales tax to 4.5%.

*—By Dave Lenckus*


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# Insurers able to further cut comp costs

By MEG FLETCHER

CHICAGO—Workers compensation insurers are in a good position to squeeze more cost savings out of the system, an insurer executive contends.

"I maintain it is workers compensation insurers—with the years of experience and know-how—who can best realize those savings on behalf of customers," said Elizabeth M. Lindner, executive vp of Kemper Risk Management Services, a unit of Kemper National Insurance Cos. in Long Grove, Ill.

Insurers can save customers money in several ways, she told the Chicago Chapter of the Assn. of Professional Insurance Women during a recent luncheon meeting.

Getting claims reported quickly reduces litigation and loss payments, she said.

"The rate of litigation is directly proportional to when the loss was reported," according to a study of Kemper National workers comp claims closed in 1994.

Less than a quarter of claims reported within 10 days of the loss result in litigation, but when more than a month passes between the accident and when it is reported, the litigation rate is 50%, the study found. In addition, the average total loss payment is about 47% higher for claims reported more than a month after the accident, compared with the payment on claims reported within 10 days. Workers compensation insurers have become "aggressive" about prompt reporting of claims, often through the use of telephone reporting systems. Use of Kemper's system has reduced average loss payments by 18% and litigation by half, Ms. Lindner said.

Even those good results may be overshadowed by the potential savings from using managed care.

"I believe we as an industry have only scratched the surface of the savings we can realize in both direct and indirect indemnity costs," as a result of managing care, she said.

Workers comp insurers do a better job than health insurers because they have special expertise and experience in getting formerly injured workers back to the job. That reduces the direct costs of indemnity payments, which account for more than half of all workers comp claims dollars, as well as the indirect costs like hiring temporary or replacement workers.

Too often, though, return-to-work programs have not been put into practice on the front lines of a store or plant. Kemper suggests arming the nurse who manages the medical treatment with job descriptions, so he or she can coach the supervisor on ways to get an injured employee back to work, even for a limited-duty position.

Also, "insurers are realizing savings through fighting fraud, most notably through their support of the National Insurance Crime Bureau," she said. The bureau's 1993 activities resulted in more than 4,000 arrests, warrants or indictments—20% better than in 1992. Kemper's own fraud-fighting efforts referred cases involving more than $10 million in fraudulent claims to prosecutors last year.

"Demographic trends show that skilled workers in the United States will be in high demand in the future. That means that our expertise in helping put resources back to work, while containing costs, is what our customers will need and want," Ms. Lindner said. BI


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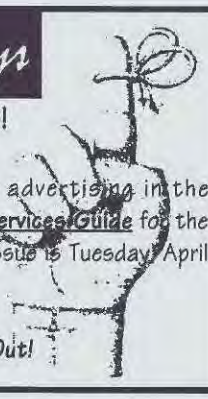
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# For the Record

## Legislator, regulator relations look warmer

ORLANDO, Fla.—Relations between state insurance legislators and regulators are improving, though they still disagree on many issues.

That is the consensus of both sides following the National Council of Insurance Legislators spring conference in Orlando, Fla., March 24-26.

"It was more open and friendlier, but I made sure they understood that the honeymoon is over," said New Jersey Assemblywoman Clare Farragher, R-Freehold. She is chairwoman of the NCOIL's Special Solvency Accreditation Committee.

Her committee and its parent—the Task Force on Insurer Solvency—formally adopted a report criticizing the National Assn. of Insurance Commissioners and its accreditation program for usurping state power to regulate insurance (*BI*, March 6).

However, NCOIL took the unusual step of postponing action by its Executive Committee on the report's findings until a July meeting.

That will give the NAIC time to provide detailed responses to NCOIL's criticism by June 1, and NCOIL time to review them.

"I thought it went pretty well," said Lee Douglass, president of the NAIC, who attended the NCOIL meeting. "Obviously, they still have objections to what we do, but it seems to me the lines of communication have opened a bit and the rhetoric has cooled."

Also at the NCOIL meeting, Vermont legislators introduced a resolution urging NAIC reforms, including increased state oversight and more open meetings. The resolution, referred for further study, also seeks to change the NAIC accreditation program's focus to regulatory performance from "formalistic model acts." Several Vermont accreditation bids have been rebuffed over the state's regulation of risk retention groups (*BI*, Dec. 5, 1994).

## Joint regulatory action may foreshadow future

In a move that may foreshadow future regulatory efforts, five states last month jointly fined Capital American Life Insurance Co. $1.6 million for misleading consumers and failing to pay claims, while imposing an unusual settlement agreement on the personal lines insurer.

The 28-page agreement with regulators from Iowa, Missouri, North Dakota, South Dakota and Wisconsin contains "a unique provision" that makes the company subject to having its license suspended in all five states if it commits "a material violation" of insurance laws in any one of the states during the next five years, said Glenn Pomeroy, North Dakota's insurance commissioner.

Each of the five states will receive $300,000 plus costs.

While other regulators have previously engaged in joint investigations and settlements, that provision likely will be a model for regulators to use in similar circumstances, said Fred Nepple, general counsel of the Wisconsin Insurance Department.

The charges stem from regulators' joint investigation of Capital American's sale of life insurance policies primarily providing payout for cancer and heart disease to rural residents in the five states. The insurer is an Arizona-domiciled company with headquarters in Cleveland.

Other states, including Ohio and Arizona, are also investigating the insurer, regulators say. BI

# Products

*Continued from page 2*

in S. 565 would:

- Abolish joint liability for non-economic damages in product liability cases.
- Set a 20-year statute of repose—or time limit on bringing suit after a good is introduced in the market—for capital goods and "durable workplace goods."
- Cap punitive damages in product liability cases to the greater of $250,000 or three times economic damages.
- Establish a national standard of "clear and convincing" evidence of a defendant's "conscious flagrant indifference to the safety" of others as a prerequisite for awarding punitive damages.

Sen. Gorton, a former state attorney general, said raising the standard of evidence to "clear and convincing" will be more important to reform than the cap on punitive damages.

Medical malpractice reforms would be the easiest type of reform to add to the product liability bill, he said. The Senate Labor and Human Resources Committee is scheduled to vote this week on S. 454, the Health Care Liability Reform and Quality Assurance Act. The bill would limit punitive damages in malpractice cases, allow periodic payment of such damages, limit the percentage of a malpractice award that can be taken as an attorney's contingency fee and create a uniform statute of limitations in malpractice cases.

While Sen. Gorton saw the malpractice reforms as the easiest add-on to S. 565, he said that securities litigation reforms would not be added to the bill.

He did not predict whether S. 565 would be amended as its House counterpart was to extend some product liability provisions, such as a cap on non-economic damages, to all civil cases.

No matter what is added, "we still have to get 60 votes" to cut off filibusters and bring the bill to a final vote, he said.

To achieve that goal, he and the bill's chief Democratic sponsor, Sen. John D. Rockefeller IV, D-W.Va., intend to strip any add-on that did not receive 60 votes on its own from the final bill. He added that anywhere from three to 10 GOP senators ultimately could vote against the bill, depending on what it contains.

"The challenge we haven't solved yet is how to get the last vote, the one in the White House," Sen. Gorton said.

He said some Justice Department lawyers visited him last week and said that only a watered-down product liability bill would be acceptable. Sen. Gorton told them that a weakening of the bill was not in the cards.

"There's no point in our making compromises if we're going to get a veto anyway," he said.

Sen. Gorton warned, however, that if President Clinton vetoes whatever product liability bill emerges from the House-Senate conference that determines the final bill, he will show that he values the plaintiffs' bar more than the desires of the NAM, the National Federation of Independent Business, the American Red Cross and Little League Baseball Inc., all of which support some degree of liability reform. BI

# The Home

*Continued from page 1*

ness with a $1 billion reinsurance program (*BI*, Feb. 13).

Under an earlier offer, by an investor group led by John J. Byrne, The Home would have remained an active insurance company following a capital injection of $420 million (*BI*, Dec. 12, 1994).

Executives from Zurich and The Home will be testifying at the hearings. They have said that enhancements added to Zurich's original offer, including an excess-of-loss insurance program and guarantees of returns on Home Holdings notes, were designed to give regulators, policyholders and bondholders greater certainty.

Some policyholders, though, fear that The Home in runoff will not have enough capital to pay all its liabilities on policies, some of which were written decades ago and cover pollution and products liability.

"It is very difficult to estimate with any degree of accuracy the amount of the claims that are presently or potentially pending against The Home on these policies," said Richard E. Poole, a lawyer who will speak at the hearing on behalf of more than 20 commercial policyholders, including American Home Products Co., Hoechst-Celanese Corp., Illinois Power Co., Maricopa and Pima Counties in Arizona, and W.R. Grace & Co.

"The only safe course," Mr. Poole, a partner with Potter, Anderson & Corroon in Wilmington, Del., wrote to New Hampshire regulators, "is to insist that after the acquisition of control by Zurich, the policyholders are able to look to The Home's assets—consisting of the desirable book of business transferred to Zurich—as well as Zurich's own assets, in the event that reserves in the runoff company prove to be insufficient."

Without this guarantee, insurance premiums paid by solvent policyholders would have been wasted. And if policyholders are driven out of business because they cannot collect on their insurance policies, claimants seeking compensation from those defunct policyholders would wind up empty-handed, he said.

In his proposed testimony, Mr. Stewart—who was New York's top regulator from 1967 to 1970 and is now a consultant with Stewart Economics in Chapel Hill, N.C.—recites some figures that have The Home policyholders uneasy.

As of 1993, The Home said in Securities Exchange Commission filings that asbestos and pollution together were reserved at $403 million gross and $189 million net, "including large amounts as bulk reserve and loss adjustment expense," wrote Mr. Stewart. "For a company with 2,100 policies with open asbestos and pollution claims, those are not reassuring numbers."

In the first nine months of 1994, though, The Home increased its pollution and asbestos net reserves to $237 million, a spokesman for the insurer said (*BI*, Nov. 14, 1994).

The Zurich deal departs from two basic ideas of insurance and insurance regulation, Mr. Stewart says in his planned testimony.

"One is that, when a company is financially precarious, different classes of policyholder and claimant should not be accorded preferential treatment. The other is that the ongoing book of business of any insurance company is one of its principal assets," he says.

Zurich's proposal would favor Zurich and the ongoing business of The Home over policyholders and claimants by shunting certain policyholders into a condemned company without their consent, Mr. Stewart writes.

Other U.S. insurers also stand to lose if the deal goes through, he contends. If The Home fails to meet its liabilities, other insurers on the same programs may have to pay some of The Home's share and many other companies—including those in unrelated lines under many states' systems—might have to pay increased guaranty fund assessments to cover the shortfall.

What's more, Mr. Stewart argues, allowing the Zurich deal might encourage other companies to funnel bad risks into some newly created pool when claims reach a high level and, with a mind-set that that could be done, insurance companies may underwrite carelessly.

Many insurers today have similar problems to The Home and the Zurich proposal may be used as a model for future transactions, Mr. Stewart's testimony says.

"Government should not encourage managements of fiduciary businesses to take catastrophic risks and pursue disaster-prone strategies," he contends.

Also at the public hearing will be representatives of Home Holdings' bondholders who have put forward an alternative proposal to the Zurich deal. The bondholders committee is headed by Robert Beach, a vp with Cargill Financial Services in Minneapolis.

The bondholders in the group own more than 67% of the $280 million issue of Home Holdings senior notes, which represents all outstanding public debt except what is owed to Trygg-Hansa.

The group proposes to split The Home's current nine-member intercompany pool into two entities: A Pool, which would continue as an ongoing insurer writing both new and renewal business; and B Pool, which would be responsible for the long-term management of existing Home policies.

The stronger A Pool would be capitalized through a $350 million subsidy from the weaker B Pool companies, a move designed to insure that A Pool secures a rating of at least A-, the point at which brokers can normally place business without obtaining special approval from risk managers.

The bondholders propose that the A Pool company would then be able to take on about $1 billion in premiums from existing business written by The Home. Under the Zurich deal, Zurich has been using cut-through endorsements and similar arrangements to stand behind The Home's policies. But Zurich's offer also specifies that if the deal does not go through, The Home will be allowed to retrieve that business, unless policyholders wish to switch insurers.

Also under the proposal, $170 million of notes securing a loan by Trygg Hansa to Home Holdings, along with 25% of the $280 million of the bondholders' notes, would be converted into new common stock of Home Holdings. That would make the bondholders owners of 17% of Home Holdings stock.

The management at The Home would also be changed, said J. Andrew Rahl, head of bankruptcy and restructuring at Anderson Kill Olick & Oshinsky, the New York-based law firm that is representing the bondholders.

The bondholders' proposal is a model and changes could be made after discussions with regulators and rating agencies to ensure that the A Pool company would receive an A- rating, said Edward Whiting, managing director of Whitman Heffernan Rhein & Co Inc. in New York, who is advising the bondholders.

"How much capital we will need and how much business we will write will be determined through discussions with regulators and A.M. Best. The Form A we filed was for modeling purposes," Mr. Whiting said.

The B Pool would run-off existing policies of The Home and write business that is not credit sensitive, he said.

The B Pool companies would be able to pay future claims through their existing reserves and a $590 million stop-loss reinsurance policy already in place, Mr. Whiting said.

"We believe that that could be sufficient," he said.

Recently, CIGNA Corp. used a similar segregation strategy to secure an A- rating from A.M. Best Co. for some of its units (*BI*, Feb. 20).

However, officials of Oldwick, N.J.-based Best are not so optimistic of the bondholders' proposal.

**If The Home can't meet its liabilities, other insurers on the same programs may have to pay some of its share and others might face higher guaranty fund assessments.**

The proposal for The Home is "too little, too late," said Senior Vp John Snyder. "An A rating is based on a company first being a viable business, and right now the company is in run-off mode."

Also, The Home will probably not be able to retrieve the large chunk of its profitable business that has already gone to Zurich, Mr. Snyder said.

"It's hard to envision a scenario that the credit holders are proposing that would satisfy the capital structure for an A rating and much less address operations, management and franchise issues," he said.

Best did not know details of the proposal before it was released, said Mr. Snyder. "It was very presumptuous of them to think that they would get an A rating."

Standard & Poor's Corp. in New York would not favor a proposal like the bondholders' plan, said Peter Wade, associate director.

"We have not seen the details, but we have given some thought to this kind of structure and we think it would be a very difficult transaction to do," he said.

Even if the companies could be completely segregated, policyholders in the ongoing company would be unlikely to stay if the runoff company were to stop paying its old claims, according to Mr. Wade.

"How do you insure XYZ company but still have an old policy with it which you are not paying the claims on? That problem doesn't exist with the Zurich proposal," he said.

It would be highly unlikely that the new company would receive an adequate S&P rating for it to attract business, Mr. Wade said.

The main aim of the bondholders seems to be to set up a company with more funds to repay the notes than they would receive under the Zurich proposal, he said. BI

## Insider Trading

**Aetna Life & Casualty Co.:** John F. Donahue, director, indirectly disposed of by gift 20,600 shares of common stock at an unreported price from Dec. 19 to Dec. 15, 1994. He now indirectly holds 216,597 common shares.

Richard L. Huber, director, bought 1,000 common shares at $18.50 each on Feb. 23 and now directly holds 1,000 common shares.

Aetna stock closed at $56 a share on March 24.

**Alexander & Alexander Services Inc.:** John Arthur Bogardus, director, disposed of by gift 580 shares of common stock at an unreported price from Dec. 18 to Dec. 19, 1994, and now directly and indirectly holds 89,880 common shares.

A&A stock closed at $22.38 a share on March 24.

**American International Group Inc.:** Aloysius B. Colayco, vp, exercised an option for 180 shares of common stock at $39.08 each on Jan. 5 and now directly and indirectly holds 595 common shares.

Axel I. Freudmann, vp, exercised an option for 937 shares of common stock at $17.33 each on Jan. 3 and now directly holds 3,057 common shares.

Leslie L. Gonda, director, indirectly disposed of by gift 15,744 shares of common stock at an unreported price from Dec. 6 to Dec. 12, 1994, and now directly holds 3,490,600 common shares.

Jeffrey W. Greenberg, vp, exercised an option for 1,500 common shares at $17.33 each on Jan. 4. Mr. Greenberg now directly and indirectly holds 27,570 common shares.

Maurice R. Greenberg, chairman, indirectly acquired by gift 102 common shares at an unreported price on Jan. 11. He indirectly bought 115 common shares at $105.38 each on Feb. 8. Mr. Greenberg now directly and indirectly holds 11,157,218 common shares.

Edward E. Matthews, officer and director, exercised an option for 5,900 common shares at $22.63 each on Jan. 4 and sold them at $97 each that same day. Mr. Matthews exercised an option for 3,550 common shares at $22.63 each on Feb. 8. He now directly and indirectly holds 202,175 common shares.

Wayland M. Mead, officer, disposed of by gift 600 common shares at an unreported price on Dec. 15, 1994. He indirectly acquired by gift 200 shares at an unreported price that same day and now directly and indirectly holds 79,124 common shares.

Robinson K. Nottingham, vp, exercised an option for 1,352 common shares and disposed of by gift 388 common shares at $29.53 each from Feb. 3 to Feb. 23. Mr. Nottingham now directly holds 3,607 common shares.

Douglas A. Paul, vp, exercised an option for 2,059 common shares at $17.33 each on Jan. 3 and now directly holds 7,263 common shares.

Frank Petralito, vp, disposed of by gift 100 common shares at an unreported price on Jan. 25. He now directly holds 5,952 common shares.

Robert M. Sandler, vp, exercised an option for 1,092 common shares at $17.33 each on Jan. 3. He now directly holds 32,392 common shares.

Kathleen E. Shannon, vp, exercised an option for 562 common shares at $17.33 each on Jan. 6 and now directly holds 10,014 common shares.

Thomas R. Tizzio, president, disposed of by gift 200 common shares at an unreported price on Jan. 19. He now directly and indirectly holds 55,879 common shares.

AIG stock closed at $105.88 a share on March 24.

**Aon Corp.:** Josephine B. Minow, shareholder, indirectly bought 2,500 shares of common stock at $32.10 each from Dec. 5 to Dec. 6, 1994. Ms. Minow now indirectly holds 20,000 common shares.

Newton N. Minow, director, indirectly bought 7,500 common shares at $32.10 each from Dec. 5 to Dec. 6, 1994. He now indirectly holds 27,500 common shares.

Aon stock closed at $36.63 a share on March 24.

**Chubb Corp.:** Chubb Corinne Trust, trustee, sold 10,000 shares of common stock at $79.93 each on Feb. 6 and now directly holds 86,780 common shares.

Percy Chubb, officer and director, indirectly sold 5,000 shares of common stock at $77.75 each on Dec. 21, 1994. Mr. Chubb indirectly sold 10,000 common shares at $79.93 each on Feb. 6. He now directly and indirectly holds 212,709 common shares.

Robert P. Crawford, vp, exercised an option for 300 common shares at $30.22 each on Dec. 6, 1994. He exercised an option for 1,400 shares of common stock at $28.63 each on Feb. 6. To cover transaction costs, he turned in 500 of them for $80 each on that same date. Mr. Crawford now directly and indirectly holds 11,845 common shares.

Gail E. Devlin, vp, exercised an option for 1,297 common shares between $30.22 and $36.38 each on Dec. 19, 1994. To cover transaction costs, Ms. Devlin turned in 562 of the shares for $76.13 each on Dec. 19 and now directly holds 8,339 common shares.

Henry G. Gulick, vp, sold 553 common shares at $80.13 each on Feb. 7 and now directly and indirectly holds 5,667 common shares.

Dean R. O'Hare, chairman, disposed of by gift 1,105 common shares at $78 each on Dec. 19, 1994. He indirectly acquired by gift 532 shares at $78 each that same day and now directly and indirectly holds 48,708 common shares.

John F. Swope, retired, exercised an option for 14,634 common shares between $23.63 and $72.06 each on Feb. 14. To cover transaction costs, he turned in 7,245 of them for $78.13 each on that same day. Mr. Swope now directly and indirectly holds 41,908 common shares.

George T. Vangilder, vp, exercised an option for 2,600 common shares between $30.22 and $36.38 each on Dec. 9, 1994. To cover transaction costs, Mr. Vangilder turned in 1,024 of the shares for $71.94 each on that same day. He now directly holds 12,642 common shares.

Chubb stock closed at $78.88 a share on March 24.

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*Insider Trading, compiled by Invest/Net Trading Group Inc. of Fort Lauderdale, Fla., from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers. The column is distributed by Tribune Media Services Inc.*

# Pensions

*Continued from page 2*

the amount of information that employers will have to provide. Employers will have to explain, among other things:

- The percentage of promised benefits that are funded.
- That if the plan terminates, some participants may lose benefits.
- The maximum monthly benefit that the PBGC guarantees.

In addition, employers with underfunded plans will have to explain that the PBGC does not guarantee certain benefits, such as health and life insurance benefits. Employers also will have to explain that benefit increases promised by employers are only partly guaranteed.

Federal pension regulators say the new disclosure statement is needed to raise employee awareness of underfunded pension programs and that there are limits on federal benefit guarantees.

"Workers must know if their pensions are underfunded so they can make informed choices about their retirement and their future," said PBGC Executive Director Martin Slate.

While the disclosure statement will not be expensive or difficult to prepare, employers may want to provide participants with a supplemental statement to allay possible fears.

For example, employers may want to explain why the plan is underfunded and what they have been doing and intend to do to improve funding, said Dick Joss, a consultant with The Wyatt Co.'s Research & Information Center in Washington.

"I think employers may want to give a more complete picture," said Fred Rumack, director of taxes and legal services at Buck Consultants Inc. in New York.

"If you have a better story to tell, do so, perhaps in a cover letter," said James Durfee, director of actuarial practice at Towers Perrin in Valhalla, N.Y.

Other employers, especially those that are nearly 90% funded, may improve plan funding and avoid having to send out the annual notice.

"I definitely see plan sponsors improving funding," said Pamela Scott, a principal with Kwasha Lipton in Fort Lee, N.J. BI

## Deficit of PBGC down sharply

WASHINGTON—The deficit of the Pension Benefit Guaranty Corp.'s single-employer insurance program fell sharply last year, breaking a four-year streak of deficit increases.

In 1994, the PBGC's deficit—the difference between its assets and the benefits it has guaranteed to participants of underfunded plans the agency has taken over—dropped to $1.2 billion from $2.9 billion.

Rising interest rates account for most of that gain. Higher interest rate assumptions have the effect of lowering the value of liabilities. In addition, the agency was not rocked in 1994, as it was in recent years, with any blockbuster terminations of underfunded pension plans.

Agency officials caution, though, that the long-term health of the agency depends on a 1994 law that will force employers with underfunded plans to kick in contributions faster (*BI*, Dec. 5, 1994).

"The decline in PBGC's deficit is a positive development, but must be viewed with caution. We cannot depend on one-year changes in the interest rate to cure the deficit," said Executive Director Martin Slate. "Real progress will come from the new pension reforms."

The surplus in the agency's insurance program for multiemployer pension plans, though, slipped to $197 million from $276 million. The decline in surplus resulted from several factors, including a decline in the value of certain fixed income assets.

*—By Jerry Geisel*

# Hutter

*Continued from page 2*

Peers and colleagues say Ms. Hutter's creativity, integrity and ability to be a role model for women and men alike also makes her worthy of the award, which was introduced by the New York-based APIW in 1976.

In addition to being "a highly respected professional woman in the reinsurance industry, (Ms. Hutter) has the actuarial challenge of the century," said Marsha Cohen, deputy director of state relations for the Reinsurance Assn. of America and president of the International Alliance of Professional & Business Women.

"An echoing theme we heard from various people is that Heidi has one of the most creative minds in the industry," said Patricia L. Saporito, president of the APIW in New York.

Ms. Hutter began her insurance career after graduating in 1979 with a degree in mathematics from Cornell University in Ithaca, N.Y.

Insurance was a career option for math majors, she said, but "I did not think I would have a career in the insurance industry."

Then, North American Reinsurance Co., the U.S. division of Swiss Reinsurance Co., came to Cornell to recruit seniors for a job in treaty assistance.

She had heard of the Treaty of Versailles, she jokes, but had no idea what treaty assistance meant.

"It sounded intriguing," she recalled. "Once I interviewed, they got me—hook, line and sinker."

Ms. Hutter eventually was promoted to the post of executive vp with Atrium Corp. in New York, the reinsurance intermediary and managing general agency for Swiss Re's financial reinsurance business. In that post, she had responsibilities for developing programs to assist insurance companies facing loss reserve deteriorations and other financial difficulties.

In 1993, she accepted the offer from Lloyd's and headed for London.

"We were sad to see her leave," recalled Jay Novik, president of Atrium. However, Ms. Hutter's appointment reaffirmed his belief in Lloyd's "because it was willing to reach out to find the best person for the job instead of looking to fill the spot from within the group."

"It hasn't been so long that Lloyd's opened up its membership to Americans and separately to women," he continued. "Its willingness to let her come over into a central role is an indication of both her ability and of its commitment to solve its problems," Mr. Novik said.

Just like she thought she would never enter the insurance industry, Ms. Hutter said she never thought she would work at Lloyd's.

**As head of Equitas, Ms. Hutter faces what may be the actuarial challenge of the century.**

"I met Peter Middleton (Lloyd's chief executive) in August of '93. If I were told then that I would be working for Lloyd's by the end of the year, I would have said 'No way.' "

Two months later, Ms. Hutter was embarking on what she said was the biggest challenge of her career.

As project coordinator of Equitas, Ms. Hutter is responsible for developing a way to close all pre-1986 syndicate accounts—which are mainly plagued by asbestos and pollution claims—into Equitas by the beginning of 1996.

Several months ago, Ms. Hutter said that Lloyd's had made substantial progress in forming the reinsurance company and syndicates can expect this summer to know how much they will have to pay Equitas to close their accounts (*BI*, Jan. 23).

"Lloyd's is incredibly complex," and Ms. Hutter "has done a smashing job over here," said Richard Keeling, Lloyd's deputy chairman and chairman of Equitas' supervisory board.

"When you deal with Heidi, you know what she says is right and that she believes in it. She has a great deal of integrity, high intellectual caliber and the skills of building a team of people," said Mr. Keeling, adding that those qualities are what Lloyd's was looking for when interviewing for the director's position.

In addition to her role with Lloyd's, peers say Ms. Hutter has excelled in being a role model and mentor for others in the industry.

"As a woman, it's important from the APIW's standpoint that (Ms. Hutter) is seen as a role model for women and for men alike," Ms. Saporito said. "One thing that impressed me about Heidi is that she provides visibility and networking possibilities for others."

Since Ms. Hutter's appointment, two other women have been appointed to senior positions within Lloyd's.

"When I decided to come to London, lots of people warned me that London was 10 years behind" the United States on issues like the advancement of women, Ms. Hutter said. "I think London has a ways to go" in changing attitudes, she said, but "I hope my situation helps other women and other employers realize there are good women out there."

Ms. Hutter said that so far in her career there is no highlight that stands out. "One opportunity leads to the next," she said. However, "sitting here today, winning this award feels pretty great. I feel recognition by your peers is the hardest thing to achieve and the most rewarding."

Ms. Hutter will be honored at a June 15 reception at the City Mid-Day Club in New York. Lloyd's Chairman David Rowland will present the award. BI

# Updates

## Fight looms on regulation bills

WASHINGTON—The stage is set for a conference committee fight over regulatory reform proposals passed by the House and Senate.

The Senate unanimously voted last week to subject many new regulations to a 45-day freeze to allow Congress time to review them. Under S. 219, the Regulatory Transition Act, executive branch rules with an annual economic impact of at least $100 million that were put in place on Nov. 20, 1994, or later would be subject to review. Existing rules, however, would not be suspended during the review period and emergency rules issued after the effective date would not be reviewed.

By contrast, a House-approved bill would freeze most new regulations until a broader bill was enacted. Non-emergency rules issued on or after Nov. 20, 1994, could be suspended until year end.

The two measures will have to be reconciled by a conference committee and returned to both chambers for a vote on a compromise bill.

## Alliance woos health plans

DENVER—The Colorado Health Care Purchasing Alliance issued proposals Friday to about 20 health care plans in the state that might be interested in bidding for the group's business, which for the first time will include fully insured employer health plans.

The alliance, a group of 170 self-insured employers that covers 100,000 employees and dependents, is expanding its membership to include small, fully insured employers.

Last year, Colorado legislators permitted the Alliance to create a Cooperative for Health Insurance Purchasing, or CHIP, which will allow small, fully insured employers to band together to buy insurance.

The alliance, founded by William Coors of Coors Brewing Co., will use its purchasing clout to secure affordable coverage for those employers, said Claire Brockbank, vp of marketing for the alliance. Among other things, the alliance will require health plans that bid on the business to adhere to specific quality, price and accountability standards. The group plans to offer small firms three to five health plan choices by October.

## DuPont fraud hearing ordered

COLUMBUS, Ga.—E.I. du Pont de Nemours & Co. Inc. must appear before a federal judge this month to prove that it did not engage in a fraudulent scheme with its attorneys to cover up evidence that its Benlate DF fungicide was tainted with a toxic herbicide.

U.S. District Judge Robert Elliott, who presided over the first Benlate case to go to trial here in 1993, late last month ordered an April 24 hearing on a petition filed by the growers in that case, who initially sought hundreds of millions of dollars in damages but later settled for $4.3 million. They are seeking unspecified sanctions against DuPont for allegedly withholding test data showing that Benlate was defective.

Judge Elliott said DuPont must explain to the court why sanctions should not be imposed. A Hawaii jury in a Benlate case did impose sanctions of $23.8 million after finding that DuPont, through its attorneys at Alston & Bird in Atlanta, pressured a laboratory to change results on soil tests (*BI*, Jan. 23). DuPont is appealing that award.

## Briefly noted

**USAir Inc. and Boeing Co.** last week settled two suits by families of people killed in the crash of Flight 427 outside Pittsburgh last year (*BI*, Sept. 12, 1994). . . . **Alexander & Alexander Services Inc.** is properly reserved for $47 million it is paying Pennsylvania regulators to settle all lawsuits over its handling of the Mutual Fire, Marine & Inland Insurance Co. insolvency. The regulators sued A&A and former unit Shand Morahan & Co. for $234 million, alleging Shand and A&A breached duties in providing underwriting management services for Mutual Fire (*BI*, Nov. 8, 1993). . . . A **model insurance fraud act** drafted by the Coalition Against Insurance Fraud would allow prosecutors to seek treble damages if the alleged activity could be shown to be part of a "pattern and practice" of fraud. Under the act, which the Washington-based group plans to press for in two or three states, one-third of any treble damages would be set aside for investigations, prosecution and consumer education. . . . The California Department of Insurance is for the first time applying an **insurer solvency early warning** system to workers compensation lines. . . . **Fireman's Fund Insurance Co.** will get a new trial only a month after a Superior Court jury in San Francisco ordered the Novato, Calif.-based Allianz A.G. Holding unit to pay $10.3 million in a bad faith suit by a dentist who refused to consent to the settlement of a malpractice claim (*BI*, Feb. 13). . . . The National Council of Compensation Insurers has proposed reducing **Vermont's workers compensation rates** by an average of 5.5% for employers in the state's assigned risk plan and 3.7% for those in voluntary markets. . . . Charles A. Donaldson, a Bahamas captive manager and former Bahamas registrar of companies, has pleaded guilty to a mail fraud charge stemming from an allegedly fraudulent reinsurance deal he helped arrange for the defunct **Physicians National Risk Retention Group Inc.** of Louisiana (*BI*, March 27; March 13). Mr. Donaldson, who is cooperating with a federal investigation of Physicians National, faces up to five years in jail. . . . A **hailstorm** that damaged cars and roofs in Dallas late last month will cost insurers at least $115 million, mostly in personal lines claims, the Southwestern Insurance Information Service says. . . . **G.T. (Terry) Van Gilder** has joined Menlo Park, Calif.-based Risk Management Solutions Inc. as chairman. He was formerly executive vp of Warren, N.J.-based Chubb & Son Inc. and chief underwriting officer of Chubb Corp. . . . Dow Chemical Co. will not have to pay a portion of a $5.2 million jury award in the first **silicone breast implant** lawsuit in which it had been found liable, after a Texas judge last week dismissed a Feb. 15 jury finding that the Midland, Mich.-based company helped Dow Corning Corp. market the implants. . . . Effective today, **Municipal Bond Investors Assurance Corp.** of Armonk, N.Y., has changed its name to MBIA Insurance Corp.

# HMOs

*Continued from page 1*

for GTE Corp. in Stamford, Conn. "Is this the best use of that capital for us as customers, when we have a lot of other needs that we have made known?"

"We all know they are awash in cash," commented Tom Elkin, chief of the health program at the California Public Employees Retirement System in Sacramento. "As a public purchaser, I take every opportunity I can to say we could use some of that extra profit in the form of refunds on premiums."

Corporate health care buyers have other concerns, as well, including the impact of the mergers on competition, quality and pricing.

But, consultants say, the newly merged HMOs will be able to offer services in more states and thus more employers will benefit from the sort of competitive pricing going on in California. WellPoint's planned acquisition of HSI, for instance, would help the merged company expand outside California.

Late last week, the HSI board had approved WellPoint's bid to acquire the company in a cash-and-stock deal, but the board of Blue Cross of California, which owns 80% of WellPoint, had yet to give the green light.

Final details were not released, but a preliminary version of the offer had HSI shareholders receiving 1.09 shares of WellPoint for each HSI share and WellPoint shareholders receiving $1.2 billion as part of a proposed recapitalization. That offer was valued at $1.78 billion. Earlier, WellPoint rejected a hostile cash-and-stock takeover offer by Blue Shield of California that Blue Shield valued at $4.5 billion. Blue Shield of California is not related to Blue Cross of California.

HSI President Roger Greaves said the company planned to expand outside of California, where the managed care market is nearly saturated.

"We're moving our wagons East," he said.

Acquiring HSI would also make it easier for WellPoint to fold its indemnity enrollment into HSI's more cost-effective closed-network health maintenance organizations.

Since its 1994 merger with Pueblo, Colo.-based Qual-Med Inc., HSI now has operations in six Western states: California, Washington, Oregon, Colorado, Idaho and New Mexico.

One very likely target for growth in the future will be Arizona, where neither HSI nor WellPoint has operations now. A possible entry to that market would be through workers compensation managed care, said Tamara Watt, vp-workers compensation for HSI. For example, she said, HSI would consider assembling a 24-hour program for self-insured employers whose workers compensation claims are handled by one of HSI's insurer partners.

Some employers that use HSI managed care services for both workers comp and group health receive premium discounts, she added.

WellPoint parent Blue Cross of California also has introduced CalCare Comp, a managed workers comp program that has enrolled about 5,000 employees since Aug. 1.

HSI also hopes to increase its Medicare risk enrollment by targeting employers' retirees, according to Michael Close, vp-Medicare.

"Our Medicare risk premiums range between $40 and $75 per month for employers," he said, while most employers pay between $120 and $180 per month for Medicare supplemental coverage. "In some cases, employers are putting employees in Medicare risk groups and saving huge amounts of money," he said.

Plan members are expected to see little disruption when the HMOs merge their physician networks. "They overlap in most markets," said Robin Weiner, managing consultant with A. Foster Higgins & Co. Inc. in Los Angeles. For example, "90% of the medical groups in Southern California contract with both HMOs."

Analysts say the overlap also will make it easier for WellPoint to convert its preferred provider business into HMO business, one objective behind the merger.

"The majority of WellPoint's enrollment is in the Prudent Buyer Plan, which is a PPO," pointed out Ms. Weiner. In contrast, nearly all HSI members are in group-model HMOs.

Although some merged HMOs may eventually offer one-stop shopping for big companies, benefit managers remain skeptical about whether the mega-mergers will help employee health plans. In fact, some worry that mergers will dampen competition.

"When mega-HMOs eat up other HMOs, I'm not sure it benefits the market. It's done primarily to help reduce the HMOs' administrative costs, but it could end up killing competition," said Mr. McNeill.

"If there are only three or four major players left (in California), it could be a problem for a purchaser like us," said Mr. Elkin of CalPERS, which currently offers 16 HMOs and two self-insured preferred provider plans. "If there are only two or three plans covering our members, it will be more difficult to persuade them to share the efficiencies they gain with us."

By contrast, though, "consolidations where there are multiple HMOs could be a plus if it takes layers out of the system, much like what has happened in corporate America," pointed out Helen Darling, manager-health care strategy and programs for Xerox Corp. in Stamford, Conn. "But if the number gets so small there is no competition, it's a worry."

Other benefit managers also worry that quality could suffer.

"Our real bottom-line concern is for the customer—the patient—and what happens to quality and the continuity of care when HMOs merge," said Suzanne Mercure, manager of benefits administration for Southern California Edison Co. in Rosemead, Calif.

Mr. Elkin said other delivery systems, such as physician hospital organizations (see story, page 3), may be viable options if the HMO market narrows too much. "It will be interesting to track (the PHO) market and see whether it can offer an option."

Some benefit executives fear HMO mergers could actually increase health plan costs.

"My most immediate concern regards the phenomenal prices being paid for these HMOs" and the extent to which shareholders will expect to get a certain return on their investment, said Ms. Darling. "As employers, we are just now getting control over our health care cost increases and premiums, and I worry this will drive the expense side."

But California HMOs have been criticized for their high administrative costs, indicating that there may yet be some fat to cut. A bill passed by the California Legislature last year would have required HMOs to report administrative costs to members. But it was vetoed by Gov. Pete Wilson after a storm of protest by the California Assn. of HMOs.

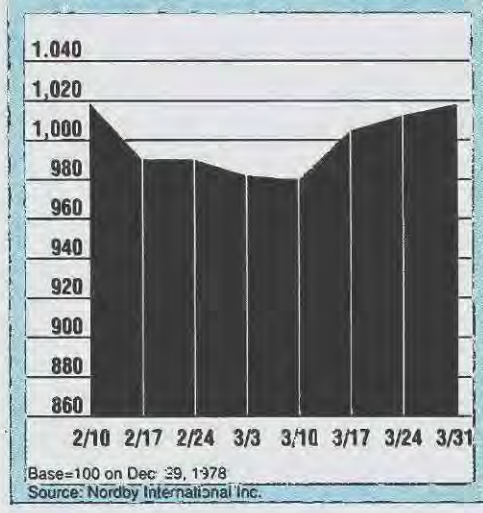
Employers also say there is no evidence that larger health plans provide better services than smaller plans.

"If we thought bigger is better, I'd deal with national companies," said Mr. McNeill of GTE. "But we don't, so I deal with niche players that understand the local market."

Some large companies, though, do prefer large HMOs with multiple locations, according to Ms. Weiner of Foster Higgins.

HMO consolidation also may spur more employers to band together to increase their purchasing power. "It may mean purchasers like us should ally ourselves with other purchasers and increase our size too," Mr. Elkin said. "It'll be a battle of the mastodons." BI

## BI Insurance Index




Base=100 on Dec 29, 1978
Source: Nordby International Inc.

## British Issues

| Mar. 23 Companies | Price pence | P/E | Div. pence | Yield % | 1 week high—low |
|---|---|---|---|---|---|
| Comml Union | 543 | 10.9 | 33.0 | 6.1 | 546—540 |
| Genl Accident | 58[illegible] | 8.5 | 36.3 | 6.2 | 581—568 |
| Gdn Royal Exch | 190 | N/M | 10.3 | 5.4 | 192—184 |
| Independent | 272 | 7.5 | 11.9 | 4.4 | 274—272 |
| Royal | 292 | 8.6 | 15.0 | 5.1 | 299—290 |
| Sun Alliance | 328 | 11.1 | 19.7 | 6.0 | 328—324 |
| **Brokers** | | | | | |
| Bradstock | 86 | 9.7 | 7.1 | 8.2 | 86—86 |
| Fenchurch | 143 | 13.0 | 10.0 | 7.0 | 145—143 |
| CE Heath | 229 | 11.4* | 20.0* | 8.7 | 229—229 |
| JIB Group | 121 | 13.5 | 9.4 | 7.8 | 121—121 |
| Lloyd Thmpson | 151 | 10.5 | 9.8 | 6.5 | 151—151 |
| Lowndes Lmbrt | 145 | 8.5* | 10.4* | 7.2 | 146—145 |
| Nelson Hurst | 168 | 13.2* | 8.3* | 4.9 | 169—168 |
| PWS Holdings | 20 | N/M | 0.8 | 4.0 | 20—16 |
| Sedgwick Grp | 153 | 13.9 | 8.1 | 5.3 | 155—153 |
| Steel Brl Jones | 113 | 13.3 | 11.3 | 10.0 | 113—109 |
| Willis Corroon | 144 | N/M | 8.3 | 5.3 | 146—144 |

Source: Philip Olsen, London * Estimated 1994 data

## Catastrophe insurance option call spreads

As of March 31

| Call spread | Price bid/ask | Rate on line % | Call spread | Price bid/ask | Rate on line % |
|---|---|---|---|---|---|
| Eastern September 1995 | | | Western Annual 1995 | | |
| 45/65 | 5.8/6.5 | 29/32.5 | 20/30 | 0.5/3 | 5/30 |
| 50/70 | 5.3/5.7 | 36.5/28.5 | 30/40 | 0.3/1.8 | 3/18 |
| 60/80 | 4/5.5 | 20/27.5 | 30/50 | 0.5/2.5 | 2.5/12.5 |
| 100c | 8.5/12 | 8.5/12 | 50/70 | 0.6/1.8 | 3/9 |
| 150c | 3.5/5 | 7/10 | 60/80 | 0.3/3.5 | 1.5/17.5 |

Total volume: 42 Total open interest: 5,246

For quotes, call the CBOT trading floor at 312-341-3342. For general information, call 312-435-3674.

Source: Chicago Board of Trade

# BI Industry Stock Report MARCH 27, 1995, THROUGH MARCH 31, 1995

| BROKERS | | Price | Weekly % change | Year to date % change | Annual High | Annual Low | Vol.(000) | $ Div. | % Yield | P/E | Book value | Mkt./Bk. value |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acordia Inc. | NYS | 32.50 | 0.78 | -2.99 | 34.50 | 24.63 | 15 | 0.72 | 2.22 | 16 | 13.24 | 2.45 |
| Alexander & Alexander | NYS | 23.63 | 5.59 | 27.70 | 23.75 | 14.00 | 370 | 0.10 | 0.42 | -9 | 6.08 | 3.89 |
| E.W. Blanch Holdings Inc. | NYS | 18.50 | -3.27 | -10.30 | 23.00 | 16.75 | 104 | 0.40 | 2.16 | 15 | 4.55 | 4.07 |
| Gallagher Arthur J. & Co. | NYS | 35.38 | -0.35 | 10.55 | 36.00 | 28.13 | 67 | 1.00 | 2.83 | 16 | 6.48 | 5.46 |
| Hilb, Rogal & Hamilton | NYS | 10.88 | -2.25 | -10.31 | 13.38 | 10.75 | 83 | 0.56 | 5.15 | 13 | 4.72 | 2.30 |
| Marsh & McLennan | NYS | 82.13 | -0.45 | 3.63 | 88.75 | 71.25 | 487 | 2.90 | 3.53 | 16 | 19.40 | 4.23 |
| Poe & Brown | NDQ | 21.88 | 1.74 | 0.57 | 22.75 | 18.00 | 12 | 0.48 | 2.19 | 14 | 4.49 | 4.87 |
| BROKERS | AVERAGE | | 0.3 | 2.7 | | | | | 2.6 | 12 | | |
| **INSURERS/REINSURERS** | | | | | | | | | | | | |
| ACE Ltd. | NYS | 25.25 | 4.66 | 8.02 | 28.88 | 20.75 | 243 | 0.44 | 1.74 | -8 | 22.45 | 1.12 |
| Acceptance Insurance Cos. | NYS | 14.88 | 0.85 | -0.83 | 18.00 | 11.38 | 126 | 0.00 | 0.00 | 9 | 9.83 | 1.51 |
| AEGON N.V. | NYS | 71.50 | 4.19 | 12.60 | 71.50 | 49.38 | 29 | 2.92 | 4.08 | 12 | 43.84 | 1.63 |
| Aetna Life & Casualty | NYS | 57.00 | 1.79 | 20.95 | 58.25 | 42.25 | 1359 | 2.76 | 4.84 | 14 | 57.21 | 1.00 |
| Allied Group Inc. | NDQ | 28.25 | 6.10 | 14.14 | 31.00 | 22.00 | 89 | 0.68 | 2.41 | 6 | 23.43 | 1.21 |
| Allmerica Prop. & Casualty | NYS | 19.13 | -0.65 | 13.33 | 20.13 | 14.25 | 263 | 0.16 | 0.84 | 12 | 19.45 | 0.98 |
| Allstate Corp. | NYS | 28.75 | 0.88 | 21.05 | 29.00 | 22.63 | 1765 | 0.78 | 2.71 | 27 | 19.60 | 1.47 |
| American General | NYS | 32.25 | 0.00 | 14.16 | 33.25 | 24.88 | 1769 | 1.24 | 3.84 | 13 | 20.39 | 1.58 |
| American Heritage Life Ins. | NYS | 18.00 | -2.70 | -5.26 | 19.75 | 16.50 | 18 | 0.64 | 3.56 | 11 | 12.42 | 1.45 |
| American Indemnity/Fin'l | NDQ | 12.00 | 0.00 | 18.52 | 14.25 | 10.00 | 72 | 0.24 | 2.00 | 3 | 15.92 | 0.75 |
| American International | NYS | 104.25 | -1.53 | 6.38 | 108.25 | 82.63 | 2329 | 0.46 | 0.44 | 15 | 49.75 | 2.10 |
| American Re Corp. | NYS | 35.00 | 5.26 | 8.53 | 35.75 | 25.25 | 439 | 0.32 | 0.91 | 17 | 16.85 | 2.08 |
| Aon Corp. | NYS | 36.50 | -0.34 | 14.06 | 37.56 | 29.25 | 646 | 1.36 | 3.73 | 12 | 21.96 | 1.66 |
| Argonaut Group | NDQ | 30.00 | 1.69 | 6.19 | 31.25 | 26.25 | 334 | 1.16 | 3.87 | 10 | 29.80 | 1.01 |
| AVEMCO Corp. | NYS | 17.63 | 6.02 | 14.63 | 17.63 | 13.38 | 27 | 0.44 | 2.50 | 15 | 6.30 | 2.80 |
| Baldwin & Lyons Inc. | NDQ | 16.25 | 3.17 | 10.17 | 17.63 | 14.00 | 2 | 0.24 | 1.48 | 12 | 13.56 | 1.20 |
| Berkley W.R. Corp. | NDQ | 36.63 | -1.01 | -2.33 | 42.00 | 32.50 | 108 | 0.48 | 1.31 | 25 | 36.47 | 1.00 |
| Berkshire Hathaway Inc. | NYS | 22650.00 | 0.33 | 11.03 | 25200.00 | 15400.00 | 1 | 0.00 | 0.00 | 29 | 9157.79 | 2.47 |
| Capital RE Corporation | NYS | 23.13 | -2.63 | -15.53 | 27.38 | 18.63 | 117 | 0.20 | 0.86 | 9 | 21.48 | 1.08 |
| Capsure Holdings Corp. | NYS | 12.50 | -0.99 | -14.53 | 16.13 | 12.13 | 55 | 0.00 | 0.00 | 13 | 13.72 | 0.91 |
| Chubb Corp. | NYS | 79.00 | 0.16 | 2.10 | 82.63 | 68.63 | 895 | 1.96 | 2.48 | 13 | 48.40 | 1.63 |
| CIGNA Corp. | NYS | 74.75 | -0.50 | 17.49 | 76.38 | 57.00 | 1002 | 3.04 | 4.07 | 10 | 80.98 | 0.92 |
| CNA Financial Corp. | NYS | 75.50 | -0.66 | 16.38 | 76.50 | 60.00 | 39 | 0.00 | 0.00 | 148 | 73.83 | 1.02 |
| Continental Corp. | NYS | 19.63 | 0.64 | 3.29 | 23.63 | 12.00 | 493 | 0.00 | 0.00 | -2 | 29.69 | 0.66 |
| EMC Insurance Group Inc. | NDQ | 10.00 | -3.61 | 5.26 | 10.88 | 8.50 | 0 | 0.52 | 5.20 | 8 | 10.77 | N.A. |
| Emphesys Financial Gr. Inc. | NYS | 36.00 | -3.36 | 13.39 | 39.50 | 21.25 | 674 | 0.60 | 1.67 | 10 | N.A. | N.A. |
| EXEL Ltd. | NYS | 44.13 | -0.28 | 11.71 | 46.00 | 36.00 | 706 | 1.32 | 2.99 | 20 | 31.62 | 1.40 |
| Fremont General Corp. | NYS | 19.63 | -1.26 | -16.04 | 26.00 | 19.38 | 53 | 0.76 | 3.87 | 5 | 22.90 | 0.86 |
| Frontier Insurance Group | NYS | 23.63 | 8.62 | 8.00 | 37.50 | 16.75 | 165 | 0.48 | 2.03 | 18 | 14.94 | 1.58 |
| Gainsco Inc. | ASE | 10.38 | 1.22 | 25.76 | 10.50 | 7.25 | 222 | 0.04 | 0.39 | 14 | 3.79 | 2.74 |
| General RE Corp. | NYS | 132.00 | 0.67 | 6.88 | 135.13 | 104.50 | 1140 | 1.96 | 1.48 | 17 | 57.17 | 2.31 |
| Guaranty National Corp. | NYS | 15.50 | -5.34 | -15.65 | 18.50 | 14.38 | 21 | 0.48 | 3.10 | 8 | 11.84 | 1.31 |
| Harleysville Group | NDQ | 24.38 | -0.51 | 0.52 | 26.50 | 19.75 | 57 | 0.68 | 2.79 | 18 | 20.18 | 1.21 |
| Hartford Steam Boiler | NYS | 43.00 | -0.58 | 7.84 | 49.50 | 35.88 | 90 | 2.20 | 5.12 | 17 | 14.62 | 2.94 |
| HCC Insurance Holdings | NDQ | 23.00 | -6.12 | 9.52 | 25.75 | 15.00 | 31 | 0.00 | 0.00 | 15 | 10.75 | 2.14 |
| Home Holdings Inc. | NYS | 7.38 | -9.23 | -21.33 | 15.00 | 3.00 | 95 | 0.00 | 0.00 | -1 | 22.36 | 0.33 |
| ITT (Hartford Group) | NYS | 102.63 | 0.00 | 15.80 | 104.00 | 77.00 | 1157 | 1.98 | 1.93 | 13 | 49.95 | 2.05 |
| Kemper Corp. | NYS | 40.63 | -4.13 | 7.26 | 65.00 | 35.75 | 3014 | 0.92 | 2.26 | 22 | 28.68 | 1.42 |
| Lincoln National | NYS | 40.25 | -0.92 | 15.00 | 43.88 | 34.63 | 392 | 1.72 | 4.27 | 12 | 31.99 | 1.26 |
| Markel Corp. | NDQ | 48.25 | 2.66 | 16.27 | 48.25 | 37.50 | 48 | 0.00 | 0.00 | 14 | 25.15 | 1.92 |
| Mid Ocean Ltd. | NDQ | 27.25 | -6.03 | 0.00 | 30.50 | 22.25 | 185 | 1.00 | 3.67 | 11 | 20.24 | 1.35 |
| Mutual Risk Mgmt. Ltd. | NYS | 27.88 | 3.24 | 6.19 | 29.25 | 21.13 | 283 | 0.32 | 1.15 | 15 | 9.11 | 3.06 |
| NAC Re Corp. | NDQ | 30.25 | 1.68 | -9.70 | 34.00 | 24.00 | 387 | 0.16 | 0.53 | 15 | 19.75 | 1.53 |
| National Re Corp. | NYS | 29.25 | -2.50 | 11.43 | 31.75 | 22.25 | 64 | 0.16 | 0.55 | 18 | 17.31 | 1.69 |
| Navigators Group | NDQ | 15.50 | 3.33 | 6.90 | 20.00 | 13.75 | 9 | 0.00 | 0.00 | -4 | 10.21 | 1.52 |
| Nobel Insurance Ltd. | NDQ | 9.13 | -1.35 | 10.61 | 9.63 | 7.63 | 31 | 0.20 | 2.19 | 4 | 6.84 | 1.33 |
| Ohio Casualty Corp. | NDQ | 33.75 | 1.69 | 19.47 | 34.00 | 26.50 | 367 | 1.52 | 4.50 | 14 | 24.68 | 1.37 |
| Old Republic Int'l | NYS | 24.00 | -1.54 | 12.94 | 25.50 | 18.88 | 245 | 0.48 | 2.00 | 9 | 24.60 | 0.98 |
| Orion Capital Corp. | NYS | 34.75 | -0.36 | -1.42 | 37.88 | 28.13 | 155 | 0.80 | 2.30 | 9 | 25.86 | 1.34 |
| Partner Re Holdings Ltd. | NDQ | 21.25 | 4.94 | 2.41 | 22.25 | 18.50 | 1915 | 0.40 | 1.88 | 8 | N.A. | N.A. |
| Penn-America Group Inc. | NDQ | 7.63 | 4.27 | 3.39 | 8.00 | 6.50 | 14 | 0.00 | 0.00 | 10 | 6.21 | 1.23 |
| Phoenix RE Corp. | NDQ | 24.13 | 4.89 | -14.60 | 29.25 | 18.50 | 133 | 0.60 | 2.49 | 5 | 22.86 | 1.06 |
| Provident Life | NYS | 22.63 | -0.55 | 4.02 | 29.88 | 21.50 | 93 | 0.72 | 3.18 | 8 | 27.09 | 0.84 |
| Re Capital Corp. | NDQ | 18.38 | 1.03 | 50.00 | 18.38 | 12.00 | 170 | 0.32 | 1.74 | 16 | 17.63 | 1.04 |
| Reliance Group Holdings | NYS | 5.38 | -2.27 | 3.61 | 6.75 | 4.88 | 410 | 0.32 | 5.95 | 14 | 3.48 | 1.54 |
| Reliastar Financial Corp. | NYS | 34.00 | -1.09 | 17.24 | 35.50 | 27.00 | 276 | 0.10 | 2.65 | 10 | 24.81 | 1.37 |
| RLI Corp. | NYS | 23.38 | 1.08 | 14.02 | 23.88 | 19.88 | 70 | 0.60 | 2.57 | -28 | 20.51 | 1.14 |
| St. Paul Companies | NYS | 50.00 | -0.25 | 11.73 | 51.00 | 37.69 | 1502 | 1.60 | 3.20 | 10 | 31.88 | 1.57 |
| SAFECO Corp. | NDQ | 54.75 | -1.35 | 5.29 | 59.75 | 46.75 | 699 | 1.96 | 3.58 | 12 | 46.94 | 1.17 |
| SCOR U.S. Corp. | NYS | 7.88 | -3.08 | -5.97 | 12.25 | 7.50 | 21 | 0.20 | 2.54 | -17 | 13.60 | 0.58 |
| Seibels Bruce Group | NDQ | 1.25 | -9.09 | -50.00 | 3.50 | 0.88 | 238 | 0.00 | 0.00 | 5 | 1.05 | 1.19 |
| Selective Ins. Group | NDQ | 28.75 | 2.68 | 13.86 | 28.75 | 23.00 | 160 | 1.12 | 3.90 | 10 | 23.36 | 1.23 |
| Sphere Drake Holdings | NYS | 15.13 | 9.01 | 9.01 | 17.00 | 10.75 | 64 | 0.16 | 1.06 | 7 | 13.15 | 1.15 |
| TIG Holdings | NYS | 22.50 | 8.43 | 20.00 | 22.50 | 17.00 | 831 | 0.20 | 0.89 | 28 | 17.25 | 1.30 |
| Titan Holdings, Inc. | NYS | 10.00 | 0.00 | 2.56 | 10.63 | 7.75 | 102 | 0.28 | 2.80 | 8 | 9.31 | 1.07 |
| Tokio Marine & Fire | NDQ | 58.36 | 8.07 | -3.94 | 66.00 | 49.88 | 51 | 0.44 | 0.75 | 51 | 57.72 | 1.01 |
| Torchmark Corp. | NYS | 41.50 | -0.60 | 20.29 | 44.50 | 32.38 | 419 | 1.12 | 2.70 | 11 | 17.49 | 2.37 |
| Transatlantic Holdings | NYS | 61.25 | 0.82 | 9.62 | 61.25 | 45.63 | 61 | 0.40 | 0.65 | 14 | 32.43 | 1.89 |
| Transnational Re Corp. | NDQ | 20.00 | 1.27 | -14.89 | 25.50 | 17.25 | 110 | 0.00 | 0.00 | 7 | N.A. | N.A. |
| Travelers Corp. | NYS | 38.63 | -0.96 | 19.31 | 39.88 | 30.38 | 2836 | 0.80 | 2.07 | 10 | 24.26 | 1.59 |
| Trenwick Group Inc. | NDQ | 41.88 | -2.05 | -1.18 | 44.25 | 33.75 | 26 | 1.12 | 2.67 | 14 | 29.20 | 1.43 |
| United Fire & Casualty | NDQ | 28.50 | 1.79 | 3.01 | 29.81 | 24.66 | 1 | 0.80 | 2.81 | 9 | 28.96 | 0.98 |
| Unitrin | NDQ | 48.50 | -1.02 | 12.79 | 51.50 | 38.50 | 142 | 2.00 | 4.12 | 16 | 38.64 | 1.26 |
| UNUM Corp. | NYS | 45.25 | -1.36 | 19.87 | 56.75 | 35.13 | 804 | 0.96 | 2.12 | 22 | 27.78 | 1.63 |
| US Facilities Corp. | NDQ | 13.75 | 0.92 | 37.50 | 14.63 | 8.25 | 277 | 0.20 | 1.45 | 13 | 11.07 | 1.24 |
| USF&G Corp. | NYS | 14.00 | 0.00 | 3.70 | 15.50 | 11.69 | 1091 | 0.20 | 1.43 | 7 | 10.04 | 1.39 |
| USLIFE Corp. | NYS | 38.13 | 1.33 | 9.32 | 39.63 | 30.88 | 170 | 1.32 | 3.46 | 9 | 40.82 | 0.93 |
| Washington National | NYS | 18.50 | -0.67 | -2.63 | 23.50 | 17.75 | 49 | 1.08 | 5.84 | 7 | 23.61 | 0.78 |
| Zenith National Ins. | NYS | 20.25 | 1.25 | -10.99 | 27.38 | 19.38 | 29 | 1.00 | 4.94 | 10 | 17.54 | 1.15 |
| Zurich Reinsurance Centr. | NYS | 30.38 | 0.00 | 5.19 | 30.50 | 24.50 | 11 | 0.00 | 0.00 | -26 | 22.26 | 1.36 |
| INSURERS/REINSURERS | AVERAGE | | 0.3 | 6.6 | | | | | 2.3 | 13.6 | | |
| **HEALTH MAINTENANCE ORGANIZATIONS** | | | | | | | | | | | | |
| FHP International | NDQ | 29.50 | 1.72 | 14.56 | 31.00 | 20.25 | 1089 | 0.00 | 0.00 | 16 | 12.22 | 2.41 |
| Humana Inc. | NYS | 25.63 | 6.22 | 13.26 | 27.13 | 15.88 | 3767 | 0.00 | 0.00 | 23 | 6.04 | 4.24 |
| Pacificare Health Sys. | NDQ | 72.00 | 3.23 | 10.56 | 79.50 | 44.25 | 429 | 0.00 | 0.00 | 23 | 14.21 | 5.07 |
| Safeguard Health Enter. | NDQ | 9.75 | 10.64 | 5.41 | 15.00 | 8.25 | 7 | 0.00 | 0.00 | 36 | 6.16 | 1.58 |
| Sierra Health Services | NYS | 32.88 | 7.79 | 3.95 | 33.50 | 21.25 | 116 | 0.00 | 0.00 | 19 | 6.04 | 5.44 |
| United Healthcare Corp. | NYS | 46.75 | 0.81 | 3.60 | 55.38 | 37.25 | 5091 | 0.00 | 0.06 | 28 | 6.57 | 7.12 |
| U.S. Healthcare | NDQ | 44.25 | -1.67 | 7.27 | 49.00 | 33.75 | 10835 | 1.00 | 2.26 | 18 | 5.04 | 8.78 |
| Wellpoint Health Networks | NYS | 35.00 | 12.90 | 20.17 | 39.00 | 24.25 | 4620 | 0.00 | 0.00 | 16 | 12.73 | 2.75 |
| HMOs | AVERAGE | | | 5.2 | | | | | 0.3 | 20 | | |
| ALL COMPANIES | AVERAGE | | | 1.9 | 6.4 | | | | 2.5 | 16 | | |

**Top advancing issues: Wellpoint Health Networks; Safeguard Health Enter.; Sphere Drake Holdings. Leading decliners: Home Holdings Inc.; Seibels Bruce Group; HCC Insurance Holdings. Most active issue: U.S. Healthcare. The BI Index rose 0.6%; the Dow Jones 30 Industrials rose 0.5%; the S&P 500 fell 0.1% and the NYSE Composite gained 0.2%.**

System design: Nordby International Inc.

# Next Stop...RIMS '95

Whether it be cable car, ferry, MUNI or BART, the modes of transportation in San Francisco are as diverse as the attractions themselves. From Fisherman's Wharf to Lombard Street, Ghiradelli Square to the Embarcadero, the list of exciting experiences you'll find in San Francisco include one more this year–and it can be found at Booth #556 in the Moscone Center.

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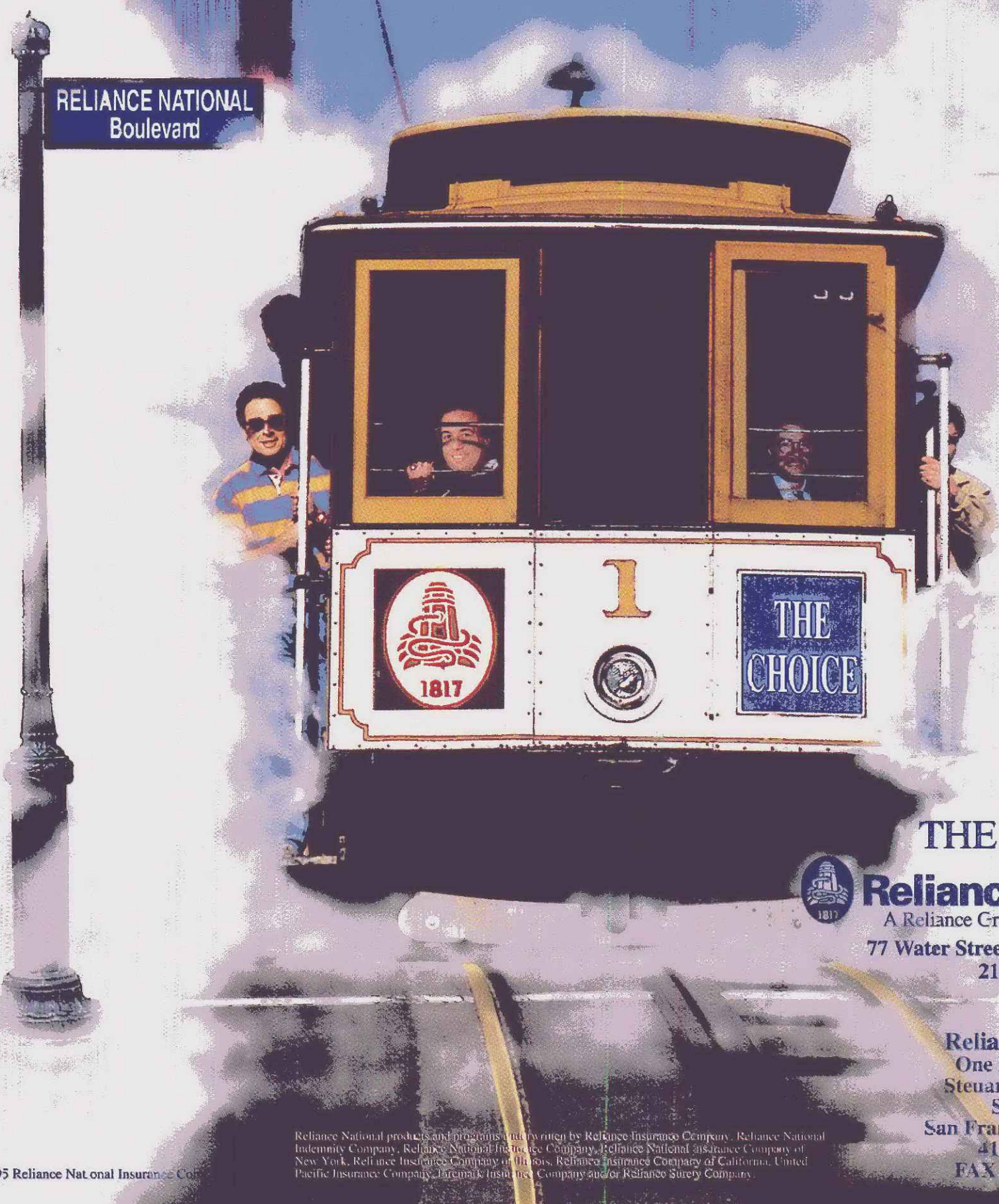


THE CHOICE

**Reliance National**

A Reliance Group Holdings Company

**77 Water Street, New York, NY 10005**
**212-858-6602**

**Reliance National**
**One Market Plaza**
**Steuart Street Tower**
**Suite 2300**
**San Francisco, CA 94105**
**415-243-8414**
**FAX 415-243-8429**

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