

Business Insurance

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

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Marsh & McLennan, EEOC settle suit over J&H retirement practices

NEW YORK—Marsh & McLennan Cos. Inc. has settled a suit for \$28 million with the Equal Employment Opportunities Commission over the retirement practices of the former Johnson & Higgins brokerage.

The money will be divided among 13 former J&H directors, 11 of whom separately are suing J&H directors who were active in 1997, when the brokerage was sold to Marsh & McLennan. The former directors allege they were defrauded in the sale.

The largest portion of the money will go
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OK sought for benefits in captive

By JERRY GEISEL

WASHINGTON—Union Carbide Corp. is asking the Labor Department for approval to use its offshore captive to reinsure employees' supplemental life insurance policies.

Danbury, Conn.-based Union Carbide wants to use a new U.S. Virgin Islands branch of its Bermuda-domiciled insurance subsidiary, Westbridge Insurance Ltd., to reinsure a portion of life

insurance policies written by Metropolitan Life Insurance Co. MetLife has written the policies for about 10 years.

Under a 1983 ruling, the Labor Department defined the Virgin Islands as a "state" under the Employee Retirement Income Security Act. One of the Labor Department's requirements for funding employee benefits through a captive is that the captive be licensed in a domestic state or territory.

Union Carbide Assistant Treas-

urer Richard Inserra says the arrangement will broaden Westbridge's book of business, ensuring a more stable base. The life insurance policies now generate several million dollars in premiums, which participants pay. Last year, Westbridge reported net written premiums of \$16.4 million.

Union Carbide's request for Labor Department approval of its

reinsurance arrangement comes more than five years after the department rejected the request by another major employer—

transportation giant CSX Corp.—to use its Vermont captive to reinsure group basic and optional term life written by Aetna Life Insurance Co. and Prudential Insurance Co. of America.

The CSX filing attracted large-scale interest in risk management

and captive circles. That interest was triggered because experts saw new opportunities for employers to take tax deductions for property/casualty premiums paid to their captives by using the captives to insure or reinsure employee benefit coverages.

The deductions, experts reasoned, would have been possible in the wake of appellate court rulings that parents can deduct premiums paid to a captive as long as

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Groups set February summit

Industry voices unite

By MARK A. HOFMANN

WASHINGTON—All for one and one for all is better than a free-for-all when lobbying Capitol Hill.

That's the thinking behind the decision made by three major commercial insurance trade groups, who will gather together at the first Commercial Insurance Legislative Summit next Feb. 7-8.

The three Washington-based groups—the American Insurance Assn., the Council of Insurance Agents & Brokers and the Reinsurance Assn. of America—last Friday announced their plans to hold



From left: Robert Vagley of the AIA, Ken Crerar of the CIAB and Frank Nutter of the RAA.

the summit. The idea arose during the past year, as the leaders of the three groups agreed that they share many common concerns and very few conflicts, said Ken Crerar, president of the CIAB.

Mr. Crerar said the groups see the summit, which will be an annual event, as representing "sort of the vertical commercial market." The CIAB's member brokerages and agencies place about 80% of the U.S. commercial insurance premium, the AIA's member insurance companies write about 75% of the primary

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New DES lawsuits seen

Research indicates danger to grandchildren

By JOANNE WOJCIK

Another wave of product liability claims is likely following the release of new research that suggests another generation may be at increased risk of developing cancer and reproductive disorders because of an antimitotic drug.

Those claims by the grandchildren of women who took DES, or diethylstilbestrol, would come on top of the enormous number of lawsuits already brought against pharmaceutical manufacturers by people who allege health problems from their mothers' use of the drug during pregnancy.

If the new DES findings trigger a new wave of claims, there also will likely be another wave of cov-

erage litigation, predicts Kevin Quinley, senior vp of MEDMARC, a medical products liability underwriter in Fairfax, Va.

"If there are no specific DES exclusions, there could be a whole new spate of coverage litigation over when did the event take place," Mr. Quinley said.

Some of the companies that made the drug may be covered for such claims, based on a 1997 federal court decision involving E.R. Squibb & Sons Inc., according to an attorney who represented Squibb in coverage litigation.

"We asked the court to make some (coverage) decisions on third-generation injuries that we believe

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HMO quality up, NCQA data finds

By MICHAEL PRINCE

WASHINGTON—Health maintenance organizations that repeatedly report quality data provide higher-quality care, a health care standards organization says.

But even beyond this group, quality of care measures have improved for HMOs nationwide, according to a report released last week by the National Committee for Quality Assurance.

The study shows that "consistency and commitment deliver better quality," NCQA President Margaret O'Kane said at a press conference announcing the Washington-based organization's third annual "State of Managed Care Quality" report.

The overall increase in HMOs' scores also demonstrates that publicizing performance has led to better quality, Ms. O'Kane said.

The report is based on performance data submitted by health plans for the NCQA's Quality Compass 1999 database, which contains data on more than 50 quality measures. Almost 250 organizations, representing 410 HMOs and point-of-service plans that cover nearly 70 million people, submitted data. Another 112 managed care organizations contributed data for calculating av-

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Data disclosure, quality linked

Percentage of patients getting specific care higher with repeat reporters

Measure	1996 national average	1997 national average	1998 national average	3-year public reporters
Beta blocker treatment	62.5%	74.0%	79.9%	85.0%
Breast cancer screening	70.3%	71.3%	72.2%	76.1%
Prenatal care in first trimester	83.4%	83.1%	83.6%	87.7%

Source: National Committee for Quality Assurance

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Updates

Marsh settles with EEOC

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to Kenneth A. Hecken, who is to get \$3.5 million. Mr. Hecken retired as vice chairman of J&H in 1991. Former J&H Chairman Robert V. Hatcher Jr. will receive \$1.8 million, said James Lee, New York regional attorney for the EEOC. Each director's share of the money was determined by his retirement date and compensation at the time of retirement, he said.

The case began in 1993, when the EEOC alleged that J&H violated the federal Age Discrimination in Employment Act by requiring its directors to retire at age 62, or at age 60 if they had been directors for 15 years or more (BI, Aug. 9, 1993).

At first, the retired directors did not endorse the EEOC's action. In a letter to BI, Mr. Hatcher stated that the retired directors had approved the retirement policy in 1983 and did not need the protection of the EEOC. "Far from representing our interests, the suit threatens those interests by involving the firm in potentially costly litigation. . . . What a sad waste of taxpayer dollars!" he wrote (BI, Sept. 6, 1993).

Many of the retired directors changed their stance, however, when Marsh & McLennan bought J&H for \$1.8 billion, with most of the money going to then-current directors.

The EEOC won a 1995 court ruling that the mandatory retirement policy violated the ADEA. An appeals court upheld the ruling in 1996. The case was due to go to trial to determine damages, but mediation efforts began in March this year, Mr. Lee said.

It would have been very difficult for the EEOC to extract such a significant settlement without the cooperation of the retired directors, he said.

An M&M spokeswoman said funds for the settlement were taken from reserves made at the time Marsh & McLennan bought Johnson & Higgins.

Insurer wins pollution ruling

HARRISBURG, Pa.—In a defeat for policyholders, the Pennsylvania Supreme Court has ruled that the absolute pollution exclusion unambiguously bars coverage in a 1991 construction site accident.

The court ruled last week in *Madison Construction Co. vs. Harleysville Mutual Insurance Co.* that coverage was barred for injuries to a worker who fell into an excavation site after being overcome by fumes from a curing agent.

When the worker sued Madison, a subcontractor at the site, the company demanded coverage from Harleysville. The insurer denied coverage based on the pollution exclusion.

In the coverage suit, a trial court and appeals court granted summary judgment in favor of Madison, but those rulings were overturned by a second appeals court ruling and, finally, the state Supreme Court decision.

In its first opinion on an environmental coverage provision in an insurance case, the state Supreme Court ruled that the curing agent constituted a pollutant within the meaning of the exclusion and rejected policyholder arguments that, because the fumes did not leave the enclosed area where the work was being performed, no release within the meaning of the exclusion took place.

The court ruled that "by its very terms, the exclusion encompasses discharges that do not leave the work site. Therefore, the exclusion is unambiguous and it encompasses the discharge or dispersal" of the curing agent.

Health cover denials high: Study

Nearly 90% of physicians in a recent survey say health plans have denied their patients coverage for services in the past two years, a new survey reports.

The most common type of denial concerns prescription drugs, according to the survey conducted by the Henry J. Kaiser Family Foundation, which is based in Menlo Park, Calif. The foundation is not associated with Kaiser Permanente. Findings were based on a survey of 1,053 doctors and 768 nurses.

Also, one-third to two-thirds of doctors say that, in their judgment, the denials of treatment had adverse health consequences for the patients.

"There is a great deal of inappropriate care in the health care system, and it is the managed care industry that has taken on the unpopular job of controlling costs, but this level of conflict and administrative haggling between doctors and plans can't be good for our health care system or for patients," Drew Altman, president of the Kaiser Family Foundation, said in a written statement.

Doctors and nurses surveyed gave managed health care mixed reviews. They say managed care has driven up paperwork, hurt the quality of care and decreased the amount of time spent with patients. But they praised managed care for preventive care, practice guidelines and disease management programs.

Two-thirds of physicians surveyed say they intervene with health plans on patients' behalf, and almost half of them report they have exaggerated the severity of a patient's condition to get coverage for medical care.

Karen Ignagni, president and chief executive officer of the American Assn. of Health Plans, criticized the survey, saying it conflicts with previous research. She pointed out that the survey did not note what percentage of treatment decisions health plans denied coverage for, or whether the treatment requested was consistent with the latest medical evidence.

Anthem to fund foundations

HARTFORD, Conn.—Anthem Inc. agreed last week to fund a charitable health care foundation in Connecticut with \$40.8 million to settle lawsuits filed against it over its 1997 merger with Connecticut Blue Cross & Blue Shield.

The lawsuits had been filed by Connecticut Attorney General Richard Blumenthal, State Comptroller Nancy Wyman and the Citizens for Economic Opportunity.

Indianapolis-based Anthem, which is seeking state regulatory approval to acquire Blue Cross plans in Maine and New Hampshire, also has agreed to fund foundations in those states with \$100 million and \$80 million.

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Who should get data?

Employers want proof-of-coverage information confidential

By MEG FLETCHER

Concern is rising among some employers, state administrators, insurers and agents about a growing number of states releasing employers' workers compensation insurance information to a private company, which in turn sells it to prospecting agents.

Nearly all states require insurers to file such information to verify that employers have state-mandated coverage to protect workers in the event of a job-related injury. Other employers, such as contractors, also can access the information in most states; they use it on a case-by-case basis to verify that potential business partners have coverage.

Many states previously had considered such employer-specific information on insurance coverage

confidential, though Florida makes such information readily available to encourage market competition.

Recent requests to state officials from Lakeland, Fla.-based DataLister Inc. seeking employers' proof-of-coverage information have cited freedom of information laws in support of its requests. DataLister's requests have caused many states to re-examine their position, sparking this controversy.

"To date, DataLister has received 26 state declarations that the workers compensation policy compliance data is public record," and the company is continuing to



Policyholders' workers compensation information can be bought on DataLister Inc.'s Web site.

pursue the remaining states, a DataLister spokesman said in a written reply to questions.

DataLister currently is selling to agents information on employers in about 22 states, which it expects to expand, he said.

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Wrap-ups gaining popularity, evolving for more varied use

By ROBERTO CENICEROS

SAN DIEGO—The use of insurance wrap-up programs for construction projects continues to gain popularity, while at the same time evolving to meet the needs of a wider variety of projects.

Wrap-ups are also referred to as owner-controlled insurance programs because such programs enable the party sponsoring the construction to purchase workers compensation and general liability insurance policies for all the contractors and subcontractors



participating in their building project.

Owners can profit from making insurance coverage centrally available for their contractors, rather than having to indirectly pay for it when built into the cost

of contracts. Companies are motivated to offer wrap-ups by other factors, too, such as the ability to centralize claims handling and centrally manage safety programs. Public entities in particular often implement wrap-ups to further minority contractor hiring goals by eliminating the cost of insurance as a factor in bidding on construction work.

The use of wrap-ups for some of the risks in smaller construction projects is a growing trend, according to George D. Dale, president of DBH Resources

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House, Senate differ on benefit provisions

Conferees to tackle tax bills

WASHINGTON—A House-Senate conference committee could meet as soon as this week to resolve differences in two tax bills.

The Senate approved the Republican tax bill last Friday afternoon by a 57-43 vote along largely party lines.

The bill that passed the House includes many provisions not in the Senate-passed bill, including:

- The House bill would raise to \$40,000 from \$30,000 the maximum annual contribution that could be made to a defined contribution plan and

would raise to \$160,000 from \$130,000 the maximum annual benefit that could be funded through a qualified defined benefit plan.

- The House bill would raise to \$200,000 from \$160,000 the amount of compensation that could be considered in computing pension benefits.

- Employers could receive a tax credit equal to 25% of expenses for building or running a child care facility. The maximum annual credit, though, could not exceed \$150,000.

- The House bill would

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PHOTO: AP/WIDE WORLD

Sens. William Roth, R-Del., left, and Pete Domenici, R-N.M., celebrate passage of a \$792 billion tax cut package Friday in the Senate.

Inside

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- The deregulation of electrical utilities on both sides of the Atlantic has created a large number of new companies that are embracing new approaches to measuring and managing risk on an enterprise-wide basis. **PAGE 35**

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Managed Care Trends & Issues

Solvency requirements portend higher premiums

By JOANNE WOJCIK

Employers should be on the lookout for higher health care premiums as states begin to implement more-rigorous solvency requirements for managed care firms.

So far only three states—Arkansas, Nebraska and Washington—have passed legislation adopting the Risk-Based Capital for Health Organizations Model Act promulgated by the National Assn. of Insurance Commissioners last year. Eventually, all states are predicted to follow suit, though one HMO official said they are expected to do so gradually enough to give plans time to prepare.

When states do adopt the standards, the new formula will apply not only to health maintenance organizations but also to all types of risk-bearing managed care plans, including independent physician associations that receive capitated payments from insurers, HMOs and direct-contracting em-

ployers. During the past decade, it has become more common for HMOs to transfer their risk by contracting with IPAs and paying them a per-member fee for providing all the medical services.

Employers should question their health plans if they use the new NAIC regulations as an excuse to raise rates, as doing so may not be necessary, at least one health care consultant says.

"I don't doubt that they may attempt to use it as an excuse for raising premiums," said Rich Ostuw, global practice director for group benefits and health care at Watson Wyatt Worldwide's Stamford, Conn., office.

But Gary Hagen, senior vp of Yountville, Calif.-based Managed Care Resources, said: "If you raise the bar, there are only a couple of ways you can generate the capital. If you're publicly traded, you can do a public offering. But this is not an attractive alternative at this time. Or, you can raise premiums."

"There will be pressure on the premium,"



agreed Carl Gerlich, chief executive officer of East Bay Medical Network in Oakland, Calif. East Bay provides services to IPAs that assume risk.

The NAIC decided to create a risk-based capital model for health care after regulators realized that many such organizations were not subject to the same rigorous solvency tests as life/health and property/casualty insurers, explained Lou Felice, supervising insurance examiner in the New York Insurance Department. Mr. Felice is chairman of the NAIC working group that developed the model act.

"Interest developed back in the early '90s when risk-based capital was inceptioned for life and property/casualty companies," he recounted. "As health reform came to the forefront, there was a recognition by the NAIC that these groups were left behind."

The NAIC got an even bigger push when news began to circulate throughout the health care industry that a few firms—such as Norwalk, Conn.-based Oxford Health

See Solvency on next page

Employers scrutinize prescription drug costs

By ROBERTO CENICEROS

Recent steep price increases for prescription drugs are driving employers to seek new approaches to rein in these escalating costs.

Some employers, in conjunction with their health plans and prescription benefit managers, have introduced copayment structures designed to encourage employees to use less-expensive drug therapies. Others have opted to take a careful look at their PBMs to see whether they really are effective in lowering drug costs.

And certain employers are looking beyond costs and exploring how prescription practices affect worker productivity and how they might best work with other medical treatments to improve employee health quality. While some PBMs are working to meet that challenge, a lack of information-sharing between health plans and PBMs remains a hindrance.

Prescription costs are expected to continue to increase at about 15% to 16% annually, according to PBM and consultant re-

ports.

So far, most of the price increases have been borne by employers and health plans, whose drug spending grew 123% between 1992 and 1997, according to the Washington-based National Institute for Health Care Management Research and Education Foundation. Meanwhile, consumer out-of-pocket spending grew only 13% over the same period, according to the foundation.

In an effort to control their spending, more employers are introducing tiered copayment structures, in which employees pay additional amounts for more-expensive drugs. Under such plan designs, employees typically pay the smallest copayment for generic drugs, an additional amount for brand products and still more for non-formulary prescriptions.

Managed care organizations offering three-tiered plan structures grew to more than 50% by the fall of last year, from 36% early in 1998, according to Scott Levin, a pharmaceutical consulting company in Newtown, Pa.

During the first quarter of 1999, 30 clients of Scottsdale, Ariz.-based PCS Health Systems Inc. adopted three-tiered

copayment structures, said Jeff Sanders, senior vp of value development. Before then, only 21 of the PBM's clients had a similarly tiered structure.

"It is looking like next year there are going to be a lot of implementations of three-tier copayments," Mr. Sanders said.

The market is definitely moving to tiered copayments, said Eileen Settineri, a health care consultant for Watson Wyatt Worldwide in New York. Because the market is still evolving, however, businesses with employees in many states may have trouble finding health plans that provide the programs in all states, she said.

In addition, improperly structured three-tiered systems may not produce the desired affect for employers, consultants said.

Pharmaceutical researcher Scott Levin found that the average copayment for generics is \$6.50, while it is \$12.04 for brand drugs and \$24.50 for non-formulary drugs, according to a drug trend report produced by Maryland Heights, Mo.-based Express Scripts.

But consumers are willing to pay more for preferred prescriptions, said Leslie

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Directory of Prescription Benefit Managers page 17

Spotlight editor:
Todd J. Behme

Employers have various options in covering catastrophic care

By DEBORAH SHALOWITZ COWANS

Some of the new tools employers and health plans are using to control the costs of catastrophic health care claims include intense case management, negotiated discounts with providers and contracting with vendors to assume all claims costs in exchange for a set fee.

For the most part, however, self-insured employers still rely on stop-loss insurers to fund and manage catastrophic health care claims.

Experts offered a wide range of numbers for what constitutes a catastrophic health care claim.

Ned Goodhue, president and chief executive officer of Avandel Inc., a catastrophic care management company based in Lynnwood, Wash., said treatment for a specific episode of care that exceeded \$50,000 could be considered a catastro-

phic claim.

Gail Nowacky, president of Triage Alliance Inc., a managed care organization in Salem, Mass., which specializes in catastrophic health care claims, said that often claims exceeding \$100,000 are considered catastrophic.

Paradigm Health Corp., a catastrophic health care claims management company in Concord, Calif., handles cases with an average cost of \$150,000 to \$250,000, according to Paul LaPine, senior vp.

And at Merck & Co. Inc. in Whitehouse Station, N.J., claims costing in excess of \$200,000 are considered catastrophic, according to Wendy Miller, senior director of benefits planning and research.

Given the wide range, some experts say that catastrophic claims are determined more by diagnosis than cost.

"It's the diagnosis that triggers whether (a claim is) catastrophic or not, not the dollar

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Solvency

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Plans Inc.—were having financial problems, Mr. Felice said.

Oxford, which had been a long-time favorite of Wall Street, reported a \$284.7 million loss for the Plans Inc.—were having financial fourth quarter of 1998.

In October 1997, the managed care company's stock fell by two-thirds after it reported difficulties in collecting accounts receivable because of computer problems, and the company reported a \$78.2 million third-quarter 1997 net loss, citing problems with its management information systems.

By December 1997, regulators ordered Oxford to add \$164 million to its New York subsidiaries' medical reserves (BI, Dec. 15, 1997).

Besides establishing standards for measuring whether a managed care organization's reserves are adequate to meet the risk it is assuming, the NAIC model act also lays out a legal framework for regulators to use when plans are heading toward insolvency.

"In most cases, (the model law) raises the capital benchmark a bit, but more importantly, it sets up a formalized structure for regulatory action," Mr. Felice said.

Before this model act was developed, "there was nothing that formally spelled out what legally needs to be done when an organization gets in financial trouble," he explained.

In some states, managed care

firms are licensed as life insurers, but that's not always the case, Mr. Felice explained.

Recognizing this, the NAIC designed its model act to apply to all health care organizations that bear risk—not just those that are licensed as insurers or HMOs. This includes IPAs that accept capitated payments for their services, because they are, in effect, acting like insurance companies. A capitation is tantamount to a premium, and providing services is essentially paying claims, Mr. Felice explained.

Fortunately, the model act does allow plans to buy stop-loss insurance to transfer some of this new risk off of their balance sheets, he said.

And "there are other tools carriers can use if their reserves are inadequate," said a spokeswoman for the Washington state Insurance Department, which applied the new model act this year to some 90 companies licensed as health care organizations.

For example, they could be acquired by or merge with a more financially healthy firm, or they could issue additional stock if they are publicly traded, she said.

"Since they would not be raising capital for operating expenses, they would be more likely to attract investors," she suggested.

But "investors won't just throw money at you to increase your reserves," countered David Erickson, director of investor relations at PacificCare Health Systems Inc., a large HMO based in Santa Ana, Calif.

"To get investors to invest, there has to be a compelling reason," he

said.

As a result, "increasing the reserve requirements could pose problems for some plans," Mr. Erickson said.

And while going to the capital markets may be an option in some cases "non-publicly traded HMOs must seek other ways to get money for reserves," he said.

Pointing out that, so far, only three states have adopted the NAIC model act, Mr. Erickson predicts the new solvency requirements will be

'Investors won't just throw money at you to increase your reserves,' says David Erickson of PacificCare Health Systems Inc.

implemented gradually so as not to disrupt the price and availability of health care coverage.

"The states aren't rushing to implement this in any great fashion," he said. "I don't think any state would cause undue financial strain on (managed care plans). They're more interested in preserving stability."

"That's why they will likely phase in (the new requirements) over time," he said. "It will be done with enough lead time so plans can prepare."

And, because the managed care industry is aware that the new solvency requirements are coming, "smarter plans should be prepared" for when they take effect, Mr. Erick-

son said.

But Watson Wyatt's Mr. Ostuw said the new solvency requirements could act as a deterrent to physician groups considering providing services in a managed care environment.

"It may well be somewhat of a barrier to entry," he said.

For example, provider groups that view the HMOs primarily as marketing tools "can't do that anymore. They'll have to think of themselves as risk-bearing entities" and establish their own reserves, Mr. Ostuw said.

Indeed, establishing reserves could be especially difficult in places such as California, where the competitive health care market is already putting the screws to some plans.

For example, Birmingham, Ala.-based MedPartners, one of the nation's most-profitable physician practice management firms, began selling off its assets last year in an attempt to turn around huge deficits in its California operations. The California Department of Corporations, which regulates health plans and contracting entities, seized MedPartners Provider Network in March, saying it didn't lacked the money and the means to pay claims.

MedPartners entered the California market in 1996, when it purchased Friendly Hills Health Care Network, a La Habra-based integrated medical delivery system.

"The difficulty is, where will the money come from?" queried Dr. Albert Barnett, chairman of the Institute for Health Care Advancement in Whittier, Calif. IHCA is a non-

profit medical research and education foundation.

Because capitation payments to doctors have pretty much held steady for the past several years, "every single IPA I know of in Northern California needs to beef up its balance sheet," said East Bay Medical Network's Mr. Gerlich.

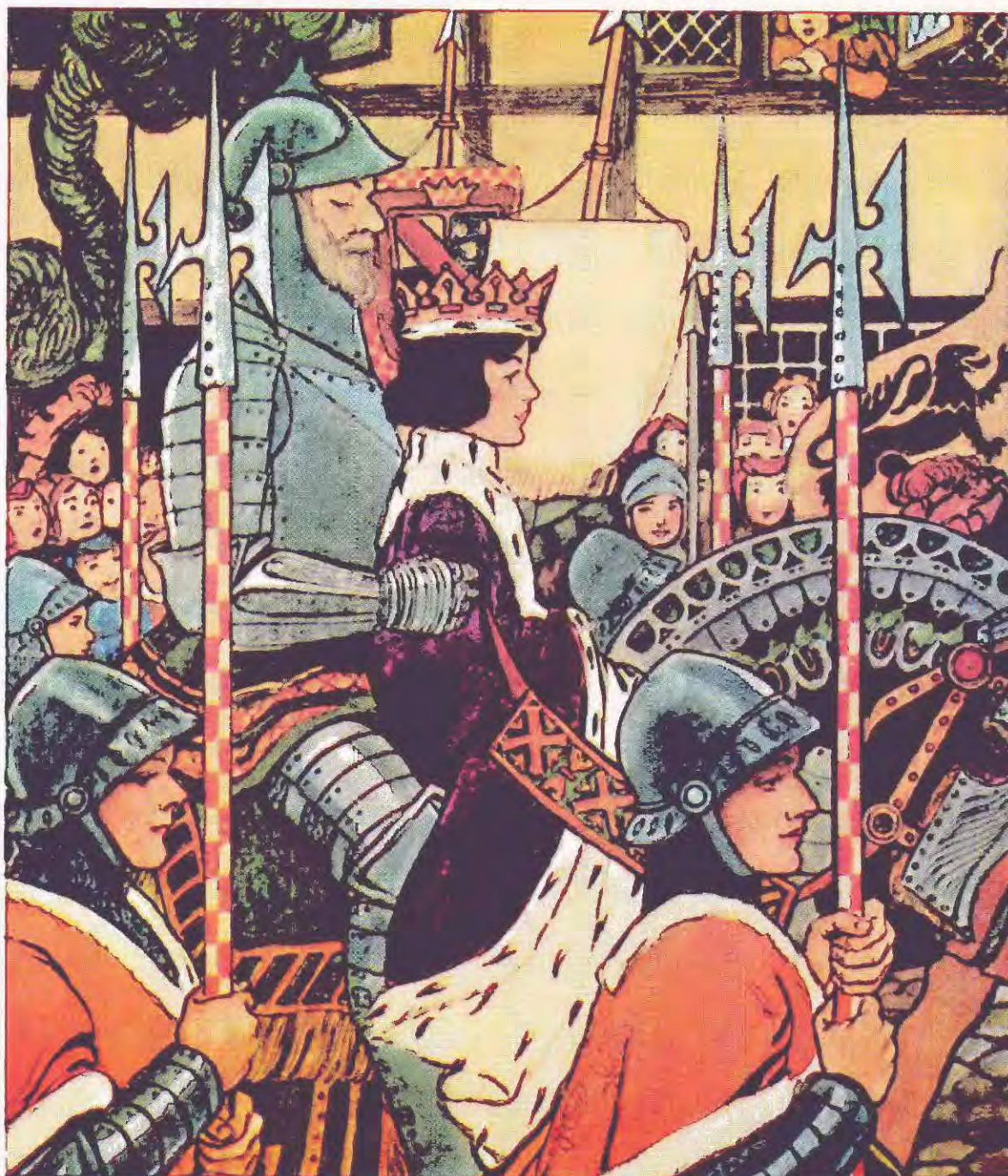
Most medical groups that contract with HMOs accept a capitation payment for each enrollee and then provide care as needed. There is no subsequent risk transfer, except when the groups purchase stop-loss coverage. But while the medical groups often buy specific stop-loss insurance to pay for catastrophic cases, few buy aggregate stop-loss, which would cap their risk should the cost of providing care to an entire group exceed a certain threshold, Dr. Barnett explained.

Besides aggregate stop-loss, other provider excess insurance products are available that will allow medical groups to cap their exposure and transfer the excess capitation risk off of their balance sheets.

For example, medical groups can buy aggregate reinsurance to pay administrative costs and medical claims that exceed their capitation payments, according to Mr. Hagen.

The product, which Mr. Hagen is developing for Managed Care Resources, "is an option to help the plans meet solvency requirements that doesn't require raising premiums," he said.

Unlike stop-loss coverage, which limits reimbursements by paying only on a pro-rata basis, this new reinsurance will pay losses on a dollar-for-dollar basis, he explained. **BI**



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PBMs

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Weitzman, a partner in Chicago for Deloitte & Touche L.L.P.'s Integrated Health Group. A \$15 difference in tiers, for example, will not affect utilization, she said.

Ms. Weitzman advises that when a three-tiered system includes non-essential drugs, such as Viagra, a specific dollar copayment should not be used for that tier. Instead, plan participants should pay a sizable percentage, such as 50%, of the cost of a drug within that tier, she said.

PBM representatives say the three-tiered structures can save their clients money, and they are eager to demonstrate how. But Ms. Weitzman said it is still too

early to determine the programs' impact on employer costs.

As employers question the general effectiveness of PBMs at holding down their drug costs, they are turning to consultants to

'Employers are starting to wonder "what am I paying for?" So (auditing) is a growing trend,' says Leslie Weitzman.

audit PBM vendors.

"PBMs have certainly not lived up to their promise of managing the cost," said Deloitte & Touche's Ms. Weitzman. "Not all

of that is their fault. But, at any rate, employers are starting to wonder, 'What am I paying for?' So (auditing) is a growing trend."

Some PBMs do provide more sophisticated services, but others do little more than string together a pharmacy network, said Edward A. Kaplan, vp in New York for The Segal Co.'s National Health Care Practice.

Out of nine PBMs that Segal has audited for employers, three consistently made errors, ranging from incorrectly coding 10% of claims to generating unwarranted dispensation and administrative fees charged to plan sponsors. Mr. Kaplan did not identify the PBMs that were examined.

On the clinical side, Segal's audits found problems such as pockets of plan participants using un-

usually high quantities of pain killers, with the abnormal use escaping the PBM's notice.

The sophisticated electronic systems used by PBMs that automatically adjudicate claims payments and review drug utilization do not catch all problems, Segal found. System shortfalls can result in increased costs for employers and employee harm or dissatisfaction.

"There are some really good PBMs," that caught spurious claims submitted by auditors, Mr. Kaplan said. "And there are others where we had these significant problems, and they were not just 1% of the claims. Upwards of 10% of the transactions had problems."

The number of PBM audits conducted by Deloitte & Touche has doubled from a year ago, Ms. Weitzman said. Most PBMs fail to report to employers the ultimate implications of prescription plan design changes made to control costs, she said.

"In general, the PBMs have not been good at taking their reports and turning them into useful information that employers can take action with," she said. "Some are better than others. But most of them in general are not very good at it."

The quality of its reporting is one of the key reasons employers contract with Systemed L.L.C., a PBM unit of Merck-Medco Managed Care L.L.C. in Franklin Lake, N.J., according to Stefan Linn, Systemed vp of marketing.

Reports on financial outlays and service quality are valued more by employers as costs rise, he said. Numerous factors drive prescription plan costs, and adequate reporting and analysis of prescription use and service quality is needed to control those costs.

Many employers, however, are too focused on controlling costs, said Ron Goetzel, vp of consulting and national practice for The MEDSTAT Group in Washington. Forward-thinking employers, he said, are looking beyond costs to the overall employee health and productivity impact of formularies.

Those employers are saying "I would be willing to spend money on medical treatment and pharmaceutical costs if it is going to have a positive impact on productivity—if people are going to be less absent, less disabled and be more attentive and productive at work," Mr. Goetzel said.

The quality of its reporting is one of the key reasons employers contract with Systemed L.L.C., says Stefan Linn.

Employers would like to have more data on the positive impact of new formularies, new medical procedures and the money they invest in their employees' health, agreed David Scherb, chairman of the Washington Business Group on Health and vp of compensation and benefits for Purchase, N.Y.-based PepsiCo Inc.

Mr. Scherb said he would like to know how many days employees are at work, rather than out ill, because of medications and treatments that were not available 10 years ago. That sort of information could help explain rising health care expenditures, he said.

"If I knew that, I might feel dif-

ferently about my drug costs," he said. "You are always going to want your costs to be lower. But I think there is another side to the story. There is something coming out of that that is positive," Mr. Scherb said.

Employers are just beginning to ask for information on the quality of health care and prescription drugs, he added.

With more employers looking beyond cost cutting, leading-edge PBMs are evaluating medical provider practices and the outcomes doctors obtain from various combinations of prescriptions and other treatments, said Michael Meredith, senior vp Southeast Atlantic Region employee benefits group for Willis Corroon Corp. of Georgia in Atlanta.

Express Scripts, for example, has a unit that merges and evaluates data on plan participants' prescription practices and their

When PBM officials know their companies are going to be sold they 'get as lean as they can,' says Michael Meredith.

medical treatment. Participating employers must provide data from their employees' health plan, which more employers are beginning to do, remarked Stuart Bascomb, executive vp for Express Scripts.

Such an approach shows that "the PBM and the managed care HMO are concerned about the quality of care," rather than just the costs involved, Mr. Bascomb said.

PCS is also focusing on quality of care by working closely with patient management company Health International in Scottsdale, Ariz., Mr. Sanders said. With the consent of employers, PCS integrates its pharmacy information for a plan participant with other health information to guide the patient through treatment.

Systemed has worked with some employers and health plans on data integration programs and outcomes management, but the practice is not yet widespread in the industry, Mr. Linn said.

A lack of information sharing between health plans and PBMs continues to hinder efforts to integrate such data, consultants and PBM officials said.

PBMs also are facing the same problems that plague other health care industries caught in a rapidly changing environment, consultants say. Mergers and acquisitions have hampered the ability of some PBMs to process claims and produce reports, consultants say.

When PBM officials know their companies are going to be sold they "get as lean as they can because that generally affects the sale price," Willis' Mr. Meredith said. "It does take its toll on the end user—the employer," he said.

In the long run, mergers could improve their service, Mr. Meredith said. But in the short run, the service—especially the service of PBMs being acquired—can suffer.

PBM officials emphatically assert that mergers have not hurt their customer service.

But after every merger or acquisition, PBMs are left with new data warehouse systems, new reports and claim systems and they often do not merge those systems to meet employers' expectations for good service, consultants said. **BI**

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Opinions

A step in right direction

WE APPLAUD THE VISION of three industry trade associations for taking an important step toward boosting their clout and efficacy when lobbying on behalf of commercial insurance interests.

The move by the groups—the American Insurance Assn., the Council of Insurance Agents & Brokers and the Reinsurance Assn. of America—to join in a single legislative affairs conference next year is a welcome initiative that will mean better coordination of insurance industry lobbying efforts.

By getting together first to discuss issues and then to lobby by Capitol Hill on issues of common interest, the three groups will be speaking with one voice.

In the past, there all too often has been a cacophony of voices from the insurance industry. As a result, efforts to win important legislative reforms have been hampered in Congress by a multitude of organizations all pressing their own agendas. Lawmakers were unable to sort through the noise and mixed signals to discern the true extent of industry support for certain measures. As a result, many legislative reforms fizzled for lack of broader and more-focused support.

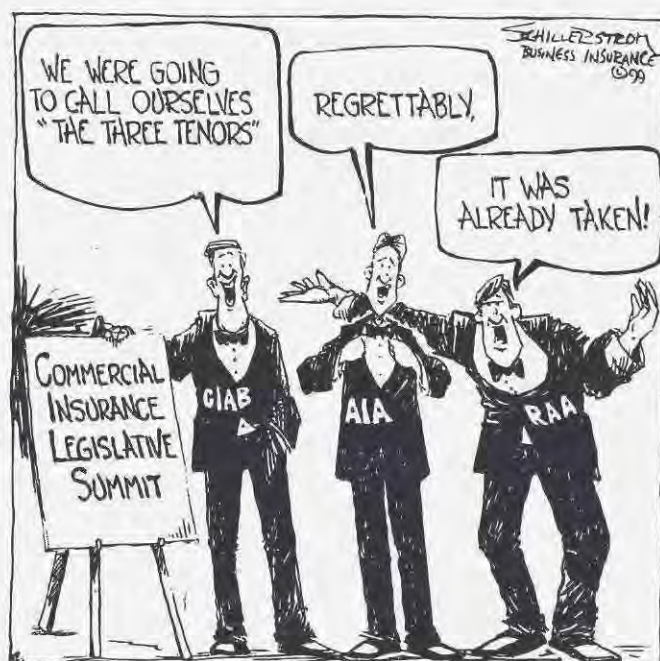
These stymied efforts include early efforts to pass financial services modernization legislation, which today is closer to becoming a reality in spite of the industry's traditional divisiveness. Other proposals that lacked uniform support include Superfund liability reform, uniform federal product liability reform legislation, and the creation of some sort of federally guaranteed reinsurance facility that would help cover losses caused by a truly catastrophic natural disaster.

This alignment of the commercial insurance groups is bound to pay more dividends when lobbying for financial services reform, Superfund reform and reasonable legislative responses to emerging questions caused by the growth of e-commerce.

The partnership behind the legislative conference makes perfect sense to us and represents a vertical alignment of most of the key stakeholders in the commercial lines arena: agents and brokers, insurers and reinsurers. Each of the three groups represents by far the largest proportion of commercial lines activity within its respective market.

In fact, the only segment missing from this partnership is the commercial insurance buyer.

We hope that in future efforts to present a unified voice for the commercial insurance industry, the Risk & Insur-



ance Management Society will be invited to join—and will accept the invitation.

To be sure, the buyers and sellers of insurance will not always have common goals. Nevertheless, at the congressional level, they do have many shared interests. The participation of buyers in a commercial lines alliance can only help boost such a group's influence when lobbying lawmakers on those issues.

RIMS in the past year also has significantly boosted its involvement in legislative affairs. In March, for example, the society brought risk managers to Washington for the first time ever to meet with lawmakers.

The society's legislative momentum has been stalled since then, however, as RIMS seeks a replacement for Anne B. Allen, who directed governmental affairs for the society and had great success in raising RIMS' profile on Capitol Hill.

When RIMS gets its legislative affairs back on track, we hope it will reach out to the CIA, AIA and RAA to explore whether the buyers' group has areas of common interest with the other commercial lines groups.

This joint conference may be one small step for the trade groups, but has the potential to be a giant leap for commercial lines interests.

Letters

Punitive damages opinion is 'immoral'

To the editor: This is in response to the July 19 editorial, "Put Brake on Punitive Awards," regarding the huge jury award against General Motors Corp. Because the article is listed under "Opinion" I respect the author's right to his or her opinion, but I do want to rebut portions of the justifications used to support that opinion.

Referring to GM's money being spent by the jury indicates the deep prejudice contained in the article. The jury made a punitive damage decision. Punitive damages are the one way a jury can fine a defendant a sum significant enough to compel the tortfeasor to change its ways. GM is a huge worldwide corporation. Its assets would make it a world power if GM were a country. How does a court bring a stop to their wrongdoing if a huge award is disallowed?

GM decided not to make their vehicles as safe as they could. The punitive damages are not determined simply as a multiple of the compensatory damages. They are also determined in a manner to punish a wrongdoer and discourage a repetition of the wrongful conduct.

If GM does not answer to the court,

then I guess they answer to no one and can continue to make vehicles less safe than they otherwise could. Making unsafe vehicles and paying the claims that result adds to the profits of the company.

I am indeed sorry for anyone who can support this idea as just or proper. To do

so is simply wrong and immoral. We do not need legislation allowing and encouraging this behavior. We need an end to the behavior by GM and any other wrongdoer. Wrong is wrong regardless of the size of the party doing it.

Bill Ford
Pell City, Ala.

Assurex not only network

To the editor: We are surprised by the statement by Graham Puttergill in the July 26 article, "Assurex Broadens Network," that the expansion of Assurex forms "the only real global alliance" in the insurance brokerage industry.

Presumably, none of the existing global networks of independent insurance brokers would consider themselves as being less than real. The global reach of these networks is quite similar to that of Assurex and continues to expand strongly.

In our experience, while global coverage is indeed essential, the real test for a network is the commitment of the network partners to outstanding service for all clients, including

even the smallest incoming account, to each other and to the strategy of the network.

Professional independent brokers, be they national or regional, have much to offer to clients. Their international effectiveness, however, depends almost exclusively on the quality of their international partners and their common ability to harness their joint talent and potential into a coherent and responsive network. This is what adds value for the client and what makes for a "real" alliance.

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PPOs taking bigger bite of dental managed care

But indemnity plans still have almost two-thirds of enrollees

By MICHAEL PRINCE

Employers are continuing the move to managed care to provide dental benefits, and enrollment in dental preferred provider organizations is growing much faster than that of dental health maintenance organizations. Although final figures for 1998 have not yet been calculated, an estimate from the National Assn. of Dental Plans puts dental PPO growth for the year at 30% to

35%, to more than 31 million members. That level of enrollment outstrips dental HMOs for the first time: the NADP estimates that dental HMOs grew 5% to 8%, to about 28 million members in 1998.

In 1997, PPOs grew by 32.63%, the NADP calculates, compared to 8.61% growth for HMOs. And PPOs achieved that level of growth even though HMOs generally have lower premiums than do PPOs.

But indemnity plans still represented, by far, the largest share of

the dental care market in 1997. Such plans covered 90.6 million people and had almost 62% of the market that year, according to NADP data. Combined, dental HMOs and PPOs had 34.6% of the market.

Indemnity plans, however, grew only 2.62% in 1997 and are estimated to have decreased between 18% and 23% in 1998.

Costs for dental services and dental insurance premiums have risen faster than those of medical plans over the past few years. NADP statistics show that premi-

ums for dental indemnity plans rose 12% in 1997, and another 12% increase may be seen when final figures for 1998 are tallied.

In response, employers are switching to PPO plans to control costs, said Bruce Skeggs, vp and general manager of Delta Dental Plans Assn. in Oak Brook, Ill. Delta Dental offers indemnity, HMO and PPO plans.

The surge in PPO growth comes primarily from employers switching out of their indemnity plans or adding a PPO to the traditional plan, consultants and insurers said.

Employer demands for a lower-cost option forced indemnity insurers to respond by offering pre-

ferred provider organizations.

"The dental PPO is the indemnity market reaction to the move to dental HMOs," said Evelyn Ireland, executive director of the NADP.

Many employers, however, have remained with their indemnity plans to avoid the administrative difficulties of switching to managed care, said Bruce Cacciapaglia, director of marketing for PacifiCare Dental & Vision in Anaheim, Calif., which offers both HMO, PPO and traditional indemnity products.

"The cost of converting to a PPO or HMO exceeds" the benefits gained, he said, because dental premiums are much lower than those of medical plans.

Employee dissatisfaction with HMOs also has played a part in some employers' decision to switch to PPOs to provide dental care.

But the rapid growth of the dental PPO may not be permanent. Even though PPO enrollment is growing faster than HMO enrollment, employers ideally would like employees to opt for and be satisfied with lower-cost dental

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networks, we rely heavily on this ongoing research and analysis. We often wonder what the other Healthcare Management companies do. Any guesses?

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'The dental PPO is the indemnity market reaction to the move to dental HMOs,' says the NADP's Evelyn Ireland.

HMOs, consultants said.

Employers often attempt to entice employees into dental HMOs by structuring the HMOs and PPOs so that the HMOs cost members less in premiums and have lower copayments.

And employers may attempt to save money by shifting employees into HMOs as they become comfortable with managed dental care. Also, if the economy cools and employers look for ways to cut costs, "HMOs will become more attractive for their cost-containment ability," said Mr. Cacciapaglia.

A dental HMO, like a medical HMO, has a panel of providers. Such a plan generally has no deductible and a small copayment—or, in some cases, no copayment—for each visit.

Dental PPOs work like medical PPOs, in that members can go out of the network for services but generally face higher copayments and a deductible when doing so.

In general, PPO premiums range from 10% to 15% below those for an indemnity plan. HMO premiums are even less, often 40% to 50% below the premium for an indemnity plan. These figures can vary, however, by plan and geographic area.

But, cost issues aside, employers frequently have faced employee dissatisfaction with dental HMOs.

Employees often object to the limited panels of dentists in HMOs and sometimes have trouble getting appointments with nearby providers, consultants and insurers said.

"The biggest problem, from an employee perspective, is access," said Gerard Vyskocil, principal with American Dental Consultants in New York.

Mr. Cacciapaglia of PacifiCare Dental & Vision said, "Access is
See Dental on page 12



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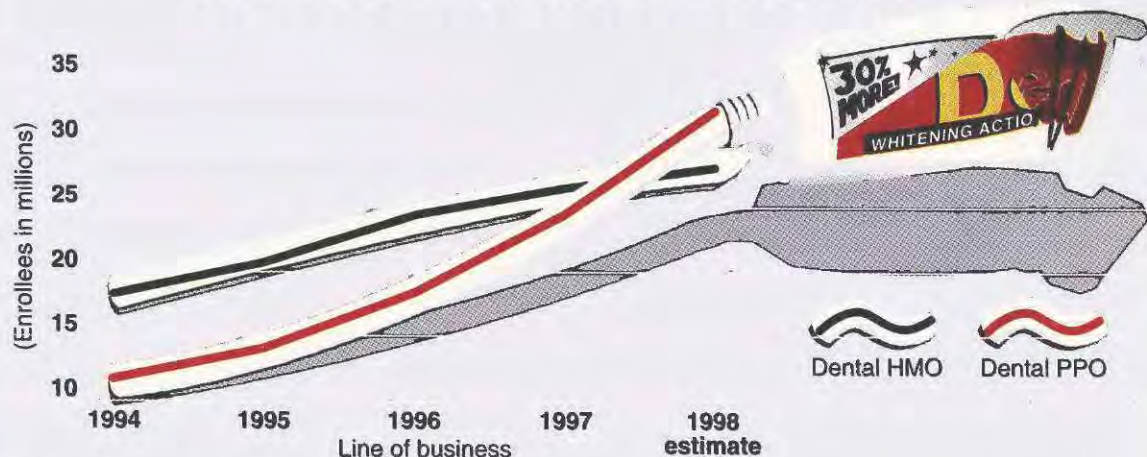
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Dental PPOs have reason to smile



Source: National Assn. of Dental Plans

GRAPHIC BY ADAM DOI

Dental

Continued from page 10
the key to satisfaction."

So, rather than push employees into HMOs and risk upsetting them, the PPO has become the managed care option of choice for employers, despite its higher costs.

Employers are "tired of the grief" with HMOs, said Mark Agnew, practice leader-group and health care for Watson Wyatt Worldwide in San Francisco. An HMO saves an employer money but "costs them in terms of hand-holding and problem resolution," and many employers simply think it's not worth it.

Most HMO growth is among employers starting dental plans for the first time, consultants and insurers said. Also, there has been strong

growth in voluntary HMO programs, where the employee pays all or most of the premium. NADP figures show that in 1997, 28% of HMO enrollees were in voluntary programs. This compares with 17% for PPO enrollees.

Mr. Agnew also noted that some employers retain their HMOs but don't recruit new employees into them. This allows an HMO's members to remain in the plan, while limiting participation by new employees who might not want to enroll in an HMO.

But managing costs is not the only way to save money, noted Dr. Alan Vogel, vp and national dental director for Metropolitan Life Insurance Co. dental and vision product management in Bridgewater, N.J. MetLife offers both PPO and traditional indemnity plans. Another money-saving strategy is to use technology to improve claims handling and information exchange between plans and individual dentists.

"You have to work with them in a way so that the dentist is more efficient," Dr. Vogel said. To help create this relationship, he said, plans can help train dental office staff on how to use the electronic equipment or help defray some of the associated costs.

A movement to manage care is in its early stages, but 'this is the direction we're going in,' says Dr. Alan Vogel of MetLife.

Another development in dental care is the mobile unit run by Redwood City, Calif.-based On-Site Dental Care, said Mr. Agnew of Watson Wyatt. The mobile unit, a converted recreational vehicle, visits a client company, parks in its parking lot and treats patients all day. Although it's not a big cost saver, it's a benefit that saves employees time, thereby increasing productivity. Rather than having employees spend lots of time away from the office for dental visits, the dentist visits the office.

The mobile unit "is a lower-cost alternative but also has the productivity advantage of bringing the dentist to the employee," Mr. Agnew said.

Dr. Vogel also noted that there is some concern within the industry about reduced availability of dental services. Dental schools are closing, fewer dentists are entering the field, and the average age of dentists is rising, he said. The reduced availability of services has been a factor in the price increases, he noted.

Also in its early stages is a movement to manage care, as opposed to simply managing costs, said Dr. Vogel. This approach requires the development of standards of care for dentists and dental plans. For example, he said, most plans provide coverage for two exams and two cleanings per year. Some studies, however, have found that biannual visits may be excessive. As a result, more research is needed to determine how often exams should be conducted and whether plans should be adjusted, he said. A plan that provides true managed care should have the flexibility to accommodate all types of patients, he explained.

This approach is still in its infancy and won't have much impact for a few years, but "this is the direction the industry has to go in," Dr. Vogel said. **BI**

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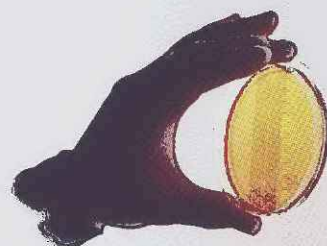
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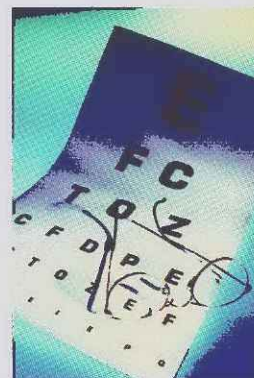


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Catastrophes

Continued from page 3
amount," said Dr. Eric Book, group vp-health management and chief medical officer for Wellmark Blue Cross & Blue Shield of Iowa in Des Moines. Wellmark covers approximately 1.5 million people in five Midwestern states.

"The sickest 1% of our members consume approximately 30% of the health care dollars," Dr. Book noted.

Typically, catastrophic health care cases include organ transplants, severe burns, head trauma and spinal cord injuries, severe neonatal cases and the final stages of some terminal diseases.

Only a small percentage of car-

diology cases reach a catastrophic level, Ms. Nowacky said. Typically, simple heart attacks and angina are not catastrophic, but cardiomyopathy and congestive heart failure are, she said.

Similarly, most cancer cases do not become catastrophic, she continued. The most expensive cancer cases to treat involve bone marrow transplants and rare blood disorders and lymphomas such as non-Hodgkin's lymphoma, Fanconi's anemia and multiple myeloma.

Experts expect the cost and frequency of catastrophic health care claims to increase in some areas and decrease in others in the future.

For example, while single-organ transplants are becoming more routine and thus less costly, mul-

tiple-organ transplants are on the rise.

Furthermore, medical researchers are exploring numerous new ways of using bone marrow transplants to cure a variety of ill-

'As technology has made medicine more successful, it has made it more expensive,' says Michael Lichman.

nesses, which could increase the frequency of these expensive treatments in the future, Dr. Book pointed out.

"As technology has made

medicine more successful, it has made it more expensive," stated Michael Lichman, senior vp that the most appropriate care is offered; that the patient's family of Willis Corroon of New York Inc. in New York. "People are surviving things that used to kill them."

For example, new technology involving the use of collagen-based coverings for burn victims is helping reduce infection and facilitate skin grafting, but the cost is three to four times higher than the cost of the more-traditional treatment using pig or cadaver coverings, pointed out Paradigm's Dr. Alvin McLean, senior vp-product development.

And while the frequency of spinal cord injuries from swimming pool diving accidents has gone down slightly because of

successful public health campaigns, the accidents that still occur tend to be severe, he noted.

Some employers and health plans are using very tight case management to control the costs of catastrophic health care claims.

"We make sure there's active case management" on all catastrophic claims, Merck's Ms. Miller said. Usually a catastrophic case requires inpatient hospitalization, so when the company's utilization review firm is called for precertification, the case is referred to a case manager, she said.

Wellmark recently instituted a new case management program for individuals in the final stages of terminal diseases, according to Dr. Book. The Personal Pass Program is designed to make sure

See Catastrophes on page 16

FORWARD THINKING

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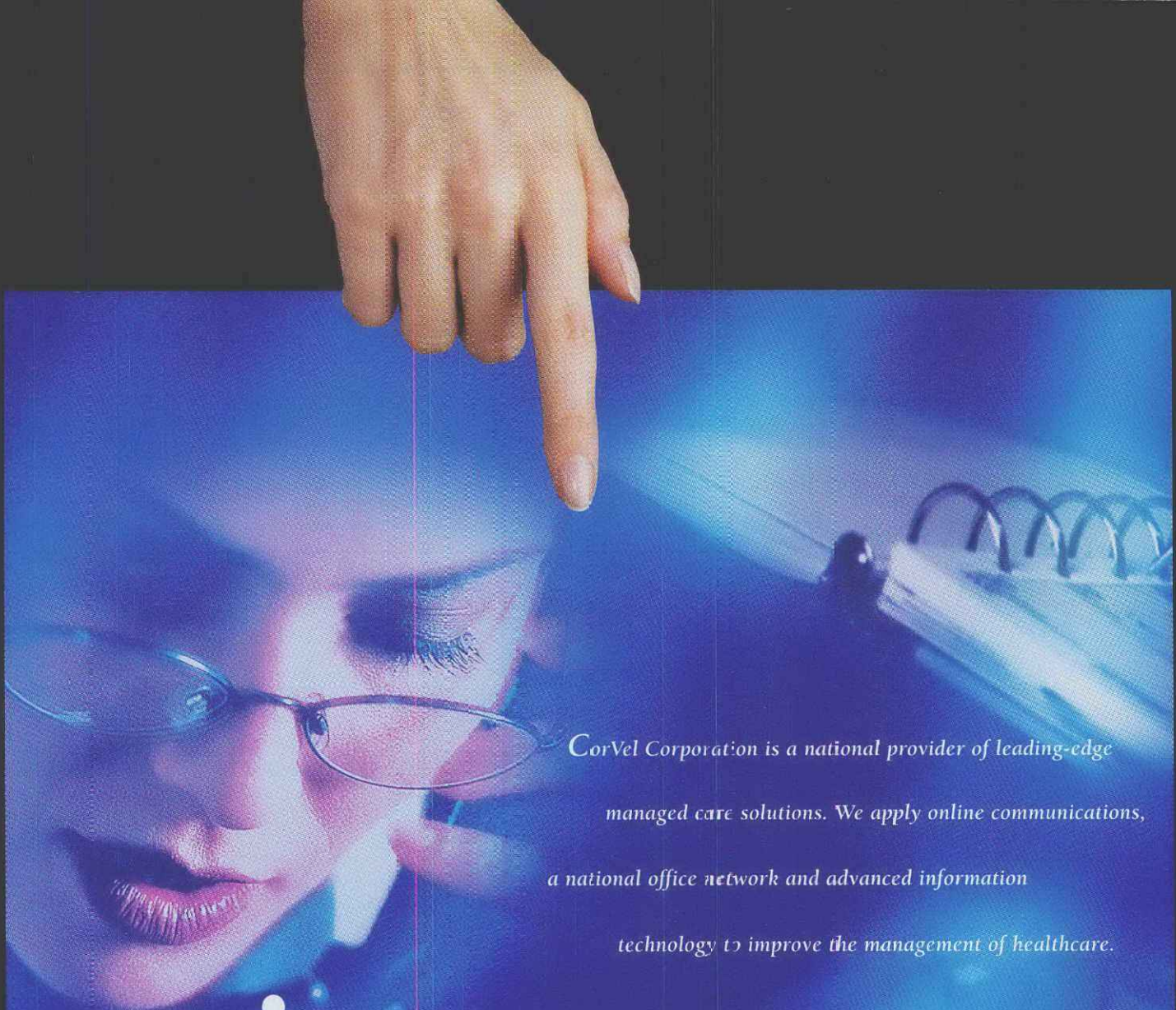
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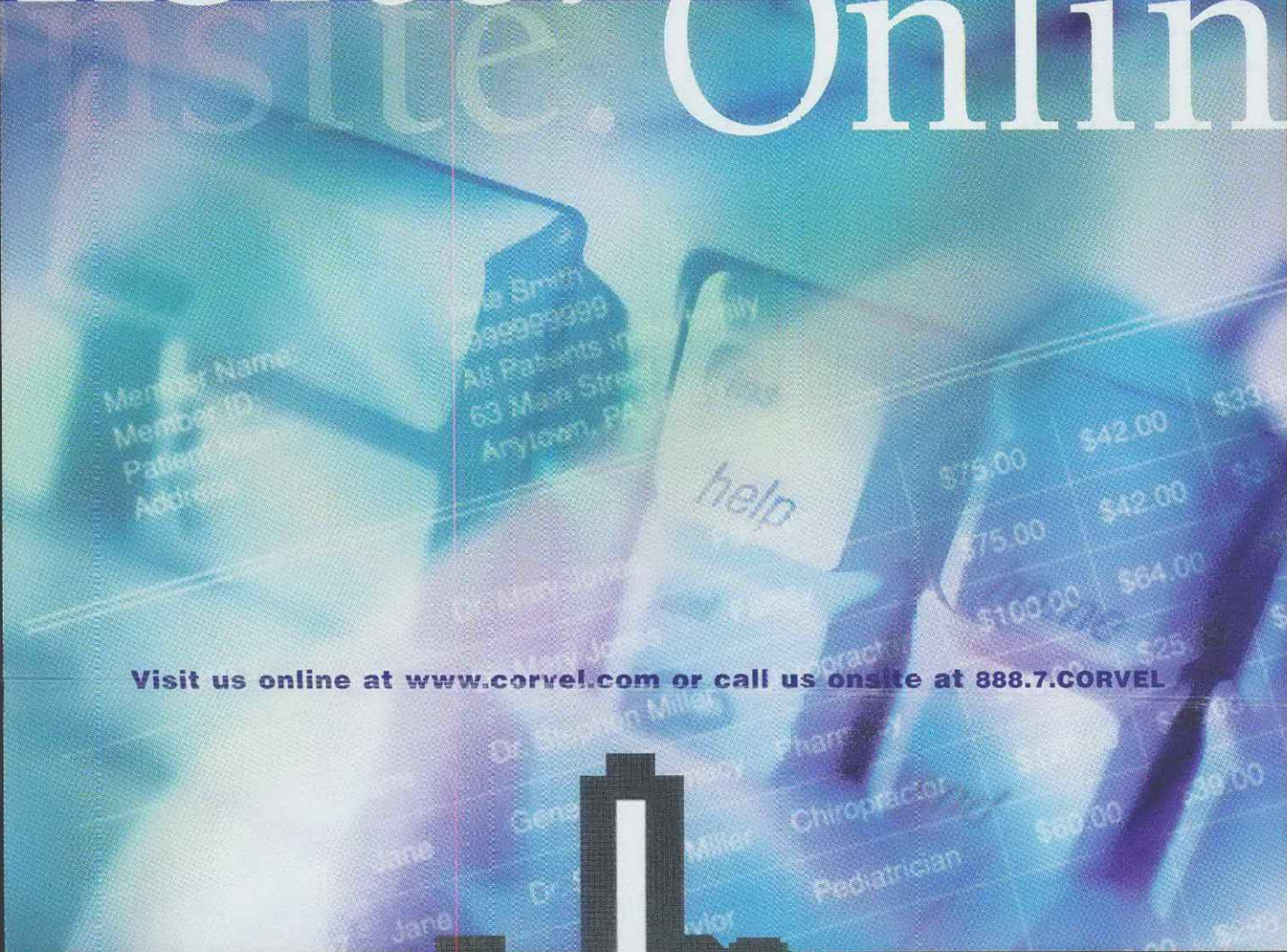
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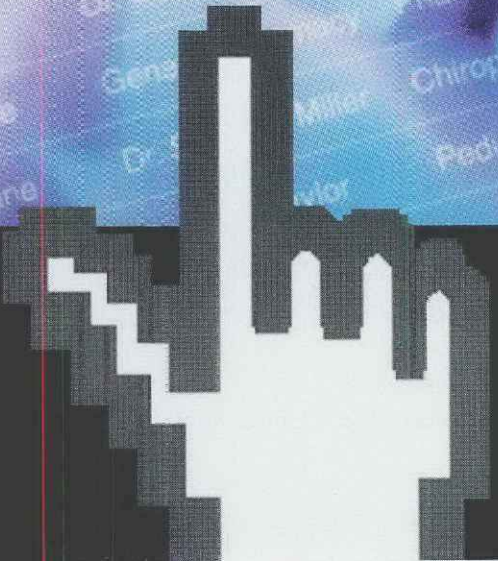
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Member Name:	John Smith		
Member ID:	0999999999		
Patient Name:	All Patients in		
Address:	63 Main Street		
	Arlington, PA		
help		\$75.00	\$42.00
		\$75.00	\$42.00
		\$100.00	\$64.00
		\$25.00	\$25.00
		\$100.00	\$100.00
		\$60.00	\$39.00
		\$20.00	\$20.00

CorVel



Catastrophes

Continued from page 14

that the most appropriate care is offered; that the patient's family is aware of community resources, such as hospice care; and that information is properly disseminated to the patient, the patient's family and all health care providers involved in the case.

The voluntary program is offered to patients within certain diagnostic parameters. If a patient decides to participate in the program, he or she is referred to a case manager who is responsible for an average of 10 cases, far fewer than the 60 to 90 cases a case manager typically handles. Although the program eventually may save the insurer money, initially it will increase costs, Dr. Book said.

Of eight patients who have been offered participation in the Personal Pass Program, seven have accepted, Dr. Book said.

Another option for an employer looking to cut catastrophic health care costs is to work with a company that has negotiated discounts for this kind of care.

Triage Alliance has negotiated discounts with health care providers "that tend to be deeper than (a company) would normally get" through a managed care group such as a health maintenance organization or a preferred provider organization, asserted Ms. Nowacki.

Triage's clients, which include employers, reinsurers and stop-

loss insurers, total approximately 1.5 million covered lives.

Triage sends patients requiring catastrophic care to hospitals that specialize in the particular problems the patients face. Because Triage sends these facilities a substantial number of high-cost cases, the company is able to receive significant discounts on the care of those cases, she explained.

Furthermore, "the more volume a hospital sees, the greater the chance of a more-successful outcome," she added. Hospitals that specialize in complex catastrophic cases can prevent and are more prepared to handle medical complications, she added.

The fees that Triage clients pay the company are determined on a case-by-case basis.

A health plan sponsor can control catastrophic health care claims costs by contracting with a vendor that agrees to assume all medical costs associated with a particular case for a set fee.

After a catastrophic case comes to its attention, Avandel offers clients the option of paying a predetermined amount for all medically related costs up to one year after the catastrophic event.

Medical costs covered include inpatient and outpatient hospitalizations; skilled nursing and rehabilitation facilities; surgery; follow-up and home care; durable medical equipment; pharmacy expenses; diagnostic X-ray and laboratory fees; and physical, occupational and speech therapy.

The employer is protected against runaway costs, Mr. Good-

hue pointed out.

Avandel works with employers, insurers and third-party administrators and currently covers approximately 7 million lives in 47 states.

Paradigm offers a similar service. But instead of covering all costs up to 365 days after a catastrophic event, Paradigm agrees, in exchange for a set fee, to assume all costs associated with a claim up to a certain, defined, outcome.

Paradigm assigns all aspects that could affect a case certain weights that are factored into a multiple regression analysis, Dr. McLean explained. Physical, psychological, social and emotional issues are considered in determin-

ing the fee.

Then, Paradigm works with its client to select a defined outcome for that individual, ranging from the ability to be discharged from the hospital to the ability to return to work.

Paradigm has managed approximately 3,000 catastrophic cases, according to Mr. LaPine. The company covers approximately 1.5 million people.

Although these catastrophic claims management companies say their businesses are growing, most companies continue to rely on either their insured health plan or stop-loss insurance to fund catastrophic health care claims, experts agreed.

"We're not seeing a lot of change" in how employers fund catastrophic health care claims, reported Mr. Lichman of Willis Corroon of New York. "We're not seeing a lot of movement in funding the claim."

Most self-insured employers buy specific and aggregate stop-loss insurance, said Barry Barnett, a principal at PwC Kwasha in Teaneck, N.J. Large employers with more than 5,000 employees typically will not buy stop-loss coverage, he said.

Merck's Ms. Miller noted that the pharmaceutical manufacturer self-insures health care for its 18,000 active employees and does not buy stop-loss insurance. **BI**



28th Annual Agent/Broker geographical index online

The 28th Annual Agent/Broker geographical index of retail brokerage office locations is available at the *Business Insurance* World Wide Web site at www.businessinsurance.com/magazine/directories.html for the first time.

The geographical index lists organizations appearing in the directory and

their commercial retail brokerage branch offices by city and state, or by country if located outside the United States. Branch offices operating under names similar to that of their parent company are indexed under the parent company's name. If the name of a branch office is significantly different from that of its parent, the office name will be followed by that of the parent company in parentheses.

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B/ directory of prescription benefit managers

A

Albertson's Better Care Solutions

250 Parkcenter Blvd.,
Boise, Idaho 83706;
208-395-5920; fax: 208-395-6103

1998 revenues

Total gross revenues \$224,000
PBM gross revenues \$224,000
PBM unbundled revenues \$224,000

PBM clients

Total 12
Employee/group plans
with direct service 12

Lives covered

Total 120,000

Retail network

Pharmacy locations 40,000

Mail-order services

Percent of prescription volume 5%

Generic usage

Percent of prescription volume 42%

Staff

Total 14
Professionals 5
Registered pharmacists 3

Parent: Albertson's Food & Drug; primary business: retail pharmacy.

Services: mail-order drug distribution, claims processing, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education.

Subcontracted services: online claim adjudication; retail pharmacy network.

Reports provided: physician prescribing patterns, percent of generic vs. name-brand prescriptions dispensed analysis, prescription by age.

Service area: Western states, Arkansas, Florida, Louisiana, Missouri, Tennessee and Texas.

Billing method: fee per claim.

Ameriscript Inc.

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

1998 revenues

Total gross revenues \$736,682
PBM gross revenues \$736,682
PBM unbundled revenues \$736,682

PBM clients

Total 926
Employee/group plans with direct service 926

Lives covered

Total 250,000
Active group health plan 135,000
Workers compensation 12,000

Retail network

Pharmacy locations 42,000

Mail-order services

Percent of prescription volume 95%

Generic usage

Percent of prescription volume 42%

Staff

Total 40
Professionals 38
Registered pharmacists 2

PBM services since: 1986.

Parent: The Chandler Group of Cos.; primary business: managed health care organization.

Services: retail pharmacy network, benefit consulting, patient education.

Subcontracted Services: mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name brand prescriptions dispensed analysis, ingredients billed vs. ingredients paid.

Dispute resolution: PBM staff.

Service area: nationwide.

Billing method: fee per claim.

Officers: Arthur W. Chandler, chairman; Burton Margolis, CFO; Jim Piper, president.

Contact: miches@chandler-group.com.

C

Caremark

2211 Sanders Road,
Northbrook, Ill. 60062;
847-559-4671; fax: 847-559-4832
www.caremark.com

1998 revenues

Total gross revenues \$1,117,800,000
PBM gross revenues \$1,097,100,000

PBM clients

Total 1,045
Employee/group plans with direct service 660

Lives covered

Total 9,900,000

Retail network

Pharmacy locations 53,000 (est.)

Generic usage

Percent of prescription volume 88.8%

Staff

Total 1,968
Professionals 350
Registered pharmacists 125

Parent: MedPartners; primary business: specialty pharmaceutical, specialty health care.

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, drug utilization, top drug comparisons, executive summary.

Dispute resolution: PBM staff.

Service area: nationwide.

Billing method: capitated rate, fee per

claim.

Officers: Richard P. Scardina, president; David W. Golding, vp; Sara J. Finley, vp/secretary.

Contact: Steve Skarzynski, manager-financial reporting.

CLAIMSPRO Health Claims Services Inc.

24370 Northwestern Highway,
Suite 200,
Southfield, Mich. 48075;
800-837-9600; fax: 248-352-3714
www.claimspro.com

1998 revenues

Total gross revenues \$11,039,923
PBM gross revenues \$10,500,000
PBM unbundled revenues \$8,925,000

PBM clients

Total 1,200 (est.)
Employee/group plans
with direct service 1,080

Lives covered

Total 1,300,000
Active group health plan 1,300,000

Retail network

Pharmacy locations 48,000

Mail-order services

Percent of prescription volume 6%

Generic usage

Percent of prescription volume 40%

Staff

Total 62
Professionals 36
Registered pharmacists 26

PBM services since: 1989.

Services: retail pharmacy network, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, physician prescribing practices monitoring and management, high potential medical

Continued on page 20

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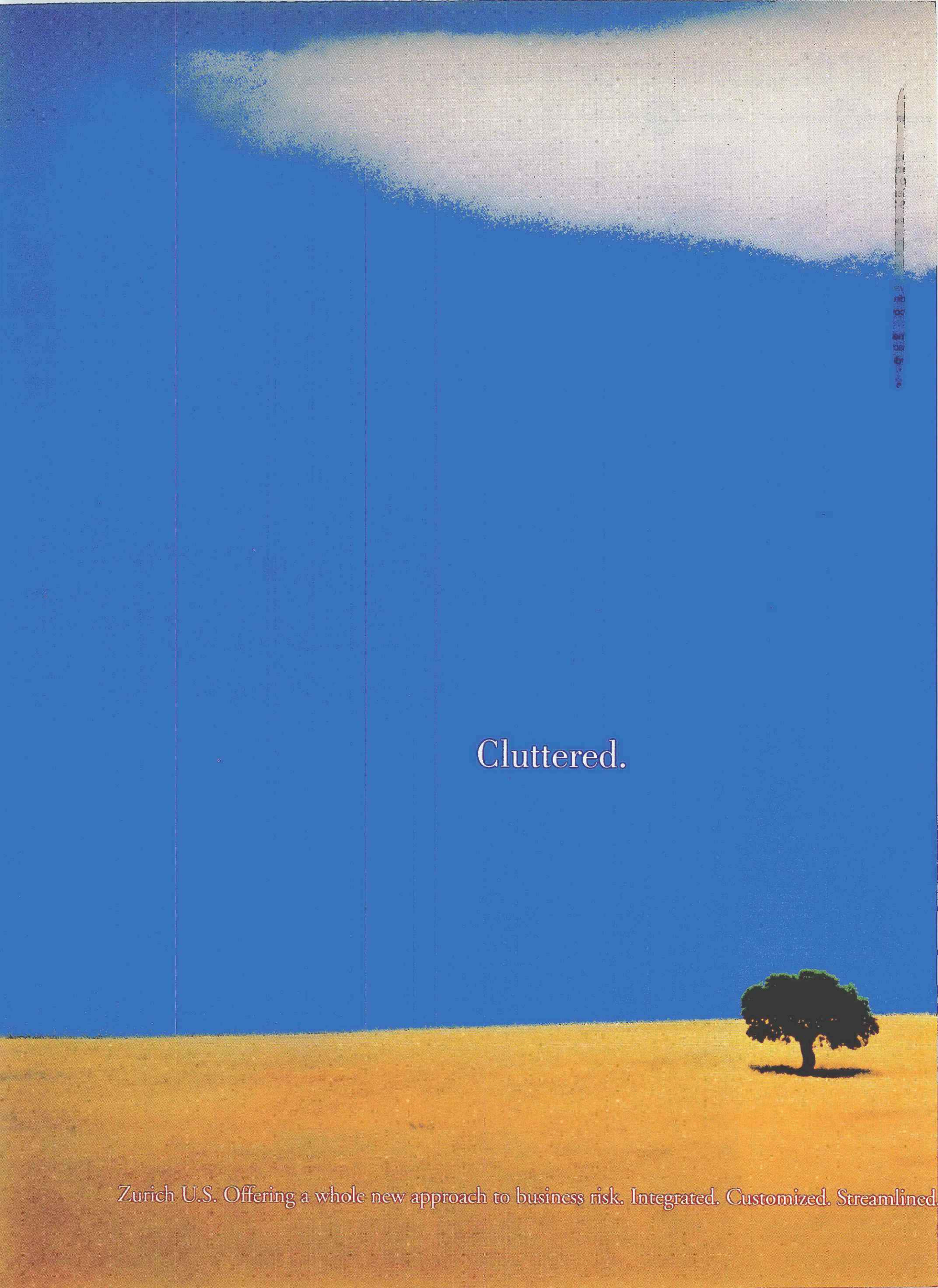
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claimants reporting.
Subcontracted services: mail-order drug distribution, formulary management/review, patient/physician education.
Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, standard reporting package that includes 12 reports.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim.
Officers: Bruce Liebowitz, president; Ron Klein, executive vp.
Contact: support@claimspiro.com.

E

Express Scripts

13900 Riverport Drive,
 Maryland Heights, Mo. 63043;
 800-332-5455; fax: 314-702-7059
 www.express-scripts.com

1998 revenues
 PBM gross revenues \$2,824,872,000
PBM clients
 Total 9,300
Lives covered
 Total 23,000,000
 Workers compensation 607,800
Retail network
 Pharmacy locations 53,000
Generic usage
 Percent of prescription volume 40.9%
Staff
 Total 3,236
 Professionals 628

PBM services since: 1986.

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, therapy class analysis, detailed cost analysis.

Dispute resolution: PBM staff.

Service area: nationwide, Canada.

Billing method: fee per claim.

Officers: Barrett A. Toan, president/CEO; Thomas M. Boudreau, senior vp-administration/general counsel/secretary; George M. Paz, senior vp/CFO.

F

First Health Services Corp.

4300 Cox Road,
 Glen Allen, Va. 23060;
 804-965-7567; fax: 804-527-6849
 www.fhsc.com

1998 revenues
 PBM gross revenues \$30,000,000
Lives covered
 Total 8,000,000
Retail network
 Pharmacy locations 46,000
Mail-order services
 Percent of prescription volume 20%
Staff
 Total 780
 Registered pharmacists 40

PBM services since: 1972.

Parent: First Health Group Corp.; primary business: managed care organization.

Services: retail pharmacy network, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education, decision support, drug rebate administration, prior authorization.

Subcontracted services: mail-order drug distribution.

Reports provided: physician prescribing patterns, member/plan recipients utilization.

Dispute resolution: PBM staff, independent panel.

Service area: nationwide.

Billing method: fee per claim.

Officers: Teresa DiMarco, president; James Council, legal counsel; Donald Spatig, vp-pharmacy division.

Contact: Steve Duvall, vp-pharmacy sales, 800-884-2822; sduvall@fhsc.com.

First Health provides PBM services to 20 states and the District of Columbia.

I

The INTEQ Group

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

1998 revenues
 PBM gross revenues \$4,500,000
PBM clients
 Total 2,500
 Employee/group plans
 with direct service 750
Lives covered
 Total 1,700,000
 Active group health plan 1,400,000

Workers compensation 10,000
Retail network
 Pharmacy locations 46,000
Mail-order services
 Percent of prescription volume 50%
Generic usage
 Percent of prescription volume 44%
Staff
 Total 61
 Professionals 55
 Registered pharmacists 6

PBM services since: 1993.

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, custom reports.

Service area: nationwide.

Billing method: capitated, fee per claim.

Officers: Andrew Fisk, president; Jerry Hosler, vp-finance/administration; John Teichgraber, vp-sales/marketing; Patti Carr, vp-pharmacy operations.

Contact: sales@inteqrx.com.

International Pharmacy Management Inc.

110 12th St. N.,
 Birmingham, Ala. 35203;
 800-476-3784; fax: 205-250-8037
 www.ipmdrug.com

1998 revenues
 Total gross revenues \$1,956,115
 PBM gross revenues \$1,956,115
PBM clients
 Total 110
 Employee/group plans
 with direct service 110
Lives covered
 Total 57,000
 Active group health plan 57,000
 Workers compensation 7,000
Retail network
 Pharmacy locations 43,000
Mail-order services
 Percent of prescription volume 12%

Generic usage

Percent of prescription volume 39%
Staff

Total 30
 Professionals 30
 Registered pharmacists 3
PBM services since: 1995.

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, retrospective utilization review, benefit design consulting, physician prescribing practices monitoring and management, patient education.

Subcontracted services: disease management, formulary management/review.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, high-dollar claim retail and mail, top 50 prescribed by number and dollar amounts, utilization by therapeutic class.

Dispute resolution: independent panel.

Service area: Mid-Atlantic, Southeast, Texas.

Continued on next page

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Continued from previous page

Billing method: capitated rate, fee per claim, insured, stand-alone.

Officers: Mac Jones, chairman; David Beauchaine, vp-finance; Greg Stein, vp-sales/marketing; Nick Black, vp-operations.

Contact: Greg Stein; gstein@ipmdrug.com.

M

Merck-Medco Managed Care L.L.C.

100 Summit Ave.,
Montvale, N.J. 07645;
201-358-5400; fax: 201-358-5783
www.merck-medco.com

1998 revenues
PBM gross revenues \$14,000,000,000
Lives covered
Total 51,000,000

Retail network
Pharmacy locations 55,000
Staff
Total 11,000
Registered pharmacists 1,700
Parent: Merck & Co. Inc.; primary business: drug manufacturer.
Services: retail pharmacy network, mail-order drug distribution, claims processing, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education, claims processing, online claims processing, demand management.
Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, custom reports, program reporting.
Service area: nationwide, Puerto Rico and certain international regions.
Billing method: capitated rate, fee per claim.
Officers: Per Lofberg, president.

MIM Health Plans
100 Clearbrook Road,
Elmsford, N.Y. 10523;
888-818-3939; fax: 914-460-1660
www.mimhp.com
1998 revenues
Total gross revenues \$451,000,000
PBM gross revenues \$29,600,000
PBM clients
Total 353
Employee/group plans
with direct service 109
Lives covered
Total 3,000,000
Active group health plan 1,900,000
Workers compensation 11,000
Retail network
Pharmacy locations 45,000
Mail-order services
Percent of prescription volume 12%
Generic usage
Percent of prescription volume 66%
Staff
Total 279
Professionals 225
Registered pharmacists 39

PBM services since: 1993.

Parent: MIM Corp.; primary business: mail order pharmacy.

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis.

Dispute resolution: PBM staff.

Service area: nationwide.

Billing method: capitated rate, fee per claim.

Officers: Richard H. Friedman, chairman/CEO; Scott R. Yablon, president/COO.

Contact: Recie B. Bomar, vp-sales/marketing.

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

1998 revenues
Total gross revenues \$123,000,000
PBM gross revenues \$103,000,000

PBM clients
Total 350
Employee/group plans with direct service 300

Lives covered
Total 750,000
Active group health plan 700,000

Retail network
Pharmacy locations 44,000
Mail-order services
Percent of prescription volume 20%

Continued on next page

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Directory terms explained

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

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

Listings begin with the company name, address, phone number, fax number and Web site address. The category **1998 revenues** includes total gross revenues, gross revenues generated from all PBM services and gross revenues from unbundled PBM services. The **PBM clients** section specifies the total number of clients, as well as the number of employer/group plans that contracted directly with the PBM in 1998.

Lives covered includes total group health plan lives, both eligible and active. Active enrollees are those participants who received prescriptions through the plan.

Active group health enrollees and active workers compensation enrollees in 1998 are also provided.

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

Staff information, given in full-time equivalents for 1998, details the total number of staff members assigned to PBM services. The total number of professional staff members is also provided, including the number of registered pharmacists on staff.

PBM services and **subcontracted services** offered by the company are listed next. The **reports** provided to the client along with the **service area** are followed by the **billing methods** and the **dispute resolutions** offered.

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

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

Continued from previous page

Generic usage

Percent of prescription volume 40%

Staff

Total 45

Professionals 31

Registered pharmacists 11

PBM services since: 1981.

Services: retail pharmacy network, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education.

Subcontracted services: mail order drug distribution.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis.

Dispute resolution: PBM staff.

Service area: mid-Atlantic, midwest, north-east, southeast, west.

Billing method: capitated rate, fee per claim.

Officers: Bert Brodsky, chairman; Marjorie O'Malley, president/CEO; Mary Casale, executive vp.

National Pharmaceutical

14301 First National Parkway,
Suite 200, Omaha, Neb. 68144;
402-964-9030; fax: 402-964-9004

1998 revenues

PBM gross revenues \$3,500,000

PBM unbundled revenues \$3,500,000

PBM clients

Total 900 (est.)

Employee/group plans with direct service 900 (est.)

Lives covered

Total 500,000

Active group health plan 178,000

Workers compensation 13,000

Retail network

Pharmacy locations 49,000

Mail-order services

Percent of prescription volume 5%

Generic usage

Percent of prescription volume 53%

Staff

Total 20

Professionals 8

Registered pharmacists 5

PBM services since: 1994.

Parent: Pharmaceutical Technologies Inc.; primary business: health care reporting software.

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education, demographic trend analysis, group modeling.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, explanation of benefits to household, group analysis.

Dispute resolution: PBM staff.

Service area: nationwide, primarily mid-west and west.

Billing method: capitated rate, fee per claim, percent of savings.

Officers: Douglas M. Pick, president/CEO;

Angella Piepen, CFO; Dr. Bill Fleming, medical director.

Contact: Douglas M. Pick, pti-dpick@ccc-corp.com.

P

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1998 revenues

Total gross revenues \$1,749,010

PBM gross revenues \$1,380,760

PBM unbundled revenues \$68,250

PBM clients

Total 761

Employee/group plans with direct service 574

Lives covered

Total 439,205

Active group health plan 127,980

Workers compensation 362

Retail network

Pharmacy locations 46,000

Mail-order services

Percent of prescription volume 3.9%

Generic usage

Percent of prescription volume 43%

Staff

Total 28

Professionals 12

Registered pharmacists 9

PBM services since: 1986.

Parent: Georgia Pharmacy Assn.; primary business: state pharmacy association.

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, member interventions.

Dispute resolution: PBM staff.

Service area: nationwide; with concentration in the mid-Atlantic and southeastern states.

Billing method: fee per claim, per employee per month.

Officers: Oren H. Harden, CEO; Charles P. Callihan, COO.

Contact: sales@pasrx.com.

Pharmacy Services Group

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

1998 revenues

Total gross revenues \$23,000,000

PBM gross revenues \$4,000,000

PBM unbundled revenues \$2,300,000

PBM clients

Total 362

Employee/group plans with direct service 164

Lives covered

Total 683,000

Active group health plan 532,000

Workers compensation 338,000

Retail network

Pharmacy locations 43,847

Mail-order services

Percent of prescription volume 40%

Generic usage

Percent of prescription volume 61%

Staff

Total 41

Professionals 11

Registered pharmacists 5

PBM services since: 1983.

Parent: Managed Healthcare Systems Inc.; primary business: mail order pharmacy.

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education, unit dosing of liquids and capsules.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, as required by client.

Dispute resolution: PBM staff.

Service area: nationwide.

Billing method: fee per claim.

Officers: Ken Sack, CEO; Mike Marine, CFO; Stan Freedman, pharmacy director.

R

Rx Direct Inc.

1445 Clarksville,
Paris, Texas 75460;
903-785-4197; fax: 903-785-3218
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1998 revenues

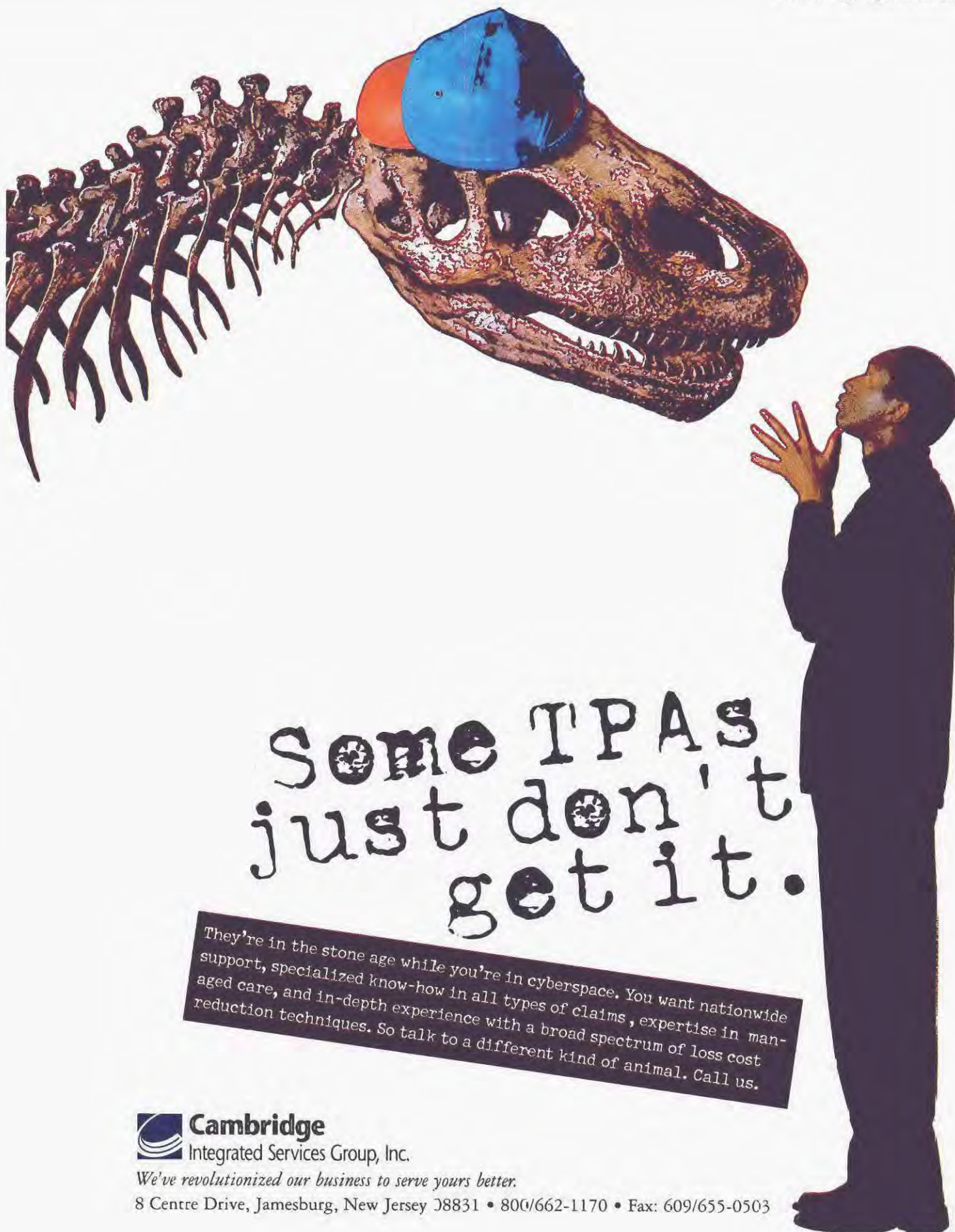
Total gross revenues \$25,000,000

PBM gross revenues \$25,000,000

PBM unbundled revenues \$25,000,000

PBM clients

Total 4,100



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A monthly editorial section sent exclusively to agents and brokers

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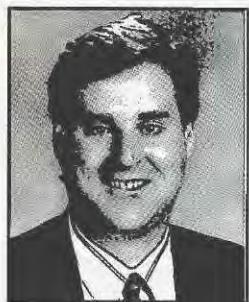
Industry's voice in federal regulation



Reform

Continued from page 22B

The National Assn. of Professional Insurance Agents also supports H.R. 10 and remains neutral on S. 900.



'We believe (H.R. 10) is a modest improvement over the status quo. The safe harbor and functional state regulation provisions are an improvement over current law.'

— Dean Sackett

"We believe (H.R. 10) is a modest improvement over the status quo for agents," said Dean Sackett, vp-government affairs for the PIA in Alexandria, Va. "The safe harbor and functional state regulation provisions are an improvement over current law."

In addition to containing various legislative declarations assuring that states will remain the primary regulator of all insurance

sales activities—including those of national banks and their affiliates—H.R. 10 also establishes 13 "safe harbor" provisions that protect certain existing state insurance laws from pre-emption by the OCC.

The National Assn. of Life Un-

commissioners in the event there is a pre-emption challenge by a federal bank regulator, said Michael L. Kerley, senior vp-government affairs for the NALU in Washington.

"The sad fact" is that, in cases where there is a dispute between banking and insurance laws, courts most of the time give greater consideration to the federal comptroller of the currency, Mr. Kerley said.

Provisions in H.R. 10 give state regulators equal deference on state laws enacted after Sept. 3, 1998. "We'd like to see some consideration given to commissioners prior to Sept. 3," he said.

"We're still working with the powers that be on the House Banking Committee and the Senate Banking Committee and the leaders of the House and Senate to see if it is possible to create a little more equality with insurance commissioners and the comptroller of the currency," Mr. Kerley said.

Mark A. Hofmann contributed to this report.

NARAB aims to make history of interstate licensing hassles

By MARK A. HOFMANN

A congressional effort to break down the barriers among insurance, banking and securities could also break down a barrier that's been hampering agents' and brokers' efforts to do business in more than one state.

That's the barrier presented by various and complicated state licensing laws with wide-ranging requirements, some of which—such as countersignature and residency requirements—critics see as nothing more than protectionist measures that serve only the interests of in-state agents.

But H.R. 10, the financial mod-

ernization bill recently passed by the House of Representatives, calls for the creation of a new entity, the National Assn. of Registered Agents and Brokers, or NARAB, that could help remedy that situation.

NARAB, while stopping short of creating a single federal license, would act as a clearinghouse for multistate licenses, making it much easier for agents to conduct business in more than one state. Members of NARAB would have to meet professional standards higher than any state now requires to participate, and states would continue to collect licensing fees and enforce consumer protection laws.

The Senate version of financial services reform, S. 900, doesn't contain the NARAB provision, but NARAB supporters—notably the Washington-based Council of Insurance Agents & Brokers—hope it will be part of the final bill when it emerges from a conference committee in the next year.

The CIAB has advocated the NARAB concept for years, and it is easy to see why. Even though it represents fewer than 300 member firms, those firms sell more than 80% of the nation's commercial insurance, pointed out Joel Wood, senior vp-government affairs for the CIAB.

"A typical broker in a typical member firm of ours may have to hold over 100 licenses to be able to conduct business. Those burdens, if anything, have gotten worse, not better. The reality is, of all the reforms that have taken place, the pace of consolidation, the pace of financial services convergence and the pace of globalization have far outstripped the pace of the reforms that have occurred thus far," said Mr. Wood.

He praised the National Assn. of Insurance Commissioners for adopting the "uniform treatment model" in 1998. "There's been more progress made in the last two years" toward easing the interstate licensing hassles at the NAIC level than has taken place over the prior 10 years, he said.

Mr. Wood said the NAIC's uniform treatment model sets forth a framework for "reciprocity, which we think is the ultimate solution that preserves state insurance regulation in a competitive and efficient way. We're still a long way away from pure reciprocity. That's why we strongly believe that the incentive of NARAB needs to remain in place to strongly drive the states on that path toward reciprocity."

Mr. Wood explained that the See NARAB on page 22E



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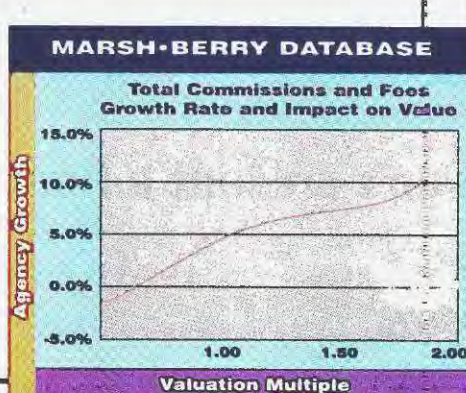
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NARAB

Continued from previous page

uniform treatment model holds that states that agree to it will treat resident and non-resident agents equally, which at least theoretically would allow each state to set its own unique standards, provided that they applied to both resident and non-resident agents. Reciprocity would mean that states would accept and enforce the licensing laws of other states without burdening non-resident agents with any additional requirements.

Mr. Wood stressed that reforms have occurred in many states, including the repeal of costly countersignature laws.

Such reforms are starting to bear fruit, he said. He predicted that by end of year, the NAIC will have developed a model producer licensing application. "We can whittle away at the remaining barrier," he said. But the CIAB thinks there must be a "strong incentive" for the states to continue making this progress because those other forces—consolidation, convergence, globalization—may even pick up speed, Mr. Wood added.

"Those reforms that have occurred simply haven't translated yet in the average member firm of ours. I have yet to have a member of our association say, 'You know, this has gotten easier for me,'" he said.

Mr. Wood said the "most important fact" about NARAB is that it provides incentives for states to move forward on multi-state licensing, while "the biggest misconception" is that it would create a federal license. He added that some CIAB members certainly would prefer a single license to the current regime.

Mr. Wood pointed out that the NARAB provision allows states to create a reciprocity regime. If any 26 states enact full reciprocity or uniformity within three years of the enactment of a bill containing the NARAB provision, NARAB would not be created. But if those three years pass and 26 states have not enacted reciprocity, the NAIC would be authorized to set up NARAB within itself and would be granted peremptory authority over residency barriers, he said.

Agents and brokers meeting NARAB's criteria—which would involve higher professional stan-

pay the licensing fees and remain fully subject to state laws governing such issues as unfair



The 'most important fact' about NARAB is it provides incentives for multistate licensing, while 'the biggest misconception' is that it would create a federal license.

— Joel Wood

dards than exist in any of the states today—would be able to gather licenses in other jurisdictions, provided they continue to

trade practices and market conduct.

"It's one-stop shopping, but still subject to state enforcement

with regard to regulatory activity," he said.

If the NAIC does not create NARAB, and if within another two years 26 states representing a "majority of commercial premium in the U.S." have failed to enact reciprocity, then NARAB will be established as an independent agency. The president would appoint the agency's governors from among state insurance commissioners.

"We've done everything we could possibly think of to make this a comfortable fit with state insurance regulation," said Mr. Wood.

Mr. Wood said the CIAB has

been "garnering support from groups ranging from the American Bankers Assn. to the Risk & Insurance Management Society" in its efforts.

"RIMS' support has been very important to us because, frankly, people on Capitol Hill ask on every provision, 'Where are the major industry groups and where are the consumer groups?' To the extent that this is going to impact consumers, the biggest beneficiaries are going to be the corporate consumers of insurers, rather than more localized life insurance and property/casualty insurance products," Mr. Wood said. BI

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Industry seeks to shape health care bills

By RODD ZOLKOS

As patient protection legislation remains a contentious issue in Congress, those representing various insurance industry interests continue their efforts to influence any final measure.

Their approaches are generally very similar, though they vary occasionally with the specific segment of the industry being represented.

The Health Insurer Assn. of America, for example, is fairly outspoken in its contention that the best possible outcome would be no new legislation.

"We ultimately think the consumers and the employers would be better served if no legislation were to pass," said Richard Coorsh, a spokesman for the HIAA in Washington.

The group opposes the bill that has passed in the Senate, "because we feel that it has several mandates in there that will raise the cost of insurance to employers," Mr. Coorsh said.

And in the House, "it's quite likely that what is proposed will contain some type of liability provision, which we do not care for at all," he said.

Other groups are more open to legislation that aims to correct problems they acknowledge exist in the country's health care system, even while they lobby to ensure that any changes don't dismantle the many positive elements they see in the present system.

The Independent Insurance Agents of America, for example,

has worked with the HIAA in its lobbying effort, but it also has worked closely with congressional leaders to implement some changes it sees as necessary.

The IIAA came out in support of a bill shepherded through the Employer-Employee Relations Subcommittee of the House Education and the Workforce Committee in June by Rep. John Boehner, R-Ohio. That bill combined several reform proposals into a single measure.

In particular, the IIAA, whose members chiefly are small businesses, favors a provision that would allow small employers to pool together in association health plans in order to purchase coverage for employees.

"We think what the Republicans have done is reasonable," said Maria L. Berthoud, vp-federal government affairs at the Alexandria, Va.-based IIAA. Because the IIAA represents the interests of small businesses, it "recognizes the problem a lot more acutely," she said.



"Not only do we sell health insurance, but we also want to provide it," Ms. Berthoud said. "We are small-business people, and a lot of our clients are small-business people. And so we need to

look at what's the best way to get people insured while not damaging the level of insured we already have."

The IIAA has been working closely with the Nashville, Tenn.-based National Federation of Independent Business in pro-



Even without legislative mandates, health insurance plans have been moving toward such measures as external review provisions and increased access to providers.

— Bill Pierce

moting the association health plan concept.

Bill Pierce, director of public affairs for the Blue Cross & Blue Shield Assn. in Washington, suggested that patient protection legislation passed by the Senate wasn't as bad for business as it might have been, though he questioned its necessity.

"Clearly, what the Senate

Because many IIAA members are small businesses, 'we need to look at what's the best way to get people insured while not damaging the level of insured we already have.'

— Maria L. Berthoud

passed could have been much worse," Mr. Pierce said. "But when you look at what the private sector is doing, clearly, we are addressing the issues with which they are concerned."

Even without legislative mandates, health insurance plans have been moving toward such measures as external review provisions and increased access to health care providers in response to marketplace demand, Mr. Pierce said.

But, as the debate on the legislation continues in the House, so

does the BC/BS lobbying effort.

"We have, all along, been lobbying both the House and the Senate, and we'll continue to do both," Mr. Pierce said.

The Blues' efforts have included running policy advocacy advertisements in Washington, as

well as targeted lobbying.

"We have, obviously, been targeting very much," Mr. Pierce said. That has involved both the traditional approach of talking to key congressional members and staff, as well as "using grassroots efforts a lot," he said. Mr. Pierce said BC/BS has also used what he calls a "grasstops" approach, which involves targeting opinion leaders within key legislators' districts.

With Congress set to take its summer recess Aug. 6, Mr. Pierce said BC/BS continues to lobby as though there will be a House vote before that break.

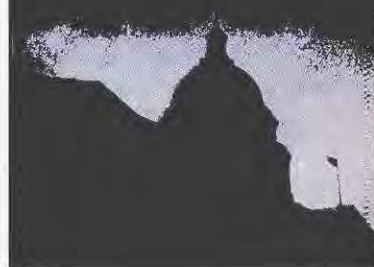
"We're continuing to do what we do," he said. "No matter what, you've always got to do that. You can never let your guard down."

One of the most visible lobbying efforts on patient protection legislation has been that of the American Assn. of Health Plans.

"For almost two years now, we've really been fighting a two-pronged fight here, one on patients' bill of rights and one on Medicare," said John Murray, director of public affairs for the AAHP in Washington.

Two years ago, the group recognized that "the prism through which this was going to be focused was one of politics and one of election cycles," Mr.

Government Relations



Pierce said. That convinced the AAHP it had to be prepared to deal with the issue from both a policy standpoint and a political standpoint.

Part of the group's approach has been to conduct campaigns in Iowa and New Hampshire. These campaigns seek to educate the public and focus debate on the issues in the states where the initial stages of the 2000 presidential campaign will take place.

Although the AAHP is also working within the Beltway, its national lobbying effort is key, Mr. Murray said.

"The politics inside Washington has been so poisoned that, while you have to work inside the Beltway, we thought it was essential to take our message outside the Beltway as well," he said.

Like many of the other associations, individual insurers and employers, the AAHP also has been active in the Health Benefits Coalition in its lobbying efforts on the patient protection issue.

The coalition can press the lobbying effort on a broad front, said the Blues' Mr. Pierce, while its member organizations can direct their efforts to the specific issues that apply to them.

"The coalition is, basically, carrying forward the broad 'no mandates' issue," Mr. Pierce said. "We're carrying forward the other specific issues." **BI**

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Its efforts earn Michigan agency white-glove treatment from insurer

Head of Michigan Millers honors agency with service—his!

By ELIZABETH LINDSEY

When Bruce W. Herrick, the president and chief executive officer of Michigan Millers Mutual Insurance Co. in Lansing, Mich., donned his tuxedo and gloves June 11, he wasn't headed to a black-tie party. He was going to spend the afternoon working at an insurance agency.

The Fred C. Haight Insurance Agency of Muir, Mich., won Michigan Millers' first-ever Most Valued Agent award, which entitled them not only to a plaque but also an afternoon's labor by Mr. Herrick.

Mr. Herrick said there are people who believe he shouldn't dress up and play servant because a CEO should have a more-dignified image—an opinion he considers "baloney."

The award originated because the insurer, which writes both personal and commercial lines, wanted to demonstrate it was truly offering good customer service.

So executives decided to establish a quarterly award that would include a visit from a company executive who would provide some special service to the winning agency. Mr. Herrick said the service won't always be a tuxedo-clad free employee, but it will always be unique.

To win, agencies must demonstrate loyalty to, generate business for and maintain good communication with Michigan Millers. In addition, an agency must have a work atmosphere that would allow employees to enjoy the executive's visit.

The Haight agency met all of the award's requirements. There was no application process; Michigan Millers simply called the agency after selecting it as the winner.

According to a press release from Michigan Millers, the Haight agency has worked with the insurer since 1985. One indication of the good relationship between the agency and the insurer is the fact that the agency has generated about \$60,000 in premiums for Michigan Millers since January, according to R. Alan Crooke, a Haight co-owner and agent. Mr. Crooke also serves on Michigan Millers' Presidents Council, which offers suggestions from the agents' perspective on how the insurer can improve its performance.

When he arrived at the agency, Mr. Herrick discovered it indeed had the proper atmosphere for his visit. He spent the day weeding flowers, washing windows, vacuuming, filing and even making an

ice cream run.

"It was quite an honor to, A, be chosen as the first one and, B, have him come out," Mr. Crooke said.

The honor aside, agents weren't above teasing their guest a little. While Mr. Herrick was working as a receptionist, a woman came in to the office to register a complaint. She then announced that her problems were due to Michigan Millers.

When Mr. Herrick told her he was the president of Michigan Millers, she began to harangue him, his employees and his com-

pany. The largest business centers—from the list of states it served, the company began to struggle financially. When Mr. Herrick arrived, the company was in the midst of downsizing. In addition, many agents were looking to other companies to provide coverage for their clients.

"During this period of time, both the employees and the agents became unexcited and docile," Mr. Herrick said.

So Mr. Herrick, who describes himself as a hands-on executive, decided to speak with a large number of agents, both individu-



PHOTO: COURTESY OF MILLERS MUTUAL INSURANCE CO.

Michigan Millers Mutual CEO Bruce W. Herrick donned a tuxedo to perform tasks for the Fred C. Haight Insurance Agency as servant for a day.

pany in general. Eventually, after employees behind the counter began giggling, they explained to Mr. Herrick that the woman was related to one of the agency's owners and had no real complaint.

In spite of being teased, Mr. Herrick said, "I had a ball doing this."

His good sportsmanship paid off. Mr. Crooke said everyone in the office—which employs 11 agents in addition to Mr. Crooke—enjoyed the day.

The Most Valued Agent award is not the only effort Mr. Herrick and the other executives at Michigan Millers have made to improve service to agents. When Mr. Herrick joined the company in late 1997, it was struggling to find its niche, and the executives decided to focus on customer service.

The company's problems began in 1992, when Hurricane Andrew hit Florida, and worsened when the Northridge earthquake struck California two years later. Although the company remained financially sound, the two catastrophes did persuade it to stop writing coverage in those states.

After cutting California and Florida—its second- and third-

largest business centers, to determine how the company could revitalize itself. They told him that service was really lacking in the industry.

In response to the company's difficulties and the input he received from agents, Mr. Herrick developed three goals for the company: stop the downturn in premiums, improve profitability and raise the morale of employees and agents.

Because he believed the company couldn't improve service or agents' morale without support from Michigan Millers' employees, he began a program to raise morale internally. The program was called the Great Michigan Millers Mutual Comeback.

The comeback campaign kicked off at one of the monthly meetings Mr. Herrick had instituted to discuss company goals. Before that meeting, the senior managers arrived at the office at 6 a.m. and plastered "Great Michigan Millers Mutual Comeback" stickers all over what Mr. Herrick described as a typical, conservative insurance office and had a balloon placed over the building.

When that morning's meeting

See **Award** on next page

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Agent/Broker Topics

Award

Continued from previous page

started, employees encountered senior management wearing company windbreakers. Employees were given pompoms, and an office pep rally began.

"As much as they say they don't, people love that schmaltzy stuff," Mr. Herrick said.

In addition to providing some well-timed schmaltz, another big change Mr. Herrick made was to have employees ask agents when they need quotes and provide them by that time. Like many companies, Michigan Millers used to attempt to meet only internal standards and deadlines when agents asked for quotes. That meant agents sometimes didn't receive their quotes until after their own deadlines.

Mr. Herrick said that agents occasionally request a deadline that the insurer can't meet. In such cases, employees of Michigan Millers tell the agents up front that the insurer can't pro-

vide the quote by that time. He added that the insurery does meet agents' deadline expectations 99% of the time.

Mr. Crooke said that under Mr. Herrick's leadership, Michigan Millers has become much more focused on its agents. "It's like, 'How can I help you today?' instead of 'Why are you bothering me today?'" Mr. Crooke said.

The morale-boosting program has improved both customer satisfaction and the company's financial health. Mr. Herrick said that in 1997 the company lost \$3.6 million, but last year it turned a \$6.6 million profit. In addition, premium volume is up 3% from 1998.

Mr. Herrick said the internal campaign has been key to the company's turnaround. Agents used to tell Mr. Herrick they didn't want to do business with Michigan Millers because the company acted as though it didn't want to write insurance. Now agents are eager to deal with the company.

"There's a whole new attitude," Mr. Herrick said. **BI**

Good storytelling effective in marketing, consultant says

Structuring the story after getting information also called important

By SALLY ROBERTS

Whether used to sell products, build a corporate culture or polish an executive's leadership image, storytelling can improve marketing communications, a consultant contends. "As communicators, our job is to capture the hearts and minds of our customers," said Ann Wylie, president of Wylie Communications, a Kansas City, Mo.-based consulting firm. "Whoever tells the best story will win."

During a session at the recent Insurance Marketing & Communications Assn.'s annual conference in Keystone, Colo., Ms. Wylie explained that storytelling sells be-

cause it gets the audience's attention and keeps that attention longer than any other means of communication.

This is important, she said, considering that most Americans are bombarded with roughly 1 million bids for their attention each year through various advertisements.

Marketers, she said, need to use creativity in their writing "to cut



through the clutter."

In addition to getting an audience's attention, storytelling also is more memorable than dry abstract material lacking a creative hook. It can enhance credibility, it lingers longer in peoples' minds and gets passed along further and faster, she added.

Storytelling can be used, for example, to develop a company's corporate culture, said Ms. Wylie. She suggests that during orientation for new hires, employers tell them the story of how the company began.

"When you want to nurture a culture, it is almost impossible to tell them what the culture is," she said. Thus, "you need to show them what the culture is."

Storytelling also can be used to polish a company leader's image, Ms. Wylie said. By becoming better storytellers, corporate executives will seem more personal and more human to others, who, in turn, will be more apt to buy in or follow the leader, Ms. Wylie said.

Storytelling also is a great way to sell ideas and products and services, she said.

In describing ways to develop good anecdotes, Ms. Wylie suggests that marketers take existing stories—from both within and outside the company—and adapt them to the specific need.

Other means include mining the organization for news stories, she said. In particular, people who have resolved a crisis within the company often can provide good stories, she said.

When encountering difficulty finding stories from people within the company, Ms. Wylie suggests

that marketers ask "when" questions.

Anecdotes, she said, often emerge out of a specific period of time, she said. "When did you know you were going to be in financial trouble?" she asked rhetorically.

Ms. Wylie also suggests asking specific questions when fishing for anecdotes. For example: "What's one thing you've done in your career that you wish you hadn't done?"

If that approach doesn't work, try "writing by hanging around," Ms. Wylie suggests. She suggests, for example, following an agent around for the day or going to the claims office to observe.

"Some stories you won't get any other way," she added.

Once the information to craft a story has been obtained, it is important to know how to structure an anecdote.

Every anecdote needs a character, a plot, action, a pivotal moment and a punch line, she said.

The pivotal moment is the crisis, change or decision made; it is essential to the success of an anecdote, Ms. Wylie said, adding that the pivotal moment needs to be one moment in time.

The anecdote needs to have only one principal character, she said. This will make it easier for the audience to care about that character. Other less-important characters need to be included as well to develop the story and help readers care about the main character, she said.

The plot also is important to the anecdote. Ms. Wylie said that in corporate communications, the plot should be simple.

The anecdote also needs action, and "the most powerful form of action is suspense," Ms. Wylie said.

At the end of the anecdote, there needs to be a "punch line," she said. Like all comedians telling jokes, marketers need to pause before giving the punch line. "This builds tension and gives a better reaction," she said.

Marketers can pause and build tension through phrasing, punctuation and paragraphing, she added.

Overall, Ms. Wylie urged marketers to not embellish stories, asserting that stories are more effective if they're real. **BI**

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28th Annual Agent/Broker geographical index online

The 28th Annual Agent/Broker geographical index of retail brokerage office locations is available at the Business Insurance World Wide Web site at www.businessinsurance.com/magazine/directories.html for the first time.

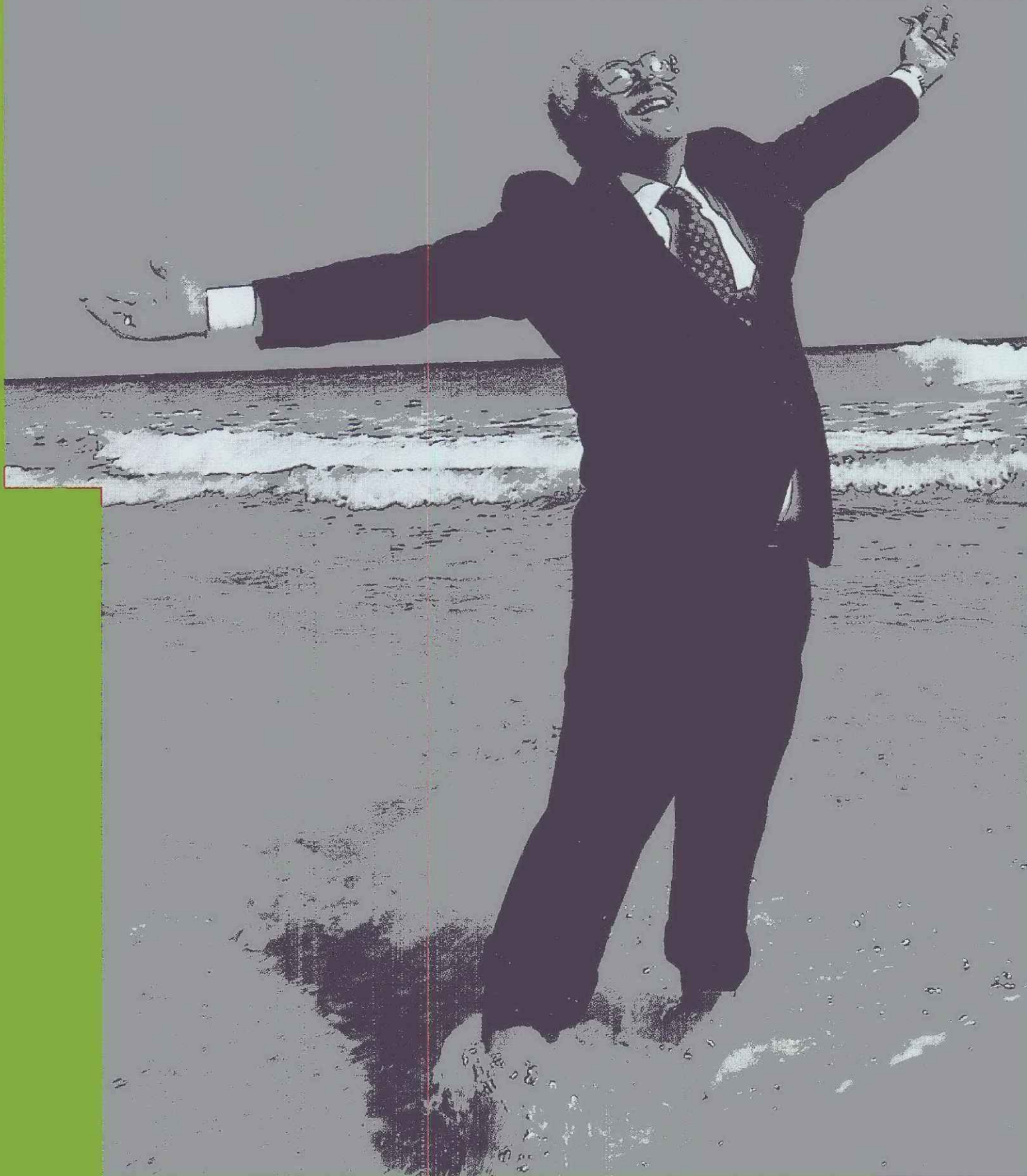
The geographical index lists organizations appearing in the directory and their commercial retail brokerage branch offices by city and

state, or by country if located outside the United States. Branch offices operating under names similar to that of their parent company are indexed under the parent company's name. If the name of a branch office is significantly different from that of its parent, the office name will be followed by that of the parent company in parentheses.

www.businessinsurance.com/magazine/directories.html

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GROUP, LLC

www.hobbsgroup.com

Continued from page 22

Employee/group plans
with direct service 4,000
Lives covered
Total 850,000
Active group health plan 211,200
Mail-order services
Percent of prescription volume 100%
Generic usage
Percent of prescription volume 40%
Staff
Total 53
Professionals 22
Registered pharmacists 3
PBM services since: 1994.
Services: mail-order drug distribution, concurrent utilization review, benefit design consulting, patient education.
Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis.
Dispute resolution: independent panel.
Service area: nationwide.
Billing method: discounted percentage of average wholesale price.
Officers: Gerry Teague, president; Jim Slaton, secretary/treasurer; Bob Coopman,

director.
Contact: Jim Slaton.

**United Drugs**

7227 N. 16th St., Suite 160,
Phoenix, Ariz. 85020;
602-628-1179; fax: 602-678-0772
www.corp.uniteddrugs.com
1998 revenues
Total gross revenues \$1,000,000,000 (est.)
PBM gross revenues \$600,000 (est.)
Lives covered
Total 200,000
Retail network
Pharmacy locations 25,000
Mail-order services
Percent of prescription volume 5%
Generic usage
Percent of prescription volume 60%
Staff
Total 40
Professionals 10

Registered pharmacists 2
PBM services since: 1989.

Parent: American Associated Druggist Inc.; primary business: cooperative of independent pharmacies.

Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis.

Dispute resolution: PBM staff.
Service area: southwestern and western states.

Billing method: fee per claim.

The directory of prescription benefit managers begins on page 17; directory terms are explained on page 21.

Contact: B.A. Semingson, vp-managed care sales.

**Walgreens Health Initiatives (WHI)**

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

1998 revenues
Total gross revenues \$609,256,428
PBM gross revenues \$6,052,216
PBM clients
Total 763
Employee/group plans
with direct service 740
Lives covered
Total 1,900,000
Retail network
Pharmacy locations 44,646
Mail-order services.....*

Generic usage

Percent of prescription volume 51%

Staff

Total 222
Professionals 31
Registered pharmacists 9,000
PBM services since: 1995.

Parent: Walgreen Co.; primary business retail pharmacy.

Services: retail pharmacy network, mail-order drug distribution, claims processing online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education, community health initiatives, home care pharmacy, specialty pharmacy.

Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, standard financial and management reports depending on plans requirements.

Dispute resolution: PBM staff.

Service area: 37 states, Puerto Rico and Virgin Islands.

Billing method: fee per claim, fee for service.

Officers: Robert H. Halaska, president; Julian A. Oettinger, Allan M. Resnick, Edward H. King, vps.

*Mail order services percentage varies by plan

**York Prescription Benefits**

1 Church St., Fifth Floor,
New Haven, Conn. 06510;
203-781-0649; fax: 203-781-4896
www.yorkpbm.com

1998 revenues
PBM gross revenues \$4,000,000
Lives covered
Total 100,000
Workers compensation 5,000
Retail network
Pharmacy locations 45,000
Mail-order services
Percent of prescription volume 5%
Generic usage
Percent of prescription volume 45%
Staff
Total 27
Registered pharmacists 8
PBM services since: 1995.
Parent: USIA Administrators; primary business: insurance services.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring and management, patient education, demand management, vision, life, dental, accidental death.
Reports provided: physician prescribing patterns, employee utilization, percent of generic vs. name-brand prescriptions dispensed analysis, PBM trend analysis.
Service area: nationwide.
Billing method: capitated rate, fee per claim, per employee per month.
Officers: Jim Pennington, chairman; Jim Bigl, president/CEO; Lily Khodadoost-Kamvar, vp-clinical services/network delivery.
Contact: info@yorkpbm.com. **BI**

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Business Insurance list of employee benefit information resources

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■ A booklet available from Aon Consulting Worldwide reviews the **Medicare+Choice** program, its plan design, administration and communication implications for employers with retiree medical plans, as well as Medicare's current features and evolution. Request item 501.

■ Aon Consulting Worldwide offers a booklet on the **trend measurement of the workforce commitment index** and the key orga-

nizational and individual factors that drive this commitment. Request item 502.

■ A booklet covering general provisions of the **Health Insurance Portability and Accountability Act**, summary plan description regulations under HIPAA, sample SPD language and forms, and a checklist of requirements is available from Aon Consulting Worldwide. Request item 503.

■ Aon Consulting Worldwide offers a booklet on the **employee benefits due diligence process**, which covers the M&A process, key benefits issues and alternative benefits strategies; and provides a checklist for collecting and reviewing benefits information. Request item 504.

■ The defined behavior of a committed worker and descriptions of **which benefit programs help drive worker commitment** are offered in a booklet available from Aon Consulting Worldwide. Request item 506.

■ ARAG Group offers **software for people seeking answers about benefits**, which offers easy connections to benefits-related Web sites. Request item 508.

■ The third edition of the ARAG Group's facts guide explains what a **group legal benefit plan** is, its popularity, comments about it and many more facts. Request item 509.

■ BNA Books offers a pamphlet that briefly summarizes **benefits under the Social Security and Medicare programs**, which include hospital and medical insurance as well as retirement, disability, and survivors' benefits. Request item 510.

■ Buck Consultants Inc. offers a bulletin describing statements issued by the Financial Accounting Standards Board that change the **disclosure requirements of FASB statements**. Request item 511.

Continued on page 30

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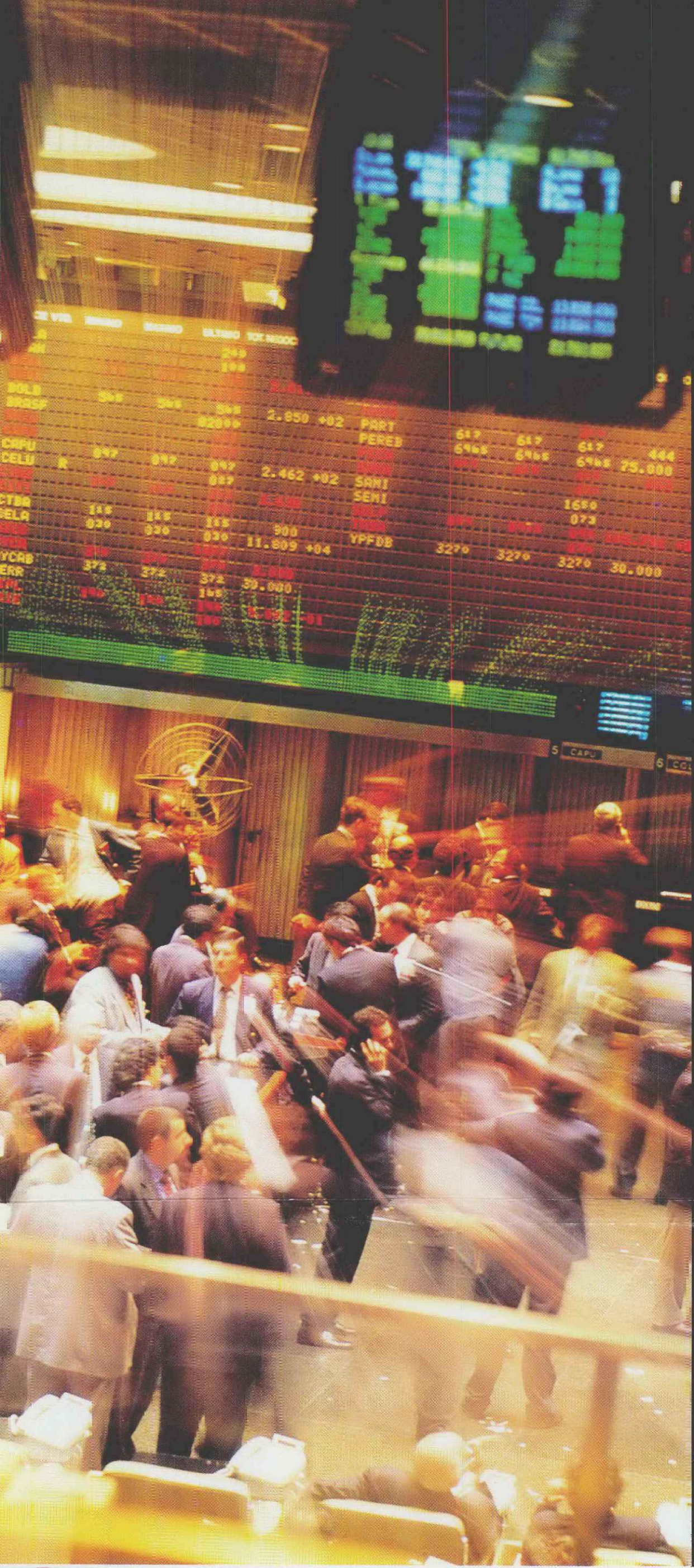
- CEBS Course 3—Retirement Plans: Basic Features and Defined Contribution Approaches
- CEBS Course 4—Retirement Plans: Defined Benefit Approaches and Plan Administration
- CEBS Course 7—Asset Management

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- Number of employees:

1 ☐ 150 or fewer	3 ☐ 500-999	5 ☐ 5,000 or more
2 ☐ 151-499	4 ☐ 1,000-4,999	6 ☐ Unknown
- My title is best defined as:

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Continued from page 28

■ A bulletin from Buck Consultants Inc. discusses the **automatic election concept** in response to a recent ruling by the IRS to find automatic or negative elections under a qualified 401(k) plan permissible. Request item 512.

■ Employee benefit provisions of the **IRS Restructuring and Reform Act of 1998** are covered in a bulletin by Buck Consultants Inc. Request item 513.

■ Buck Consultants Inc. offers a guidance bulletin issued on the **Newborn's and Mother's Health Protection Act of 1996**. Request item 514.

■ An analysis discussing the Medicare program and the latest changes to the program as enacted in the **Balanced Budget Act of 1997** are

covered in a bulletin by Buck Consultants Inc. Request item 515.

■ Insights into the decisions faced by employers that consider offering **domestic partner benefit coverage** can be found in a bulletin by Buck Consultants Inc. Request item 516.

■ The **Certified Employee Benefit Specialist** Program offers a descriptive catalog containing information and forms for enrolling in the CEBS program, a 10-course program in employee benefits. Request item 517.

■ Child & Elder Care Insights Inc. offers a collection of statistics, corporate report summaries, and other documentation supporting the basis of why **work/life programs** are successful and growing in corporate America. Request item 518.

■ Deloitte & Touche L.L.P. offers a pamphlet on how to succeed in **integrated health disability**, and workers compensation benefits. Request item 519.

■ Hewitt Associates L.L.C. offers a booklet highlighting current research, business successes and innovative thinking on people-related topics with the intent to help employers maximize their own **HR/workforce capabilities** and overall business results. Request item 522.

■ Research about companies that are successfully creating an ownership culture through **employee ownership** is available through Hewitt Associates L.L.C. Request item 523.

■ The International Foundation of Employee Benefit Plans offers a catalog of **employee benefit books** the IFEBP has to offer for 1999. Request item 524.

■ An International Foundation of Employee Benefit Plans catalog details all the **employee benefits educational opportunities** the IFEBP has to offer for 1999. Request item 525.

■ A survey of multi-employer health fund administrators providing information about the **types of health plans currently offered by multi-employer funds** can be obtained from the International Foundation of Employee Benefit Plans. Request item 526.

■ The International Foundation of Employee Benefit Plans offers a survey of **Internet and intranet use by employee benefit professionals** concentrating on communicating employee benefit plan information. Also included are cost issues and concerns. Request item 527.

■ The International Society of Certified Employee Benefit Specialists offers a quarterly magazine providing a comprehensive over-view and detailed analysis of the major **trends and issues in the employee benefits industry**. Request item 528.

■ Martin-Dennison Press offers a pamphlet describing how employers can solve their workforce **absenteeism problems** by using self-scoring self-assessment questions. Request item 530.

■ Meridian Resource Corp. offers a description of **diagnostic-related group reimbursement methodologies** and why a DRG validation program is essential for cost containment. Examples of diagnostic-related group validation audits are included. Request item 531.

■ Prosource Financial L.L.C. offers

Continued on page 32

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Continued from page 30

a newsletter on current trends and legislative action for **employee benefits**. Request item 532.

■ The Segal Co. offers a 1999 calendar indicating **general reporting and disclosure requirements** applicable to employee pension and welfare benefit plans on an annual basis. Request item 533.

■ A report of changing **trends in benefit costs**, including employer health care, defined pension and retiree health care plan expenses, is available from T.E. Brennan Co. Request item 534.

■ A newsletter by T.E. Brennan Co. explores the pros and cons of the consulting business, explaining **methods of choosing a consultant** and ways to work with that consultant for optimum success. Request item 535.

■ A booklet describing the effects of

changes in the structure and administration of **health, disability and workers compensation benefits** is available from Tillinghast-Towers Perrin. Request item 536.

■ A survey by Watson Wyatt Worldwide addresses how employee benefit programs can be used strategically to **align workforce behaviors to employers' business goals**. Industry-specific reports are also available. Request item 537.

■ Westport Benefits L.L.C. offers a pamphlet containing information about **serious-illness insurance** and descriptions of sample policies. Request item 542.

■ A booklet offering suggestions for the effective implementation of an integrated approach to **workplace disability and workers compensation** is available from Willis Corroon Corp. Request item 543.

■ Duncanson & Holt Group offers a comprehensive overview of **long-**

term care insurance, discussing topics such as underwriting, claim administration, policy design and marketing. Request item 546.

EMPLOYEE BENEFIT INFORMATION SYSTEMS

■ Information Products Inc. offers a booklet giving an overview of **interactive voice response technology**, with descriptions of IVR computerized systems and a glossary. Request item 601.

■ A Watson Wyatt Worldwide survey on **virtual human resources technology** highlights trends reported by more than 460 companies in seven countries. The report discusses how companies and their employees utilize the World Wide Web to conduct human resources transactions online. Request item 602.

FINANCIAL SERVICES

■ Watson Wyatt Worldwide offers a study that can help employee benefit managers evaluate the advantages and drawbacks of granting large amounts of **employee stock op-**

tions. Request item 802.

■ Hershey Financial Group offers a commentary on **trends in insurance and financial services** firms compete for business. Request item 803.

■ Structured Financial Associates Inc. offers software that present the basic definition and technical functions of **structured settlements** in an individual claim. Request item 805.

INTERNATIONAL

■ Aetna Global Benefits offers a list of **usual and customary benefits** for more than 50 countries. Request item 901.

■ A Baker & McKenzie newsletter discusses worldwide developments on **labor, employment and employee benefit issues**. Request item 902.

■ Globex International Inc. offers a newsletter on laws and trends facing **employers with international operations**. Request item 903.

■ Hewitt Associates L.L.C. provides an executive summary on how global companies can use employee benefits, among other tools, to **attract, develop and retain the best managers**. Request item 904.

■ Watson Wyatt Worldwide features a quarterly magazine that discusses **benefits management issues**, global research conducted by Watson Wyatt, Web sites as well as other resources. Request item 908.

■ Employers Reinsurance Corp. offers a brochure on the different approaches of the 11 European Union countries **adopting the euro** and its implications for insurance

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■ Duncanson & Holt Group offers an overview of **long-term care insurance**. It includes discussions of demographics, government programs and private insurance. Request item 910.

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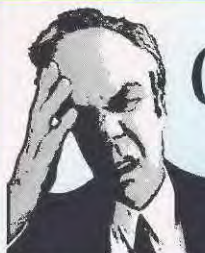
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Data

Continued from page 2

Similar requests, however, have been denied for a variety of reasons—at least for the short term—by Arkansas, Georgia and Wisconsin, according to the American Insurance Assn.

In the 22 states where the National Council on Compensation Insurance serves as insurers' agent for proof-of-coverage reporting, "the information reported for each employer always includes the name of the carrier and the policy expiration date, and often includes additional information like the employer's total payroll and number of employees," according to a statement by Bill Schrempf, president and chief executive officer of the NCCI in Boca Raton, Fla.

The DataLister spokesman said that somewhat similar information from seven states with independent rating organizations already is being sold through the Insurance Bureau Bulletin Board Service Network, an electronic resource for information and statistical data on workers comp insurance.

The information that IBBSnet is selling includes the Workers' Compensation Insurance Rating Bureau of California's summary of employers' experience rating modification factors. The other six states are Delaware, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania.

Proponents of releasing compliance information for commercial use emphasize the advantages of encouraging increased competition in the marketplace.

The DataLister product, which consists of cleaned-up and enhanced data and "a robust" search engine, "heats up competition in states between insurance companies and insurance agents for employer workers compensation accounts," the DataLister-

spokesman stated.

An agent may be able to search by a variety of categories, including key policy date, industry codes, geographic location, insurers and number of employees, according to the company's Web site. "This enhanced competition lowers prices and delivers greater value to employers," the spokesman said.

The DataLister product has been available since 1995, though the company was not incorporated until January 1998, according to information based on a Dun & Bradstreet Corp. background report. The company, which has about \$300,000 in annual sales, employs eight people and has 250 to 300 accounts, the spokesman said in an interview.

Opponents of releasing such information say it infringes on several fundamental concepts, including employers' privacy, insurers' trade secret protections and independent agents' legal rights to future renewals.

Two workers comp observers said they initially see more harm than good from the availability of such employer-specific information.

Revealing even such minimal information could give an industry competitor an edge, said Eric J. Oxfeld, president of UWC Inc., a Washington-based business advisory and research organization.

Even the most basic information, such as the timing of coverage renewal, could be significant, for example, if it revealed that the employer was having to shop for coverage during a hardened market, Mr. Oxfeld said. In addition, an employer's class code could be significant if it revealed overhead costs, he said.

"While the business community is generally a strong advocate of competition, there is fair and unfair competition," he said. "Anything that would move away from the confidentiality of proprietary

Continued on next page

Continued from previous page
information in the name of competition is something that needs to be examined closely," he added. Mr. Oxfeld said his comments reflect his own opinion and not those of his members, because he has not surveyed them on the topic, he said.

"From a risk manager's standpoint, I'm not sure that I would want unsolicited bids coming in during my renewal period based on information from proof-of-coverage filings," said Lance Ewing, director of insurance and loss prevention for GES Exposition Services in Las Vegas and chair of the Risk & Insurance Management Society Inc.'s external affairs committee.

"There is plenty of competition in the soft market without adding another tool to the box that agents and brokers have," he said. "I want to be able to pick and choose who brings proposals to me without getting spammed by unsolicited bids," he said.

Most of his risk manager acquaintances will think that way, too, he predicted. The issue, however, is new to him and the RIMS committee. He plans to place it on the committee's fall agenda.

Workers comp insurers are among the most vocal opponents of releasing employers' proof-of-coverage information to a private company for other commercial purposes.

"The scope of the information available and the openly commercial purpose for which it is obtained raises a question as to whether competitively sensitive information submitted to a public agency for statutory compliance purposes is automatically transformed into public information, thereby effectively nullifying a state's trade secrets protections,"

said Bruce C. Wood, assistant general counsel with the American Insurance Assn. in Washington.

"Carriers have expressed the view that disclosure of the contents of the proof-of-coverage database for commercial purposes would result in unfair competitive injury to the insurers submitting the information," according to the NCCI's Mr. Schrepf. "We have requested state agencies to classify the proof-of-coverage database as confidential commercial information not subject to public disclosure, unless clearly required by law," he said. In addition, the NCCI has begun adding a note to all submissions to state agencies stating that "This material contains trade secret, confidential and proprietary information and may not be transmitted to a third party or publicly disclosed."

The controversy already has sparked a court case in Arizona.

"We historically considered that

information to be confidential, but after careful scrutiny of Arizona law, we could not find any state basis for that policy of confidentiality," said Larry Etchechury, director of the Arizona Industrial Commission in Phoenix. However, "I don't feel comfortable with being the vehicle for that release of the information. I just don't think it is right."

The National Assn. of Independent Insurers objected to the release of the information, and a Maricopa County (Ariz.) Superior Court issued a temporary restraining order in June preventing the Industrial Commission from releasing insurers' proof-of-coverage information to private organizations for a commercial purpose. A trial is scheduled to begin next month.

Utah's labor commissioner is expected to decide in mid-August whether to release similar informa-

tion that DataLister has requested.

The issue is a particularly tough one for agents' groups to resolve.

"There is no question about it that agent groups are torn between wanting to protect their clients and their own asset and wanting to compete," said Patricia A. Borowski, division vp with Alexandria, Va.-based National Assn. of Professional Insurance Agents.

Given an independent agent's legal right to a policy's subsequent renewals, the national Independent Insurance Agents of America Inc. is "upset and distraught and feels it is a violation of the property of independent agents and insurers currently writing the coverage," said Todd Muller, assistant vp of consumer and technical affairs. He may ask the board to take an official position on it.

However, at least one independent state affiliate of the IIAA has accepted as an associate member

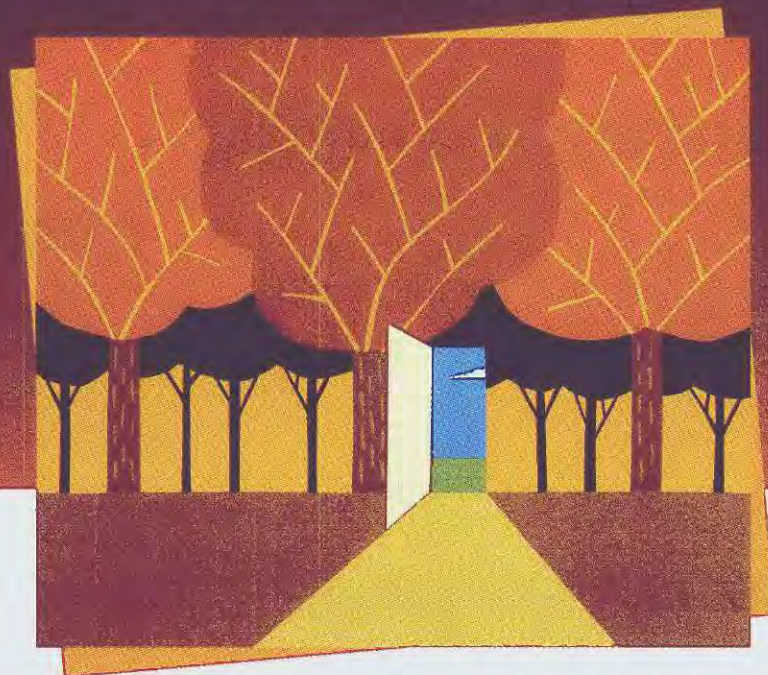
IBBSnet's vendor. This permits IIBSnet to use the IIAA's logo on its literature, said Tim Tucker, the IIAA's senior state government affairs representative.

"This kind of issue has been evolving steadily" during the past 10 years as computer search capabilities have expanded and now "is a burgeoning problem," Ms. Borowski said.

"The fundamental question is: When does something stop being public record because you have changed the character and purpose of it?"

The International Assn. of Industrial Accident Boards & Commissions "certainly has had a lot of inquiries from administrators about how other states have handled such requests," said Jamie Beletz, executive director in Lawrence, Kan. He plans to discuss the issue with the National Assn. of Insurance Commissioners soon. **[B]**

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Global Briefs

Hartford, Conn.-based **The Hartford Financial Services Group** is expanding its reinsurance operations in Europe. HartRe Co. L.L.C., Hartford's reinsurance arm, is opening a new Paris-based subsidiary under the management of Francois Lanoote to write reinsurance for companies in France, Luxembourg and Belgium. HartRe also is starting a Milan, Italy-based operation and has appointed Marco Ghio as general manager of that operation. The moves in France and Italy will increase The Hartford's number of European operations to five. In addition, HartRe is planning to expand its London marine reinsurance business, and John A. Miklus, senior vp-marine, will be joining the London operation this fall. . . . London-based broker **RK Harrison Insurance Brokers Ltd.**, recently the subject of a management buy-out from Hiscox Harrison Group, has been registered as a Lloyd's broker. RK Harrison Chairman Richard Corfield said the Lloyd's broker status "will enable us to expand our interest into new lines of business, including international areas." . . . Richard Harris has been appointed senior vp and head of risk finance at **AIG Europe (U.K.) Ltd.**, based in London. He most recently was chief operating officer for AIG Credit U.K. . . . London-based rating agency **Standard & Poor's** has revised its outlook on Union-america Insurance Co. Ltd. to stable from negative and has affirmed the insurer's "A" financial strength rating. S&P's decision was based on London-based Unionamerica's strong position in the U.S. professional indemnity insurance and reinsurance markets, its very strong operating performance and its strong and improving capitalization, according to the rating agency. . . . The scheme administrators for **OIC Run-Off Ltd.**, formerly The Orion Insurance Co. P.L.C., and The London and Overseas Insurance Co. Ltd. have increased the scheme of arrangement payments to 25%, up 5% on the previous level. At the end of last year, the two defunct insurers had estimated total assets of \$1.6 billion and estimated liabilities of \$2.3 billion. . . . Risk management consultant Liz Taylor has been appointed the first full-time chief executive officer of the **Assn. of Local Authority Risk Managers** in the United Kingdom. Before becoming a consultant, Ms. Taylor was group risk management and operations director for Equifax P.L.C., and she is a former chairman of the Assn. of Insurance & Risk Managers. . . . London-based Catlin Underwriting Agencies Ltd. is to open a **Singapore office** by the end of the summer. This will be the Lloyd's of London underwriting agency's first overseas office and will write a mixed book of business similar to that of the agency's Lloyd's syndicates 1003 and 2003. Both the Monetary Authority of Singapore and Lloyd's regulators have approved in principle the operation, to be known as Catlin Asia Pte. Ltd. . . . **Richard Carver**, former director of non-marine reinsurance at Odyssey Re (London), is to join St. Paul Syndicate Management Ltd. in London as underwriter for syndicate 314. . . . Liberty Syndicate Management Ltd., the Lloyd's managing agency arm of Liberty Mutual Group of Boston, has announced **John Dunn** will join the agency as finance director at the beginning of next month. . . . **QBE Underwriting Agency Ltd.** is restructuring its Lloyd's operations from the beginning of next year. Instead of operating separate syndicates, the Australian-backed organization will run the business under a new umbrella syndicate, with the current two syndicates, 1223 and 2724, operating as subsyndicates. In addition, QBE will start a new subsyndicate underwriting non-marine reinsurance, underwritten by Mark Harrington, at the beginning of 2000.

Record fine for U.K. train crash signals get-tough stance: HSE

By CAROLYN ALDRED

LONDON—Great Western Trains Co. Ltd. must pay a record fine of £1.5 million (\$2.4 million) for a 1997 railway accident that killed seven people and injured 147 others, an Old Bailey judge ruled last week.

The fine exceeds the previous record for health and safety violations of £1.2 million (\$1.9 million), which was imposed at the Old Bailey earlier this year on construction company Balfour Beatty for the collapse of tunnels at Heathrow Airport (*BI*, April 12).

"This prosecution and record fine sends a vital message to the railway industry: Safety must come first," said Jenny Bacon, director general of the Health and Safety Executive, a government agency responsible for monitoring health and safety at work.

"The case is a warning to railway companies and industry generally: Lip service and token gestures are not enough. Safety, like any other aspect of a successful business, must be properly managed," Ms. Bacon said.

A charge of corporate manslaughter against the rail company was dropped in early July, when the prosecution was unable to prove gross negligence by one person in a position of responsibility, as required under existing corporate manslaughter law. The dropped charge led to calls for a change in the law (*BI*, July 12).

Richard George, head of the rail division of FirstGroup P.L.C., GWT's parent company, and former director of health and safety for the company, responded to criticism over his failure to attend the hearing by explaining that his absence was due to legal advice and not "a lack of remorse for the appalling loss of life."

No other comment was available from the company.



GRAPHIC BY JOHN HALL

Separately last week, London Underground Ltd. was fined £300,000 (\$479,100) at Isleworth Crown Court following the death of a passenger who fell between two cars of a subway train from a station platform Dec. 30, 1996. The blind spot on the platform had not been identified and corrected by LUL, and the train driver did not see the passenger.

Vic Coleman, Her Majesty's inspector of railways for the HSE, welcomed both verdicts. "Safety is vital—it is too important to be ignored or marginalized," he said.

Enterprise risk management utilized

Competitive market means power companies must consider new exposures

By MARIA KIELMAS

LONDON—The deregulation of electricity companies in Europe and the United States has created new companies that are embracing new approaches to measuring and managing risks on an enterprise-wide basis.

As power utilities move from operating as monopolies that earn low but stable incomes, into a market where they must compete for customers and capital, both the nature of the risks they face and how they manage those

risks is changing dramatically.

The enterprise approach to risk management involves looking beyond hazard risks to also consider other exposures, such as operational, legal or market risks. This approach typically reviews how this wider range of risks affects a company's earnings and how risks can be better managed to increase shareholder value and achieve the company's strategic objectives.

Power utility risk managers from the United States and Europe, bankers, insurers and

consultants discussed the measurement and management of these risks at a conference titled "Enterprise Risk Management in Energy and Power," held last month in London.

"The transition from regulation to competition is a major shift which is changing the ways electric utility companies create shareholder value," said Remy Schosmann, principal at London-based Strategic Decisions Group, a consulting firm specializing in enterprise risk management.

See *Enterprise* on next page

Credit risk growing for utilities

Deregulation leading companies to plug into risk management

By MARIA KIELMAS

LONDON—Deregulation of electrical utilities on both sides of the Atlantic has created a large number of new companies that have little or no credit history themselves, and little or no experience managing customer credit risk.

In particular, the growth of entirely new types of electrical companies, such as wholesale power marketers, creates new cus-

tomers and many unknown risks and exposures for buyers and sellers in the privatized electrical industry.

In Europe, the management of credit risks will be a major undertaking for the industry, said Richard Hunter, senior director at the London office of credit rating agency Fitch IBCA.

In the old system of state-run power utilities, a utility's credit risk was restricted to the risk of non-payment by a small

number of customers in a captive market, Mr. Hunter explained. A power utility could always simply cut off service to those non-payers and not worry about the small loss of revenue.

Robert Heller, chief risk officer of Chicago-based Commonwealth Edison Co., a division of Chicago-based Unicom Corp., said that attitude used to be evident at his company.

Mr. Heller recalled that one senior executive at Commonwealth Edison's first risk management committee meeting said:

See *Credit* on page 37



New Cap Re liquidation recommended

SYDNEY, Australia—Facing estimated losses of \$200 million, Australia's New Cap Reinsurance Corp. Ltd. should be liquidated, the reinsurer's administrator recommends.

John Gibbons of the Sydney-based accounting firm of Ernst & Young Australia, was appointed by New Cap Re in April to administer the company's underwriting business, which had estimated 1998 losses of \$140 million (*BI*, May 3).

New Cap Re, established in December 1996 with \$200 million in capital, underwrites from Bermuda and Sydney. The reinsurer's holding company, New Cap Reinsurance Corp. Holdings Ltd., is based in Hamilton, Bermuda, and is being liquidated by the Bermuda Registrar of Companies.

In a report to New Cap Re creditors last week, Mr. Gibbons recommended liquidation as the "most appropriate course of action" for the reinsurer's Australian underwriting business.

He said the recommendation is based on the size of New Cap Re's losses and the potential for creditors to achieve returns and pursue recovery actions.

New Cap Re creditors, which are mainly foreign insurers that are cedents of the reinsurer, are expected to vote on Mr. Gibbons' recommendation at a meeting in Sydney this week.

Mr. Gibbons estimates New Cap Re's Australian losses are now "in the vicinity of \$200 million." That figure does not include the losses of the reinsurer's Bermuda parent

company.

New Cap Re's losses stem from a string of 1998 disasters, including hurricanes, airline crashes and satellite failures.

Mr. Gibbons said liquidating New Cap Re is more advantageous than a scheme of arrangement, which would see the company wound down and placed in runoff, as liquidation allows more rights for recovery actions through the courts in the United States and the United Kingdom.

"A liquidator is likely to have greater recognition to recover assets than an administrator in these jurisdictions," he said.

Mr. Gibbons estimates liquidating New Cap Re could give creditors a potential return of 15 to 50 cents on the dollar.

—By Matthew MacDermott

Enterprise

Continued from previous page

In the past, utilities were answerable mainly to a government regulator that determined the rates they could charge. Their markets were like fortresses and returns were dull but reliable, noted Mr. Schosmann.

In deregulated markets, competing power companies have or soon will have access to power transmission networks, giving them access to a utility's formerly captive market, Mr. Schosmann said. The unregulated potential for big returns is exciting but also more risky, he added.

In the United States, the 1992 Energy Policy Act established the principle of deregulation and open access to electricity transmission networks. This initiated new competition in the wholesale marketing of electricity.

In the European Union, a deregulation directive called for open access to E.U. electricity transmission networks beginning in February of this year.

The pace of deregulation varies by country, however. The United Kingdom liberalized its electricity market

completely in the late 1980s, when the former state-owned monopoly was privatized, while France, whose market still is served by a state-owned monopoly, has yet to pass legislation implementing the E.U.'s directive.

The electricity companies in the United States and the European Union are facing very special challenges right now because these new deregulated markets are immature, the risks they face are complex and they have a price volatility unheard of in other asset classes, said Chris Harris, risk manager at London-based National Power.

"The fact that there is a market means that there is volatility, and the fact that it is immature means that it is difficult to get a hold of any hedge product, let alone the right one," he added.

Risk managers, though, have a growing number of enterprise risk management solutions available, including insurance and other risk financing tools, he noted.

"These must be reinterpreted as traded products, couched in the language of derivatives," Mr. Harris said of such solutions. Whether a market risk is traded or securitized de-

pends on the amount of price information that is available, he added.

"If it moves, price it," suggested Martyn Turner, director-energy derivatives at the London office of Frankfurt, Germany-based Deutsche Bank.

In the kind of complex environment faced by the electricity utilities in a deregulated market, it is important for risk managers to be able to model future risk scenarios and re-create past ones to gain an understanding of risks, Mr. Turner said.

Adopting a comprehensive enterprise risk management approach can

The unregulated potential for big returns is exciting but also more risky for power companies, says Remy Schosmann.

be a powerful tool for lowering a utility's risks and creating value, according to Mr. Schosmann. Such an approach lowers the cost of risk through the identification of things driving risk and focuses on risk mitigation, making for easier risk transfer solutions, he explained. "This is not rocket science. It is a discipline."

Companies must be able to measure their operational risks properly and have an understanding of those critical risks they face, said John Park, group insurance manager and risk adviser at Cardiff, Wales-based electricity and water utility Hyder P.L.C. "There is a need to win the hearts and minds of all managers, not just senior management, so that unnecessary risks are not taken," he says.

Mr. Park explained that for his company, which employs 9,000 people, it was necessary to infuse an enterprise-wide culture of understanding risk encountered daily. He cited, for example, an employee who mistakenly grabbed a live power cable with both hands and lost his arms.

Hyder's system is to identify operational risks in a number of different categories, such as people risk, technological risk, regulatory risk, physical risk and liability risk, and subdivide each risk further, he said.

Under technological risk, the company must ask itself if it is moving too fast with technology and if it is too dependent on technology, Mr. Park explained. Regulatory risks are subdivided into utility price reviews, increasingly harsh regulatory or environmental standards, new legislation, and competition.

The deregulated marketplace has created plenty of new risks for existing utilities, as experienced by Com-

monwealth Edison Co. in the summer of 1998, explained Robert Heller, chief risk officer of the Chicago-based utility, a division of Unicom Corp.

ComEd serves about 3.5 million customers in the Chicago metropolitan area and owns the largest amount of nuclear power generating capacity of any U.S. utility, he said.

Mr. Heller described how in June 1998 three of its 10 nuclear plants were out of service for planned maintenance when unseasonably high temperatures led to an unexpected surge in power consumption, driven largely by air conditioning machines (BI, July 6, 1998).

The company's power supply was further constrained when tornadoes hit transmission lines and power plants in the Midwest, leading to power shortages.

ComEd and other utilities were forced to buy additional power on the wholesale market; their cost for this emergency supply skyrocketed, in some cases more than 1,000%, compared with normal costs.

ComEd incurred losses equivalent to \$1 to \$1.50 per share because of its expenses in buying additional power supply to meet the demand crunch.

Coincidentally, at the same time ComEd was facing this serious shortage risk, the company was busy setting up a risk management committee. Mr. Heller said the losses it incurred from the shortages prompted an executive on the committee to remark about risk management: "It seems like we're swatting flies while the elephants run by."

For utilities whose production depends on weather conditions, the modeling and forecasting of such risks is a major undertaking.

Thorstein Jenssen, director of Hydro Energy, the energy subsidiary of Oslo, Norway-based Norsk Hydro A/S, said fluctuations in electricity production are due almost 100% to the weather.

Hydro Energy tries to model its worst expected profit shortfall due to the weather through adapting the value-at-risk statistical analysis methods, Mr. Jenssen explained.

VAR was developed initially by analyzing a corporation's physical assets at risk, but the utility has adapted it to also take into account profits and cash flow at risk. For example, Hydro Energy could try to balance a likely weather pattern with the company's profits and energy output as well as its cost of purchasing hedges against a hot summer.

Hydro Energy also relies on extensive computer modeling to look at possible loss scenarios.

It is important that risk managers also realize that the risks they are trying to manage could have a natural hedge, according to Mr. Schosmann

of Strategic Decisions Group.

He cited a telecommunications company that for years had bought an insurance policy covering it against property damage and loss of profits due to extreme weather conditions. After years of paying insurance premiums with no losses, eventually extreme weather arrived, downing phone lines and interrupting service.

After the catastrophe, however, "people were calling each other like crazy," Mr. Schosmann said. As a result, the company made more money because of the inclement weather.

There was a natural hedge in the company's business, and the insurance was never really necessary, he explained. He suggested that there are also natural hedges for power utilities, but they have to find them.

The emergence of electricity trading companies also has redefined the concept of utility risk management, said Thain Grant, senior vp-risk management of Boston-based Citizen's Power. In the late 1980s, this company pioneered the business of buying and selling electricity it did not generate.

"Basically we are a trading company. We don't own any assets," he said.

The old model of risk management was seen as too pessimistic. "The idea was, we'll employ someone who will worry about the downside all the time and tell people about it," he said.

Instead, the risk management strategy that Citizen's Power employs addresses the objectives of the company, considers why and what is traded, its capital at risk, how this risk capital is measured and allocated, and the relationship between risk and reward.

In a commodity business such as electricity trading you cannot trade without taking risk, and you should not trade without understanding how much risk you are taking, he said.

William Baker, senior consultant-energy for London-based consultants Infinity, gave a list of financial disasters that occurred when traders of various types did not heed of their exposure limits:

- Misunderstanding market risk in 1993, German trading company Metallgesellschaft lost \$1.3 billion when oil prices fell. It had built a large position in oil futures and hedged with forward contracts it had sold.

- The London-based Barings Bank was bankrupted in 1995 through unauthorized trading in Singapore, because inadequate operational risk controls were in place.

- In 1998, European banks especially lost hundreds of millions of dollars in the wake of the Russian devaluation crisis, a misunderstanding of country risk.

"It's only a matter of time before an energy-specific (disaster) happens," Mr. Baker said. **BI**

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INTERNATIONAL

Credit

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"We're a \$7 billion corporation; do we really care if we have to charge off half a million dollars in credit losses?"

That stance may have worked when customers had no other alternatives, but with deregulation come multiple power company choices, as well as more opportunities for these utilities to be burned for non-payment as their margins shrink. For wholesalers the client now may be a retail electricity distributor, many orders of size larger than a mere homeowner not paying his bills.

Utility investors and risk managers no longer can believe in the myth of a regular income stream, as was previously the case for monopo-

listic utilities, Fitch IBCA's Mr. Hunter said.

He predicted that complacency about customer credit risk among privatized utilities in Europe will continue until a company experi-

Fitch IBCA, do not provide the kind of information that utility risk managers need in the new power markets to assess the creditworthiness of clients. Bond rating agencies instead rank a company's ability to meet its

Complacency about customer credit risk among privatized utilities in Europe will continue until a company experiences a major loss, predicts Richard Hunter.

ences a major loss, perhaps even causing the utility to default on bond payments.

Bond rating agencies, such as

obligations to the capital markets. "Companies will always meet those obligations first rather than trade obligations," he said.

Some rating companies, such as Dun & Bradstreet Corp., do provide credit information on private companies that could help a company assess creditworthiness, he noted.

Another risk facing these companies is regulatory risk, especially as governments come to terms with how to regulate the evolving new power markets.

The European Union, for example, has left much of the regulation to be developed by member nations, some of which have been slow to adopt the E.U. deregulation directive and break up their national power companies.

"The E.U. directive is a framework of the bare minimum acceptable, and national governments can choose how it is implemented," Mr. Hunter said.

In the United States, each state

may choose how to restructure its power markets.

In this period of transition, the political, economic legal and regulatory framework can change at very short notice.

"Established trading partners will undergo profound changes and alter your exposure," Mr. Hunter said.

In Central and Eastern Europe, he warned, what may appear as cash on a utility's income statement may not be cash at all. As some of the post-communist economies are cash-poor, many utilities receive payment in kind from their customers, such as in chickens and steel girders.

"They do not distinguish between this and cash," said Mr. Hunter, but warned further, "every company in the world has its chickens. The numbers on the accounts are not what they appear to be."

Practical advice for changing culture

By MARIA KIELMAS

Risk management concepts need to be introduced in practical, understandable ways if they are to be embraced, says a utility executive.

Paddy Purcell is the group internal auditor at the Electricity Supply Board, a state-owned company in Dublin, Ireland. Mr. Purcell, speaking at last month's Enterprise Risk Management in Energy and Power conference in London, described an innovative yet down-to-earth way that his department developed a new culture of risk management at his company.

Mr. Purcell explained that new concepts of risk have been hard to introduce into utilities, where risk management traditionally has been based on the analyses of engineering events or financial models. For example, when ESB's group internal audit department

took on the job of corporate risk analysis in 1992, its findings were not implemented by any of ESB's business units.

The problem, Mr. Purcell said, was that line managers in the units had not provided input for the report. Furthermore, the internal audit department report did not address business planning.

"So, it didn't make any difference. It just sat there for two years," Mr. Purcell said.

Then in 1994, the internal audit department decided the ESB needed a formal framework to incorporate risk analysis into corporate planning. The department's staff wanted the framework to be followed up by management, in the form of a written statement by the board accepting their responsibility for the process.

The first step was to develop a technical knowledge of risk with

See Culture on next page



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Culture

Continued from previous page

in the company. Each of the managing directors of the business units was asked to produce a risk report that would identify possible risks in his unit, calculate risks' probability and impact, draw up contingency plans and name an individual to be responsible for each risk.

"Different units used different approaches," Mr. Purcall said, but the common factor was that the managing directors brainstormed with groups within their units and used this input when producing their reports. The final risk reports, of varying quality, were delivered first to the chief executive officer, and only then to internal audit. The department did not have any

direct input into the reports, only providing advice to the business units when it was requested.

The business units' line managers, Mr. Purcall said, "were the people who know their business, whether it's fuel supply or financial penalties." Corporate management also produced a similar risk report.

ESB repeated the exercise in 1995, but the internal audit department gave more advice to the business units, and the reports improved, he said.

In 1996, the issue of corporate governance came to the fore at ESB following the publication in the United Kingdom of the Cadbury Code on Best Practice, which required boards to ensure that their companies had internal financial management controls.

"Managers were encouraged to

identify weakness and corrective actions," Mr. Purcall said. In addition, they commented on current risk controls. The audit department then took the managers' input directly to the company board. The ESB then produced its first board-approved corporate governance statement, in keeping with the Cadbury report.

Since 1997 and 1998, the internal audit department has stressed the integration of risk analysis and risk management into running EBS.

The business units have the same responsibility to produce the risk analysis reports as before, but their approach has improved. Now line managers use more-sophisticated statistical analysis techniques. "It was not forced on them by top management. They were doing it on their own initiative," Mr. Pur-

call said. The results have been formal governance statements written by line managers.

To promote financial reviews, a one-day workshop was conducted in each of the business units. Mr. Purcall sat in on the meetings but didn't say much, he recalled. After the assessments were complete, the financial controller of each business unit signed a statement addressed to the group financial director testifying that financial controls were operating effectively in his or her unit. The group accountant and the internal audit department formally signed off on the overall process to the group finance director.

In the area of corporate governance, the CEO requests statements from the business units' managing directors, who use input from the business units in the form

of monthly and ad hoc reports. The managing directors then report to the CEO, who, in turn, writes to the board of directors. The board then creates its own corporate governance statement based on these efforts.

Mr. Purcall said risk analysis will not succeed if the line managers' responsibilities are not clear. Furthermore, the analyses must cover the range of business risks, technical risks and political risks in each manager's unit.

The new concepts of risk have to be explained in terms line management can understand.

"If you speak to a line manager below the level of financial controller about value at risk, you have every chance of losing him. But if you tell him about engines breaking down, you start to make sense to him," Mr. Purcall said. **BI**

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UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK

IN RE PETITION OF PHILIP JOHN SINGER AND IAN DOUGLAS BARKER BOND,
AS JOINT PROVISIONAL LIQUIDATORS OF THE CHARTER REINSURANCE COMPANY LIMITED,
CASE NO. 99-B-44653 (CB)

NOTICE IS HEREBY GIVEN THAT, IN CONNECTION WITH THE PETITION FILED ON JULY 27, 1999 PURSUANT TO SECTION 304 OF THE BANKRUPTCY CODE FOR THE CHARTER REINSURANCE COMPANY LIMITED (THE "COMPANY"), PURSUANT TO AN ORDER OF THE UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK (THE "BANKRUPTCY COURT") DATED JULY 28, 1999, A HEARING WILL BE HELD ON AUGUST 6, 1999 AT 2:00 O'CLOCK P.M. BEFORE THE HONORABLE CORNELIUS BLACKSHEAR IN ROOM 601 OF THE BANKRUPTCY COURT, ONE BOWLING GREEN, NEW YORK, NEW YORK (THE "HEARING"), TO CONSIDER THE PETITIONERS' REQUEST FOR A PRELIMINARY INJUNCTION:

1. ENJOINING AND RESTRAINING ALL PERSONS AND ENTITIES FROM: (A) TRANSFERRING, RELINQUISHING OR DISPOSING OF ANY PROPERTY OF THE COMPANY IN THE UNITED STATES, OR THE PROCEEDS OF SUCH PROPERTY, TO THIRD PARTIES; (B) COMMENCING OR CONTINUING ANY ACTION OR OTHER LEGAL PROCEEDING (INCLUDING, WITHOUT LIMITATION, ARBITRATION, OR ANY JUDICIAL, QUASI-JUDICIAL, ADMINISTRATIVE OR REGULATORY ACTION, PROCEEDING OR PROCESS WHATSOEVER), INCLUDING BY WAY OF COUNTERCLAIM, AGAINST THE COMPANY, OR ANY PROPERTY IN THE UNITED STATES THAT IS INVOLVED IN THE FOREIGN PROCEEDING, OR ANY PROCEEDS THEREOF, AND SEEKING DISCOVERY OF ANY NATURE AGAINST THE COMPANY; (C) ENFORCING ANY JUDICIAL, QUASI-JUDICIAL, ADMINISTRATIVE OR REGULATORY JUDGMENT, ASSESSMENT OR ORDER OR ARBITRATION AWARD AGAINST THE COMPANY, AND COMMENCING OR CONTINUING ANY ACT OR ACTION OR OTHER LEGAL PROCEEDING (INCLUDING, WITHOUT LIMITATION, ARBITRATION, OR ANY JUDICIAL, QUASI-JUDICIAL, ADMINISTRATIVE OR REGULATORY ACTION, PROCEEDING OR PROCESS WHATSOEVER) OR ANY COUNTERCLAIM TO CREATE, PERFECT OR ENFORCE ANY LIEN, SETOFF, ATTACHMENT, GARNISHMENT, OR OTHER CLAIM AGAINST THE COMPANY, OR ANY OF ITS PROPERTY IN THE UNITED STATES, OR ANY PROCEEDS THEREOF, INCLUDING, WITHOUT LIMITATION, RIGHTS UNDER REINSURANCE AND RETROCESSION CONTRACTS; (D) DRAWING DOWN ANY LETTER OF CREDIT ESTABLISHED BY OR AT THE REQUEST OF THE COMPANY IN EXCESS OF AMOUNTS EXPRESSLY AUTHORIZED BY THE TERMS OF THE CONTRACT OR OTHER AGREEMENT PURSUANT TO WHICH SUCH LETTER OF CREDIT HAS BEEN ESTABLISHED; AND (E) WITHDRAWING FROM, SETTING OFF AGAINST, OR OTHERWISE APPLYING PROPERTY THAT IS THE SUBJECT OF ANY TRUST OR ESCROW AGREEMENT OR SIMILAR ARRANGEMENT IN WHICH THE COMPANY HAS AN INTEREST IN EXCESS OF AMOUNTS EXPRESSLY AUTHORIZED BY THE TERMS OF THE TRUST, ESCROW OR SIMILAR ARRANGEMENT;

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ALL PARTIES-IN-INTEREST OPPOSED TO THE PETITIONERS' REQUEST FOR A PRELIMINARY INJUNCTION MUST APPEAR AT THE HEARING AT THE TIME AND PLACE SET FORTH HEREIN. ALL PAPERS SUBMITTED FOR THE PURPOSE OF OPPOSING THE PETITIONERS' REQUEST FOR A PRELIMINARY INJUNCTION SHALL BE FILED WITH THE COURT WITH A COPY TO THE CHAMBERS OF THE HONORABLE CORNELIUS BLACKSHEAR AND SERVED ON CHADBOURNE & PARKE LLP (ATTN: HOWARD SEIFE AND JONATHAN BANK) SO AS TO BE RECEIVED ON OR BEFORE AUGUST 4, 1999 AT 5:00 O'CLOCK P.M. NEW YORK TIME. THE ORDER DATED JULY 28, 1999 AND SUPPORTING PAPERS WILL BE MADE AVAILABLE UPON REQUEST AT THE OFFICES OF THE PETITIONERS' UNITED STATES COUNSEL AT THE ADDRESS BELOW.

CHADBOURNE & PARKE LLP
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Louisiana city will appeal verdict

HOUMA, La.—The City of Thibodaux, La., will appeal a \$9.5 million award that a jury says must be paid to the victims of a 1996 rampage by a sheriff's deputy.

The state court jury earlier this month ruled that the city, its police department and former police chief were negligent in hiring Chad Louviere and later recommending him for the deputy's job with the Terrebonne Parish Sheriff's Office. The sheriff's office was assigned 10% of the blame for the incident, but had settled before the trial for \$1.5 million.

Mr. Louviere is serving two consecutive life terms in prison for raping a woman he pulled over in a traffic stop and then murdering a bank teller and raping three others during a 25-hour standoff at a bank.

Liability insurance that covers the city, the police department and former chief has limits inadequate to cover the award, according to defense attorney Dennis Phayer of the Law Offices of Alan A. Zaunbrecher in Metairie, La.

The coverage "may end up being an issue between the company and the insured," he said. The case will be appealed to the 1st Circuit Court of Louisiana in Baton Rouge, according to Mr. Phayer.

The city's coverage was written by Coregis Insurance Co. in Chicago, according to Bill Dodd, an attorney with the Houma, La., firm Weigand & Dodd, which represented the sheriff's office.

Mr. Dodd said the sheriff's office's \$1.5 million settlement was funded by a self-insured retention, a self-insurance fund run by the Louisiana Sheriff's Assn., and an excess insurer he was unable to identify.

St. Paul Re entering health reinsurance

NEW YORK—St. Paul Re, a unit of The St. Paul Cos. Inc., is making its first entry into the health reinsurance market with a new international health care unit.

The health care unit will focus on reinsuring health plans, health insurers, managed care organizations and other health care financing organizations outside the United States. Although the unit will consider business from U.S.-based companies, its primary focus will be on indigenous business in other countries, said a St. Paul spokesman. "Our market research and the research of other companies certainly is showing that

there are more growth opportunities in various market places internationally" than there are domestically, he said.

For instance, he noted the number of health insurance policyholders in Brazil has increased to 40 million from 30 million over the past three years.

The unit, which will be based in New York and headed by Joël Thompson, St. Paul Re's vp-treaty underwriting, does not expect to write a significant amount of business this year, said the spokesman.

St. Paul Re President James Duffy said in a statement, "As we evaluate these opportunities, we expect to grow in a measured, deliberate fashion over the next several years, adding to the diversity of our product mix."

The spokesman said St. Paul's primary competitors in the international health reinsurance market include Swiss Re Group; Munich Re Group; Hannover Re Group; Berkshire Hathaway/General Re/Cologne Re; ESG Re; Employers Re Group and Lloyd's of London syndicates.

Surcharge going down in Massachusetts

BOSTON—Massachusetts regulators are lowering a surcharge imposed on payments made to hospitals and ambulatory centers in the state.

Effective for bills paid on or after Oct. 1, the surcharge will be 3%, down from the current 5.06%. The surcharge is imposed on third-party claims administrators, insurers, health maintenance organizations, preferred provider organizations and employers nationwide that administer their own health care plans.

Revenues generated by the surcharge are used to fund a pool to reimburse hospitals for care provided to the uninsured (BI, Dec. 22, 1997).

The surcharge decrease was expected. State regulators said the surcharge was set higher initially because it was put in place later than expected. As a result, it had to be set initially at a higher level, as more revenue had to be collected over a shorter period of time. Once reduced, the amount of the surcharge should stay at about the 3% level for the next three years, said Katharine London, policy development manager at the Massachusetts Division of Health Care Finance and Policy in Boston.

"The surcharge collection process has gone well, and payers have been cooperative," she said.



Mr. Thompson

Massachusetts and New York are the only two states with laws requiring hospital bill surcharges to be directly paid by buyers of health care services.

Comings & Goings: Industry

Atlanta-based Crawford & Co. has named Grover L. Davis president and chief operating officer. He succeeds Archie Meyers Jr., who now is chairman and chief executive officer. . . Donald Waardenburg has been named president and CEO of Harrisburg, Pa.-based Merchants & Business Men's Mutual Insurance Co., an affiliate of Liberty Mutual Insurance Co. Mr. Waardenburg previously was underwriting vp.

Information in brief

Hartford, Conn.-based Hartford Steam Boiler Inspection & Insurance Co. recently acquired Structural Integrity Associates, a San Jose, Calif.-based engineering consulting and inspection services firm. Terms of the acquisition were not disclosed. . . Capital District Physicians' Health Plan Inc. has announced it will buy Kaiser Permanente's New York business. Kaiser recently announced it planned to pull out of the Northeast. Terms were not disclosed. . . Political risk insurer Sovereign Risk Insurance Ltd. has increased its limits and extended its terms of coverage. Sovereign will now offer coverage up to \$125 million for a single project—up from \$100 million—and its maximum coverage term is now 15 years, instead of 10. Sovereign was formed in 1997 to underwrite political risks on behalf of ACE Bermuda Insurance Ltd. and XL Insurance Ltd. . . New York Gov. George Pataki has re-introduced a bill that would allow New York-based mutual life insurers to form mutual holding companies. The state's General Assembly failed to pass a similar bill last year. . . The Centris Group, based in Costa Mesa, Calif. has completed the sale of its USF Re Insurance Co. unit to Folksamerica Holding Co. Inc., a wholly owned unit of Hanover, N.H.-based Fund American Enterprises Holding Inc., in a transaction valued at \$92.5 million. Separately, Centris is continuing discussions with interested parties regarding its potential sale, but the company would not release additional details. . . Chubb Corp. has completed its acquisition of Simsbury, Conn.-based Executive Risk Inc. in a deal valued at about \$850 million. . . The House of Representatives has approved the Regulatory Right-to-Know Act. The act would require the Office of Management and Budget to conduct cost-benefit analyses of federal regulations that have an economic impact of more than \$100 million annually.

Wrap-ups

Continued from page 2

Inc., a Los Angeles-based risk management consultant.

Generally, it is thought that construction projects need to be valued at \$100 million or more in construction costs to justify the administrative expense of using a typical wrap-up program. A wrap-up, including coverage for workers compensation and general liability insurance, for a construction project valued at less than \$100 million remains uncommon, Mr. Dale said during an Insurance Wrap-up Programs conference held last month in San Diego and sponsored by the New York-based Institute for International Research.

Detached home and high-rise condominium builders, however, increasingly are implementing wrap-up programs for general liability coverage only on projects valued at \$10

million to \$50 million, Mr. Dale said. The contractors and subcontractors in such projects still must buy their own workers comp coverage.

Wider use of "rolling" wrap-ups also is gaining steam. A rolling wrap-up is an insurance program that encompasses construction projects at several sites.

School districts, with construction projects dispersed among hundreds of sites, and residential home builders are fueling this trend, Mr. Dale said. The approach of combining of several smaller sites is generating broker and insurer interest in writing wrap-up coverage for smaller projects, he said.

But the practice also is adding to the complexity of wrap-up administration and oversight by introducing the need to manage several locations.

As the complexity grows, there is a shortage of construction safety managers experienced with wrap-ups to keep pace with the growth of these

programs, risk managers say.

"What I have found in looking throughout the United States is a shortage of construction safety professionals, specifically owner-controlled insurance program construction safety professionals," said Marge P. Layne, insurance manager for the San Francisco International Airport, which has a wrap up for its current construction plan (see related story).

To meet the airport's need for a safety construction professional, Ms. Layne promoted and trained an airport maintenance engineer for this role.

Training current employees in construction safety management responsibilities is probably the best way to overcome the shortage, said Craig J.T. Rochette, director-insurance and risk management for engineering and construction company Fluor Daniel in Greenville, S.C.

Writing guaranteed-cost insurance for wrap-ups is another continuing

trend, conference attendees and speakers said. That trend is fueled by underwriters who have found that wrap-ups can be very profitable for the underwriter and the owner, said Mark E. McGinnis, vp of construction practice for Marsh USA Risk & Insurance Services in Los Angeles.

Despite the growth of guaranteed-cost program offerings, owners who pay close attention to safety can still see profits under loss-sensitive wrap-up insurance programs, Mr. McGinnis said.

The implementation of contractor-controlled insurance programs, as opposed to owner-controlled programs, also continues to grow.

That trend has led to more risk managers working for large construction management companies, which offer CCIPs as an added service for construction sponsors in the private sector, the experts said.

But an even more recent development is the growth of partnership

programs in which the owner and the contractor share in the wrap-up's profits and losses, Mr. Rochette said. He referred to such programs as "PartnerCIPs."

The greatest growth in wrap-ups is occurring in the private sector, while their use remains steady among public agencies, Mr. Dale said.

"There is a gold-rush stampede to get into this business," and more brokers and insurers are getting into it, he added.

But Mr. Dale said he fears that such growth, combined with the growing incidence of smaller project wrap-ups, could lead to wrap-ups becoming less financially successful than their owners had hoped.

With smaller and less-sophisticated sponsors, and vendors just learning the practice, there is greater possibility that the quality of planning and analysis necessary to determine the feasibility and profitability of a project will diminish, Mr. Dale said.

Airport program gets off the ground

By ROBERTO CENICEROS

SAN DIEGO—A wrap-up insurance program is not for the faint-hearted, but a well-run program can be an exciting challenge and can broaden the pool of contractors available for a project, a risk manager says.

"Risk managers, as a rule, love to transfer risk," said Marge P. Layne, insurance manager for the San Francisco International Airport.

"Every time you look at anything, you figure, 'Who can I lay this on so we don't have to suffer any kind of loss,'" she said.

But a wrap-up, more formally known as an owner-controlled insurance program, requires a different mind-set, she said.

"You are taking on a tremendous amount of risk," she said. "You are

taking on the risk of every contractor and subcontractor who will come to work at your site," she said during a session at an Insurance Wrap-Up Programs conference last month in San Diego, sponsored by the New York-based Institute for International Research.

Ms. Layne is overseeing the OCIP for a \$2.4 billion master construction plan that is currently at its peak, with 45 major construction projects under way at the airport. These projects involve some 13 construction management teams overseeing 605 contractors and subcontractors with 4,000 workers. The projects include building a light rail, an international terminal and other airport facilities.

Workers compensation coverage for the airport OCIP is underwritten by Menlo Park, Calif.-based Argonaut

Insurance Co., while Lloyd's of London underwriters provide general liability coverage and Factory Mutual Insurance Co. writes builders' risk insurance.

The airport's OCIP provides \$100 million of general liability coverage for every contractor and subcontractor.

While the program provides first-dollar coverage for workers comp losses, deductibles for general liability and builders risk coverage are layered. There is no deductible for claims below \$100,000. For losses between \$100,000 and \$5 million, the per-occurrence deductible is \$2,500. The per-occurrence deductible is \$10,000 for any loss above \$5 million.

One of the airport's main goals by offering the OCIP is to make it easier for small, minority- and women-

owned businesses to afford to bid on airport projects, Ms. Layne said. In fact, of the 605 contractors working on various projects, 219 are either minority- or women-owned. The deductible structure helps meet that end.

Ms. Layne also worked on a wrap-up project for the San Francisco Bay area Rapid Transit District. But no two programs are alike, and OCIPs take a long time to implement, she advised.

When she first began work on the airport OCIP in 1994, she assumed her earlier wrap-up experience could be transferred easily to the new project. But it wasn't as easy as she had thought, as there is no boilerplate wrap-up plan that can be easily used for diverse projects, she explained.

To create the OCIP, Ms. Layne held



meetings with insurer representatives, contractors, brokers and staff. Each contributed a different piece of wrap-up experience to help solve the specific problems facing the airport.

"So you had a piece from a wrap-up here and another wrap-up there, and we created my wrap-up," she said. "Now we meet once a month, and it's for a half hour. It took us a year to put this program together."

Safety is a key element for a successful OCIP, Ms. Layne said.

"Contractors are responsible for the safety of their projects," she explained. And "we are responsible for

See Airport on next page

Airport

Continued from previous page

the safety oversight. It is amazing how much oversight you have to do on some contractors."

A general contractor's safety philosophy flows down through all of its subcontractors. For example, two different contractors are building identical airline boarding areas using the same subcontractors. Yet one contractor's loss experience is 10 times worse than the other's, she said.

If she were overseeing a project for a privately owned organization, rather than a public agency, Ms. Layne said she would more thoroughly scrutinize contractors' loss histories and also would implement a substance-abuse policy.

But she is not able to do those things because the airport's public agency status requires that it hire the lowest bidder, and San Francisco policies preclude her from implementing a substance-abuse policy.

But the airport's wrap-up still has a good track record, she said. Additionally, airport officials have said they would expand the OCIP to include potential future projects, such as a planned ferry terminal.

As part of the focus on safety, Ms. Layne's staff members and her broker's personnel regularly walk through construction sites with the contractors' safety professionals and point out potential problems.

The airport's contract documents

require all contractors to comply with any state, city, airport and federal requirements, Ms. Layne said. Each contractor must submit a job-specific safety program, which is reviewed by her safety personnel, who can accept or reject the program.

Some contractors assume her staff does not read the proposed safety programs, she said, and some have even submitted standardized safety program forms bearing the name of an entirely different contractor.

"We read every one of them," she said.

The eight employees in her department work as a team, crossing responsibility lines to help one another. If her department is having trouble obtaining payroll information necessary to track a contractor's workers comp activity, then her safety administrator may stop by the contractor's office during an inspection.

The airport also has a safety incentive program for contractors' employees. Based on the number of hours worked without a lost-time injury, the employees can earn belt buckles, caps, sweatshirts and a leather jacket with airport logos.

These incentives also can be used to prod contractors to provide their payroll data. When employees come looking for their belt buckles or caps, they might be told that they can't receive them until their boss supplies the necessary payroll data, she said.

"We have 4,000 contractors' employees running back to their shop, saying, 'Get that stuff in,'" Ms. Layne said. "It works." **BI**

Planning important to wrap-up success

By ROBERTO CENICEROS

SAN DIEGO—Failing to plan and implement a wrap-up insurance program early, before a construction project begins, can hinder the success of the coverage program, several experts say.

With early planning, the owner, contractors, broker and insurer can accurately evaluate a proposed project to ensure a wrap-up is financially advantageous. They can clarify the project's main goals and emphasize a safe workplace culture, the experts said during a panel discussion at an Insurance Wrap-up Programs conference in San Diego last month, sponsored by the New York-based Institute for International Research.

Yet sponsors of wrap-ups, also called owner-controlled insurance programs, sometimes wait until just days before scheduled groundbreaking to notify insurers that they are seeking coverage, said Bob Haskell, vp of underwriting for Argonaut Insurance Co. in Menlo Park, Calif. As a result, coverage details sometimes still are being worked out six months or a year after a project begins.

Much is lost in those situations, he said. The participants must play catch-up, leaving little time to outline all the benefits participants expect to glean from the wrap-up program. As a result, benefits such as cost savings, minority participation and public safety all will be diminished, Mr. Haskell said.

Rather than assuring safety programs are running smoothly, project managers instead will be attending to paperwork, enrollment procedures and other administrative details. The crucial early days of a project, when all the parties should be moving up a learning curve for safety lessons, will be lost.

"A couple of good pops early on in

the wrap-up and you could spoil the results," Mr. Haskell said.

It is common for a sponsor to tell the general contractor after construction has begun that the owner wants to implement a wrap-up program, said Craig J.T. Rochette, director of insurance and risk management for engineering and construction company Fluor Daniel in Greenville, S.C.



But Mr. Rochette advised listeners to remember that the contractor's main goal at that point is to complete the construction project according to specifications, on time and under budget.

"Anything that interferes with that is a problem for us," he said. "So if a wrap-up is brought in after we have an executed contract, after we have started work, and we are trying to back into that to capture payroll and get people enrolled, it injects a lot of confusion. It certainly upsets our subcontractors."

Contractor and subcontractor payroll information is needed for tracking workers compensation results.

Project sponsors also should determine in advance if there will be enough money savings to warrant a wrap-up program, Mr. Rochette said. There is no golden rule that a certain monetary value of a construction project automatically warrants implementation of a wrap-up program, he explained.

"The reality of the situation is you have to know what the job is, where

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Commentary

The real reason benefits work

It's a fact that most employees today fail to appreciate the benefit plans that their companies make available to them. They take them for granted or, worse, complain that they aren't enough; they want more.

It's like giving a child an ice cream cone, only to have the gesture rejected for being the wrong flavor.

This no doubt vexes most top executives, who probably think it's pretty grand that they offer health and retirement benefits at all. It's downright alarming to professional benefit managers whose jobs, after all, depend on managing these underappreciated programs.

To their credit, some companies are trying to rejigger these plans to make them more beneficial and, therefore, cherished by employees.

Many other employers, however, stubbornly resist the thought of throwing good money after bad, as far as investing in employee appreciation is concerned. They are skeptical that paying to redesign plans or boost health and pension benefits will pay the dividends they seek.

As a result, a growing number of companies are embracing other, cheaper "benefits" to win employee loyalty and respect. These other plans have the dual advantage of costing virtually nothing and also assuring that workers spend more time being productive.



Paul D. Winston

And, in a perverse twist, employees think of them as *real* benefits and are overjoyed to have them, even though in some developed nations they might be considered inalienable rights.

Yes, I am referring to so-called work/life benefits.

Let's examine some of these popular new programs, especially those that stretch the label "benefits" too far.

Take, for example, flexible scheduling. This is where companies offer workers the option to work twice as hard to get their job done in a fraction of the time. No matter that

these workers probably are doing something other than learning tai chi with their newfound leisure time. Before employers repackaged this as a benefit, it was variously referred to as "the night shift," "a part-time job" or "slave labor."

One of the more popular of this new breed of benefits is casual dress. This is where the company gives generously of itself to allow workers to dress as they would if they were not working. It's a state-of-mind thing that evokes the *joie de vivre* of working on the weekends. Many employees love it more than health insurance.

Speaking of health insurance, some consultants surprisingly count it among potential work/life benefits. I guess they are thinking that health insurance may come in handy for sustaining life, enabling an employee to work. Makes sense.

Child care is a huge focal point of work/life benefits. Most of these center on counseling on where to find caregivers so parents can work, creating onsite daycare so parents can work, hosting summer camps so parents can work and providing onsite schooling so parents can work. Enabling the worker bees to be so productive is a valued benefit. Scandinavians—who offer something like three years of paid maternity leave—are no doubt laughing at us.

Several companies offer quiet places for workers to relax or nap, and at least one company has pitched pup tents in its offices to allow workers to enjoy the benefit of snoring in the office. I guess workers no longer appreciate the old-fashioned "benefit" of going down to the company cafeteria, laying one's head on a Formica tabletop and nodding off. Ingrates.

We might soon see companies take this trend even further in an effort to ratchet up employee devotion, gratitude and, yes, productivity.

Consider, for example, calling heating and air conditioning a benefit (many workers don't have these conveniences, after all).

Or maybe electrical lighting? For the company that really wants a benefit that caters to workers' individual expression, the benefit could be structured to allow workers to bring their own lanterns, flashlights and candles to work.

Eventually, this strategy of repackaging routine expectations and marketing them to employees as new work/life benefits could yield greater appreciation of health and pension benefits.

That's because just as employees start to wonder if they are being hoodwinked, and begin to grumble and grouse for a *real* employee benefit program, instead of one that merely accommodates a pressing life need, employers can dust off their managed care plans and defined benefit pensions.

Editor Paul D. Winston's column appears fortnightly. Contact him at pwinston@craim.com.

Prepare

Continued from previous page
it is, and how you are going to execute it before you start making a decision to go with a wrap-up," he said.

Aside from getting an early start, panelists advised that project sponsors work only with general contractors or construction managers with a reputation for good employee safety programs.

"If you are not working with a general contractor or a construction manager who has a rep for safety and taking care of business with that being job one, a wrap-up is probably not going to work," said Mark E. McGinnis, vp of construction practice for Marsh USA Risk & Insurance Services in Los Angeles.

Running a profitable program also depends on working with a contractor, insurer, risk manager and other parties who truly believe in the wrap-up concept and support its goals.

"It's not a matter of ramming the ideas and goals down the throats of the insurer or the general contractor," Mr. McGinnis said.

"Through all the wrap-ups that

Marsh Mac has done and the ones I have been involved in, the ones that are successful are the ones in which the general contractor completely buys into the concept of the wrap-up," he said.

Contractors ultimately are responsible for site safety; their cooperation exponentially helps assure loss containment goals are met.

Yet it is common for contractors to be at odds with the wrap-up concept, conference speakers said.

Sometimes winning their support requires sharing potential savings with them, Mr. McGinnis said.

A contractor's rush to complete a project on time and under budget also can detract from their attention to safety measures called for in their contracts, said Marge P. Layne, insurance manager for the San Francisco International Airport. They also have varying safety philosophies and degrees of concern. Therefore, overseeing a program requires the owner's risk manager to constantly ride herd to minimize losses, she said.

Choosing appropriate brokers and insurers for a wrap-up also is crucial, said William D. Motherway, vp and risk manager for Tishman Realty & Construction Co. Inc.

DES

Continued from page 1
were the consequences of injuries to second-generation claimants," said Louis Solomon, a partner at Solomon, Zauderer, Ellenhorn, Frischer & Sharp in New York who has been representing the company in its DES coverage litigation.

Underwriters at Lloyd's of London are appealing the ruling granting coverage of third-generation risks and other parts of Squibb's coverage case, which continues to wend its way through the courts after 17 years.

DES is a synthetic form of estrogen introduced in 1941 to prevent miscarriage. It was used by an estimated 2.4 million U.S. women until it was banned in 1971 for use during pregnancy.

Earlier scientific research had shown that the drug appears to cause structural changes in the reproductive organs of both female and male children exposed to DES before birth.

But a new study suggests the effects may be more far-reaching.

Revealed at a DES Research Update Conference held earlier this month in Washington, the study found that 11% of third-generation mice bred from DES-exposed grandmothers developed malignant reproductive tract tumors.

While so far no third-generation research has been conducted on humans, the "mouse model has been predictive in other cases, and there is enough evidence that granddaughters and grandsons should be (monitored) as well as the daughters and sons of women who took DES," according to Retha Newbold, a researcher at the National Institute of Environmental Health Sciences who conducted the study.

Besides cancer, Ms. Newbold's study found that the third-generation mice also were more likely to develop fertility problems and reproductive tract abnormalities.

Attorneys and product liability experts expect the new research will trigger another wave of DES litigation.

"To quote Yogi Berra, it could be 'deja vu all over again,'" said MED-MARC's Mr. Quinley.

"I think that the plaintiffs attorneys, especially those who have invested heavily in preparing for DES litigation, will perpetuate a second and maybe even a third generation

of claims," he said.

Furthermore, "the past cases couldn't have addressed extinguishing the legal rights of subsequent generations," he said.

Jim Otto, a partner in the Los Angeles office of Kroll, Rubin & Fiorella, agrees that a spate of new litigation is likely.

He said: "The companies still face potential liability unless they discharge all of the DES claims in bankruptcy," as Dow Corning Corp. did when it filed for protection under Chapter 11 of the U.S. Bankruptcy Code when faced with tens of thousands of product liability claims over silicone breast implants.

More DES litigation also is probable because "most states have passed laws that make the date of discovery the trigger for running the statute," said Mr. Otto. While these laws were passed mainly to provide an opportunity for victims of asbestos-related ailments to recover damages, they could apply to DES cases as well, he said.

A spokesman for Bristol Myers Squibb, one of the companies that made and marketed DES, said, "Most states don't recognize a cause of action for third-generation claims."

In particular, he referred to a 1991 decision in *Enright vs. Squibb*, in which the New York Court of Appeals, New York's highest court, upheld a trial court's dismissal of a case brought by the granddaughter of a woman who took DES, finding she had no cause of action.

"We've also had a few other types of unrelated third-generation cases dismissed," the spokesman said.

Some attorneys who have defended companies in medical products liability cases said they did not expect the new study to trigger any new litigation.

"I have not heard of any precedent for claims to be filed by people who were not even conceived at the time of the incident," said Bud London, a partner in the New York law firm of London Fischer L.L.P.

"It would create a class of claimants that would go on in perpetuity," he suggested. "That would make it impossible for the companies (that made DES) to stay in business."

But calls are increasing to DES Action, a consumer group formed in Oakland, Calif., to handle inquiries about DES exposure and to make legal referrals.

in New York. He addressed the group but was not part of the panel.

A broker with construction-specific experience and an account executive that has worked on building projects is crucial, he advised. Whether the broker is a large national organization or a smaller regional one is not as important as their construction experience.

"I don't want an account executive who specializes in retail stores or even real estate," he said. The broker's loss control personnel and claims personnel also need to know the construction industry.

"I don't want someone who goes from store to store looking for slips and falls," Mr. Motherway said. "I need a guy who knows what construction is all about. How steel is erected, concrete, curtain walls, electrical, mechanical. They need to know what they are doing."

Insurers chosen for a wrap-up also must understand construction, he said.

"I want somebody who can work with my supervisor, work with the broker, work with my safety people," he said. "Once again, they have to have specific industry knowledge."

"The volume of calls is up this year with the increased awareness of the third-generation findings," said Pat Cody, program director.

DES daughters—women whose mothers took the drug—are calling for increased research in response to these findings, she said.

"These studies raise some very alarming questions for DES daughters and their children," she said.

So far, while there have been thousands of individual claims against drugmakers, there has been no class-action litigation in connection with the anti-miscarriage drug, despite a landmark 1980 ruling in *Sindell vs. Abbott Labs* by the California Supreme Court that allowed plaintiffs to sue using a market share liability theory. That theory, later upheld by the U.S. Supreme Court, holds that when a specific manufacturer of a harmful product cannot be established, all manufacturers must divide the liability based on their market share.

Some drug companies—such as Squibb—still are litigating with their insurers over product liability coverage for these claims.

Squibb's case is on appeal to the 2nd U.S. Circuit Court of Appeals in New York after a federal district court ruled in June that a single underwriter at Lloyd's could be sued by the company as a representative of all of the underwriters on the risk.

The case had originally been remanded to the district court late last year after the appellate court ruled that, to sue Lloyd's in a U.S. court rather than an English court, a policyholder must first identify every name backing an underwriter on a policy in dispute and meet a diversity threshold by showing that each name resides outside the policyholder's own state and is individually responsible for at least \$75,000 in coverage (*BI*, Dec. 21, 1998).

Fortunately, Squibb already won coverage for third-generation claims, according to Mr. Solomon.

"We argued—and the court agreed—that these types of consequential damages should be covered on the same trigger points as for second-generation claims," he said.

Lloyd's is appealing that portion of the case, however, as well as the jurisdictional issue, he said.

Squibb marketed DES between 1947 and 1969. Other companies that also made and sold the drug were Eli Lilly & Co. and Abbott Laboratories.

Neither Lilly nor Abbott Labs spokesmen returned calls.

NCQA

Continued from page 1

erages and benchmarks but would not allow their names to be released.

Rather than provide detailed information on all 50 quality measures, the report focuses on the 12 the NCQA determined are most important.

The 12 quality measures are: adolescent immunizations, advising smokers to quit, antidepressant medication management, beta blocker treatment after heart attacks, breast cancer screening, cervical cancer screening, chicken pox vaccination, childhood immunizations, cholesterol screening after heart attacks, eye exams for diabetics, follow-up after hospitalizations for mental illness, and prenatal care in the first trimester.

Consistent with last year's results, "plans that have publicly reported data to NCQA for two or three years outperformed the national average on every single measure of clinical quality and member satisfaction," the report states.

For example, on average for 1998, 40.9% of diabetics received eye exams, compared to 49.4% of diabetics in plans reporting data for the third year. In contrast, for those plans reporting data for the first time, 38% of diabetics received such exams.

And while 62.5% of members who smoke received advice to quit smoking, 66.1% of those in repeat-reporting plans received the advice. Only 59.9% of smokers in plans reporting for the first time got this advice.

This is good news for the future, the report states, as this finding suggests that plans that have just started submitting data will see improvements in quality in the coming years.

"If so, we can collectively look forward to a steady, meaningful advance in performance across all measures of care and service," the report states.

Improvements in quality over the years come as HMOs begin the process of improving quality in one

year and fine-tune those plans in subsequent years, the report states.

Beyond the repeat reporters, the average quality of plans has improved at least slightly for most measures in 1998 compared to 1997. For example, overall, the number of people receiving beta blocker treatment after heart attacks improved to 79.9% in 1998 from 74% in 1997. Also, breast cancer screening increased to 72.2% of women in 1998 from 71.3% in 1997.

Of the 12 measures the NCQA deemed the most important, overall scores declined slightly in three measures. For example, overall, 62.5% of smokers in 1998 were advised by plan providers to quit, while a slightly higher 64% got that advice in 1997. Also, the percentage

The average quality of plans has improved for most measures over the past year, the NCQA study says.

of children who got all the recommended vaccinations by age 2 declined to 64.8% in 1998, from 65.4% in 1997.

Other findings from the report include:

- Plans with NCQA accreditation have higher quality than non-accredited plans, and plans that publicly report performance have higher quality than those that submit data but not for public release. The accredited plans scored between 3% and 16% higher on the 12 quality measures and scored higher on every core measure of quality. This leads the NCQA to conclude "that accountability drives quality," the report states.

One explanation for the difference, the report suggests, is that while accredited plans have improved quality, the non-accredited plans "are essentially treading water, or even sliding in terms of performance on some measures."

- Newly added measures saw larger improvement than did older

measures, "driving home the message that 'what gets measured gets done,'" the report states. For example, the rate of chicken pox vaccinations rose from 40% of children in 1997, the first year it was measured, to 51.9% in 1998. And the rate was even higher for plans that reported vaccination rates for both years, standing at 52.6% of children for 1998.

- Plans with high quality scores also scored high on member satisfaction, the first time this link has been established. The report states that those plans with the highest quality scores have the most satisfied members as measured by a member satisfaction survey.

Specifically, those plans in the top quarter for quality performance received high satisfaction marks from 62.6% of members, while the rest of the plans got high satisfaction rating from only 55.3% of members.

- The quality of health plans varies by geographic region. As in the past, New England plans performed better than did plans from other regions of the United States. New England plans scored the highest on nine out of the 12 quality measures the report examined. In contrast, plans in the South Central region scored lowest in nine out of 12 measures.

Some of the regional disparities were quite dramatic. For example, in New England, 73.7% of adolescents received their immunizations by their 13th birthday, compared to 40.4% in the South Central region. The national average is 52.3%.

A spokeswoman for the American Assn. of Health Plans, a leading HMO organization, praised the report's conclusion that HMOs repeatedly reporting quality data improved most. On the other hand, she noted that an ideal comparison of health insurers also would include fee-for-service plans and preferred provider organizations.

A copy of the study is available from the NCQA World Wide Web site at www.ncqa.org. A CD-ROM version of *Quality Compass '99* can be purchased for \$2,500 from the NCQA by calling 800-839-6487.

Summit

Continued from page 1

commercial insurance premiums, and the RAA's members write about 80% of reinsurance coverage written by U.S. reinsurers or affiliates, according to the groups.

"It was just time" to hold such a common forum, said Mr. Crerar.

"It goes back to strengthening our voice even more as we work issues on the Hill. We're all lobbying on similar issues," even though the emphasis given those issues by individual groups differs, he said.

"We're trying to look at this as a marketplace effort," Mr. Crerar said.

Franklin W. Nutter, president of the RAA, said: "Our sense is the convergence of so much of the commercial insurance, reinsurance and brokerage sector has caused us to look at building alliances with others to deal with common issues."

"On the federal level, examples would include financial services reform legislation. At the state level, it would be commercial lines deregulation legislation. This summit is really just an event in the scheme of a bigger effort to try and find common ground with natural allies and work more closely together on common challenges."

"With pressure on expenses and trying to do more with less, it seemed to serve our interest to combine our resources," said

Robert E. Vagley, president of the AIA.

In addition to financial services modernization, issues of common interest include Superfund reform and e-commerce, said Mr. Crerar. "I think there's also going to be an

'It goes back to strengthening our voice even more as we work issues on the Hill,' says Ken Crerar of the CIAB.

emerging debate on regulatory issues," he predicted.

Mr. Crerar said the format will follow that of the legislative conferences the CIAB has held every February for nearly two decades, with addresses by members of Congress and others, followed by visits to Capitol Hill by members. Neither the AIA nor the RAA holds legislative conferences.

"It really made a lot of sense to follow what was an already-successful format," said AIA's Mr. Vagley.

Mr. Crerar said that bringing together chief executive officers representing producers, insurers and reinsurers will "help pump up the numbers. More people will come in because more people are here. That's a positive. The broader the

coverage on the Hill and the more we speak with a single voice, the better it is for all of us and our issues," he said.

The summit will be limited to the three initial associations for the time being, said its organizers, but that doesn't mean the three groups won't cooperate with other organizations on matters of common interest.

"No other group was asked to participate," said Mr. Crerar. But he added that the summit "is not to be an exclusionary thing, but an inclusive effort."

"The RAA is receptive to extending our working relationship to other groups within and outside the insurance industry if that would improve achieving our objectives," said the RAA's Mr. Nutter.

"I would think, as our broader industry evolves, I think we would be open to accommodating other interests if they shared our common vision," said the AIA's Mr. Vagley.

He emphasized that collaboration among the three groups will not end with the summit, but will extend to joint lobbying efforts that could move beyond the three associations.

"Our focus is on the property/casualty industry, but our vision goes beyond that to recognize the role of the property/casualty industry as a member of the broader financial services community," Mr. Vagley said.

Updates

Anthem to fund foundations

Continued from page 2

lion, respectively.

Other Blue Cross & Blue Shield plans have used similar strategies as they merge or set up for-profit subsidiaries. For example, when Blue Cross of California merged with its for-profit subsidiary, WellPoint Health Networks Inc., Blue Cross, as part of the conversion, transferred more than \$3 billion to charitable foundations in 1996 (BI, June 3, 1996).

In Missouri, Blue Cross & Blue Shield of Missouri has been awaiting court approval since March for a settlement agreement over creation of its for-profit subsidiary, RightCHOICE Managed Care Inc. (BI, March 22). The agreement reached with state officials calls for creation of a foundation. More recently, Milwaukee-based Blue Cross & Blue Shield of Wisconsin, which is seeking to convert to a stockholder-owned company, said it plans to donate the full equity value of the new entity, estimated to be \$250 million, to a public health care foundation (BI, July 5).

Oregon cleanup reform now law

SALEM, Ore.—Oregon Gov. John Kitzhaber has signed into law the Oregon Environmental Cleanup Assistance Act, which will make it easier for Oregon policyholders to recover costs for environmental cleanups under pre-1986 general liability insurance policies.

John DiLorenzo, an Oregon policyholder attorney and lobbyist, drafted the bill, which was introduced earlier this year (BI, April 5). Major components of the original proposal were passed by the state Senate and House of Representatives in early July. The governor signed the bill July 19.

Under the new law, which took effect immediately, the following rules of construction will apply in the interpretation of general liability policies involving Oregon environmental claims when policy language is not clear:

- Any action or agreement, including voluntary agreements, by the Oregon Department of Environmental Quality or the U.S. Environmental Protection Agency against or with a policyholder regarding contamination cleanup is equivalent to a "suit" or a "lawsuit," which are terms used in general liability policies.

- An insurer must cover the costs for any reasonable and necessary fees, costs and expenses by a policyholder pursuant to a written voluntary agreement, consent decree or consent order between the insured and either the DEQ or EPA.

- Oregon law shall be applied in all cases where the contaminated property is in the state.

The Legislature said that, due to the number of environmental coverage disputes in Oregon, the state "has a substantial public interest in promoting the fair and efficient resolution of environmental claims while encouraging voluntary compliance and regulatory cooperation."

In a statement, Peter Gorman, associate vp of the Western region for the Alliance of American Insurers, said, "The bill is a blatant attempt to get insurers to pay for voluntary cleanup costs of landowners who knowingly or unknowingly pollute."

Limit rejects hostile bid

LONDON—Limit P.L.C., the largest insurance group trading at Lloyd's of London, last week staved off a hostile bid for its business, but analysts say it still could be an acquisition target.

In a statement issued Wednesday, Limit announced it had received an "unsolicited and preliminary approach" from an unnamed suitor at a price that was "clearly unacceptable."

Limit Chairman Jonathan Agnew said the approach was from an "insurance group whose main activities are outside the London market, though it does have a small Lloyd's presence." Mr. Agnew characterized the approach as "opportunistic—the price was clearly unacceptable." Also, the bidder was "not somebody the (Limit) underwriters would wish to work for," he said.

At the same time, Limit continues to attract good underwriters because of its independent status, said Mr. Agnew. Last week, it announced it had acquired an onshore energy team from CIGNA International, part of CIGNA Insurance Co. of Europe SA NV. CIGNA's property/casualty operations are currently being merged into the operations of ACE Ltd.

Although few details of the bid are available, Mr. Agnew and analysts agree that Limit shares have been undervalued—along with the whole Lloyd's investment sector. "We have been pretty uncomfortable about the share price... for the last few months," said Mr. Agnew. The price rose to 146.5 pence (\$2.37) from about 129 pence (\$2.09) after the announcement.

Nicholas Johnson, analyst with London-based securities investment house Raphael Zorn Hemsley Ltd., said he thinks Limit's independent status could be compromised if another bidder were to come in with a higher offer. "I think we are going to see some action at Limit soon," Mr. Zorn said. "I think there are a number of people interested," mainly overseas insurers.

Briefly noted

XL Capital Ltd. in Bermuda and **Les Mutuelles du Mans Assurances Group** have set up a French reinsurer with 1 billion French francs (\$163.5 million) in capital that will be called **Le Mans Re**. XL will contribute 600 million francs (\$98.1 million) to **Le Mans Re** and MMA will contribute its existing reinsurance operations. The company will be 51% owned by MMA and 49% by XL. . . . The House Judiciary Committee will continue its markup of the **Interstate Class Action Jurisdiction Act** this week. The measure, which would make it easier for parties involved in certain class actions to have the suits heard in federal rather than state court, enjoys widespread employer backing but is opposed by the Clinton administration (BI, July 26). . . . The Senate Environment and Public Works Committee has rescheduled its vote on a Republican-drafted **Superfund reform bill** for Aug. 3. Action on the measure, which provides some liability relief for small potentially responsible parties but not the type of broad relief from retroactive liability sought by many businesses, was delayed last week at the request of Sen. Max Baucus, D-Mont.

Captive

Continued from page 1

the captive writes a significant amount of unrelated business.

Those court rulings preceded an Internal Revenue Service ruling that employers can deduct group term life premiums paid to the captives because the premiums represent unrelated business.

According to the reasoning, if the parent funds enough employee benefits through the captive, the captive could be considered as writing a significant amount of outside business. That would increase the likelihood that the parent would be able to deduct property/casualty premiums paid to the captive.

But that theory never got a chance to be tested: In April 1994, the Labor Department rejected CSX's filing, saying that too much of the captive's business was related to CSX.

About 90% of CSX Insurance Co.'s captive premiums were derived from CSX-related risks. That exceeded a 1979 Labor Department rule that no more than 50% of a captive's gross premiums be generated by the parent in order for the captive to be used by the parent to fund employee benefit risks.

The Labor Department has long felt that a significant amount of outside business helps safeguard an employee benefit plan against less-than-arm's-length transactions.

With few captives having at least 50% of premiums generated by unrelated business, the Labor Department ruling in the CSX case was a crushing blow to employers and their advisers, who saw funding benefits as a way to increase the likelihood of tax-deductibility of property/casualty premiums paid to their captives.

But captive experts say there are good reasons—beyond tax considerations—for funding benefits in a captive. Those include letting a captive share in the profits that otherwise would go to a commercial insurer and diversifying a captive's book of business.

Indeed, with more than 60% of Westbridge's premiums unrelated to Union Carbide risks, tax considerations are not an issue in using Westbridge to fund the life insurance policies, Mr. Inserra said.

Instead, the proposed transaction is being driven by the desire to broaden the captive's

The proposed transaction is being driven by Union Carbide's desire to broaden its captive's risks, among other things, says Richard Inserra.

risks, keep the cost of the policies down and share in the policy profits with MetLife, Mr. Inserra said.

In its filing with the Labor Department, prepared by the law firm of Kelley, Drye & Warren L.L.P. in New York, Union Carbide said approval of its application will permit generated funds to be reinvested in its insurance subsidiary, Westbridge, rather than MetLife, an unaffiliated company. And that will ultimately benefit Union Carbide and its employees, according to the filing.

"An economically strong employer is important to the continued employment of the employees of Union Carbide and its sub-

sidaries and to the future provision of wages and benefits derived from that employment," according to the filing.

If the application is denied, "Westbridge would be deprived of a legitimate business opportunity to reinsure risks on an arm's-length basis to the detriment of Westbridge," the filing said.

The proposed transaction, according to the filing, will not in any way adversely affect the cost of life insurance to participants. "Plan participants will be afforded insurance protection by MetLife at competitive rates arrived through arm's-length negotiations."

While Westbridge's percentage of unrelated business exceeds the Labor Department's 50% test, department approval still is required; under a 1979 department rule, reinsurance arrangements involving the use of captives to fund benefits are reviewed on a case-by-case basis.

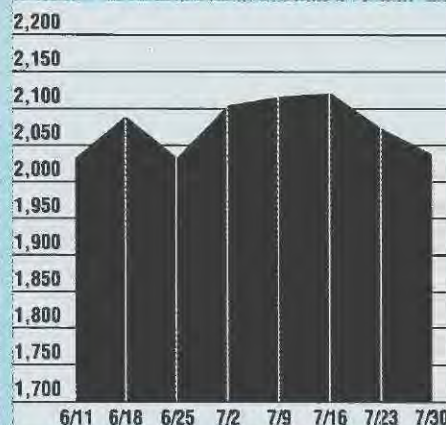
Mr. Inserra said the CSX case should not be viewed as an indication that the Labor Department will never approve the use of captive to fund a parent's employee benefits risks.

"It became apparent that the factors that worked against them (CSX) were in our favor," he said, contrasting the CSX captive's percentage of outside business—about 10%—with Westbridge's more than 60%.

Still, Mr. Inserra says that most captives would not have the same opportunity as Westbridge to fund employee benefits because most do not insure or reinsure enough outside business.

Union Carbide would like to put the new life insurance funding program in place by Oct. 1. It is seeking expedited Labor Department review of its application. **BI**

BI Insurance Index



Base=100 on Dec. 29, 1978

Source: Nordby International Inc. (nordby.com) Boulder, Colo.

PCS catastrophe options

As of July 30	Call spread	Price bid/ask	Call spread	Price bid/ask
National Annual 1999			California Annual 1999	
40/60	15.0/19.5		60/80	0.7/1.8
60/80	8.0/16.0		80/100	0.5/1.5
80/100	4.0/—		150C	0.8/1.2
150C	3.5/—			
200/250	2.5/6.0		Western Annual 1999	
			80/100	0.6/1.9
Southeastern September 1999			Midwest June 1999	
40/60	2.0/—		10/20	8.7/9.7
60/80	—/2.3			
80/100	1.6/1.9		Florida Sept./Dec. 1999	
			100/150	0.7/—
Eastern September 1999				
40/60	1.3/—			

Total volume: 80 Total open interest: 10,150

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

Tax bills

Continued from page 2

remove one cap that limits the number of tax-favored medical savings accounts to 750,000 and a second cap that bars employers with more than 50 employees from offering MSAs. MSAs also could be part of a flexible benefit plan.

- The House bill would partially repeal the IRS "use it or lose it" rule for flexible spending accounts by allowing up to \$500 in unused balances to be carried over to the next year. Alternatively, FSA balances unused at year-end could be rolled over into a 401(k) plan.

Provisions that are the same, or nearly so, in both the House and Senate bills include:

- 401(k) plans. The bills would gradually

raise to \$15,000 from \$10,000 the maximum annual salary deferral. In addition, employees age 50 and older could make special "catch-up" contributions of up to \$5,000 a year. While the House bill would make such contributions subject to non-discrimination testing, the Senate bill would not.

- Benefit portability. Employees moving between tax-exempt and private sectors could move funds between 401(k), 403(b) and 457 plans.

- Vesting. Employers that match employees' savings plan contributions would have to vest those contributions under at least a three-year cliff or six-year graded schedule.

- Non-discrimination tests. The Treasury Department would have authority to modify current mechanical tests in favor of a "facts and circumstances" test to determine that a

pension plan does not favor highly-paid employees.

Both bills also contain provisions of interest to the property/casualty industry.

The most notable would extend the so-called Subpart F tax provision for five years. That provision of the Internal Revenue Code allows U.S.-based insurers, brokerages and other financial services entities to defer U.S. taxes on their active earnings overseas until the income is returned to the U.S. parent. This means that financial services would be governed by the same rule as non-financial entities when doing business abroad.

The measures also would provide for a limited federal tax exemption for certain state residual property insurance markets.

—By Jerry Geisel and Mark A. Hofmann

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high-low
Gdn Royal Exch	360	5.6	4.3	1.2	423-227
Legal & Gen	150	18.5	3.6	3.1	237-147
Royal & Sun	521	18.2	23.0	5.5	633-455
Brokers					
Lmbt Fenchurch	83	8.1	4.2	6.3	94-58
JLT	234	10.5	12.0	6.4	253-166

Note: Prices are July 30 closings; other numbers from July 29.

Source: Nordby International Inc. (nordby.com) Boulder, Colo.

BI Industry Stock Report JULY 26, 1999, THROUGH JULY 30, 1999

BROKERS

BROKERS			Price	Weekly % change	Year to date % change	Year to date		
						High	Low	Vol.(000)
Aon Corp.	NYS	37.44	-3.85	0.17	46.69	32.19	2102	
Clark Bards Holdings	NDO	22.25	17.11	31.75	23.12	18.62	0	
E.W. Blanch Holdings Inc.	NYS	65.50	-7.42	40.29	71.75	34.88	432	
Gallagher Arthur J. & Co.	NYS	52.13	-0.83	19.14	56.00	34.88	173	
Hibb, Rogal & Hamilton	NYS	22.38	4.99	20.13	22.50	15.56	63	
Kaye Group Inc.	NDO	8.56	2.24	18.10	9.13	5.00	10	
Marsh & McLennan	NYS	76.00	-0.82	28.54	81.50	43.38	3423	
Brown & Brown	NYS	36.00	-3.52	3.04	41.88	29.31	30	
BROKERS AVERAGE			-0.89	21.54				

INSURERS/REINSURERS

ACE Ltd.	NYS	23.25	-8.37	-28.87	38.06	22.88	8594
Accel International Corp.	NDO	1.44	-4.17	-52.08	3.38	1.25	112
Acceptance Insurance Cos.	NYS	15.31	-0.41	-22.95	23.06	12.06	118
AEGON N.V.	NYS	76.13	0.58	-37.57	130.13	69.25	4260
Aetna Life & Casualty	NYS	82.00	-4.02	2.74	99.88	60.19	1918
AFLAC Inc.	NYS	46.38	4.07	5.40	56.75	25.13	3017
Alimerica Financial Corp.	NYS	59.19	-1.66	4.53	75.25	38.38	1031
Allstate Corp.	NYS	35.63	4.78	-7.47	48.38	34.00	14777
AMBAC Indemnity Corp.	NYS	55.63	-1.55	-7.19	62.38	40.88	770
American Bankers Ins.	NDO	54.69	0.00	14.53	60.63	30.13	718
American Financial Group	NYS	32.75	-3.50	-20.49	43.88	30.50	255
American General	NYS	77.38	-0.72	-1.12	81.38	52.38	2418
American Heritage Life Ins.	NYS	31.06	0.61	29.09	31.25	18.63	1146
American Indemnity/Fin'l	NDO	14.50	0.43	36.47	15.38	10.25	10
American Intl Group	NYS	116.13	-2.11	19.26	134.00	64.88	8260
American Safety Insurance	NYS	7.75	-3.88	-18.42	11.38	6.63	102
Argonaut Group	NDO	25.13	0.50	4.69	31.75	21.25	142
AXA-USA Group	NYS	59.06	-0.74	-17.47	80.25	38.25	264
Baldwin & Lyons Inc.	NDO	20.38	-5.23	-12.83	26.00	18.50	83
Berkley W.R. Corp.	NDO	24.13	-3.50	-28.52	37.00	23.50	225
Berkshire Hathaway Inc.	NYS	67805.00	-0.72	-0.72	81100.00	57000.00	1
Capital RE Corporation	NYS	13.38	-10.83	-31.63	35.38	11.94	198
Capitol Transamerica Corp.	NAS	14.06	-0.88	-20.49	22.00	12.50	31
Centris Group Inc.	NYS	9.38	-6.83	0.00	14.06	7.94	51
Chartwell Re	NYS	18.38	-2.65	-20.97	29.63	13.25	75
Chubb Corp.	NYS	59.61	-8.07	-7.89	78.81	54.00	4446
CIGNA Corp.	NYS	88.19	0.79	13.42	98.63	57.19	2684
Cincinnati Financial Corp.	NYS	37.63	0.00	5.43	41.88	30.50	1510
Citigroup	NYS	44.56	-5.94	32.20	51.75	19.00	39204

		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
CNA Financial Corp.	NYS	35.94	-0.17	-8.59	45.31	33.00	452
CNA Surety	NYS	15.00	0.00	0.42	16.00	10.19	54
EMC Insurance Group Inc.	NDO	12.69	-5.14	-0.49	14.13	9.00	37
ESG Re Limited	NDO	15.38	1.65	-22.40	23.00	12.75	537
Enhance Financial Services	NYS	20.75	-3.49	-31.40	34.00	17.31	420
Everest Reinsurance	NYS	31.25	-4.58	-14.82	43.50	28.75	937
Fremont General Corp.	NYS	17.00	-3.55	-29.53	28.88	16.50	492
Frontier Insurance Group	NYS	14.69	3.07	17.50	19.50	10.88	660
Gainsco Inc.	NYS	5.63	-4.26	-10.89	8.06	3.94	154
Harleysville Group	NDO	19.50	-1.27	-23.53	27.25	17.00	104
HSB Group Inc.	NYS	40.69	0.93	1.24	54.13	34.75	266
HCC Insurance Holdings	NYS	22.69	-5.47	33.95	25.13	16.00	274
ING Groep N.V.	NYS	50.88	-4.24	-16.60	76.38	36.06	269
IPC Holdings Ltd.	NDO	20.00	1.27	-12.09	27.88	17.38	138
Hartford Financial Services	NYS	54.00	-7.10	-3.25	66.44	37.63	2764
LaSalle Re Holdings Ltd.	NYS	16.31	-4.04	-20.91	36.25	11.63	100
Lincoln National	NYS	50.00	-5.88	20.66	57.50	33.50	1708
MAIC Holdings Inc	NYS	30.00	3.67	-6.25	33.13	23.25	63
Market Corp.	NYS	191.50	0.79	6.24	193.00	132.00	72
MBIA Insurance Group	NYS	57.38	-4.77	-13.48	72.94	46.06	1228
Meadowbrook Insur. Group	NYS	12.88	-1.90	-21.07	29.44	12.31	31
MMI Cos. Inc.	NYS	16.31	2.35	-2.25	21.75	13.75	117
Mutual Risk Mgmt. Ltd.	NYS	29.81	-1.45	-21.42	43.25	25.38	935
Navigators Group	NDO	15.63	0.81	2.46	18.50	13.25	18
NYMag Inc.	NYS	14.25	-5.79	-31.74	28.25	12.00	25
Ohio Casualty Corp.	NDO	17.94	6.30	-12.77	21.81	16.75	1588
Old Republic Int'l	NYS	16.81	-4.27	-21.57	28.63	16.38	1688
Orion Capital Corp.	NYS	47.56	0.00	21.37	51.00	27.56	831
Partner Re Ltd.	NYS	38.00	-3.03	-15.91	50.00	33.63	388
Penn-America Group Inc.	NYS	10.13	1.25	9.46	13.25	8.13	12
PMA Capital Corporation	NDO	20.38	5.16	4.15	21.13	16.63	66
Philadelphia Cons. Holding	NDO	21.50	-0.86	1.18	25.50	18.63	53
PXRE Corp.	NYS	16.13	0.78	-36.14	29.88	15.63	113
Reliance Group Holdings	NYS	5.88	-2.08	-54.59	17.94	5.75	1848
ReliaStar Financial Corp.	NYS	45.38	-3.33	1.40	50.25	29.00	667
RenaissanceRe Holdings Ltd.	NYS	37.06	4.59	2.60	48.31	30.00	91
Risk Capital Holdings	NDO	14.00	-0.88	-33.73	25.13	12.00	70
RLI Corp.	NYS	37.00	-0.67	10.86	44.19	27.88	57
St. Paul Companies	NYS	31.13	-5.86	-11.07	37.50	28.06	3354
SCOR	NYS	48.06	-1.01	-24.52	72.75	48.00	15

		Price	Weekly % change	Year to date %change	Year to date High	Year to date Low	Vol.(000)
SAFECO Corp.	NDO	38.06	-4.40	-10.44	47.50	36.69	198
SCPIE Holdings Inc.	NYS	31.13	1.43	3.53	33.00	23.69	
Seibels Bruce Group	NDO	4.88	-4.88	39.29	7.25	2.69	2
Selective Ins. Group	NDO	19.75	0.64	-2.47	23.00	16.69	17
Terra Nova Ins Co. Ltd	NYS	23.88	-4.50	-2.05	32.56	21.25	15
Tokio Marine & Fire	NDO	58.50	0.00	-0.64	62.88	39.00	6
Torchmark Corp.	NYS	32.88	-4.19	-5.40	45.50	30.69	111
Transatlantic Holdings	NYS	74.19	1.54	-1.90	94.50	72.50	30
Travelers Property Casualty	NYS	39.50	-2.17	28.98	45.38	24.13	113
Trenwick Group Inc.	NDO	24.13	-0.52	-23.72	35.88	24.13	6
Unico American Corp.	NDO	10.19	0.00	-11.65	15.13	8.63	2
United Fire & Casualty	NDO	25.25	0.00	-24.13	39.38	22.25	3
Unifrin	NDO	39.19	-3.54	10.58	42.38	27.88	31
UNUM Corp.	NYS	51.75	-5.48	-13.66	62.50	41.75	191
Vesta Insurance Co.	NYS	4.63	10.45	-19.57	18.38	3.38	32
XL Capital Ltd.	NYS	52.50	-8.99	-26.64	83.25	52.00	175
Zenith National Ins.	NYS	23.63	-5.26	2.16	28.19	20.31	3
INSURERS/REINSURERS AVERAGE			-1.61	-6.33			

HEALTH MAINTENANCE ORGANIZATIONS

	Price	Weekly % change	Year to date % change	Year to date High	Year to
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