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Updates

Court denies Lloyd's names' request to appeal order

LONDON—A London Court of Appeal Friday turned down an application by more than 500 members of Lloyd's of London seeking to appeal a High Court order to pay more than £150 million ($245.5 million) to cover their share of insurance claims against the Lloyd's market.

All those individual Lloyd's members, known as names, who had sought leave to appeal, had rejected Lloyd's 1996 settlement offer, made under its £3.2 billion ($5.24 billion) reconstruction and renewal program,

See **Updates** *on next page*

Factory Mutuals to merge

By MARK A. HOFMANN

Soon there may be only one Factory Mutual insurance company.

Allendale Mutual Insurance Co., Arkwright Mutual Insurance Co. and Protection Mutual Insurance Co. last week announced plans to merge into a single entity to be called Factory Mutual Insurance Co.

The merger, which would be effective Jan. 1, 1999, after obtaining regulatory and policyholder approval, would yield greater financial resources, loss prevention expertise and international breadth, making the combined company a stronger competitor in the highly protected risk market, executives say. The Factory Mutual companies invented the HPR concept in response to the perils faced by New England mill owners in the last century.

Policyholders and insurance industry analysts view the proposed merger as a positive development.

"The Factory Mutual system is a great system; they have served the policyholder well over the years," said Robert J. O'Toole, chairman and chief executive officer at A.O. Smith Corp., a manufacturer in Milwaukee. "But as the economy gets more competitive, I'm not sure you can afford to have three or four different organizations."

Industry observers say the merger is a logical response to heavy competition in the HPR property insurance market.

"I think it was a somewhat inevitable move. As the competitive environment continues to increase, the three individual companies were not able to compete as effectively by themselves as they would as one consolidated

See **Merger** *on page 42*

Building an HPR powerhouse

The Factory Mutual insurers' GAAP financial data, in millions, as of Dec. 31, 1997

	Allendale	Arkwright	Protection Mutual	Combined
Net premiums earned	$433	$326	$253	**$1,012**
Losses and underwriting expenses	405	389	248	**1,042**
Net income	91	(10)	32	**113**
Surplus	1,022	819	488	**2,329**

Note: Net earned premiums, losses and underwriting expenses and net income exclude the effects of 1997 reserve strengthening for discontinued insurance lines.

Source: Allendale Mutual Insurance Co., Arkwright Mutual Insurance Co. and Protection Mutual Insurance Co.

NCQA unveils new reports

By ROSEANNE WHITE

WASHINGTON—The National Committee for Quality Assurance will begin distributing reports next year that aim to provide consumers more complete and understandable information on health plans.

The reports also are intended to help consumers discern the industry's top performers.

Last week, the Washington-based NCQA released its prototype consumer report, which is based on Accreditation '99, its new oversight accreditation program that will be implemented next July.

The reports will be organized by region and product type: private commercial insurance, Medicare or Medicaid. They will show how HMOs ranked on five factors expressed in terminology familiar to laypeople: access and service; qualified providers; staying healthy; getting better; and living with illness. An overall accreditation status for each plan also will be shown. The new accreditation categories are: excellent, commendable, accredited, provisional and denied.

See **NCQA** *on page 41*

Setting standards in quality

The NCQA evaluates health plans on five weighted categories:

Criteria	Weight
• **Access and service** Do health plan members have access to the care and service they need?	40%
• **Qualified providers** Does the health plan assess each doctor's qualifications and what health plan members say about their providers?	20%
• **Staying healthy** Does the health plan help people maintain good health and avoid illness?	15%
• **Living with illness** How well does the health plan care for people when they have chronic conditions?	15%
• **Getting better** How well does the health plan care for people when they become sick?	10%

Source: National Committee for Quality Assurance

Court to hear CIGNA appeal

By DAVE LENCKUS

PHILADELPHIA—Pennsylvania's Supreme Court will determine whether the state's former top insurance regulator conducted proper public hearings before approving CIGNA Corp.'s liability-based restructuring.

The July 27 order is a victory for CIGNA and the Pennsylvania Insurance Department over a group of policyholders and rival insurers that oppose the reorganization.

"Our position that no additional hearing is needed will prevail on appeal," predicted a spokesman for CIGNA.

The court agreed to review a 1997 Pennsylvania Commonwealth Court ruling that vacated the department's approval of the reorganization and ordered regulators to conduct trial-like hearings (*BI*, March 10, 1997). CIGNA and the department had appealed the Commonwealth Court's finding.

In another setback for opponents of the reorganization, the state Supreme Court declined to hear their cross-appeals. That means the court will focus only on the adequacy of the Insurance Department's original hearings and not opponents' other arguments that the reorganization violated federal and state constitutional law and insurance regulations. Those claims were not addressed by the Commonwealth Court.

The Pennsylvania Supreme Court's latest order marks not only a victory for CIGNA and regulators, but also a reversal of fortune for their opponents in recent weeks.

In June, opponents celebrated a series of high court orders denying all appeals of the Pennsylvania Commonwealth Court ruling. As a result, the restructuring dispute was returned to the Insurance Department for a new trial-like hearing (*BI*, June 15). But, the court vacated those orders two weeks later, saying only that it had made an "administrative error" (*BI*, June 29).

Ironically, the court's third series of orders in the case within the past two months follows a 14-

See **CIGNA** *on page 43*

Vertical insurance integration

Risk managers reserve judgment on recent investments

By SALLY ROBERTS

While the effects of vertical integration in the insurance industry have yet to unfold, risk managers are raising some concern over potential conflicts of interest between brokers and their insurer investors.

Risk managers generally welcome the investments if the purpose is to keep choice in the distribution system, but they wonder whether the moves are more of a strategic deal to control where insurance products are placed.

Whatever the outcome, in a market where prices are soft, consolidation is key and two behemoths are dominant, this vertical integration is likely to continue, observers say.

Late last month, Willis Corroon Group P.L.C. announced that a consortium of investors, led by U.S. private equity firm Kohlberg Kravis Roberts & Co. L.P. and including five insurers, made a $1.56 billion offer to acquire a majority stake in the world's fourth-largest broker. The deal, if completed, would end speculation over Willis' future and take the company to private ownership, allowing it to focus more on long-term shareholder value (*BI*, July 27).

At about the same time, San Francisco-based USI Holdings Inc. announced that a consortium of seven insurers and Chase Manhattan Corp. made a private equity investment of more than 50% in USI, the world's 11th-largest broker. That strategic deal allows USI to meet its objective of offering various financial products and

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Updates

Lloyd's names lose ruling

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which had been accepted by the majority of names.

The names were seeking to appeal against a ruling in Lloyd's favor in March that they must pay their share of the claims due under the settlement offer. In that ruling, the judge had refused the names leave to appeal to the Appeal Court; it was their direct application to the court for leave to appeal that was refused Friday.

Giving his ruling, Lord Justice Hobhouse said the application was refused because "the proposed appeals would have been bound to fail, as would have the defenses they were seeking to raise."

Lloyd's welcomed Friday's ruling, saying it means it can now enforce the earlier High Court judgment for the recovery of the £150 million.

GE Capital to buy Kemper Re

STAMFORD, Conn.—In a deal between two very recent combatants, GE Capital Corp. is buying Kemper Reinsurance Co. for an undisclosed price.

Both companies insist the deal has no connection with the June settlement of their two-year legal battle over the insolvent Electric Mutual Liability Insurance Co.

"The business terms of the EMLICO settlement were agreed before any discussions" regarding the purchase of Kemper Re, a GE Capital spokeswoman said.

Kemper Re, which GE Capital is buying from Kemper Insurance Cos. of Long Grove, Ill., will add a broker market reinsurer to GE Capital's stable of reinsurers, which is dominated by Employers Reinsurance Corp., the Overland Park, Kan.-based direct reinsurer.

"The acquisition of Kemper Re establishes GE Global as a major participant in the broker segment of the U.S. reinsurance market and bolsters its participation in the global reinsurance arena," Kaj Ahlman, chairman and chief executive officer of ERC, said in a statement.

GE also owns broker market reinsurer First Excess Reinsurance.

Kemper Re had 1997 policyholder surplus of $529.6 million, net premiums of $807 million and profits of $52.8 million.

The deal is yet another example of the consolidation in the reinsurance industry, said Michael Lewis, an analyst at SBC Warburg Dillon Read & Co. in New York (see story, page 2).

However, GE may have to tread carefully with some brokers that may be wary of placing business with a reinsurer that is so closely linked with a direct reinsurer, he said.

"GE has obviously considered this, and they must think that they can smooth out any problems," Mr. Lewis said.

The deal comes less than two months after Kemper Re and General Electric Co., parent of GE Capital, settled a prolonged legal dispute over the redomestication to Bermuda of EMLICO, whose sole policyholder was GE. Kemper had alleged that the redomistication was made so that GE might benefit, at the expense of its reinsurers, under Bermuda's liquidation laws. Terms of the settlement were not disclosed (*BI*, June 22).

Patient bill put on hold

WASHINGTON—Senate Republican and Democratic leaders agreed last week to put off consideration of patient protection legislation until after Congress returns in September from its summer recess.

The delay occurred after the two sides could not agree on rules to debate the legislation. Without an agreement, the issue could be endlessly debated.

Republican and Democratic patient protection bills before the Senate share certain common elements, including giving patients direct access to certain specialists, expedited reviews of disputed claims and greater assurance that emergency room care treatment would be covered.

A key difference in the two bills is that the Democratic bill would open up group plans and employers to state damage awards in coverage dispute suits, while the Republican bill would not.

Meanwhile, trying to find a center ground, Sen. John Chafee, R-R.I., last week unveiled a so-called centrist patient protection bill that would amend the Employee Retirement Income Security Act to allow health care plan enrollees to recover compensatory damages. ERISA now limits awards to actual losses.

Sen. Chafee said that if Congress wants to pass a patient protection bill, "here it is," referring to his measure, which so far has been backed by four other senators.

The House of Representatives earlier passed patient protection legislation, which also doesn't allow state damage awards in coverage suits (*BI*, July 27).

Indiana to appeal ruling

INDIANAPOLIS—Indiana's attorney general will appeal last week's dismissal of the state's lawsuit against the tobacco industry.

State Court Judge Gerald Zore wrote in his ruling that the state lacks the authority to bring the claim and "cannot recover damages allegedly caused by the defendants because the injuries are derivative and too remote."

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Errors & omissions

- Due to an editing error, a liftout quote in the July 27 issue was incorrectly attributed. David Gamble, executive director of the Assn. of Insurance & Risk Managers, said, "Managers of small companies, once they understand risk, are among the best risk managers."
- The July 20 directory of agents and brokers contained several inaccuracies, corrected as follows: Morris & Mackenzie Inc. derived 8% of revenues in 1997 from employee benefit business, not 87%; the full title for John F. Kelly of Frenkel & Co. Inc. is executive vp and chief operations officer; Brown-Hiller-Clark & Associates Inc. is based on Fort Smith, Ark.

Reinsurers consolidate

Gerling buys Constitution Re, Swiss Re to acquire Life Re

By GAVIN SOUTER

NEW YORK—Consolidation in the global reinsurance industry is continuing, as two European reinsurers buy U.S. companies.

Gerling Global Reinsurance Corp.'s purchase of Constitution Re Corp. for $700 million will significantly increase the capital of the Cologne, Germany-based reinsurer's U.S. operations.

The increase in size and the compatibility between the two reinsurers will greatly boost Gerling's position in the United States, said Charles D. Troiano, president and chief executive officer of Gerling Global Reinsurance Corp. of America.

Meanwhile, Swiss Reinsurance Corp.'s $1.8 billion purchase of Life Re Corp. in Stamford, Conn., will add to the Zurich, Switzerland-based reinsurer's already substantial life reinsurance business.

"It's all part of the consolidation that is going on in reinsurance," said Gloria L. Vogel, an analyst at Advest in New York.

Constitution Re will make Ger-

See **Reinsure** *on page 45*

Court limits personal liability

Managers shielded from certain bias suits: California court

By JUDY GREENWALD

SAN FRANCISCO—A California ruling will provide managers with immunity from discrimination claims for personnel-related actions, such as firing and disciplining workers.

The ruling will enable managers to make decisions in the best interest of their company—even though the employer still may be sued for bias—rather than ones that will minimize their personal liability, according to attorneys.

Some attorneys warn, however, that the decision also could leave managers more free to discriminate, which they say ultimately could hurt the company.

The July 16 California Supreme Court decision in *Reno vs. Baird* says that while managers can be held personally liable for harassment under the California Fair Employment and Housing Act, they cannot be sued as individuals for discrimination, because personnel decisions are an integral part of their jobs.

"The decision allows managers to do their jobs and make personnel decisions on the merits, instead of worrying about which decision would put them in the best position for possible litigation," said Thomas P. Klein, an attorney

See **California** *on page 36*

Congress running short on time to address Y2K liability immunity

By MARK A. HOFMANN

WASHINGTON—Congress must decide how much liability relief to grant companies grappling with the Year 2000 computer problem.

Lawmakers cannot afford to dawdle in making that decision, said the chairman of the President's Council on Year 2000 Conversion.

"There is obviously a major timing problem," as lawmakers scramble toward their traditional August recess, John Koskinen said during an appearance at the National Press Club last week.

Mr. Koskinen described the Clinton administration's so-called "Good Samaritan" bill—which arrived on Capitol Hill hours after he spoke—as a means to encourage the voluntary exchange of information among entities affected by Year 2000 problems by granting them limited immunity from lawsuits under certain circumstances.



Mr. Koskinen

But a competing bill, introduced a few days earlier by Rep. David Dreier, R-Calif., would provide much wider immunity. Even before the administration bill reached Capitol Hill, Rep. Dreier dismissed the White House's limited liability proposal as a "pop-gun response to this potentially immense problem."

Mr. Koskinen, who spoke at the National Press Club in Washington last Tuesday to launch the

See **Koskinen** *on page 45*

Bill targets settlement buyers

Companies offering lump sums to victims would face new tax

By MEG FLETCHER

WASHINGTON—A House bill would create new tax penalties for companies that buy a portion of structured settlements awarded to accident victims.

The targeted transactions involve specialty finance companies that make discounted cash payments to settlement recipients in exchange for receiving a portion of the periodic payments under an annuity.

The legislation was sparked by "dramatic growth" in these transactions, in which injured parties who have won damages—including workers hurt on the job—are induced "to sell off future structured settlement payments intended to cover ongoing living and medical needs in exchange for a sharply discounted lump sum that then may be dissipated, placing the injured victim in the very predicament the structured settlement was intended to avoid," said Rep. E. Clay Shaw Jr., R-Fla.

Rep. Shaw late last month co-sponsored the bill, H.R. 4314, with Rep. Pete Stark, D-Calif., and 15 other House members signed on to it. The measure has been referred to the Ways and Means Committee, and sponsors hope it will become part of a larger tax bill considered in September.

The "Structured Settlement Protection Act" would amend the Internal Revenue Code to create a new excise tax to be paid by the so-called factoring companies that purchase such settlements.

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Inside

- Businesses must lobby Congress if they desire liability relief for Year 2000 solution sharing, one of this week's editorials says. **PAGE 8**
- A California court upholds an insurer's use of a total pollution exclusion, but then depublishes the decision, nullifying its precedential value. **PAGE 43**
- Michigan has rejected a minimum participation rule used by Blue Cross & Blue Shield of Michigan. **PAGE 46**

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Managed Care Market Report

Directory of Prescription Benefit Managers: Page 20

Spotlight Editor: Todd J. Behme

Is the gatekeeper necessary?

By MICHAEL BRADFORD

The classic gatekeepers for health maintenance organizations slowly are being removed from their posts.

Patient and provider dissatisfaction with the gatekeeper HMO model—where patients must go through primary care physicians for referrals to specialists—along with a lack of proof that gatekeeping holds down costs, is opening up patient access to specialized care.

The gatekeeper model is "rapidly disappearing," and there's not much support to keep it, said Barry Rosenfeld, a consultant with Apex Management Group Inc. in Princeton, N.J. "There's no pressure to keep the gatekeeper," he said. "I haven't seen anyone out campaigning for it."

Mr. Rosenfeld and others question whether any savings that come from the gatekeeper system are worth the effort. "I'm not sure anyone ever proved it was truly advantageous as it affected bottom-line costs or quality of care," he said.

"We don't have enough history to know if the cost would be significantly more if you take the gatekeeper away," agreed John Erb, area vp with Gallagher Benefit Services in Boca Raton, Fla.



Barbara D. Levine, vp-national consulting practice at The MEDSTAT Group in Stamford, Conn., said: "The feeling generally is that (removing) it wouldn't necessarily have to add to costs. It would depend on the benefit plan design. If you're passing on the cost through a higher copay, there would not be much impact on employers."

The gatekeeper function is responsible for a small percentage of the overall cost savings afforded by managed care; a loosening of that function probably wouldn't greatly affect costs, she said.

The debate is leaving employers in an uncomfortable position. Some are hearing complaints from employees frustrated with their inability to see specialists without first making trips to their primary care physicians. Employers must balance that concern with their own worry that allowing unfet-

See **Gatekeeper** *on page 15*

Prescription costs need rapid therapy

Employers using several strategies

By JOANNE WOJCIK

There are perhaps as many strategies for treating escalating prescription drug costs as new medications entering the marketplace.

In spite of those efforts, prescription drugs are likely to remain one of the costliest components of group health plans, as doctors implement more aggressive drug therapies and workers get older.

Exactly how much are drug costs going up?

Well, "the trend for 1998 was 12% to 15% over 1997, and in 1999 we're projecting drug costs to increase 20% over 1998," said Rich Sinni, health care practice leader for Watson Wyatt Worldwide in New York.

One reason for the increase is the introduction of many new—and often more expensive—drugs. Reforms at the Food and Drug Administration have expedited the government approval process, so that while perhaps fewer than 30 new drugs were introduced in 1993, 62 new drugs were launched in 1997, and 120 entries are expected this year, according to Mr. Sinni.

The fact that drug manufacturers have begun directing their marketing campaigns at patients rather than physicians also is expected to heighten demand.

"Patients for years have gone to their doctors after talking with their neighbors about their drug therapy. Direct-to-consumer advertising just really expands the chitchat. So doctors are hearing a lot more requests for drugs by name," observed Bridget Eber, a pharmacist and prescription benefit practice leader for consultant Hewitt Associates L.L.C. in Lincolnshire, Ill.

Add to these developments the undeniable fact that the overall U.S. working population is aging and that the older people get, the more likely they are to need medication, and employers have a real cost-containment challenge on their hands, pharmacy benefit experts say.

Indeed, the medical treatment standards for many diseases are more aggressive today than in the past, observed John Voris, executive vp of PCS Health Systems, a PBM based in Phoenix.

For example, when the American Diabetes Assn. lowered the blood glucose level threshold for diabetes last year, "that's about 2 million people they added just to be treated for diabetes rather than just controlling it through diet and exercise," he said.

Likewise, the American Heart Assn. has proposed lowering the

See **PBMs** *on page 16*



Provider-owned plans face extra hurdles, but evolving

By JUDY GREENWALD

The failure rate of provider-owned health organizations has been pretty high to date, but don't be in too big a hurry to write them off yet, say some observers.

Many managed care health organizations owned by physicians or hospitals are either posting losses or already have been sold because of a variety of problems, including insufficient capital, poor management and doctors' inclination to reimburse themselves overgenerously.

Furthermore, even those provider-owned health organizations doing relatively well still shrink in size beside the health care giants that have risen in the field, such as Aetna U.S. Healthcare and Kaiser Permanente.

For these reasons, among others, some dismiss the concept of provider-owned health organizations as inherently flawed.

But others say this segment of the health care market is only experiencing a rocky start to what could potentially become a lucrative business once these organizations move further along the learning curve.

They also note that the entire concept is getting a boost from the federal government. Legislation approved last year encourages the disbursement of Medicare funds to "provider-sponsored health organizations." It is only a small additional step for these PSOs, which have been set up to accept Medicare funds, to offer the same services to the commercial market as well, say some experts.

Employers say they are favorably inclined toward the idea behind these organizations. "I like the concept," said Fred Hamacher, vp-compensation and benefits for Minneapolis-based Dayton-Hudson Corp. "It puts more players in the field vs. just the traditional health plans and insurance company plans," he said. "It adds another player in the game with a little different focus."

"I can't think of a reason why they couldn't be successful. It's a matter of understanding what they need to do and being pretty diligent about it," said Mr. Hamacher.

Andrea Velasquez, division president in Coral Gables, Fla., for Vincan Group, a professional employee organization, said although her firm's experience dealing with several provider-owned health organizations has been a mixed bag to date,

See **PSOs** *on next page*

Employers pare HMO options

By MICHAEL PRINCE

Employers are adopting a variety of strategies to make managed care plans more responsive to their needs and to hold down costs.

One growing trend among employers is to buy standardized health care plans offered by HMOs, according to Leslie Schneider, a principal with Buck Consultants in Atlanta. This approach contrasts markedly from that of the past few years, when employers sought to customize their managed care plans, Ms. Schneider said.

Many employers are turning to the standardized plans, she said, "because they want something easily understood by employees and simply administered by plans."

Additionally, standardized



plans are generally less expensive to the employer, which is important when some employers are looking at double-digit cost increases for 1999.

"You can have a little bit of customization without driving up costs, but when you get into heavy customization, you drive up costs more," Ms. Schneider said.

The increased use of standardized plans means HMOs can offer fewer plans. So, rather than offer scores of plans, HMOs are providing five to 10 plans and cutting down on their administrative costs, said Helen Darling, practice leader for group benefits and health care in the Stamford, Conn., office of Watson Wyatt Worldwide.

It benefits both HMOs and employers to have less customization and more standardization, according to Ms. Darling. Administration "can be chaos," she said. "It makes some sense to bring it down to a manageable number."

One problem for some HMOs trying to achieve more standardization nationwide, however, is that many of the large HMOs have merged in recent years and are still working on integrating their

See **HMOs** *on page 12*

PSOs

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"I think over time, as they evolve and develop their management systems, that's going to be the way to go, because of the elimination of the middleman and the patient focus that's been lacking in managed care."

Critics of provider-owned health organizations say a major reason many have been unsuccessful to date is a failure to recognize that running a managed care organization is a whole different animal than caring for patients.

"Historically, doctors have not been very good managers," said Jack Doerr, national group benefits practices leader for Sedgwick Noble Lowndes in Chicago. "They're excellent care givers, but they are not professional managers. And even though they hire professional managers to run the organizations, they still have ownership and they're still on the board of directors and they still have the ultimate say in the important decisions that are going into it. I don't think they are able, by virtue of their background and training and probably inclination, to manage as effectively and profitably as professional managers do."

Providers are "excellent at providing care, but there's another set of capabilities that's necessary in order to run a health plan," said Greg Yust, president and chief executive officer of Carmel, Ind.-based Sagamore Health Network Inc., which is sponsored by four Catholic organizations. Sagamore's core product, a preferred provider organization network, covers 700,000 lives.

"It takes a great deal of discipline to make it work and have it work effectively," said Patrick Aberle, senior vp-managed care for Sacramento, Calif.-based Sutter Health, which is now considering whether to sell or seek a capital partner for its majority-owned Omni Healthcare health maintenance organization, as well as its Sutter Preferred Health & Life Insurance Co.

Providers are 'excellent at providing care, but there's another set of capabilities that's necessary in order to run a health plan,' says Greg Yust of Sagamore Health Network.

"I think a lot of providers have discovered that they do a good job of running hospitals or providing medical services to enrollees, but few of them have the skill sets to really run a health plan. They don't have the core competencies inside their organizations, and they don't have the discipline to do that," said Mr. Aberle.

It is kind of like assuming that because you can drive a car, you can build one, said Don Gasparro, managing director at Princeton, N.J.-based Apex Management Group Inc. There is more involved than "putting the engine on a chassis and taking off."

A hospital administrator will say, for example, "We want to put together a managed care plan and compete with United to get our days up," said John Erb, area vp for Gallagher Benefit Services in Boca Raton, Fla.

"Well, no," Mr. Erb continued. "In insurance, you want your days to go down, not up, so there's kind of an inherent conflict between being the deliverer of this service and being the payer of these services, and that's the hurdle they can't get over."

Stuart Veach, vp at Winston-Salem, N.C.-based PARTNERS National Health Plans of North Carolina Inc., a health care organization operated by the Novant Health hospital system, said, "Where I have seen failures with this type of arrangement is because the HMO is not allowed to operate independently, so it doesn't, you might say, act like an insurance company."

"We have had the good fortune here to be able to operate independently," added Mr. Veach. "The board of directors that has governed the plan has been able to have the vision to recognize that that was the best way to do it," he said. "Their decisions are driven from the standpoint of what's best for this company, not necessarily what's best for providers."

Physicians have the idea they want to cut out the middleman, said Dr. Peter Kongstvedt, health care partner with Ernst & Young L.L.P. in Washington, D.C. "What they fail to realize is the middleman does a lot of stuff, and you actually can't cut out the middleman."

"All you can do is recreate them," Dr. Kongstvedt said, and they must do a better job than that of competing organizations.

Furthermore, physicians normally start out by enrolling their own patients, and "that generally means you're getting a sicker than normal group" and adverse selection, he said.

A related problem is physicians' tendency to give themselves too generous reimbursements, compared with those offered by other plans. "If you have a bunch of physicians who own a managed care network, the question is, are they going to really cut their own fees and are they going to cut the fees of the other physicians who have invested in the networks?" said Barry Barnett, principal at PwC Kwasha in Fort Lee, N.J. "It's the nature of the beast," he added.

"The biggest problem has always been (that) it's kind of like the fox watching the henhouse. They're always reluctant to police themselves," said Mr. Barnett.

Provider-owned organizations "are not as tough on themselves" as independently owned organizations would be, and, as a result, they find themselves at a disadvantage in the marketplace because of their higher cost, agreed Doug Werner, San Diego-based senior vp-strategy planning and business development for Foundation Health Systems Inc.

"These are often the kinds of plans we buy," said Mr. Werner, who noted that FHS now is consolidating three Connecticut provider-owned operations it bought in Shelton, Conn. He admitted, however, that some of

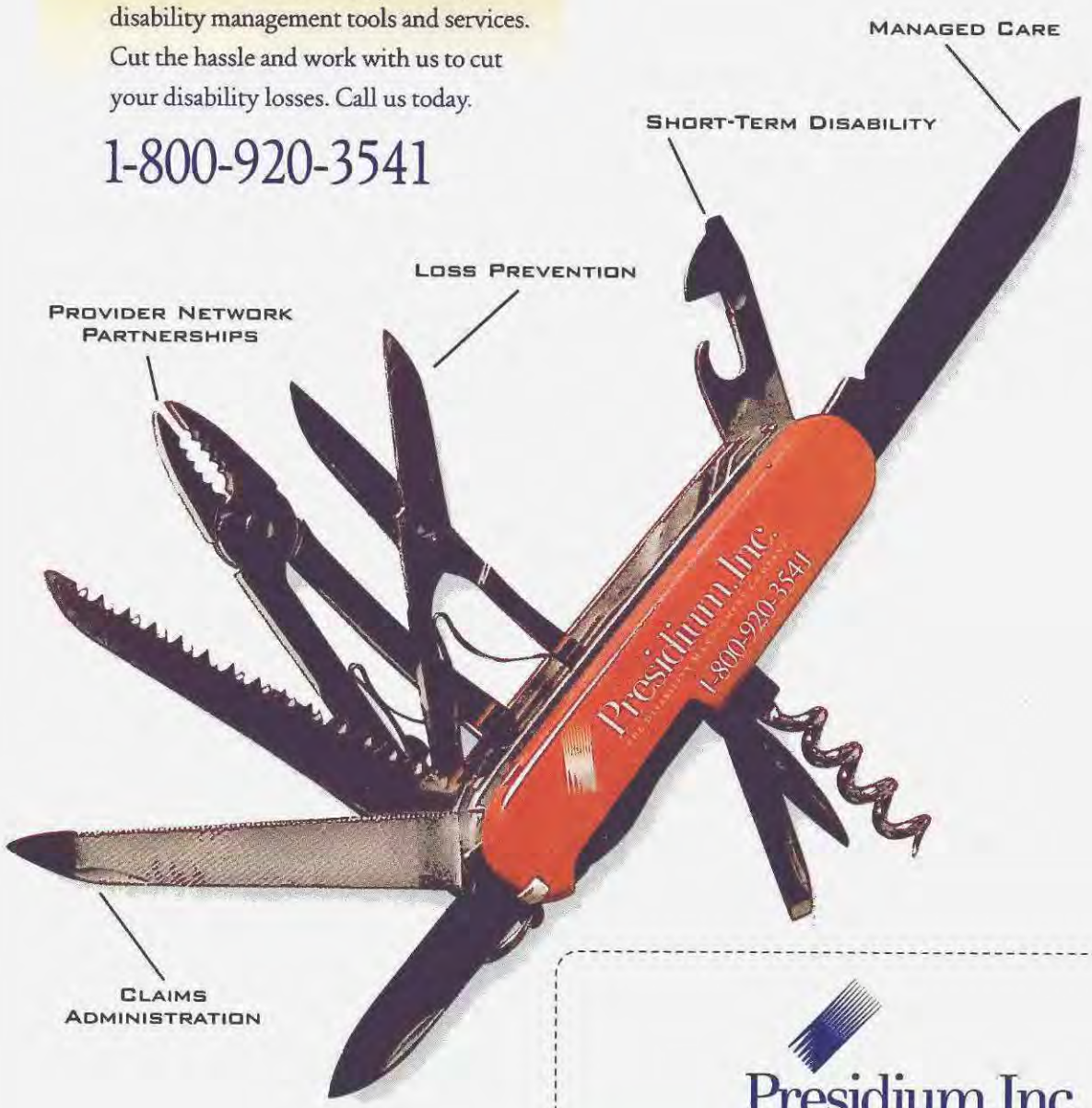
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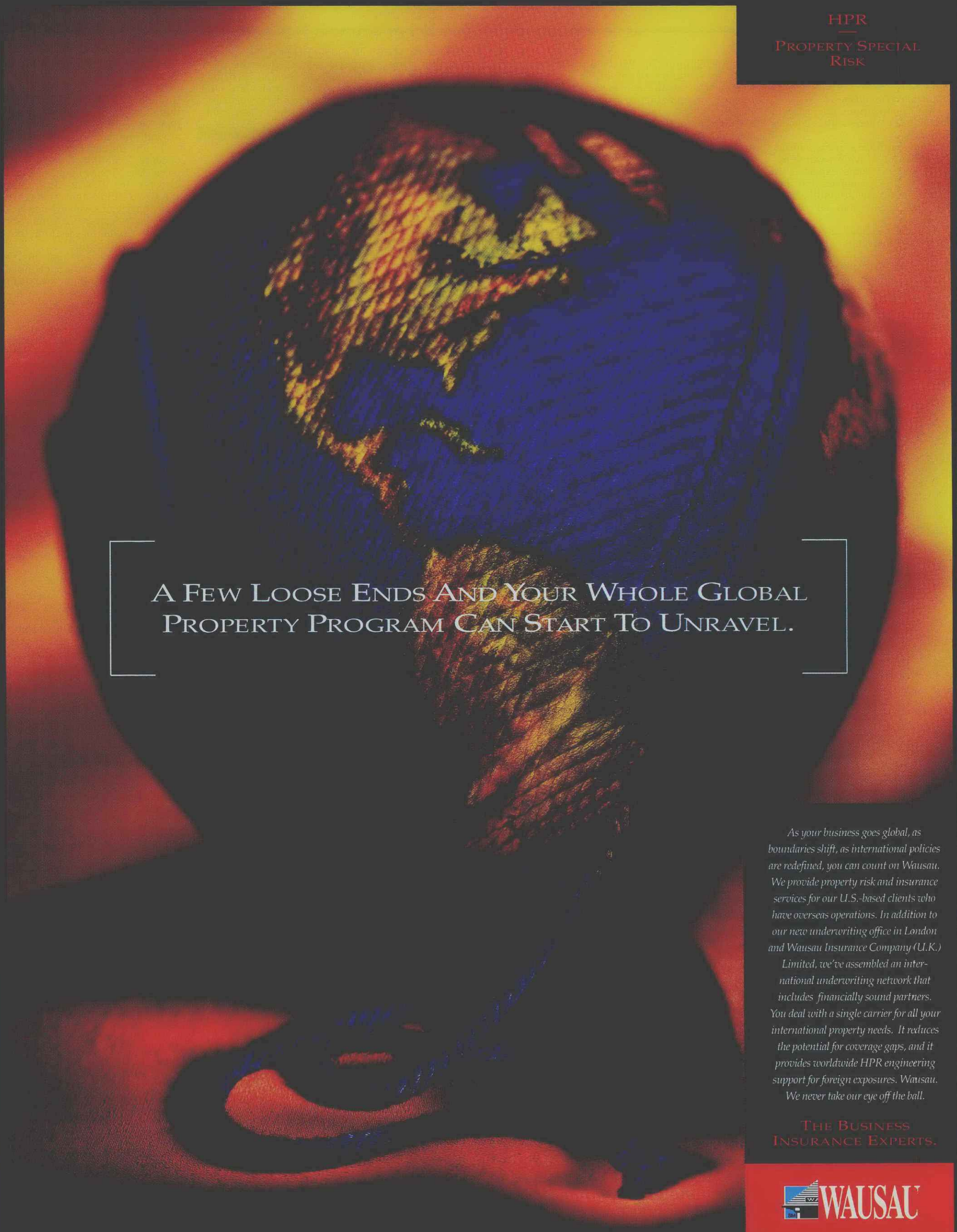
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PSOs

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these organizations do thrive in areas where there is little competition.

Undercapitalization is another problem for provider-owned operations, say some experts. "In fact, it's pretty common that they never get off the ground because of that issue," said Dr. Kongstvedt.

Providers should have $4 million to $5 million on hand before launching a provider-owned health organization, said Dr. Kirit Patel, president and chief executive officer of Stockton, Calif.-based Medcore Medical Group. Medcore, previously known as Omni Independent Physicians Assn., had been a part owner of Omni. This total, Dr. Patel said, includes $1 million to obtain the license and start the management services organization to run the health plan, $1.5 million to market the plan for two years, and another $1.5 million to support the system for two years until it breaks even.

Size is a problem as well, said Glenn Smith, senior health care consultant for Watson Wyatt Worldwide in San Francisco. "They tend to be very parochial in their view of the market," he said. A provider-owned organization may have 150,000 or 160,000 members, and that is "just not enough folks to be able to afford all the support systems and still manage their costs at competitive levels."

Mistrust of providers has been another factor, said Ken Jacobsen, national director-health care practice for the Segal Co. in Atlanta. "From a financial standpoint, it makes people a little bit nervous," he said. "Nobody wants to see medical inflation again. And if the doctors are in control, there's a perception, at least, that some of the utilization and cost control measures may be relaxed."

'I think there's an opportunity for (PSOs), and that opportunity rests in the public backlash against managed care,' says Glenn Smith of Watson Wyatt Worldwide.

Despite all these problems, however, some believe the essential concept behind provider-owned organizations is sound. None of the provider-owned organizations' problems is irreparable, said Paul Makens, senior vp and national practice leader for Aon Consulting Worldwide's health care industry practice in San Francisco. Mr. Makens said he views it as a situation of people getting their toes wet in the water and finding out what they do not know.

"I think you're going to go through a period of time where there's going to be a lot of work done to turn the situation around," he said.

"I think the concept makes a lot of sense," said Rowayton, Conn.-based Dr. Nirmal Patel, medical director for Hewitt Associates L.L.C. "I think that there are many physicians who are now acquiring the business skills that are necessary to be successful in that type of environment."

"I think there's an opportunity for them, and that opportunity rests in the public backlash against managed care," said Watson Wyatt's Mr. Smith. "If provider-sponsored plans can be financially competitive and deliver a message to the market that the providers are in control, they could make market gains, because the big commercial HMOs have a cloud hanging over them, and that is a certain level of consumer distrust."

Consolidation will encourage development of these organizations, said Tom Beauregard, a Hewitt consultant in Rowayton. "The managed care industry continues to consolidate rapidly," he said. "That, in turn, creates more pressure on physicians, because the managed care plans will have more leverage to negotiate deeper discounts, which in turn will cause physicians to organize more effectively."

"I think there are a lot of opportunities for the provider groups to build local organizations," and build outward from there, said Apex Management's Mr. Gasparro, who also noted that health care delivery is a "very local issue."

"I think that it can be done," said Joan Levinson, vp-sales and marketing for Oakland, Calif.-based California Advantage Inc., a managed care operation created by the California Medical Assn. that filed for bankruptcy in June.

In California Advantage's case, Ms. Levinson said, the organization failed due to problems that included poor planning and timing and insufficient capital. "If California Advantage had started out with a different situation, we could have been successful," she said.

Meanwhile, provider-owned health organizations are getting a boost from the federal government. The PSOs established by the 1997 Balanced Budget Act have lower minimum enrollment requirements than other plans participating in the new "Medicare + Choice" plans, as well as temporary waivers of state licensing requirements.

Once the PSOs are in place, "then the transition to the commercial marketplace is relatively easy," said Aon's Mr. Makens.

After they are established, "many of them are quickly discovering it's not much more trouble to go after the commercial population as well," said Sandy Wolff, director of health plan and provider consulting for Buck Consultants Inc. in Los Angeles. Furthermore, she said, "it makes a lot of sense."

"I think that it's basically a given, once they become established, it's going to be very easy for them to expand their network," said Dr. Ted Lewers, vice chairman of the board of trustees of the American Medical Assn. "I think the patients and the public are going to demand that they move into that market." BI



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Opinions

Clock ticking on Y2K bills

TIME IS RUNNING out for businesses to eliminate problems caused by the Millennium Bug, and time also is slipping away for lawmakers to act on proposals that would make it easier to solve the problem.

Unfortunately, there is a small window of opportunity to get such legislation enacted, and lawmakers do not appear to be in a rush to do anything before it is too late. Both the White House and congressmen are talking a good game, but without any push from business they are unlikely to make the legislation a priority in the 105th Congress.

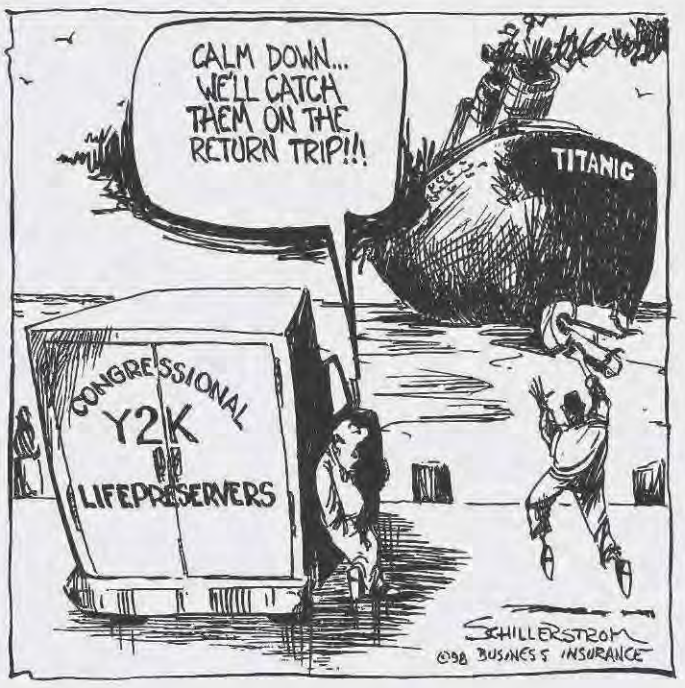
As we have reported, President Clinton has proposed a bill that would provide immunity from liability for statements made in good faith that ultimately turn out to be inaccurate. The measure is intended to promote the exchange of information among businesses and organizations at risk of the Year 2000 problem without fear of running afoul of antitrust laws or being exposed to liability for efforts to help others.

In addition, Rep. David Dreier, R-Calif., has introduced legislation that would limit the liability of virtually any party involved in the manufacture or use of computer software and hardware that might be affected by the computer problem, provided they made solutions available to customers to limit their losses.

In introducing his proposal, Rep. Dreier disparaged the White House proposal as a "pop-gun response to this potentially immense problem." While the president's proposal may not be as sweeping as the congressman's measure, we think such rhetoric is hardly productive to enacting legislation that would help business solve the problem.

In fact, we do not see the two proposals as mutually exclusive and wonder why conferees cannot craft legislation that would adopt elements of both proposals.

The president's proposal is aimed at encouraging the sharing of information about possible solutions to the Year 2000 problem. That exchange of information could prove crucial to adopting solutions before the clock winds down. It also could prove useful in assuring all of a company's vendors are compliant by encouraging organizations to share potential fixes with their vendors.



Rep. Dreier's proposal focuses more on minimizing liability after the fact, though it also provides antitrust protection for companies that share information to fix or mitigate the problem. It would limit immunity for companies that made a good-faith effort to stem the problem by offering replacement products to buyers and giving customers formal notice that a product could fail because of the Y2K bug. The measure also would require that manufacturers and other vendors replace software or hardware products introduced on or after Jan. 1, 1995, for free to qualify for the limited immunity. The bill does not shield from liability companies that negligently ignore the problem despite all the notoriety surrounding the exposure.

If businesses wish to help others—or be helped themselves—in eliminating the risk of losses from the Millennium Bug, these proposals deserve their support. Without business backing, this window of opportunity to lick the problem will be shut for good.

Delay avoids rush job on health reform

WHEN IT COMES to health care legislation, experience has shown that speedy action by Congress can be dangerous.

That is why we are relieved that Senate leaders agreed last week to put the brakes on patient protection legislation until Congress returns to Washington in September after its summer recess and has a chance to carefully consider the proposals.

It was frightening enough to watch the House of Representatives last month debate its version of patient protection legislation without many—perhaps most—members having had time to even study what they were voting on.

Indeed, a frequent and fair complaint that members voiced on the House floor was that they had received the actual text of the bill they were voting on only hours before the vote.

Given the hurried drafting of this legislation and the even more rushed consideration of it, would it be any surprise that the legislation might be severely flawed?

We don't know if that in fact is true. But given what is at stake—rules affecting hundreds of thousands of health care plans covering roughly 160 million people—finding out after the fact strikes us as a disastrous way to put together legislation.

But that, at least until now, has been what Congress has been doing on patient protection legislation. The traditional and logical way Congress generally considers important legislation is to hold hearings to debate the pros and cons, vote on the measure at the committee level and then—if the bill has moved forward—schedule votes by the full House and Senate.

This vetting process—if not altogether perfect—at least gives a greater chance for not only the public to be heard, but also to assure there is sufficient time to spot problems and correct them.

But that logical consideration of the patient protection bills has not occurred, despite the potential impact of the measures. Congressional leaders elected to skip committee consideration of the bills and send them straight to the floor.

The haste with which these measures are being considered makes us wonder if legislators have a different agenda in mind. Rather than making a serious effort to pass legislation, it seems that each party is using health care patient protection—a potent political issue—to bash the other side.

Indeed, many of the remarks made by House Republicans and Democrats when that body considered patient protection legislation had more to do with blasting political opponents than the merits of the measures.

All of this isn't to say that we don't believe that some type of patient protection legislation isn't needed. We have seen enough evidence that some type of federal intervention is needed to protect enrollees from managed care plan abuses.

Ideally, legislation should be put off until next year. But if not, we hope that Senate leaders and their staffs from both parties can get together during the long recess and carefully assemble a bipartisan bill. That would give members more time to review it before scheduling a vote by the full Senate.

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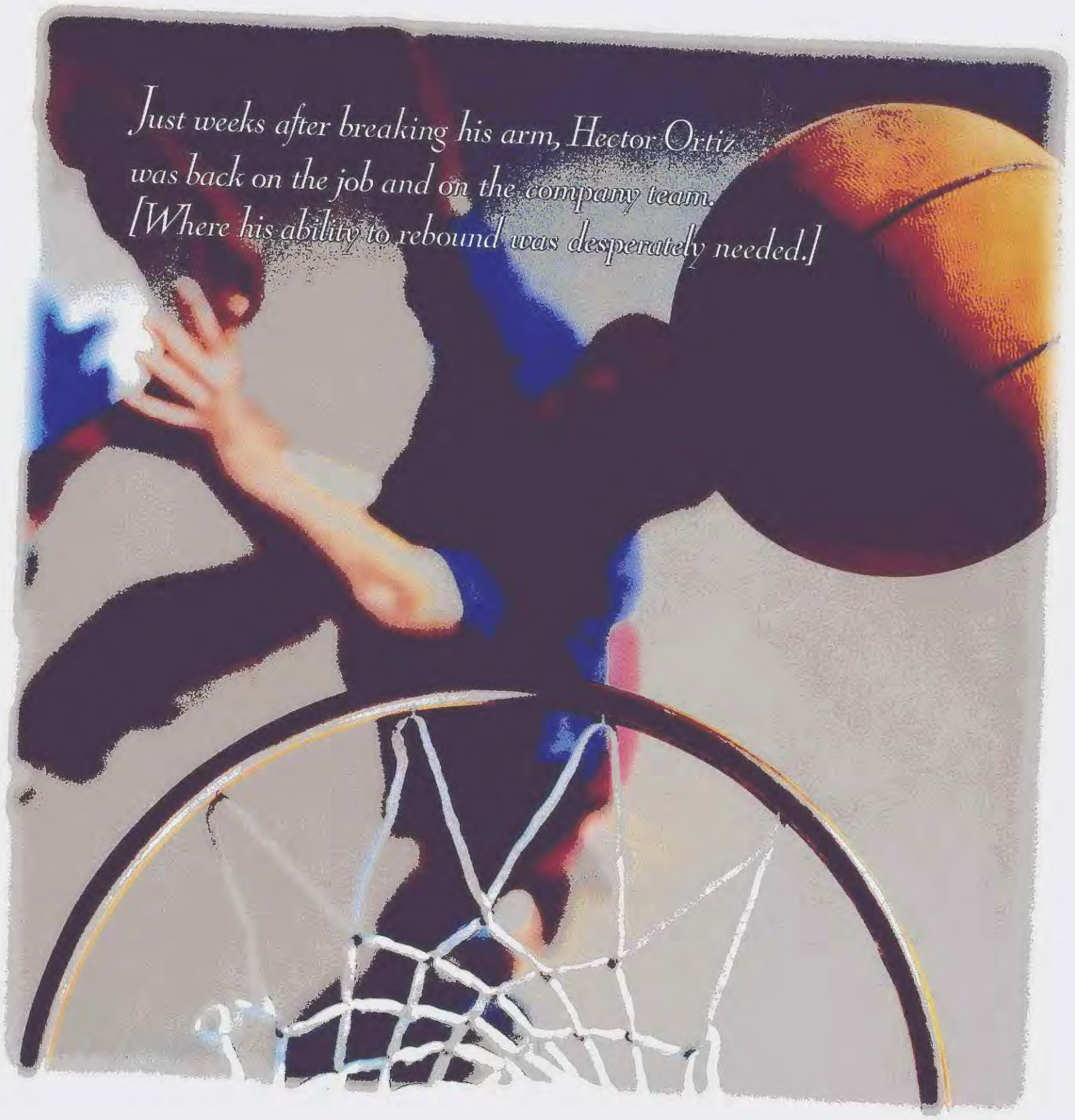
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Know and follow Medicare/Medicaid rules: Speaker

By JOANNE WOJCIK

Managed care organizations that provide care to Medicare and Medicaid beneficiaries must develop a "compliance culture" to avoid allegations of fraud by the federal government, a managed care liability expert asserts.

Such steps are necessary to respond to stepped-up enforcement of federal regulations aimed at protecting beneficiaries enrolled in managed care organizations, said Paula J. McCann, an attorney with the Denver law firm of Kutak, Rock.

The government has allocated billions of dollars to strictly enforce the Health Insurance Portability and Accountability Act, the Balanced Budget Act of 1997 and the False Claims Act, according to Ms. McCann.

"The uncertainty isn't whether or not there are enforcement activities taking place. The uncertainty is what direction are they going to come at you from," Ms. McCann told a group of risk managers for managed care organizations attending a recent seminar hosted by J&H Marsh & McLennan Inc. in Marina Del Rey, Calif.

Managed care companies should keep up on enforcement trends because "just about any mistake can now be deemed fraud. You need to be prepared," she said.

For example, "on June 26, when we all woke up, compliance plans were no longer optional. They are now required," Ms. McCann said, referring to Interim Final Rule 42 C.F.R. 422.501(b)(3)(vi), which was added to the Code of Federal Regulations.

Under this regulation, everyone involved in a managed care organization must participate in the compliance plan: doctors, staff, vendors and the management team.

"Choose your business partners wisely. Due diligence is not just a term to be thrown about," she said.

"Under HIPAA, you can't do business as a Medicare managed care contractor with someone who has any degree of ownership or who has an equity position in your plan who has been deemed unacceptable in any federal health program," she pointed out.

"If they've been thrown out of any federal health program, they cannot participate in an ownership manner or a management manner in your new venture. So you've got to do background checks," Ms. McCann said.

In adopting a "compliance culture," managed care companies also should educate their entire staffs about "why the law is what it is," she advised.

"People picking up the phones on your membership services line should know more than what the rule says. They have to understand where the rule came from. They have to understand that in order to apply facts, in order to adjudicate issues without causing problems," she said.

To ensure fair treatment of Medicare and Medicaid beneficiaries, employees of managed care organizations should be reminded daily "that they stand in the shoes of the federal government, that they're dealing with beneficiaries who have rights," Ms. McCann said.

In particular, managed care companies need to be careful how they handle "dual eligibles," or those patients eligible for both Medicare and Medicaid, she said. Medicare pays primary, she explained.

"For those of you who do both Medicare managed care and Medicaid managed care contracts. . .I feel for you," she said. "You are dealing with the most complex payer mix in the country, if not in the world."

"There are very limited amounts of skilled human talent in this area of Medicare-Medicaid managed care. It's hard to find people who truly understand the nuts and bolts," Ms. McCann said.

Among Ms. McCann's other admonishments to the risk managers:

- Make sure your providers are licensed and that they have active—*active*—Medicare provider numbers."

Furthermore, "triple check, especially in an urban area, that providers have hospital privileges, because it is deemed lying to HCFA to list anyone who is not a bona fide provider on your Excel spreadsheets."

HCFA, the Health Care Financing Administration, administers the federal Medicare program.

- Don't illegally enroll beneficiaries. Don't lie to them; don't tell them their doctor is in the network if he isn't. That means your marketing staff has to be trained very, very well, and there has to be tremendous oversight."
- Don't refuse to provide Medicare-covered services unless you deem it—and really document it—as not medically necessary."
- Train doctors not to counsel or advise patients on which plan to enroll in."

While there are no specific provisions in any of the new laws prohibiting doctors from serving as counselors, "there are in the Medicare marketing guidelines, where HCFA explains that they don't want the line between physician as healer and treater being confused by the beneficiary with physician as insurance counselor," Ms. McCann explained.

- Prohibit staff of providers or providers themselves from health screening."

Health screening is the practice in which healthy beneficiaries are encouraged to enroll in managed care plans, while unhealthy beneficiaries are discouraged from enrolling or advised to disenroll because they've become sick.

Managed care companies found to have practiced health screening can be fined $100,000 for every beneficiary involved, according to Ms. McCann.

"This is a very high-stakes game" with very little margin for error, she warned. BI



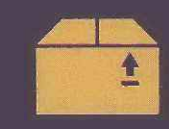
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HMOs

Continued from page 3

systems, said Neil Austin, director of national consulting practice for the MEDSTAT Group in San Francisco. "The kinks are not yet worked out," he said. As a result, employees in one area of the country may not be treated the same as employees in other areas.

A similar employer strategy for easing health plan administration has been to try to negotiate similar plan designs with multiple HMOs and to allow employees to choose among the plans.

This has been done by Laboratory Corp. of America Holdings, said Craig Drake, director of corporate benefits for the Burlington, N.C.-based company. Rather than administer its HMOs individually, the company has a policy of managing its entire spectrum of plans as a group, he said. Starting in late 1996, the company attempted to equalize the services offered by each of the 16 plans it currently uses, so that the services are now essentially the same. This forces the employees to choose plans not based on what services are covered but by the providers in the network and the costs of the plan. As a result, the HMOs now compete on the basis of price, customer service and their selections of providers, he said.

Rather than change health plans and disrupt employees, many employers are opting to work with health plans to address the issues that are driving up claims costs, says Rich Sinni.

Also, the company now offers only two HMO options at each of its locations, helping to reduce employee confusion over the plans. This also allows the HMOs to obtain enough enrollees to provide stable rate bases, he said. Since the HMOs are familiar with the plan, "in a sense, it's very easy to implement," Mr. Drake said.

A similar strategy has been pursued by the Pacific Business Group on Health, according to Emma Hoo, senior project manager for the employer coalition in San Francisco. In 1994, PBGH negotiated a standard HMO package with 12 HMOs in the state. To date, more than 400,000 people from the coalition's 35-member companies have enrolled in these plans.

The idea is "to be able to compare the value of one plan relative to another, so you're looking at the same package," Ms. Hoo said. "It compares apples to apples," she added.

Rather than having employees compare different plans from different HMOs, the standard plan lets employees choose based on the panel of providers and the plans' performance, as evaluated by the coalition.

Beyond the standard plans, each plan offers certain options that members' employers can choose from, like picking additional options to customize a new car. Employers can choose more or fewer options, which will be reflected in the cost of the plan.

Rather than change health plans and disrupt employees, many employers are opting to work with health plans to address the issues that are driving up claims costs, said Rich Sinni, New York health care practice leader in the New York office of Watson Wyatt Worldwide.

"It's basically looking at what's not been working with the plan and improve it," Mr. Sinni said. "If there is a particular illness or disease within that plan, make sure it is addressed," he noted.

To help employers, Watson Wyatt has been conducting "a health plan evaluation" with some of its clients, he said. The goal is to "evaluate the health plan and see what's not working," and then correct it.

After the evaluation is done, Watson Wyatt and the employer bring the findings to the plan and ask it to develop a strategy to correct the problems. The key to correcting the problem is a good relationship, almost a partnership with the plan. "If it's an adversarial relationship, it's not going to happen," Mr. Sinni said. "You each have to do your part."

Although few employers are adding covered services to their HMOs, many are including disease management programs or are strengthening existing programs that address health problems among their employees, consultants said.

Employers want the health plans not only to have disease management programs but to "focus them on the right diseases," said Blaine Bos, principal in the Chicago office of William M. Mercer. For example, a company that has identified a problem with asthma among its employees might initiate an HMO's disease management program to reduce the number of asthma attacks.

Perhaps in response to requests by employers, many HMOs now are promoting their disease management features. "Health plans and drug companies are compet-

See **HMOs** *on page 14*

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HMOs

Continued from page 12
ing on this," Ms. Darling said.

Beyond managing diseases, employers, principally large ones, are looking at ways to improve their HMOs' operations, to make them work better while also reducing costs.

Employers "look to improve the way the health plan delivers services," Mr. Bos said.

Most sophisticated buyers realize that "if they tweak the health plan design, it won't have a large impact on cost." So they focus on changing the operations to make it more efficient and to keep cost increases in line, he said.

The response by plans has been somewhat mixed, Mr. Bos said, with some appreciating that employers want to work with them, while "some plans are saying, 'Get out of my business,' " he said.

Ameritech Corp. in Chicago, for example, asks that the many HMOs it contracts with meet certain administrative conditions, said Alan Peres, manager for benefit strategy and implementation. Over the years, they have pushed the HMOs to be accredited by the National Committee for Quality Assurance, and they have customized their plans to exclude coverages such as dental or vision care that are covered by other, separate plans.

Most sophisticated buyers realize that 'if they tweak the health plan design, it won't have a large impact on costs,' says Blaine Bos of William M. Mercer.

Pushing HMOs to add providers or hospitals has also been used by employers to tailor their plans, consultants said. "The most important customization is who's in the network," said Watson Wyatt's Ms. Darling.

This kind of change is hard for plans, however, as plans generally already have a full network of providers.

An important factor that often determines what type of changes are sought is the size of the employer, said Carmine Morano, president of Anthem Health & Life Insurance Co. of New York. For small employers, "the most important thing is price and network," Mr. Morano said.

The best way for smaller companies to lower health plan costs is to raise the employees' copayments, raise the deductible, or reduce the percentage covered for out-of-network providers, he said. Another method is to lower the amount that plans consider reasonable and customary for out-of-network services, thus increasing the employee's portion of the charge.

"Smaller employers will work within standard parameters that a plan has—to put a different variety of the plan in existence—in order to reduce expenses," Mr. Morano said.

He said a standard procedure with some health plans, when sending out a notice of a proposed rate increase, has been to include a list of ways to reduce the increase by altering the plan. "Activity in that area is robust," he said. "Almost all employers are making some sort of plan change."

Large employers can use the same techniques to lower a rate increase, but they have additional tools not at the disposal of small employers, he said. "They have a lot more flexibility within the scope of the plan than small groups have," Mr. Morano said. For example, they can attach riders that exclude certain coverages, such as for certain drugs or services.

Another strategy is to charge employees more for the plan, something employers rarely do, as it upsets employees. The best thing for employers is "to change the things in the plan the employees don't see," such as increasing the out-of-network charges, Mr. Morano said. BI

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Gatekeeper

Continued from page 3

tered access to specialists could drive up health care costs.

"Employers are sitting on the hot seat," said Dr. Thomas D. Barela, a Phoenix-based physician and medical director for The Segal Co. With only so much discretionary income to spend on health care, employers have to be careful not to let costs spiral out of control, he added.

Ms. Levine said employers are divided over what to do with the gatekeeper model. "Some employers aren't ready to let go because they are concerned about increased cost. Some say employees won't stand for it, so they have opened it up completely."

Mr. Rosenfeld pointed out that pressure to remove the gatekeeper has been building for a long time from patients who don't like having a single physician taking responsibility for all their health care needs.

Mr. Erb said the "single most irritating aspect of managed care, from an employee perspective, is the gatekeeper function."

He said that while the system worked well when managed care first began gaining acceptance, "10 or 20 years later, we're looking at the system and saying, 'Wait a minute; why does a child with a broken arm need a referral to an orthopedist?' "

The inconvenience to employees is one reason that Sbarro Inc. opted for a preferred provider organization without a gatekeeper restriction.

"We've resisted going to a gatekeeper plan; we just don't believe in it," said Ash Kilada, director of risk management and benefits at Comack, N.Y.-based Sbarro.

Mr. Kilada said Sbarro's approach hasn't raised costs significantly. "I've seen the breakout for specialists visits, and it's really minimal. I don't think it's a big portion of our costs," Mr. Kilada said.

'I've seen the breakout for specialists visits, and it's really minimal. I don't think it's a big portion of our costs,' says Ash Kilada of Sbarro Inc.

He pointed out that Sbarro has other controls in its plan that are as effective "if not better than a gatekeeper," in controlling its health care costs. He said high deductibles and a copayment prevent employees from seeking expensive treatments unless they really need them.

Sbarro's network is made up of general practice doctors and specialists. A consultation with any network provider costs the employee $10. If a procedure is performed, the patient pays a $250-per-year deductible and 10% of the treatment cost above that amount.

Seeing a provider outside Sbarro's PPO bumps up the deductible to $400 a year. The 10% copay requirement after hitting the deductible still applies.

Not all employers, however, are critics of the gatekeeper system.

At Hartmarx Industries Inc. in Chicago, the gatekeeper HMO is "serving its purpose," said Michael Pikelny, corporate actuary and employee benefits consultant. "Most of our employees know, when they sign up for the HMO, that they are restricted as to whom they can see. We haven't had that problem here," he said regarding employee dissatisfaction with the gatekeeper arrangement.

Mr. Pikelny pointed out that a patient with an emergency can see a specialist immediately, whereas non-emergency care from a specialist may require the patient to wait, perhaps up to three weeks for an appointment.

Mr. Pikelny said he is sure that without the gatekeeper control in place, his company's health care costs would rise. "Absolutely. The main reason HMOs have been able to provide service at a lower cost. . .is the gatekeeper factor. If you do away with it, it seems it would have to lead to higher costs."

Physicians aren't the biggest fans of the gatekeeper model, Mr. Rosenfeld said. "On the provider side, I don't think there has ever been tremendous acceptance or fondness of the concept."

Mr. Rosenfeld said anecdotal evidence suggests physicians feel some pressure as gatekeepers to keep the patient at the primary care level. That makes some doctors uncomfortable, he said, because they feel pressured to provide care that they believe specialists should deliver.

HMOs have reacted to the debate by making changes that eliminate or streamline the physician's role as a gatekeeper.

PacifiCare Health Systems Inc., for example, last year began offering to PacifiCare of California members its Express Referral program. The program lets a primary care physician send a patient—after an office visit—directly to a specialist in any of 16 fields, including cardiology, dermatology, neurology, obstetrics and gynecology, and others.

The new program allows doctors and patients to avoid long waits for approval to see specialists, said a spokeswoman for PacifiCare Health Systems. Before the program was introduced, most approval requests were granted anyway, she said, and the Express Referral system eliminates much of the administrative work that was needed to gain the approvals.

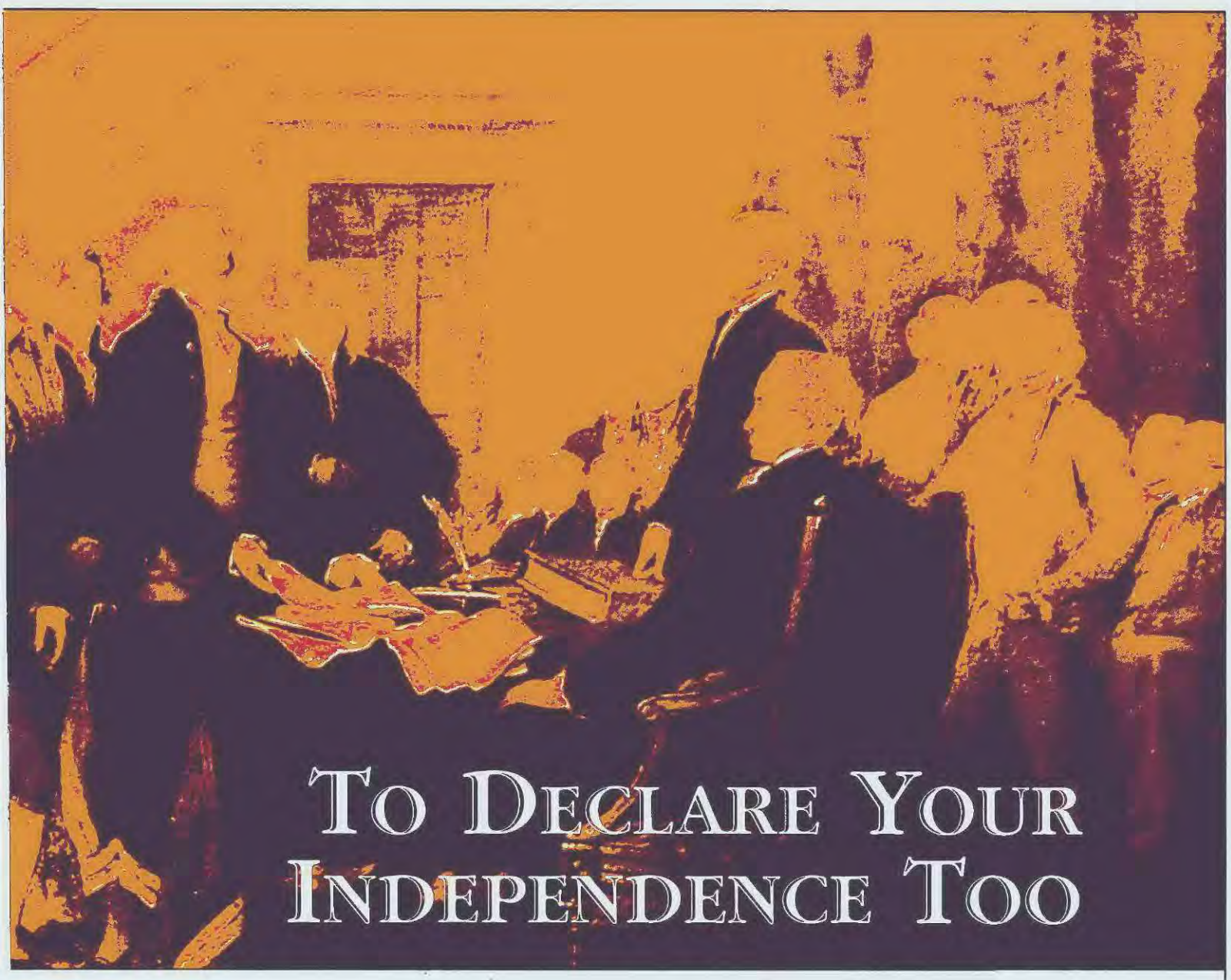
The program has been expanded to PacifiCare operations in Texas and the parent company plans to offer it in other states, the spokeswoman said.

Kaiser Permanente, a large HMO based in Oakland, Calif., never has used gatekeepers.

"We don't use the gatekeeper model," said Dr. Sharon Levine, associate executive director at Kaiser Permanente in California. "It doesn't make any sense, given our group practice."

Kaiser members can make appointments directly with specialists in several practice areas. Someone with a skin problem, for

See **Gatekeeper** *on next page*



Express Scripts® ◆ ValueRx

Gatekeeper

Continued from previous page
example, could call the plan's dermatology department to schedule an appointment with a dermatologist.

Kaiser is working to speed up access to specialists in other ways, Dr. Levine said. One method is through the HMO's "bone phone," which gives a physician an immediate link to an orthopedist. Dr. Levine explained that a pediatrician treating a child in the physician's office, for example, could reach an orthopedist who carries a cellular phone. The orthopedist could then give advice over the phone or come to the office to take a look at the child.

Ms. Levine of The MEDSTAT Group pointed out that many HMOs have made moves to change the role of the gatekeeper. "There are a number of different ways of approaching it. I think health plans are getting very flexible in response to employee concerns."

Dr. Barela said there is a new tendency to create illness-specific networks, being formed to exclusively treat, for example, diabetics, patients with renal disease, patients with oncology needs, and others.

"There is data that suggests that, given the choice, patients will choose a specialist as their primary care physician if they have a specific illness," he said.

Even as it appears that the gatekeeper is vanishing from the scene, some controls on patient access likely will remain in place, according to Dr. Barela.

After all, the original concept of managed care "was for the patient to give away choice" in return for lower costs, he pointed out. "There will need to be some mechanism, whatever it is," Dr. Barela said. 'Some form of controls will be needed."

Ms. Levine noted that while employers and plans are responding to patients' concerns about restrictions to access, "that doesn't mean they're all ready for the gatekeeper models to disappear. There isn't good evidence that it saves or costs any substantial money."

Mr. Erb said the evolution of the current system is "definitely a work in progress. It's gone about as far as it can, it seems, with the classic gatekeeper HMO. The question is: Where do we go next?" BI

PBMs

Continued from page 3
cholesterol level treatment threshold to 200 from 240. "That could increase the number of people eligible (to be prescribed medication) from 38 million to 97 million people," Mr. Voris estimated.

If doctors adopt these more aggressive medical standards, "there's more potential to spend more on pharmaceuticals than there would have been in years past," he said.

So what can employers providing prescription drug coverage do to keep these costs in check?

According to consultants, the most popular strategies are:

- Instituting multitiered copayments that encourage the use of generics and less expensive brand name drugs.
- Offering mail-order programs for maintenance drugs, which would mean lower prescription costs because the drugs are purchased in bulk.
- Requiring utilization review for certain high cost drugs.
- Excluding or limiting coverage for so-called "lifestyle drugs," such as the anti-impotence drug Viagra and the anti-baldness medication Rogaine.

While some strategies, such as the multitiered copayment strategy, are not really new, they're getting a second look because of drug cost inflation, said Hewitt's Ms. Eber. Employers are "starting to think about why their current copayment structure is the way it is," she said, especially when employees are paying the same copayment for expensive brand name drugs as for less expensive generic drugs.

"A lot of people are starting to examine this, because it still maintains physician and patient choice and yet it puts a little bit of the burden of the expense back onto the member or the employee," said PCS' Mr. Voris. The tiered approach is much like the point-of-service plan, which provides higher benefits for using in-network providers than for out-of-network providers, he explained.

The most common tiered approach is a $5 copayment for generics, a $10 copayment for formulary brand name drugs and a $25 copayment for non-formulary brand name drugs, according to David D. Halbert, chief executive officer of Advance Paradigm Inc., a PBM in Irving, Texas.

A recent William M. Mercer Inc. survey of employers using PBMs found that retail copayments averaged $5 for generic drugs and $10 for brand name drugs, while copayments for mail-order prescriptions were somewhat higher, averaging about $6 for generics and $13 for brand name drugs (see chart on next page).

But many consultants and PBMs recommended there be at least a $10 differential between copayments for each of the three tiers—generic drugs, brand name formulary drugs, and brand name drugs not on the formulary—to provide a real deterrent from using the more expensive drugs.

"You need a $10 differential to really influence physician and consumer behavior," observed Mr. Voris.

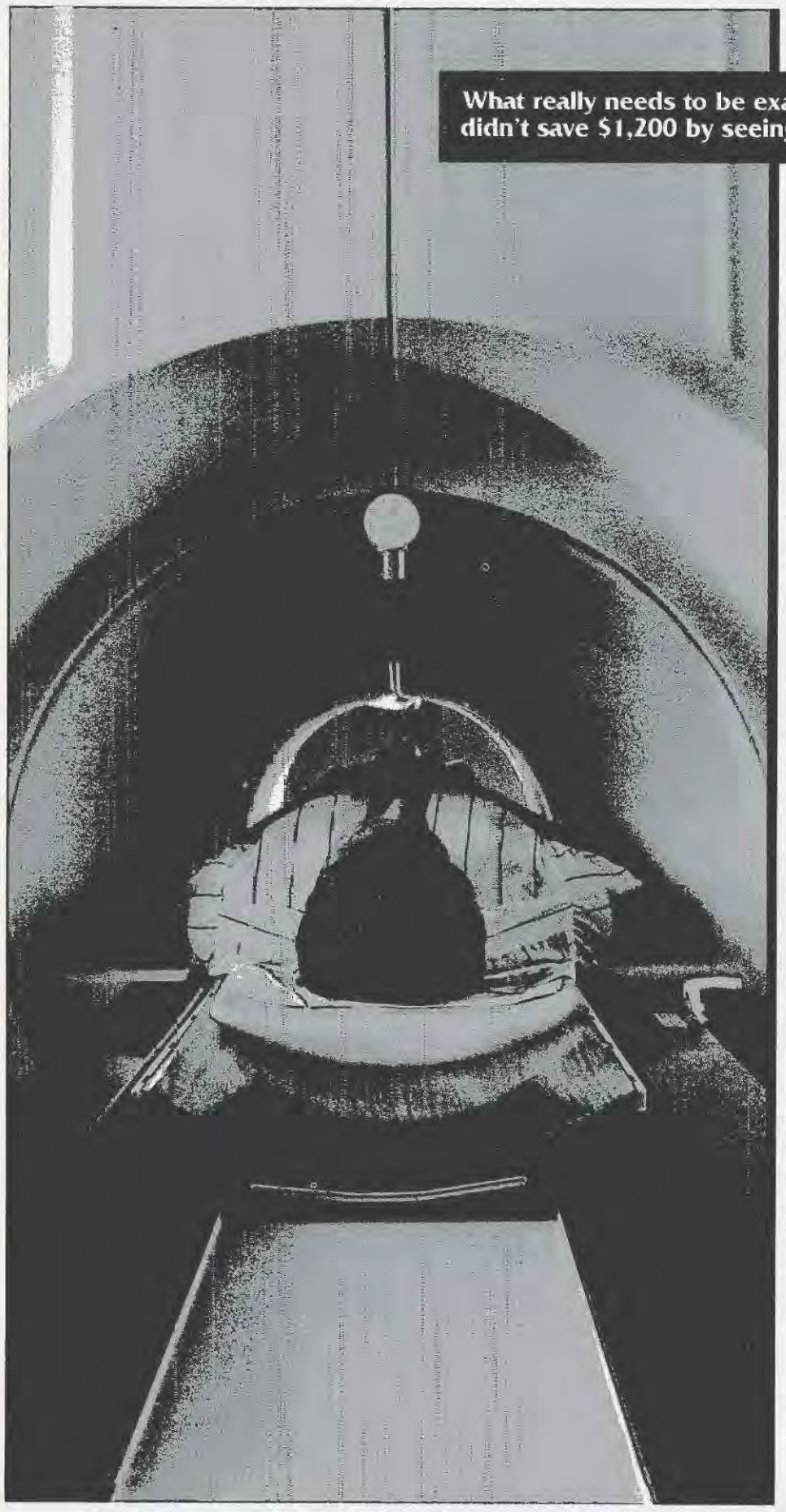
In some cases, employers are implementing co-insurance provisions, such as covering a fixed percentage of a drug's cost. This way any inflationary increases are shared equally by the employer and employee, explained Andrea O'Boyle, an employee benefits consultant with Buck Consultants Inc. in New York. It also gives employees a better idea of the drug's real cost, she added.

While a multitiered approach may work for influencing retail prescription drug purchases, a flat copayment structure still is recommended for mail order purchases, according to Ms. O'Boyle.

That's because these prescription medications are purchased and filled in bulk and cost a lot less. "Employers can save money with mail order because the discounts are higher," Ms. O'Boyle said.

Indeed, "there are more clients asking about mail order," said Hewitt's Ms. Eber. "And occasionally we see clients consider mandatory mail order provisions

Continued on next page



Continued from previous page
for maintenance drugs."

Some employers, particularly those that self-insure, are restricting coverage for certain expensive drugs that usually are approved for restricted use by the FDA, according to Ms. Eber. "These are drugs that are usually included on formularies but can be abused if they're not given for their intended use," she said. For example, growth hormones prescribed for children often are sought by athletes wanting to build muscle.

In other cases, if certain "lifestyle drugs" such as Viagra or Rogaine are included on formularies, employers are either seeking limits on what quantity of a drug they will cover or are choosing not to cover them at all, according to Ms. O'Boyle. "This is likely to occur more with the increased direct-to-consumer advertising of these drugs," she said.

"All of these lifestyle drugs are adding tremendously to drug plan costs," pointed out Watson Wyatt Worldwide's Mr. Sinni.

For the most part, employers are not involved in selecting the drugs included on PBM formularies, pharmacy benefit experts say. But some of them are beginning to question why certain drugs are included or excluded.

"Employers want to know what the formularies are and may want certain drugs included, but for the most part, they're leaving the formularies up to the health plans," said Mr. Sinni.

"We have 20 clients with their own P&T (pharmacy and therapeutics) committees, but they're mostly health plans," said Advance Paradigm's Mr. Halbert. This year marked the first time an employer client set up such a committee, he said.

Besides implementing these cost-containment strategies, employers also are beginning to audit PBMs to evaluate their performance and implement guarantees, according to Mr. Sinni. "They're putting their PBMs' feet to the fire just as they did with health plans," he said. "While perhaps 15% of employers did this fiv years ago, now 35% to 40% ar doing it today."

As part of performance guaran tee negotiations, some employer are asking to share in the volum rebates prescription benefit man agers receive from drug makers according to Buck's Ms. O'Boyle.

Major-brand pharmaceutica companies pay an estimated $ billion in "incentive payments, or rebates, annually to the PBM industry, according to an articl in the April 1997 issue of *Pharma ceutical Executive*.

Employers and health plans als are pressing PBMs to provide dat on prescription drug use, accord ing to Hewitt's Ms. Eber. "What see are written performance guar antees that PBMs make drug uti lization data available to healt plans to use at the health plans discretion," she said. She ex plained that health maintenanc organizations in particular wan the data to see what thei providers are prescribing.

As a result of this pressure t keep drug costs in check, th PBMs themselves are institutin cost containment measures inter nally as well, according to Ad vance Paradigm's Mr. Halbert For example, "we profile physi cians and pharmacists every quar ter, comparing their prescribin habits with formularies and th practice of their peers," he said.

In addition, the computer sys tem accessed by the 52,000 phar macies online with Advanc Paradigm automatically alert pharmacists about generic substi tutions, as well as possible drug interactions and allergic condi tions that could add to medica treatment costs, Mr. Halbert ex plained.

"We have a complete arsenal o cost-effectiveness programs," said Jeffrey Jones, executive vp and chief operating officer of Brook field, Wis.-based PBM ProVan tage Inc.

Perhaps the most innovative program is the use of computer al gorithms to identify potential sav ings in pharmaceutical spending For example, "many patients are on drugs longer than they should be, or a patient may be taking re dundant drugs prescribed by two different physicians," Mr. Jones explained.

In some cases, "we can predict that certain drug combinations will increase the risk of a patient going to a hospital," he added Based on data derived from its own database as well as that ProVantage obtained through the recent acquisition of Arlington Va.-based PharMark Inc., "be tween 7% and 10% of hospital stays are drug-induced," he said.

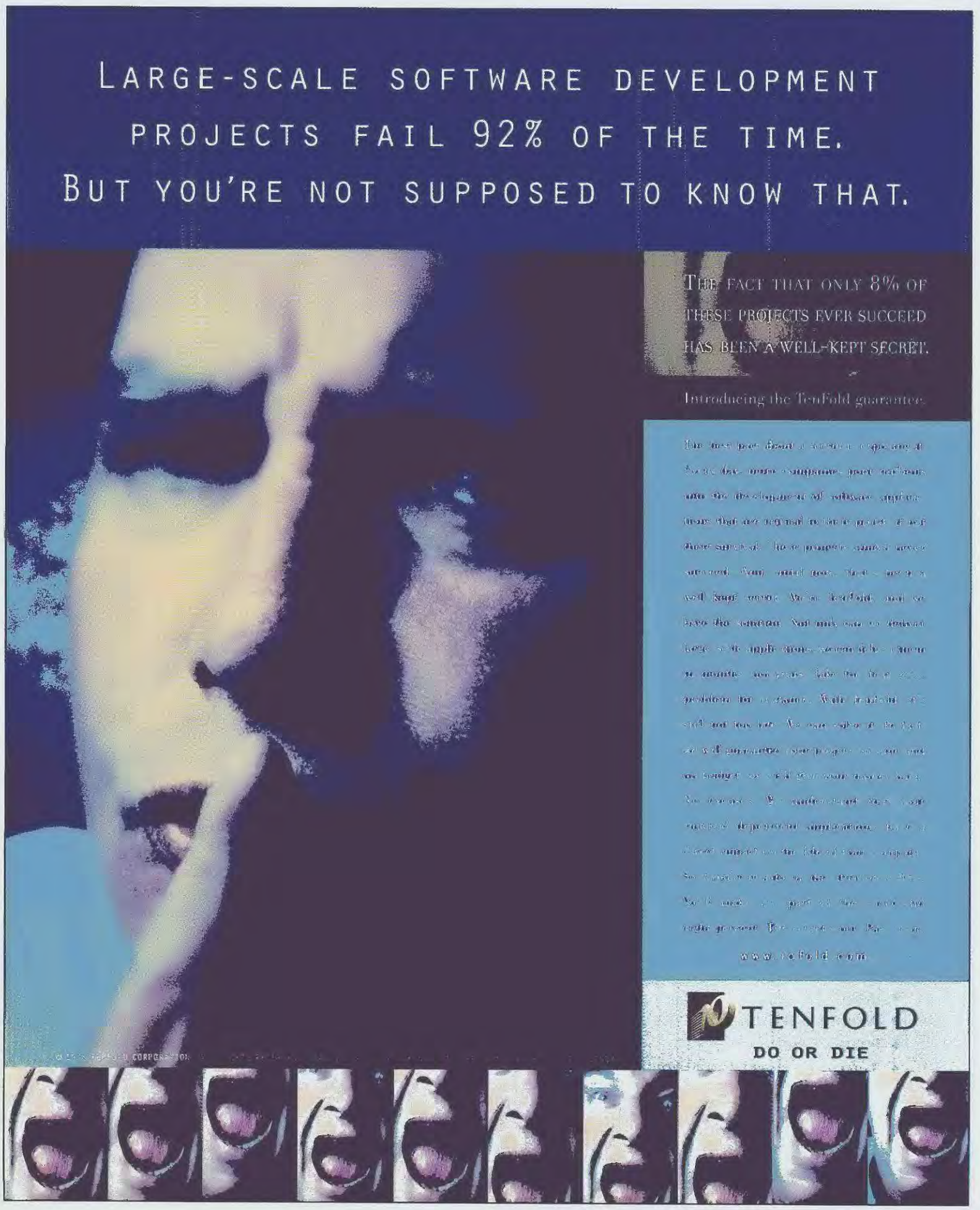
PharMark designs, develops and licenses software products, pro viding access to a proprietary database containing more than 75 million patient years of U.S. and international health care en counter data. BI



Out-of-pocket Rx costs

A William M. Mercer Inc. survey of employer-sponsored plans found these median copayments for various prescription drugs:

	PPO/POS	HMO	PBM
Retail: brand-name	$10.0	$10	$10
Retail: generic	5	5	5
Mail order: brand-name	12	10	15
Mail order: generic	5	5	5





THE SIXTH ANNUAL

Business Insurance® WORKERS COMPENSATION CONFERENCE



OCTOBER 26-28, 1998

The Ritz-Carlton Hotel Marina del Rey, California

WHO SHOULD ATTEND

Risk managers, loss prevention and safety managers, workers compensation and benefit managers, plus insurers, brokers, consultants and representatives from HMOs, PPOs and state and local governments.

PROGRAM AGENDA

MONDAY, OCTOBER 26

9:30 AM
GOLF TOURNAMENT
Hosted by: Deloitte & Touche LLP and SAC³

3:00 PM
EARLY REGISTRATION

4:00 PM
EMPLOYER'S PRIVATE ROUNDTABLE
Moderator:
Kathryn J. McIntyre
Vice President, Publisher and Editorial Director
Business Insurance

5:30 PM
WELCOME RECEPTION
Hosted by: Integra Group

TUESDAY, OCTOBER 27

7:45 AM
REGISTRATION AND CONTINENTAL BREAKFAST
Hosted by: Bayne Consulting Group, Ltd.

9:00 AM
OPENING REMARKS
Alexandra Scott
President & CEO
International Business Forum

9:05 AM
KEYNOTE
Bruce G. Sundquist
Vice President
American Re-Insurance Company

CHALLENGING TRADITIONAL WORKERS COMPENSATION PARADIGMS

9:45 AM
THE NEW WORLD OF WORKERS COMPENSATION
Moderator:
Maddy E. Bowling
Independent Consultant

William Granahan
Senior Consultant
Milliman & Robertson Inc.

Barry E. Thompson
National Practice Co-Leader
Workers Compensation and Disability Management Services
Deloitte & Touche LLP

Daniel J. McVey
President
Missouri AFL-CIO

Greg Owen
Manager, Claims Administration
Risk Management
Harrah's Entertainment Inc.

Scott Lund
Vice President, Marketing
SAC³

10:30 AM
TABLE-TOP EXHIBITS
REFRESHMENTS
Hosted by: Paradigm Health Corporation

11:00 AM
THE DECISION WHETHER TO IMPLEMENT AN INTEGRATED DISABILITY MANAGEMENT PROGRAM
Moderator:
Terry R. Bolz
Vice President, Casualty Managed Care
Wausau Insurance Companies

Tom Parry
President
Integrated Benefits Institute

Victor Paganucci
Director, Integrated Disability Systems
Champion International Corp.

Joanne L. Pomerleau, B.S., RN
Workers Compensation Coordinator
Maine Employee Health and Benefits

Arthur Wilcox
Director, Public Employee Division
New York State AFL-CIO

12:00 PM
MEETING THE CHALLENGES CREATED BY THE AMERICANS WITH DISABILITIES ACT AND FAMILY MEDICAL LEAVE ACT
Moderator:
Betsy Robinson
Vice President
Product Development and Management
GENEX Services Inc.

Robert B. Steggert
Vice President, Casualty Claims
Marriott Corporation

Ken Mitchell
Vice President, Return-to-Work Programs
Provident Insurance Company

Marylou Kinlen
Manager of Disability Plans
Norwest Bank Corp.

Sharon Kaleta
Director of Risk and Benefits
Paragon Steak House Restaurants Inc.

12:45 PM
LUNCHEON
Hosted by: Intracorp

1:45 PM
LUNCHEON SPEAKER
Susan K. Moreland
Director of Risk Management
San Francisco Newspaper Agency

A CASE STUDY ON REDUCING WORKERS COMPENSATION LIABILITIES

2:15 PM
BREAK

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- Integra Group
- Paradigm Health Corporation
- SAC³
- Specialty Risk Services / The Hartford
- TravelersPropertyCasualty/ Constitution State Services
- Wausau Insurance Companies

2:30 PM
CONCURRENT SESSIONS: A OR B

Session A:
ALTERNATIVE DISPUTE RESOLUTION

Moderator:
Duncan Ballantyne
Senior Analyst
Workers Compensation Research Institute

Ed Zutler
Vice President, Integrated Benefits
AIG

Pat McGinn
Senior Business Representative
Regional Council of Carpenters

Mike Massey
Assistant Executive Director
Piping Industry Progress and Education Trust Fund

Session B:
ARE YOU USING THE RIGHT REPORT CARD?

Moderator:
Peter F. Rousmaniere
President
Rousmaniere Designs

Nicholas J. Lannutti
Senior Vice President, Corporate Actuary
National Council on Compensation Insurance Inc.

Alex Swedlow
Research Consultant
California Workers Compensation Institute

Eloise Lincicum
International Workers Compensation/ Employers' Liability Manager
Apple Computer Inc.

Fred Scardellette
Vice President, Information Management Services
Intracorp

3:30 PM
TABLE-TOP EXHIBITS REFRESHMENTS
Hosted by: Wausau Insurance Companies

4:00 PM
CONCURRENT SESSIONS: C OR D

Session C:
FUNDING MECHANISMS

Moderator:
Jeffrey W. Pettegrew
Vice President
Insurance and Risk Management
Western Staff Services

Robert B. Hill
President
Professional Underwriters

Darin R. Haines
Manager, COSE Workers Compensation Program
Greater Cleveland Growth Association

John R. Keenan
Chief Executive Officer
Keenan & Associates

Session D:
EVALUATING ERGONOMICS PROGRAMS

Moderator:
Alexandra R. Charish
President
Charish Ergonomics Inc.

Soha Sadek, Ph.D.
Ergonomist Consultant
Applied Risk Management Inc.

Sam Fulginiti
Risk Manager
Godiva Chocolatier

5:00 PM
COCKTAIL RECEPTION
Hosted by: GENEX Services Inc.

WEDNESDAY, OCTOBER 28

7:45 AM
CONTINENTAL BREAKFAST
Hosted by: TravelersPropertyCasualty/ Constitution State Services

9:00 AM
KEYS TO RESPONSIVE RETURN-TO-WORK PROGRAMS

Moderator:
Dr. Thorv Hesselund
Director of Vocational Programs
Paradigm Health Corporation

Jean M. Long, RN, COHN, CCM
Manager, Loss Control
Fireman's Fund Insurance Company

Clifton Matsuno
Administrator for Rehabilitation Services
Pretect Physical Therapy

Marshall Sherman
Director, Risk Management
Aramark Corporation

Soraya M. Wright
Corporate Risk Manager
The Clorox Company

John J. Larkin Jr., M.D.
Vice President, Clinical Affairs
Integra Group

10:00 AM
TABLE-TOP EXHIBITS REFRESHMENTS
Hosted by: Specialty Risk Services/The Hartford

10:30 AM
DOING WHAT'S BEST FOR THE WORKER: CAUGHT BETWEEN THE EMPLOYER, THE TPA, INSURANCE COMPANY AND THE OCCUPATIONAL HEALTH PROVIDER

Moderator:
Stephen M. Holcomb
Senior Vice President
Specialty Risk Services/The Hartford

Panelists:
Leo Costantino
Workers Compensation Manager
UCLA

Jerry L. Thomas
Managing Director, Workers Compensation
American Airlines/AMR Corp.

11:30 AM
WORKERS COMPENSATION INSURANCE FRAUD: SPECIFIC STEPS AND SOLUTIONS TO COMBATING FRAUD

Moderator:
Dominic Dugo
San Diego County District Attorney

William Kizorek
President
InPhoto Surveillance

Jeff Nale, Esq.
Bello, Tade & Nale

Kevin Saucier, R.S.A., REA
Director of Environmental, Health and Safety
Guess? Inc.

Maria Bayne
President
Bayne Consulting Group Ltd.

12:30 PM
LUNCHEON
Hosted by: AIG American Home Assurance/ Specialty Workers Compensation

1:30 PM
LUNCHEON SPEAKER
Jerry L. Thomas
Managing Director, Workers Compensation
American Airlines/AMR Corp.

THE AMERICAN AIRLINES SUCCESS STORY; BEST PRACTICES AND LESSONS LEARNED

2:00 PM
BREAK

2:15 PM
LOW BACK TREATMENT GUIDELINES

Moderator:
Edward C. Woodward
President
California Workers Compensation Institute

Nancy Geedey, RNC, CCM
Director, Case Management
Managed Care USA Services

Michael D. Roback, M.D.
Diplomate, American Board of Orthopaedic Surgery
Industrial Medical Council of California

3:15 PM
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COMMENTS FROM SOME OF LAST YEAR'S ATTENDEES:

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Business Insurance directory of prescription benefit managers

A

Albertsons Better Care Solutions

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

1997 revenues

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

PBM clients

Total	12
Employer/group plans with direct service	12

Lives covered

Group Health:	
Total	120,000
Through employers	98%
Through Medicare/Medicaid	2%
Workers Compensation:	
Active enrollees	200
Through employers	100%

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

Includes: 3 registered pharmacists

PBM services since: 1994.

Parent: Albertsons Food & Drug; primary business: retail pharmacy.

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

Formularies offered: Open, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, prescription by age.

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

Billing methods: Fee per claim. Volume discounts to employers.

** Subcontracted.*

AmeriScript Inc.

4301 Darrow Road, Suite 4200,
Stow, Ohio 44224;
330-686-7010; fax: 330-686-7011
www.chandler-group.com

1997 revenues

Total gross revenues	$589,346
PBM gross revenues	$589,346
PBM unbundled revenues	$589,346

PBM clients

Total	741
Employer/group plans with direct service	741

Lives covered

Group Health:	
Total	137,514
Through employers	100%

Retail network

Pharmacy locations	40,000

Mail-order services

Percent of prescription volume	95%

Generic usage

Percent of prescription volume	50%

Staff

Total	38
Professionals	34

Includes: 4 registered pharmacists

PBM services since: 1986.

Parent: The Chandler Group of Cos.

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including CVS, Eckerd, Kmart, Rite Aid, Walgreens and Wal-Mart.

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

Service area: Nationwide.

Billing methods: Fee per claim.

Officers: James Keith Piper, president; Joe Colosi, senior vp-managed care; Arthur W. Chandler, chairman; Michelle Swigonski, president-AmeriScript; Cindy Craig, senior vp-operations.

Contact: Michelle Swigonski.

** Subcontracted.*

Continued on page 22

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July 1998

$80,000,000

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extendable to May 31, 2005

The proceeds from this offering have been used to collateralize a retrocession agreement between Pacific Re, Ltd. and Münchener Rückversicherungs-Gesellschaft, the world's largest reinsurance company, covering a pool of insured property risks originally underwritten by The Yasuda Fire and Marine Insurance Company Limited, the second largest non-life insurance company in Japan, against risk of loss arising from typhoons.

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Explanation of directory terms

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

The package of services must include several of these 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 World Wide Web site address. The category **1997 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 1997.

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

Active group health enrollees and active **workers compensation** enrollees in 1997 are also provided. Along with the number of active group health enrollees is a breakout indicating the percentage enrolled via direct contract with employers, through third-party vendors and through Medicare/Medicaid. The percentage of active workers compensation lives enrolled through direct contract with employers also is provided.

Retail network information details 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 1997, details the total number of staff members assigned to prescription benefit management services. The total number of professional staff members is also provided, including the number of registered pharmacists on staff.

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

Network design specifies the types of formularies offered by the PBM. Open formularies allow patients to receive prescriptions from a relatively unrestricted list of drugs, whereas closed formularies impose limitations on the brand names/generic drugs which are available through a given plan. Restricted/customized formularies usually provide reduced coverage for drugs not specified in the formulary, and may allow the client to have some input in the design of the formulary.

The sections that follow indicate the types of **pharmacies** participating in the network, as well as the names of participating retail chains. The types of **reports** provided to the client, the **service area** and **billing methods** offered are also provided. If volume discounts are given to employer clients, it is noted.

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

Listings are generated through responses to a *BI* 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.

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Continued from page 20

Caremark Inc.

2211 Sanders Road,
Northbrook, Ill. 60062;
847-559-4700
www.caremark.com/pharmacy

1997 revenues

Total gross revenues	$1,400,000,000
PBM gross revenues	$1,000,000,000

PBM clients

Total	973
Employer/group plans with direct service	973

Lives covered

Group Health:

Total	8,441,000
Active enrollees	6,330,000
Through employers	97.3%
Through Medicare/Medicaid	2.7%

Retail network

Pharmacy locations	51,000

Mail-order services

Percent of prescription volume	96.3%

PBM services since: 1985.

Parent: MedPartners; primary business: physician practice manager.

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

Formularies offered: Open, closed, based on incentives.

Pharmacies contracted: Independently owned; retail chains.

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

Service area: Nationwide.

Billing methods: Client-specific.

Officers: John Arlotta, president; Sara J. Finley, vp/secretary; Peter J. Clemens, vp/treasurer.

CLAIMSPRO Health Claims Services Inc.

24370 Northwestern Highway,
Suite 200, Southfield, Mich. 48075;
248-352-2852; fax: 248-352-3714
www.claimspro.com

1997 revenues

Total gross revenues	$7,383,412
PBM gross revenues	$7,014,241
PBM unbundled revenues	$5,962,105

PBM clients

Total	960

Lives covered

Through employers	70%
Through third-party vendors	27%
Through Medicare/Medicaid	3%

Retail network

Pharmacy locations	43,000

Mail-order services

Percent of prescription volume	6%

Generic usage

Percent of prescription volume	40.5%

Staff

Total	46
Professionals	27

Includes: 1 registered pharmacist

PBM services since: 1989.

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, high potential medical claim trigger.

Service area: Nationwide, Puerto Rico, Virgin Islands.

Billing methods: Capitated rate, fee per claim.

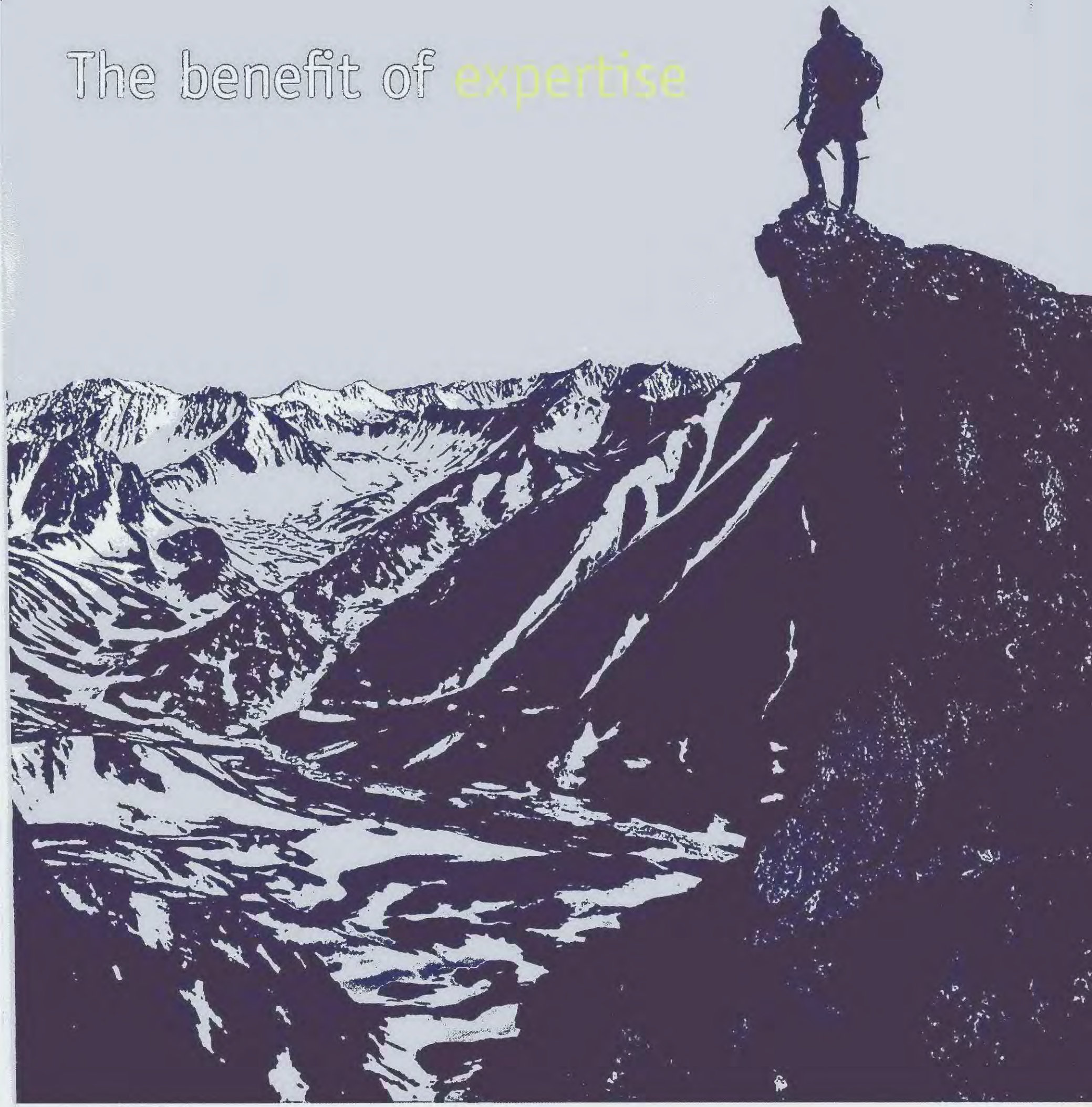
Officers: Ron Klein, executive vp; Bruce Liebowitz, president.

Contact: Ron Klein.

* *Subcontracted.*

Continued on page 24

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Continued from page 22

E

Eckerd Health Services

620 Epsilon Drive,
Pittsburgh, Pa. 15238;
412-967-2300; fax: 412-967-2335

1997 revenues

Total gross revenues	$790,000,000
PBM gross revenues	$20,000,000

PBM clients

Total	320
Employer/group plans with direct service	292

Retail network

Pharmacy locations	49,000

Staff

Total	1,600
Professionals	162

Includes: 140 registered pharmacists

Parent: Eckerd Corp.; primary business: retail pharmacy chain.

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, ad hoc reporting, drug utilization review, disease state management.

Service area: Nationwide.

Billing methods: Capitated rate, fee per claim. Volume discounts to employers.

Officers: Fran Marasco, president; George Watt, vp-business development; Lloyd McDonald, vp-marketing/client service; Jim Smith, vp-managed care operations.

Contact: George Watt, 412-967-2323.

Express Scripts/Value Rx

1400 Riverport Drive,
Maryland Heights, Mo. 63043;
314-770-1666; fax: 314-770-2367
www.express-scripts.com
www.valuerx.com

1997 revenues

Total gross revenues	$2,884,000,000
PBM gross revenues	$2,884,000,000
PBM unbundled revenue	$1,384,000,000

PBM clients

Total	8,568
Employer/group plans with direct service	7,000

Lives covered

Group Health:	
Total	22,000,000
Workers Compensation:	
Active enrollees	440,000

Retail network

Pharmacy locations	52,700

Staff

Total	3,400

Includes: 270 registered pharmacists

PBM services since: 1986.

Services: Retail pharmacy network, mail-order distribution, claims processing, online claims processing, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient education, informed decision counseling, combined med/Rx data analysis.

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, therapy class analysis, detailed cost analysis.

Service area: United States, Canada.

Billing methods: Fee per claim. Volume discounts to employers.

Officers: Howard L. Waltman, chairman; Barrett A. Toan, president & CEO; Stuart Bascomb, executive vp; Thomas Boudreau, secretary/general counsel; George Paz, senior vp/CEO.

Contact: Thor Anderson, vp-marketing, 314-770-1666 ext. 7736.

I

Immediate Pharmaceutical Services (IPS)

5540 Wallings Road,
North Royalton, Ohio 44133;
800-233-3872; fax: 440-230-9011
www.IPSRX.com

1997 revenues

Total gross revenues	$60,000,000
PBM gross revenues	$1,000,000
PBM unbundled revenues	$1,000,000

PBM clients

Total	2,100

Lives covered

Group Health:	
Total	2,000,000
Active enrollees	1,000,000
Through employers	60%
Through third-party vendors	40%
Workers Compensation:	
Active enrollees	5,000
Through employers	30%

Retail network

Pharmacy locations	52,000

Mail-order services

Percent of prescription volume	15%

Generic usage

Percent of prescription volume	49%

Staff

Total	70
Professionals	12

Includes: 6 registered pharmacists

PBM services since: 1987.

Parent: Discount Drug Mart; primary business: retail drug chain.

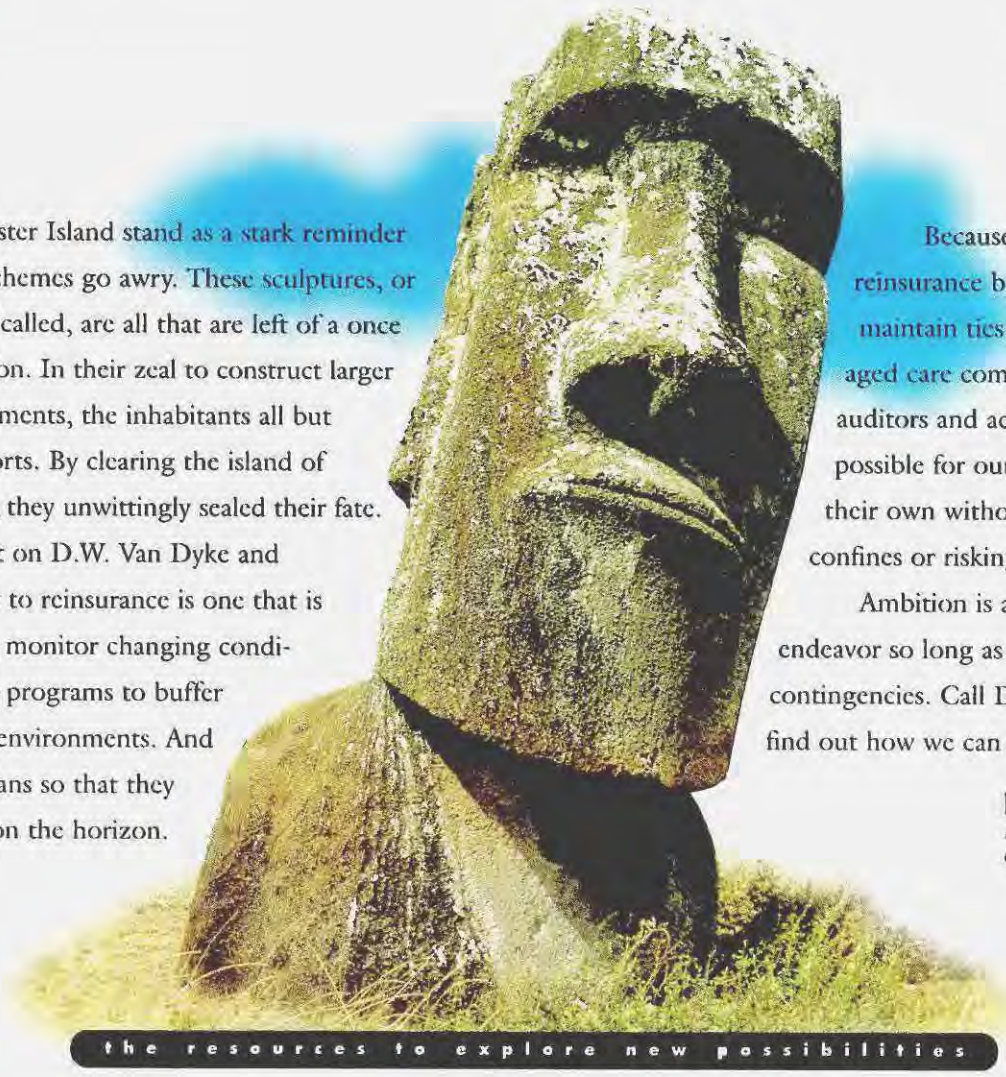
Continued on page 30

Imagine if AMBITION LACKED FORESIGHT



The 600 statues on Easter Island stand as a stark reminder of what happens when grand schemes go awry. These sculptures, or moai as they are called, are all that are left of a once thriving civilization. In their zeal to construct larger and larger monuments, the inhabitants all but ignored the impact of their efforts. By clearing the island of trees to hoist their monuments, they unwittingly sealed their fate.

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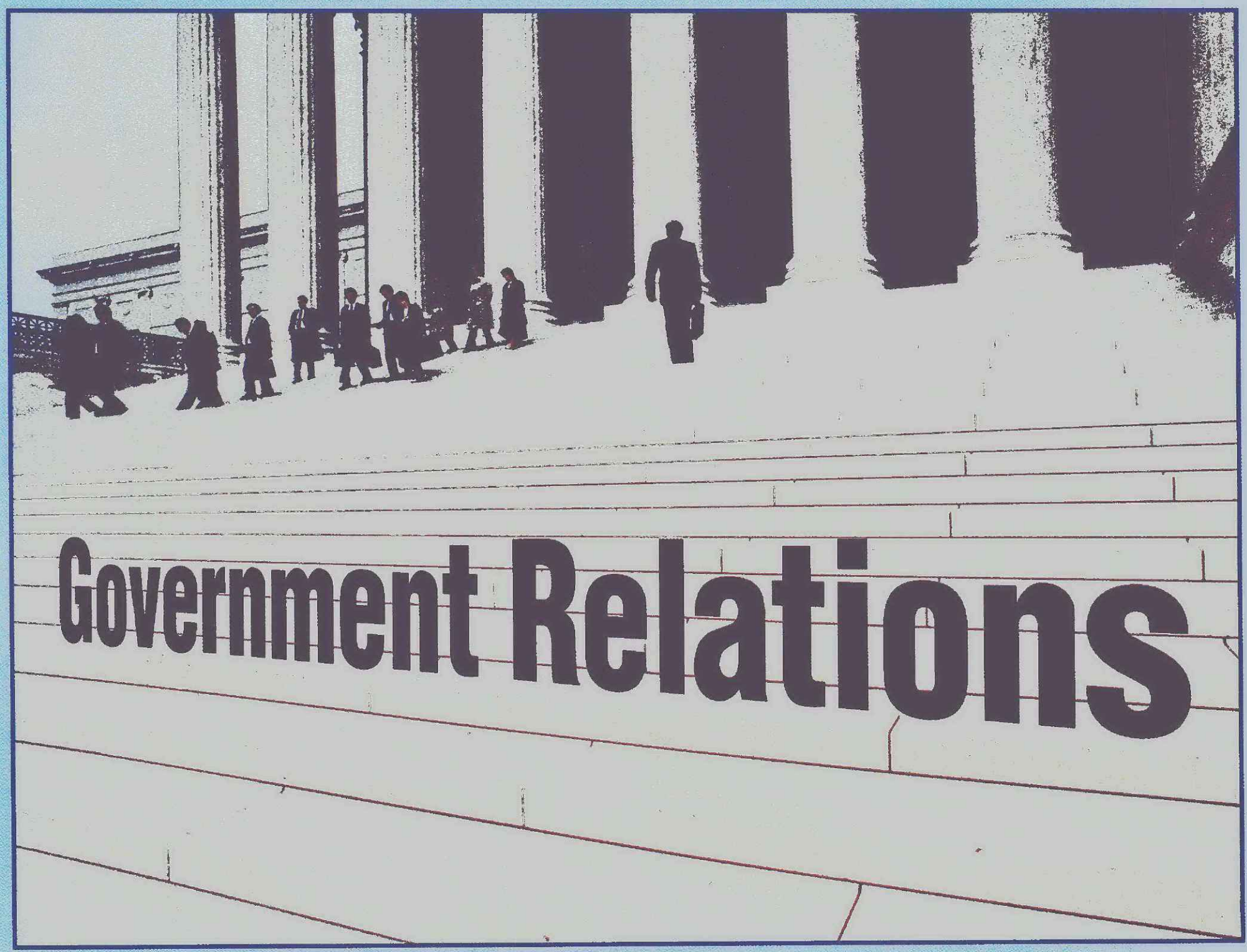
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Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers



Government Relations

Inside:

Merger of CIAB, NAIB strengthens voice with lawmakers Page 24B

IIAA institute shows winning a campaign is possible for agents Page 24E

Worldwide Broker Network offers more international choices Page 24G

Council

Continued from page 24B

extension of the so-called Subpart F provision, which stemmed from the Balanced Budget Act of 1997.

The provision, which was enacted for one year, allows U.S.-based brokerages, insurers, banks, securities firms and other financial services entities to defer the U.S. taxes on their active earnings overseas until that income is returned to the U.S. parent company. This permits financial services to be governed by the same tax rule that governs most other non-financial services firms doing business abroad.

"I am very upbeat we will get" at least a one-year extension, said Mr. Wood.

"Fortunately, when you talk about the implications of the NAIB merger. . .not only have we been in sync on legislative goals for many years, particularly on federal issues, we also have shared the same tax counsel," he said. The tax counsel is Matt Dolan, a partner in the Washington office of Baker & Hostetler.

Mr. Wood said that the most important "emotional issue" the organization faces on the federal level is to avoid "punitive" repercussions of patient rights legislation.

Many CIAB members are involved in placing benefits as well as property/casualty insurance business, and they fear they could become targets of suits for the mistakes of managed care organizations, he said.

On another benefits related-issue, the CIAB is attempting to encourage—"to whatever extent we can"—the rights of small-group self-insured plans to enjoy preemption from state benefit mandates under the Employee Retirement Income Security Act. Mr. Wood added, though, that he thinks congressional Democrats want to keep health care alive as a campaign issue for the fall elections.

Mr. Crerar said that the CIAB is still determining exactly how its legislative team will work as a result of the merger, though Mr. Wood will remain the group's chief federal lobbyist. He will be backed in this role, when needed, by Barbara Haugen, a senior vp who formerly served as the NAIB's director of federal affairs.

Ms. Haugen will also play a role in the CIAB's international efforts. "We've quietly been involved in the international area for a long time, since 1991, 1992," said Mr. Crerar, who added that Coletta Kemper, the CIAB's vp for industry affairs, will become increasingly volved in international issues as well.

As part of the merger, the CIAB created a "global issues committee" that gives some of the larger members—those that may be interested in issues that don't affect all members—a way to quickly move on something and self-fund it, he said.

Mr. Wood said the CIAB is looking for ways to increase its international activities and the international clout of its members.

He said that trade protection issues cut both ways, and that the United States erects some barriers to commerce that Europeans are tearing down. Mr. Wood noted, for example, that European nations have "done more to harmonize and streamline the access that brokers have" in crossing national borders than U.S. states have done in crossing state borders.

On the international front, the CIAB is a member of BIPAR, an international broker group that lobbies the European Community, and of the Coalition of Service Industries, which focuses on insurance and financial services regulation worldwide.

One direct result of the merger is that the CIAB will become more active in state insurance affairs, said Mr. Crerar.

Anne Flanagan, another former NAIB staffer, has been named the new director of state affairs. In the past, the CIAB's director of industry affairs devoted perhaps a quarter of her time to state issues. Now Ms. Flanagan will work on those issues full time, he said.

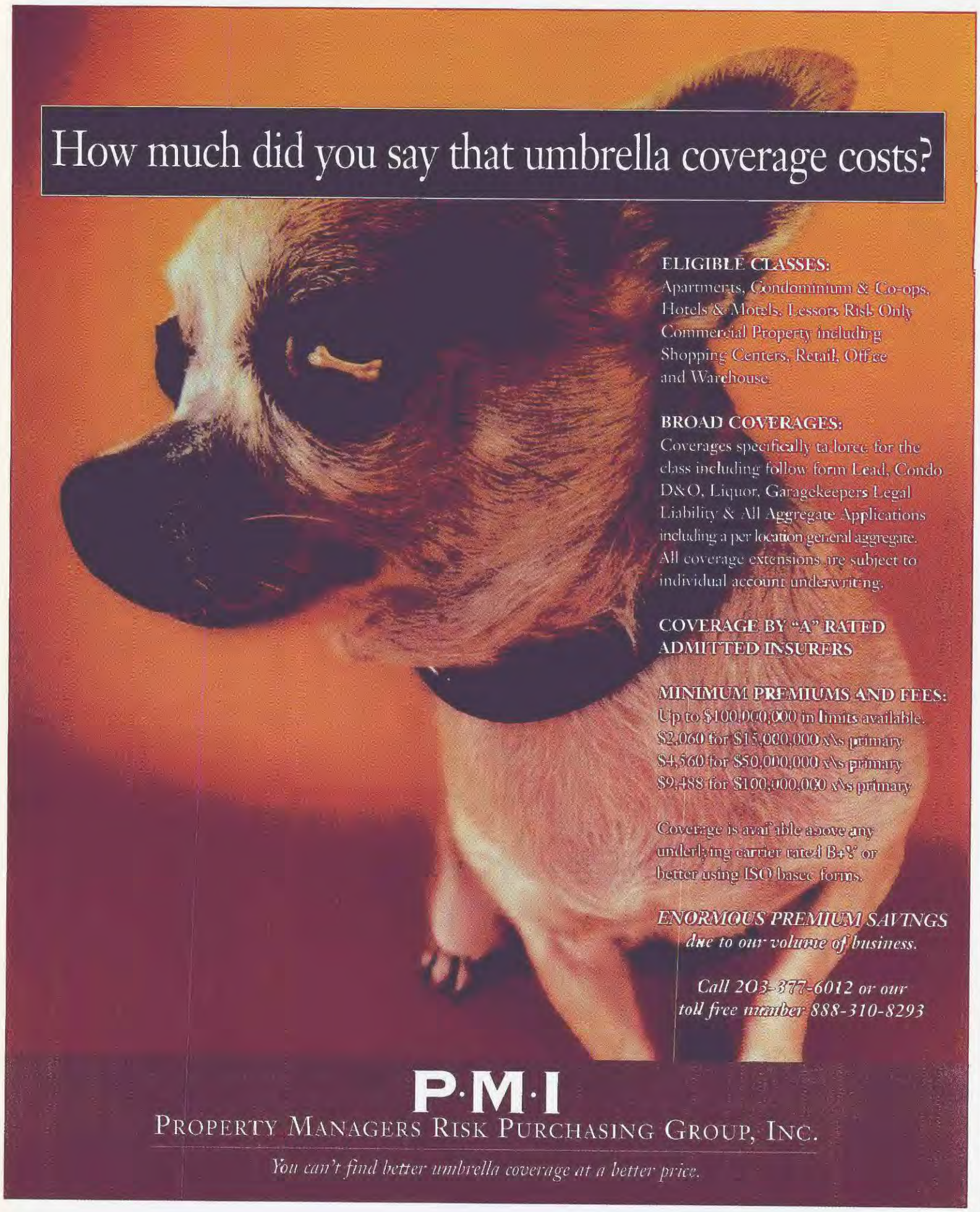
State issues that interest the CIAB include commercial lines deregulation, license streamlining, and surplus lines tax issues. "We'll play a more aggressive role than we have in the past," said Mr. Crerar.

The new state effort "dovetails very nicely with our federal effort, and it only proves a point: We don't care where we get this licensing reform and streamlining and efficiencies. We don't care if it's at the state level or the federal level. We want it done, so we're going to put resources on both sides of the equation to drive that issue so we can resolve it."

Mr. Crerar said he believes the merger has created a CIAB in which the whole is "greater than the sum of our parts," removing any reason for perceived conflict or competition.

That's particularly critical, said Mr. Wood, because competition in the agent community has proved to be "a significant drag on overall resources, not to mention a diversion from the primary goals of serving our members in an increasingly consolidated marketplace."

Mr. Crerar said that the merger does not mean that there will never be differences of opinion, arguments and internal fighting among members at times. "But at the end of the day," he said, "I think our message will be clear, and I think there will be no confusion." BI



IIAA program helping agents run for office

By SALLY ROBERTS

Independent agents seriously contemplating a run for public office need to look no further than the Independent Insurance Agents of America Inc. for assistance.

In February, about 30 agents and insurers learned the ins and outs of how to run a successful campaign by participating in the first ever bipartisan Campaign Institute, co-sponsored by the Alexandria, Va.-based agent association and Future One, a cooperative effort between the Big I and agency companies that focuses on research and government affairs.

"Given our experience and activity on the state and federal level, it was appropriate for us to bring the resources to bear to have a top notch school," said Wes Bissett, senior state government affairs representative for IIAA in Alexandria, Va.

During the two-day program, agents, who were nominated to attend by their state associations, listened to various authorities on polling, campaign research, fund raising, public events and campaign advertising. Reps. Bill Paxon, R-N.Y. and Jack Kingston, R-Ga., a former independent agent, also spoke on how to succeed in a campaign effort.

Due to the overwhelming response from the program, the Big I will sponsor another Campaign Institute, but there are no plans yet as to when, Mr. Bissett said. In the meantime, agents can call the association and receive a manual called "A Policy for Success: The Insurance Professional's Guide to Victory." The contents of the thick three-ring binder detail the nuts and bolts of campaign research, strategy, media, public speaking, voter contact, campaign structure and fund raising.

Speaking from experience, Joe Hernandez, a producer with Hamman Miller Beauchamp Deeble Inc. in Long Beach, Calif., said agents contemplating a run for public office "really need to know the mechanics of running a campaign."

Mr. Hernandez, who attended the February meeting, said he wished he could have attended the Campaign Institute before he ran, and lost, a race for city council in 1994. One of the lessons he learned was "I really needed to campaign to everyone, not just the high propensity voters. You don't want to overlook anyone who could be a possible voter."

"I highly recommend the program the IIAA put on or something similar," said Mr. Hernandez. He is contemplating a run for the General Assembly in 2000.

It is decisions like Mr. Hernandez's that are the impetus behind the Campaign Institute. The Big I wants to encourage more agents to extend their community involvement beyond the agency into public service.

"If you want your self-interests looked after, you've got to get involved," said Mr. Bissett. Furthermore, "because states are enacting term limits, there are lots of newly elected officials that do not necessarily have knowledge of insurance," he said. "In that environment, it is important to have folks elected that know what insurance is about."

Dave Bates, president of A.N. Nunes Insurance Agency Inc. in Bristol, R.I., and in his third term as a state senator, agrees. "It's extremely important for agents to get involved," he said. "Agents for a long time have sat back and figured everyone will take care of them as far as legislation is concerned. It's important to have someone in the Legislature in case something erroneous comes up."

For his part, Sen. Bates, who sits on the corporation committee that handles insurance bills, said that after the 1996 Supreme Court *Barnett* decision, which held that banks could sell insurance in towns of 5,000 or fewer residents, he co-designed a consumer protection bill.

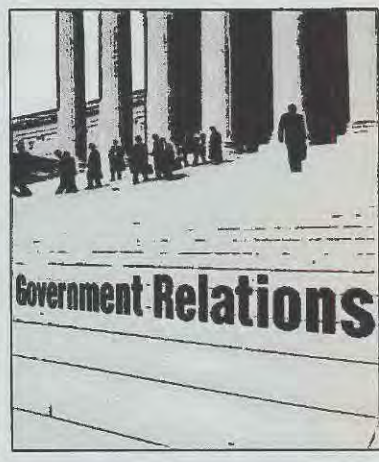
"We felt it was smart for us to take the bull by the horns to get a consumer protection bill passed," he said. Among other provisions, the bill reiterates anti-tie ins, separates the jobs of a loan officer and independent agent and separates the locations of where insurance is sold and where banking products are sold in a bank, he said.

Not only is insurance representation needed in local, state and federal posts, but running for office also is a natural extension of an agent's professional role, said Mr. Bissett.

"There are lots of things agents bring to the table that translates naturally to running and winning a campaign," he said.

Agents are typically well-known leaders in their community; they work closely with customers, which translates into a constituency base;

See **Campaign** *on next page*



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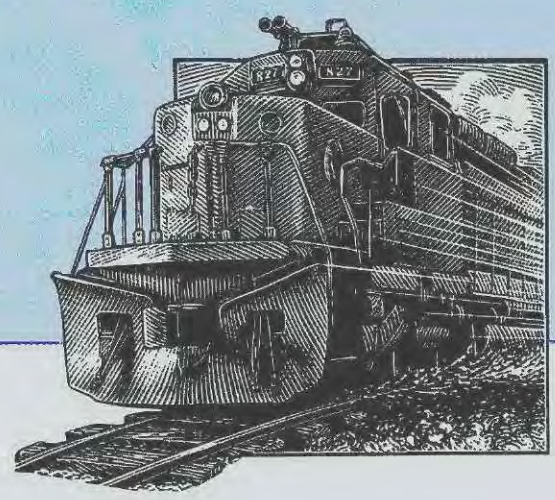
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they have a natural awareness of the concerns of their local segment of consumers; they know how businesses are running in the community; they have the ability to explain complicated issues; and they know how to close a deal, which can help in securing votes, Mr. Bissett said.

Agents agree. "We represent the community. We write insurance on all levels, from automobile, to earthquake, to business to health care to life," Mr. Hernandez said. "We have a better understanding of people's concerns in the community."

Rhode Island's Sen. Bates added: "I think the very nature of selling insurance. . .winning people's trust to write an insurance policy, helps in campaigning."

Sen. Bates, who is running unopposed for his fourth term, added one piece of advice for agents contemplating running for office: "Agents have to understand the time commitment and have a solid footing in the agency before taking the leap."

Because the Rhode Island Legislature is part-time, when it is in session Sen. Bates works at the agency every morning and all day every Monday. He goes back to the agency full-time during the five months that the legislature is not in session. BI

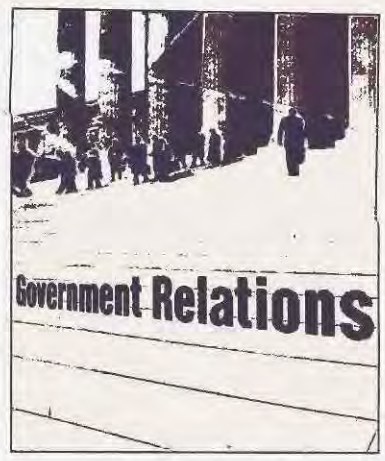
Regulators progress on producer matters

By MEG FLETCHER

State insurance regulators are making rapid progress on several producer database and licensing initiatives designed to eliminate barriers to non-resident producer licensing and to increase uniformity across state lines.

Key to the effort of the National Assn. of Insurance Commissioners is a resolution approved earlier this year that endorses the concept of uniform treatment for the licensing of all producers as being "in the best interest" of state regulation.

However, a driving force behind their streamlining efforts is the possibility of federal pre-emption of regulatory authority over producer licensing.



The U.S. Senate's Banking, Housing and Urban Affairs Committee is now planning to mark up next month a financial modernization bill that, among other things, would create a National Assn. of Registered Agents & Brokers, a national clearinghouse for insurance broker licensing (*BI*, July 7, 1997).

Under the version of the legislation approved by the House, NARAB would be controlled by state regulators but could preempt individual state regulations that didn't conform with its uniform licensing rules, according to Joel Wood, senior vp-government affairs for the Washington-based Council of Insurance Agents & Brokers, which supports the legislation.

However, state regulators are hoping that the progress they have made on recent state initiatives may diminish H.R. 10 supporters' desire for federal action.

Regulators "are literally reinventing the way the insurers and the producer community can interface with the many state insurance regulators around the country," said Glenn Pomeroy, North Dakota Insurance Commissioner and president of the NAIC. "We can make that work a lot better through these initiatives," which are included in a program known as "State Regulation 2000," he said (*BI*, Feb. 9).

The Producer Database is a cornerstone project of the NAIC effort. It will allow states and insurers to share information, including biographical and enforcement data, about producers, so they can make better decisions about who should be able to sell insurance in the United States.

Currently, insurance departments in 14 states—representing 70% of U.S. producers—regularly send information to the database. Five additional states—Arizona, California, Connecticut, Illinois and New Jersey—are expected to join them soon.

New York's recent decision to participate received an enthusiastic response from Mr. Pomeroy and producers' representatives.

That was a "huge step because of the size of the state and the producer population," Mr. Pomeroy said.

"New York's participation is extremely important, if not critical," said Dave Turner, vp-state government affairs for the Independent Insurance Agents of America in

Continued on next page

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Alexandria, Va. "It's a huge state with a large number of producers and is considered a leader in state regulation," he explained.

Mr. Pomeroy also said NAIC regulators have made "tremendous" progress in adopting the organization's Uniform Treatment Project, which seeks to reduce discriminatory practices and barriers in the appointment of non-resident producers and encourages state regulators to accept a uniform licensing application form.

Examples of discriminatory practices some states impose on non-resident producers include banning the sale of insurance by non-resident producers or requiring that a non-resident producer have an office or other physical presence in a state. Practices also include bonding or continuing education requirements different from those imposed on resident producers.

In addition, the IIAA's Mr. Turner said three or four states also have "fairly entrenched" countersignature laws, which require that coverage arranged by a non-resident producer also be signed by a resident producer—who typically requires payment for this service. However, he declined to identify those states, saying ongoing talks aimed at eliminating that requirement are politically sensitive.

Currently, about 20 states have signed a declaration indicating their readiness to use the uniform process, and many more states are analyzing what changes they need to make so they can do so in the future, Mr. Pomeroy said.

In addition, the 13 states that form the NAIC's Midwestern Zone established a reciprocity program on July 1 to jointly approve continuing education courses taken in other states. They have invited states outside the Midwest to join them.

The NAIC also is making progress in establishing its Producer Information Network, which will allow regulators and insurers to exchange producer-related information about appointments, terminations and license applications. A pilot project to test the PIN network, involving Iowa and Missouri and five insurers, will be completed by August, after which all states and insurers will be invited to participate.

For state insurance regulators, the main barrier to streamlining producer regulation is getting the issue up high enough on commissioners' radar screens so that they commit to it and begin working to implement it, Mr. Pomeroy said. That may include asking their respective state legislatures for statutory changes, he added.

While state insurance regulators have made significant progress recently in improving uniformity, supporters of the pending NARAB proposal plan to continue pushing for it, the CIAB's Mr. Wood said. "We still think there needs to be a political incentive for states to act, and the NARAB proposal provides that." BI

Global broker network seeks higher profile

First executive director says risk managers' concern about choice is revenue opportunity

By DAVE LENCKUS

As the brokerage industry's largest players beef up by swallowing competitors, members of a reconstituted broker network are counting on their independence to bolster their growth.

The challenge for the Worldwide Broker Network—a 9-year-old international broker alliance with a 2-year-old U.S. membership, a 3-month-old name and an as-yet unveiled guideline on service standards—is visibility, said George Worsley, who became the group's first executive director in May.

Many risk managers already are expressing concerns over how the fewer but mightier global brokers will influence risk-financing and related services and products.

For WBN members, risk managers' concern over adequate choice is a revenue-growth opportunity. By offering risk managers more alternatives of brokers with international service capabilities, WBN members hope to win and retain more business. Ideally, that business would be middle-market and large accounts, or companies with annual sales of about $250 million, said Mr. Worsley, who is based in London.

That business, in turn, would help network members grow without yielding their independence to other firms.

"We think the consumer needs a wider variety of choices," Mr. Worsley said.

"Major brokers may be able to provide all of the services that clients want, but clients may not

See **Network** *on next page*

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Network

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want to get these all from one broker," Mr. Worsley said.

"The alliance allows us to combine each other's resources without us relinquishing our autonomy," said Robert C. Meder, assistant director at network member Kaye Group Inc.

Network members grew their revenues originally by placing business largely within their respective countries, but that approach no longer will work, Mr. Worsley said.

To grow, network members must be able to serve international clients and prevent other brokers from winning away smaller clients as they grow.

But, new business often comes at a cost "that makes it difficult to get anything like a profit" on that business, he said.

"At first, we may have to pull out all stops" to win business, he said. But, as clients get to know the network, they will be more willing to pay a reasonable price for the services they receive, he said. In the meantime, "account retention has become so important to protect your base of income."

All WBN brokers have a significant book of international accounts and rank among the largest brokers in their geographic regions, according to Mr. Worsley.

Last year, WBN members in total generated $325 million in revenues, according to Mr. Worsley. If the network were considered a single entity, its revenue figure would place it among the world's 10 largest brokers.

World Broker Network members handled a total of $3 billion in premium volume last year, Mr. Worsley said.

WBN has eight U.S. members and 32 members abroad.

Still, visibility is a major stumbling block for the network. It is one of the main problems network members hired Mr. Worsley to solve.

Compared with the 44-year-old Assurex International network of 60 U.S. and Canadian members and 32 international affiliates, WBN is an upstart. A group of European brokers created it in 1989 to facilitate the placement of cross-frontier business.

Until May, the alliance was called the International Broker Network. But then, because of potential trademark problems in the United States, it adopted its WBN moniker.

However, Mr. Worsley said the name change "was well-timed, when you look at the developments in the market."

The network admitted its first full-fledged U.S. partner just two years ago.

Before then, network members had their own correspondent relationships with U.S. brokers. But, that meant the network often sent business to competing brokers in the same U.S. city. And, there was no standardized agreement on how network brokers would handle international business.

The network wanted a more standard approach in how business was conducted and with whom it would partner, Mr. Worsley explained.

Alburger Basso de Grosz Insurance Services Inc., the 25th-largest broker of U.S. business based on 1997 brokerage revenues, became the network's first full-fledged U.S. member in 1996 and has helped draw other brokers to the network since then.

Mr. Worsley, the 49-year-old native New Zealander, who has held positions in the international business units of insurers and brokers in Europe and the United States since 1967, said he never had heard of the network before coming to work for it.

"Some members talked of it as a known entity. It wasn't to me," Mr. Worsley said.

And he assumed it wasn't to others.

For example, since May, he has visited representatives of several major insurers, discussing ways the insurers and the WBN can work together. He said he emphasized that WBN members are local and global.

The WBN also has been attempting to raise awareness of the network among insurance buyers through informational brochures and promotions. A World Wide Web site, www.wbnglobal.com, also has been established.

But, perhaps just as important as those undertakings, Mr. Worsley said he also has had to raise the WBN's visibility among the network's own members.

Some staff in member companies "weren't aware they were part of the organization." They did not know what the WBN is and how it could assist them, he said.

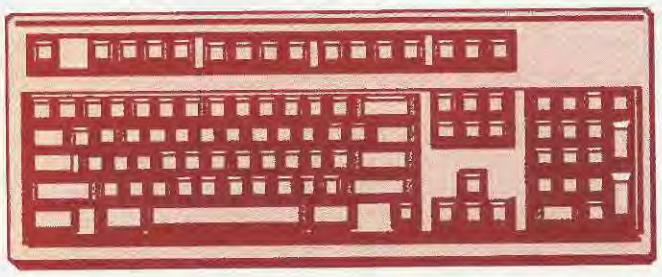
"The image has to be consistent to staff, insurers and insureds," he said.

To that end, Mr. Worsley has visited the network's eight U.S. members.

He also is conducting a "due diligence study" of all WBN members to help the network gauge its strengths and weaknesses. It also will help the WBN determine how committed each member is to strengthening the network, he said.

To aid WBN members in

Continued on next page



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assembling international programs "in as seamless way as possible," Mr. Worsley is developing guidelines. For example, in the area of loss control services, the guidelines may call for site visits every six months. WBN members then could accommodate clients that want more frequent visits, he said.

Mr. Worsley said that a "workable skeleton" of the guidelines should be completed in six months. Network members already conform to most standards he has in mind, he said, but "there's always room for improvement."

The WBN also has charged Mr. Worsley with building up the network.

The network, like Assurex, has 32 members abroad. But, there is room for WBN membership expansion in countries where the network is not already represented.

For example, insurers in Brazil, Italy and Japan are approaching the network about adding WBN brokers in those countries, Kaye Group's Mr. Meder said. Insurers there want to expand the sources of their business, he said.

WBN representatives said the network eventually may admit a couple more U.S. members, and Mr. Worsley hopes that WBN's first Canadian candidates will be approved by year's end.

But, network representatives neither expect nor want more growth than that north of the Rio Grande.

That limit on growth heightens WBN's value to members in a couple of ways, according to some broker executives.

First, when a network member needs to send business elsewhere in the network, there is no doubt where the business will land, and it will not be "diluted" among two or more members, said Rod Hampton, managing director of ABD's international services.

"We don't want so many so we're not stepping on each other's toes," Kaye Group's Mr. Meder agreed.

Second, having fewer partners simplifies keeping track of each one's specialties, Mr. Hampton said.

The WBN's U.S. members are geographically spread, though three are based on the East Coast. From east to west, the U.S. members are William Gallagher Associates Insurance Brokers Inc. of Boston; Kaye Group of New York; Riggs, Counselman, Michaels & Downes Inc. of Baltimore; Palmer & Cay Inc. of Atlanta; Hylant-MacLean Group of Toledo, Ohio; The Hays Group Inc. of Minneapolis; Summit Global Partners Inc. of Dallas; and Alburger Basso de Grosz of Belmont, Calif.

Five of the brokers rank among the 100 largest brokers of U.S. business.

Indeed, the U.S. contingent now accounts for the bulk of the network's premium volume and revenues.

Of the network's $3 billion in premium volume last year, U.S. members accounted for $2.3 billion, or 76.7%, according to Mr. Worsley.

And, of the network's $325 million in total revenues, U.S. members racked up $225 million, or 69.2% of the total.

With its 2,750 employees worldwide, the network's revenue per employee last year exceeded $118,000. That fell short of the mark set by the world's Top 10 brokers by about $2,100. It was $3,000 less than the other 182 brokers listed in *Business Insurance*'s 1998 directory of agents and brokers (*BI*, July 20).

Despite the strength of its U.S. contingent, the WBN is not a U.S.-controlled group, according to Mr. Worsley. U.S. members fill two of the seven seats on the WBN's executive committee.

That spread of member representation on the network's executive committee will help all WBN members—and therefore the network—succeed, Mr. Worsley said.

Despite continuing industry consolidation, WBN representatives said they do not envision the network or its members meeting the same fate as the UNISON network and many of its former members. UNISON unraveled last year after Marsh & McLennan Cos. Inc. acquired Johnson & Higgins, the network's flagship broker. Since then, M&M and Aon Corp. have acquired many former UNISON members.

Kaye Group's Mr. Meder noted that J&H was UNISON's lone U.S. member, whereas the WBN has eight U.S. representatives. "And each one is its own entity," he said. If one WBN member were acquired, the network still would have plenty of U.S. representation until it selected a new partner. "The impact would not be that great," Mr. Meder said.

Mr. Worsley does not have unrealistic expectations for the WBN. In the year ahead, "it's not fair" to expect the WBN to wean away the business of "10 Fortune 100 companies" from their current brokers, Mr. Worsley said.

But, if the number of brokers continues to dwindle, large companies will "look to us more," he predicted. "Those people will hear about us." BI

If the number of brokers continues to dwindle, large companies will 'look to us more,' says WBN's George Worsley. 'Those people will hear about us.'

A/BT Briefs

IIAA names CEOs

ALEXANDRIA, Va.—Jeffrey M. Yates and Paul A. Equale have been named to the newly created positions of chief executive officers of the Independent Insurance Agents of America Inc.

Mr. Yates' responsibilities comprise industry affairs, state relations, technical affairs, education, legal issues and the Best Practices program. Mr. Equale will be responsible for administration of IIAA's other activities and programs, including government affairs, communications, information technology, administration and the for-profit unit.

Robert A. Rusbuldt was named executive vp and will oversee government affairs and other operations.

HRH in Florida

GLEN ALLEN, Va.—Hilb, Rogal & Hamilton Co. is reconfiguring its Florida agency network, including selling its Fort Lauderdale office for an undisclosed amount of cash, in an effort to improve its growth and profitability in the state.

HRH is organizing its five Florida locations into two profit centers. Certain lines of business, including select commercial lines, will be handled by more efficient operating units, and resources will be deployed to focus on middle-market business, HRH said in a statement.

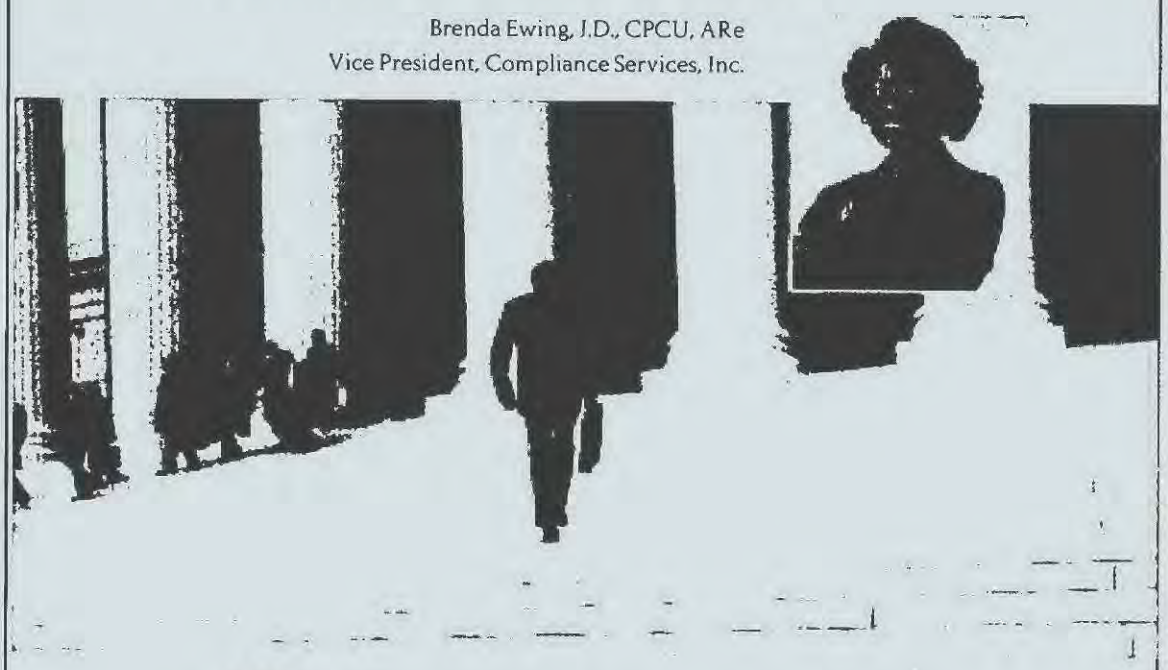
HRH also is planning to upgrade and streamline management information systems and interoffice communications in Florida.

"The new office configuration is designed to improve customer service, allowing us to serve existing and new clients effectively, while enhancing the region's profitability," Andrew L. Rogal, president and chief executive officer, said in the statement, adding that the company also is looking to pursue acquisitions in Florida. BI

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IIAA program reaches out to consumers

Assists independent agents with advertising, market research

By JENELL TALLEY

Many insurers find that promoting independent agents is smart business, and the Independent Insurance Agents of America's expanding National Communications Program is providing more opportunities to do just that.

The IIAA program motivates consumers to use independent insurance agents by increasing consumer awareness, understanding and appreciation of the value of independent agencies, said Peter van Aartrijk, vp-communications at the Alexandria, Va.-based IIAA.

The program's greatest accomplishment has been getting local agents on national television, Mr van Aartrijk said. Annually, from March through May and September through November, the organization runs a total of 1,500 commercials on the Cable News Network, Headline News and The Weather Channel. Those television spots are targeted at consumers most likely to use the services of agents or buy insurance: college graduates 35 and older with household incomes that exceed $50,000.

"We reach a cumulative audience of 400 million households per year," Mr. van Aartrijk said.

Some insurers say their participation in the program benefits their bottom lines.

"Raising the visibility of independent agents as experts helps us" retain clients, said a spokeswoman from Mayfield Village, Ohio-based Progressive Insurance. Participating in IIAA's program enables the insurer to see what communication campaigns are being used and to provide feedback on them, so the insurer can be sure consumers understand the value of independent agents, she said.

Independent agents "provide a level of personalization that a segment of the population desires in their insurance programs," said Lance Cornell, vp-marketing at Seattle-based SAFECO Insurance. SAFECO supports IIAA's program because independent agents "have intimate knowledge that provides customers with what they want today and in the future," Mr. Cornell said.

SAFECO declined to disclose the cost of its participation in the IIAA program but said there are ongoing fees.

IIAA's program supports an independent insurance company's only source of distribution, said Larry Acord, vp-marketing at National Grange Mutual Insurance Co. in Keene, N.H. "If our agents know we (financially) support the IIAA, they will appreciate National Grange more, which (encourages them to) place more business with our company," said Mr. Acord, who declined to discuss his company's participation costs.

The program does not directly generate prospects or retain clients, said Mr. Acord. However, it does help National Grange recruit more agents. The program "focuses on independent agents and consumers, so we still have to focus on creating a brand name for ourselves," he said.

Mr. van Aartrijk said that, amid increasing competition from outlets such as direct mail and the Internet and insurers' captive sales organizations, the program assists independent agents in four ways: It helps agents organize and implement advertising programs, improves the image of the independent agent system, enhances an agency's public relations efforts and generates more contact with media, and provides independent agents with market research information.

The communications campaign addresses several key issues: catastrophe preparedness, the special needs of those who work out of their homes, automobile insurance, small-business insurance and women's insurance needs. For example, about one-third of the ads on The Weather Channel are preceded by a one-minute disaster preparedness tip sponsored by IIAA.

With 300,000 members nationwide and offices in every state, IIAA works closely with its state associations and local boards to ensure that its communications program is effective on the local level. Fifty-five percent of the communication program's $3 million annual budget is provided by IIAA. The remainder is funded by 24 participating companies.

Large insurers' advertising "tends to be more image-oriented rather than telling people how to buy," said Mr. van Aartrijk. "The National Communications Program fills in that gap. We want people to say, 'Oh, I have a local agent that I know and trust, one that has access to advertising.' "

"We're trying to be the link between local and distant (markets), human and impersonal," he said. "We want to help people say, 'I need an independent insurance agent because they provide a lot of value.' "

Name recognition is the program's biggest benefit, said Alex Soto, president of the Miami-based agency INSOURCE Inc. Insurance & Financial Services and vp-communications for the IIAA. 'Whenever we promote independent agents and push people to utilize them. . .we all benefit," he said.

The public sees the insurance industry almost as a utility, Mr. van Aartrijk said. "It's a distant, faceless industry. It has low consumer appeal. But independent agents are local and touchable. They can explain what (insurance) means. They can put a face on our industry with good names and good products."

IIAA said that over the past 18 months, the group has seen a 25% increase in the number of people recognizing that independent agents offer a choice of insurers and can fit a policy to their needs. The majority of people it has polled said they need a value-added partner to assist them with insurance issues and decisions. The problem is that they don't know where to turn for help.

"That's the challenge for us—telling them that we're here," Mr. van Aartrijk said.

What had been missing was a cohesive market and a campaign to get in front of consumers, he said. "Competition is doing a more expansive job of advertising," so we have to step up to compete, he said. "You have to be a part of the mix if you're going to be a player. And we consider ourselves players."

Independent agents write 55% of all P/C premiums, 70% of commercial business and 35% of personal lines business, Mr. van Aartrijk said.

"We are firmly committed to expanding beyond cable to network TV in the years ahead," he said, recalling the tremendous response IIAA's network TV ads—which featured Raymond Burr—received in the mid-1980s. "Consumers choose insurance companies based on the ads they see on TV. It's called 'mind share.' In the visual society that we live in, you have to be" in front of consumers to be successful, he said.

The number of hits IIAA receives on its World Wide Web site address doubles to 140,000 from 70,000 each month that the advertisements are running, Mr. van Aartrijk said. The consumer information area and the search engine are the most popular spots on IIAA's Web site.

Enhancing that Web site is the next phase of the IIAA's program. It plans to link consumers to local member agents and to make available commercial and personal lines insurance products, enabling agents to write business over the Web.

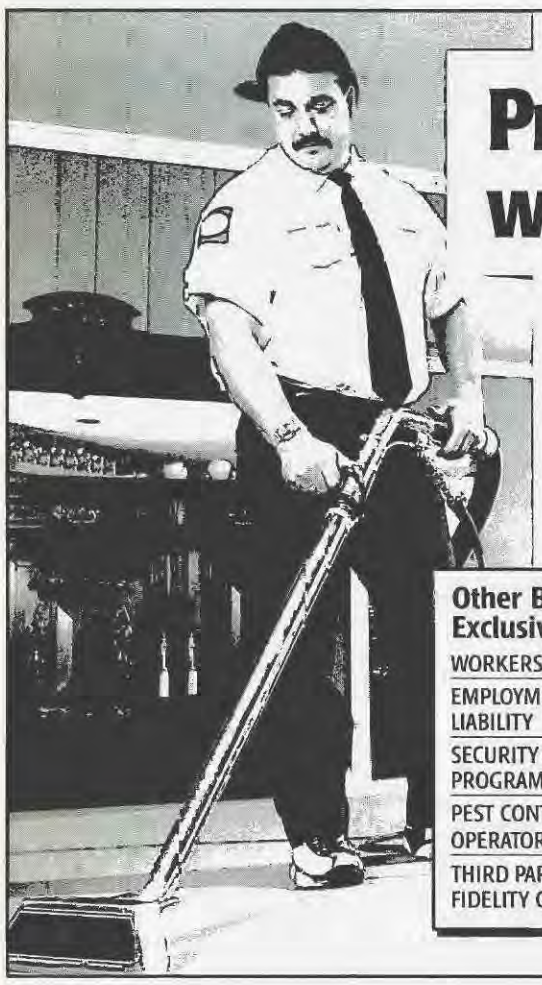
"Our goal pertaining to the Internet is to get the agents online and enable them to write business over the Internet," he said.

Also among future plans is a toll-free hot line to answer consumer questions and to increase their understanding of the industry. It will be available later this year, Mr. van Aartrijk said.

IIAA will conduct a consumer-recognition study in November, after the 1998 ad campaign ends.

No aspects of its communications program did not work well, said Mr. van Aartrijk. "We've been pleasantly surprised by insurance companies' and the media's support," he said. "Insurance companies are thrilled, because we act as an extension of what they do. And we act as a better spokesperson, because our information is more consumer-friendly. (Consumers) won't get so suspicious (when we present the information), because we're objective."

"IIAA's program is unique," because insurers and agents are promoting the system," Mr. van Aartrijk said. BI



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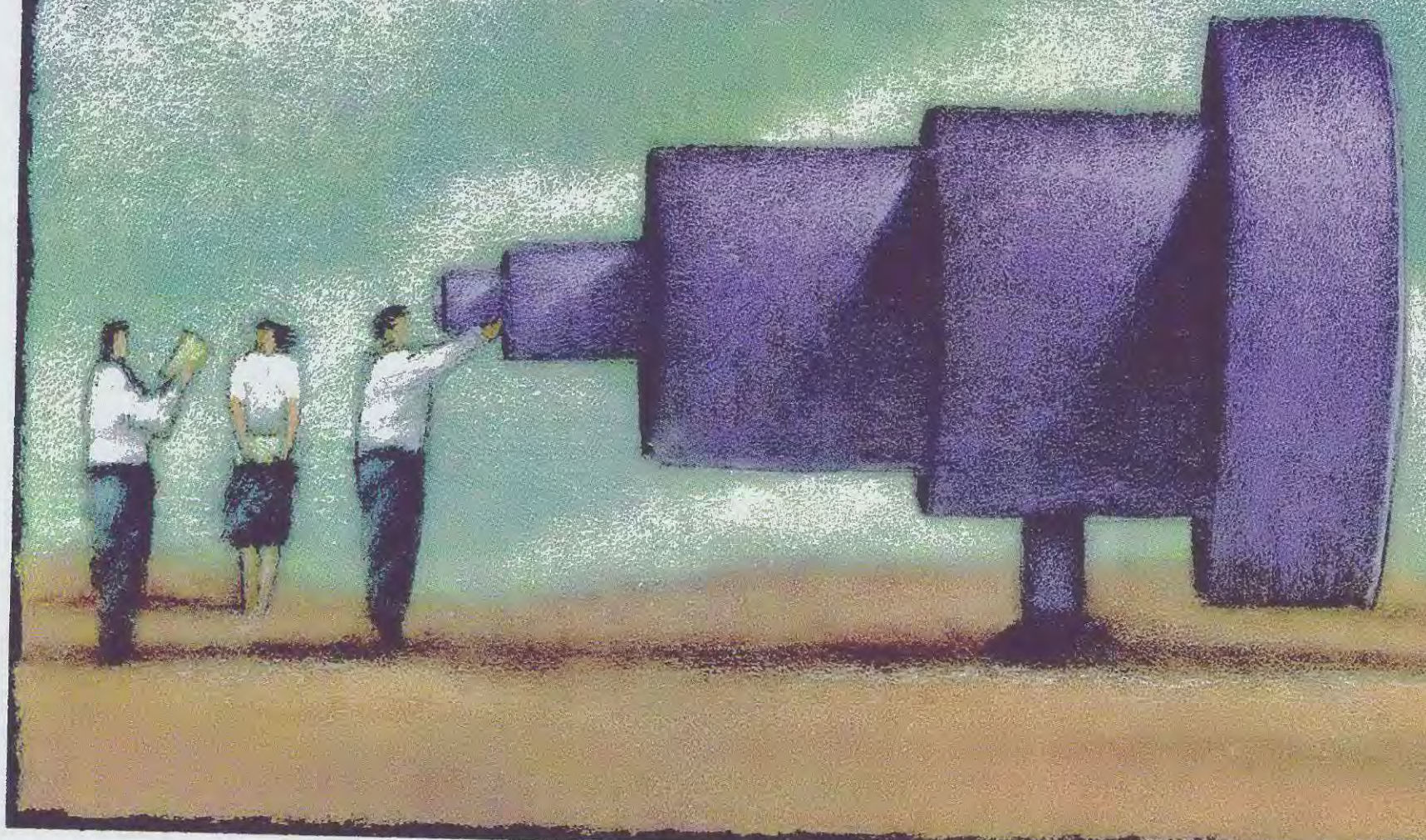
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Agents logging little new business online: IVANS

By MICHAEL BRADFORD

Agents are slowly turning to the Internet as a way to market their products, but so far they haven't been welcomed by a lot of online buyers.

A survey conducted by IVANS Inc. by mail and fax from April 1 through June 30 found that agents are becoming more comfortable using the Internet as a business tool. But they are still grappling with how best to use the technology to increase business.

The survey follows an earlier one, conducted in February and March, in which Greenwich, Conn.-based IVANS found that insurance buyers are not so easy to come by in cyberspace.

Only 6% of Internet users surveyed said they were seriously interested in purchasing insurance online. Most of the remaining 94% indicated they prefer a more personal touch when buying coverage, according to IVANS.

The recent survey of agents showed that 59.9% of the 535 respondents are interested in selling insurance over the Internet.

World Wide Web sites already are in place at 38.7% of the surveyed agencies, and another 33.1% said they plan to have a site up and running within a year.

Those numbers are encouraging because they show agents are becoming comfortable with the Internet and are interested in making the investment in time and money to use the technology, said Chip Lawson, senior product manager with IVANS in Tampa, Fla. "It really gives us a positive outlook for the future," he remarked.

Agents are mainly using the Internet as an information resource; according to the survey, 65.6% responded that they use it for that purpose. The Internet is used as a marketing tool by 17.4% of the survey respondents, and 12% said they use it to generate sales leads.

Agents indicated in their responses that they are interested in selling coverage over the Internet because it provides an effective way to provide product information to prospective customers and to collect sales leads. Agents also said the technology allows them to provide 24-hour service that is fast and secure.

Mr. Lawson pointed out that agents face an uncertain future with regard to online sales.

"The great fallacy of the Internet is about it being the most important place for consumers today. Insurance is a fairly complex product," according to Mr. Lawson, and it is not easy for buyers to make decisions about buying coverage without some help.

'More people are dabbling with getting quotes on the Internet, but very few are buying coverage,' according to Chip Lawson of IVANS.

"More people are dabbling with getting quotes on the Internet, but very few are buying coverage," Mr. Lawson noted.

A summary of the key findings of the study said, "The fully transactional Web site is the key to the agents' future. These sites can be prepared to deal with a variety of customers, ranging from those who are merely gathering information to those who are ready to buy."

While electronic communication with policyholders is developing slowly, agents already are wired to insurers. The survey showed 94.6% communicate electronically with insurance companies. The type of electronic communication that agents have with insurers was not defined, but it could include all forms of agency/company interface, including e-mail.

The survey summary said that a "quick scan of the industry reveals that leading (insurance) companies have many new applications under development and in use. An independent agency force that is electronically connected will be able to take full advantage of new technology as it is introduced."

•

Copies of the survey, "Insurance Agents and Technology," are available at no charge from Jim Kalach at 203-532-2139, or through e-mail at jim.kalach@ivans.com. Requests by mail should be sent to Mr. Kalach at IVANS, 777 West Putnam Ave., Greenwich, Conn. 06830.

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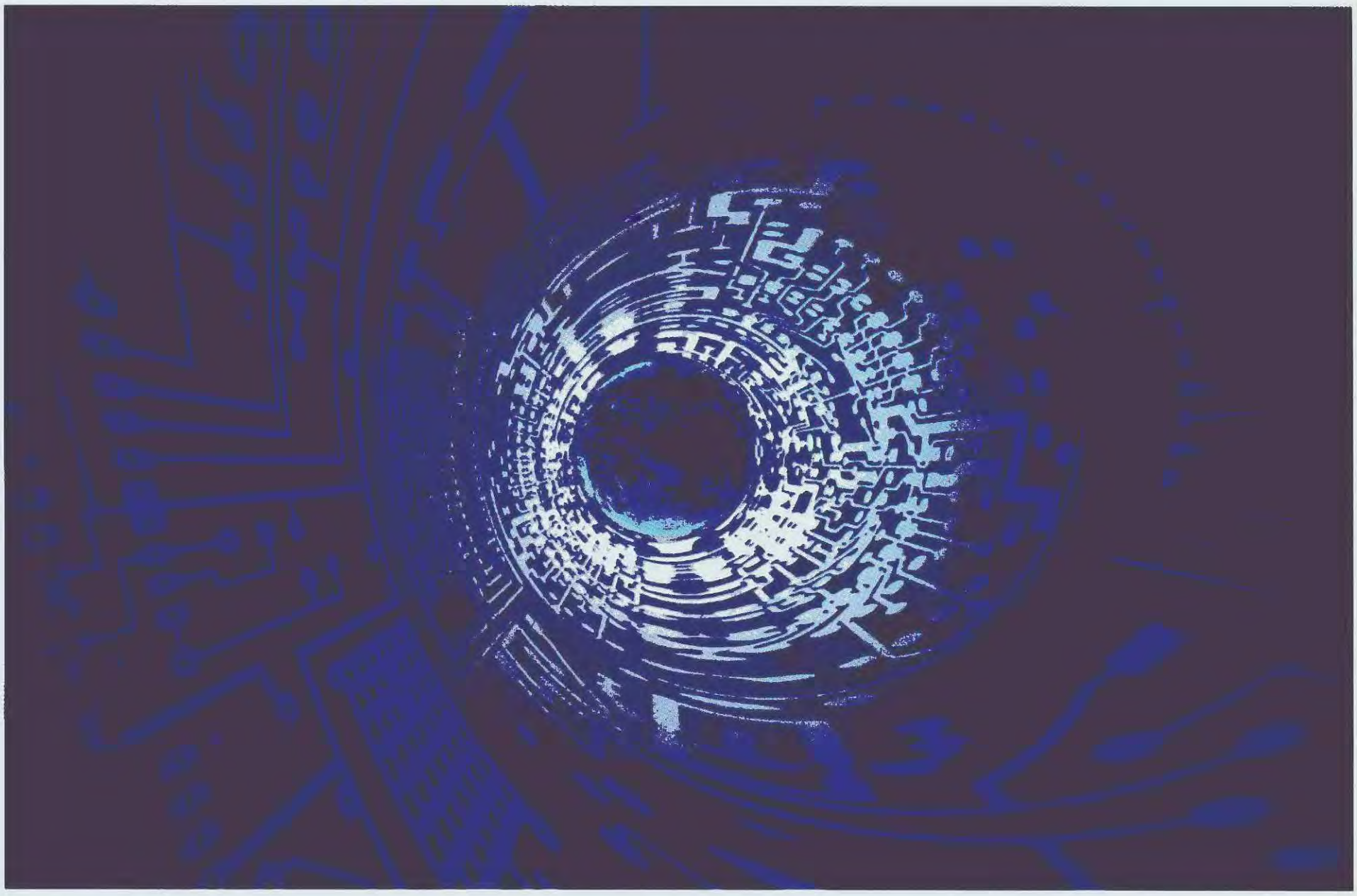
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Minimizing waste minimizes risk

By Valerie Fogleman

IN THE FACE OF ever-increasing environmental liabilities, risk managers may be able to save their companies substantial sums of money and adverse publicity by persuading them to adopt measures to prevent, control or reduce pollution.

One of the most important environmental measures that a company can adopt is to minimize the waste that it generates. Under the "polluter pays" principle, which has been adopted by many countries, companies that pollute must pay for the right to do so. Thus, a company that discharges waste into the air or water must pay for an authorization permitting it to conduct the discharge.

The charge for such a permit will generally include the government's cost of administering the discharge system, while the accompanying regulatory system will generally require the waste to be treated before it is discharged. Many regulatory systems are "technology forcing"; that is, polluters must continually upgrade their pollution prevention equipment to comply with the terms and conditions of their permits.

When waste is not discharged directly into air or water but, rather, is collected from facilities for landfills, incineration or some other form of disposal, the generators of the waste must generally pay transport, handling and disposal costs and, in some countries such as the United Kingdom, a tax on the amount of waste that is placed in landfills. The cost of disposing of waste on land is continually increasing, for example, by requiring the pretreatment of many types of waste before it may be disposed.

A second action a company can take is to reduce the energy and other resources used to produce a product and operate a business. Indications are that the cost of these functions will rise.

For example, the increased use of water in many countries has resulted in an extension of metering and, in some areas, the introduction of a priority system of use. Commitments made by participants at last year's United Nations environmental conference in Kyoto, Japan, to reduce the emission of greenhouse gases may well lead to increased costs for certain types of energy.

A third action is for a company to adopt an environmental management system. Many countries have adopted strict liability standards for environmental offenses and the remediation of environmental damage. The result of this approach is that inadvertent pollution incidents may lead to prosecution, requirements to remediate pollution, and even claims for damages by individuals affected by the pollution.

The adoption of an environmental management system will not only reduce the risk of pollution incidents but also, if an incident occurs, the measures inherent in the system should minimize damage. The existence of the system also may mitigate any sanction levied against the company or, possibly, its officers or directors. Even if a company succeeds in avoiding a high fine or, in some cases, the imprisonment of a director or officer, the adverse publicity involved in a prosecution may have a lasting negative effect on the company's name.

A fourth action is for companies that own facilities on which potential pollutants are stored to install pollution prevention measures. A company that does not do so may be convicted of an environmental offense if the act of a third party causes a pollutant to enter a waterway.

For example, in 1996, the New South Wales Court of Criminal Appeal upheld the conviction of the owner of a petroleum products distribution depot following the release of oil into a waterway by the lessee. The conviction was based on the lessor's failure to take practicable measures to avoid a foreseeable risk of pollution, as required by statute.

In a somewhat similar case in February 1998, the U.K. House of Lords upheld the conviction of a company that owned a facility containing a diesel tank. The court held that a vandal's deliberate act in opening the unlocked tap on the tank did not break the causal connection between the company's storage of diesel in the tank and the pollution of a nearby stream.

The court noted that the company had rendered a bund, or earthen berm, surrounding the tank useless by installing a pipe to connect the tank to a drum located outside the bund.

A fifth course of action applies to companies in countries in which programs to remediate contaminated land are being introduced. Such a program can have a disastrous economic effect on a company with a long history of disposing of waste on land, particularly if the company has dumped toxic substances, such as solvents, on permeable soils that overlay drinking water aquifers.

As noted above, the standard of liability for remediating contamination is generally strict. Thus, it is no defense to have legally dumped waste in compliance with past industrial norms. In addition, liability is generally retroactive and may well ensnare companies that currently own or occupy contaminated land even though they did not cause the original contamination.

A sixth action is to examine the implications for a company of a regime that establishes liability for natural resource damages. The European Commission is expected to issue a white paper on civil environmental liability in the next few weeks.

Although an E.C. directive still is in the relatively distant future and is not expected to apply to historic pollution, the white paper is expected to recommend the imposition of liability for harm to natural resources. Thus, companies currently polluting wetlands or other environmentally sensitive public areas should consider changing their practices and, if feasible, consider restoring the damaged natural resource.

The actions described above are not meant to be comprehensive, but they do provide an indication of measures that some risk managers are persuading their companies to adopt to reduce environmental costs and exposure to environmental liabilities. Other measures include the purchase of specialized environmental liability insurance policies.

Risk managers cannot, of course, advise their companies about all the environmental risks they face, because some risks are not known until after a substance has been produced or used in a certain way. Scientific advances in recent times have revealed further information about the human health and environmental effects of substances such as, for example, asbestos, lead and solvents.

One issue with potentially far-reaching consequences is the effect on the normal functioning of an individual's or animal's endocrine, or hormone, system of substances such as sewage effluent, industrial chemicals, pesticides and phthalates.

In addition to newly discovered risks, risk managers cannot predict major pollution incidents or their effect on legislators. Such incidents frequently lead to a dramatic change of law.

Examples include:

- The introduction of an international civil liability and compensation system for marine oil spills following the Torrey Canyon oil spill in 1967;
- The E.C. directive on major accident hazards after the release of dioxin following an explosion at a factory in Seveso, Italy;
- The U.K. Deposit of Poisonous Waste Act of 1972 following the discovery of cyanide waste in Nuneaton, England; and
- The U.S. Superfund legislation following the migration of hazardous waste from the Love Canal waste dump in New York in the late 1970s.

Risk managers of companies considered to be traditional polluters are, no doubt, well aware of the factors described above. Risk managers of other companies, however, should consider whether it is in their company's interests to adopt these measures. BI

Valerie Fogleman is a partner and head of the Environmental Liability Group at solicitors Barlow Lyde & Gilbert in London and is a member of the Environmental Task Group of the Assn. of Insurance & Risk Managers in the United Kingdom.

Identifying workplace trends and their risks

By Rebecca S. Bruce

WHAT ARE THE KEY trends in the workplace today? Risk managers should consider the following, because they have an impact on risk:

- **Dawning awareness of occupational risks abroad.** Most large U.S. employers have made substantial progress getting their domestic workers compensation and disability costs under control. They are starting to realize that the next logical step is to tackle the same issues at their foreign subsidiaries.

Increasingly, companies are operating globally. U.S.-based companies are buying or opening foreign subsidiaries, and foreign companies are doing the same here.

In much of the world, including most of Europe and South America, the equivalent of workers comp has traditionally been a state function. Employers had no incentive to institute return-to-work programs because they weren't paying for wage replacement.

That has changed. In several countries, employers are now at least partly responsible for paying disability wages; other countries are following their lead and turning toward private systems. Now U.S. companies have an incentive to control their employment risks abroad.

On the other hand, managers at foreign companies are eager to learn about U.S.-style cost-containment programs. And they're coming here to get that information. For instance, Comp Camp, Aon Management Institute's training program, has attracted corporate managers from Brazil, the Netherlands, the United Kingdom and Israel.

- **Closer scrutiny of managed care organizations.** Managed care organizations are feeling increased pressure from the media, politicians, employees, employers and doctors to provide quality care. Fueled by negative media coverage, the public's distrust for managed care organizations will continue. Physicians are successfully fighting managed care organization "gag rules" and reasserting control. Doctors who are achieving savings by better managing treatment of injured workers are looking for their monetary reward.

See **Trends** *on next page*

Trends

Continued from previous page

One response is to set up more onsite medical care. In the recent past, many companies have eliminated company nurses. Now they're coming back. For example, one of our clients, a major airline, recently set up clinics at all its major hubs.

A skilled, caring company medical practitioner can provide immediate medical attention that can pay big dividends. Immediate care can often prevent small problems from becoming far worse. The presence of a clinic also tells workers that the employer is concerned about their health.

Because managed care organizations have such a big market share, employers can't avoid or ignore them. Managed care organizations, in all their varieties, obviously are here to stay. The issue becomes how to best use them. Public pressure may result in their becoming more patient-friendly and less driven by cost factors. Meanwhile, company clinics can fill the communication and compassion gap.

• **Growing focus on return-to-work programs.** Today, enlightened employers realize that it's not acceptable for injured employees to be unproductive. Most health care, manufacturing and transportation companies now have some type of return-to-work program. These programs have been proven to work, and employers realize they must continue to manage and upgrade their programs. Any industrial company without a return-to-work regimen risks becoming a dinosaur.

Now employers are looking at return-to-work programs for workers who aren't in traditional settings. Telecommuters, for instance, pose special challenges. More people today work out of their homes, including salespeople and claims adjusters. Many such workers depend on their ability to drive to make a living. Since telecommuters aren't at the work site, alternate-duty jobs aren't readily available. Creative approaches are required, such as giving the worker a package of files and having him or her make follow-up calls from home.

• **An increasing focus on safety.** Recently viewed as a bit passé, safety is becoming a hot button under the name of "change management."

Safety—reducing or preventing injury and illness—remains a key for cost control and employee morale. Today's safety experts, however, must go beyond traditional inspections for physical hazards. Safety now encompasses ergonomics and industrial hygiene. Indoor air quality represents a major risk, as shown by several high-profile cases, such as that of Massachusetts' new Registry of Motor Vehicles building, which had to be shut down because of worker complaints.

To make safety a corporate priority, risk managers need to display leadership skills and win the backing of senior management. That is why what we are really discussing here is change management. Safety pros and risk managers need to be able to think "outside the box" and raise awareness of safety throughout the corporation.

To ensure better safety, risk managers will increasingly turn to outside experts to solve technically difficult problems, such as environmental and ergonomic risks.

• **Growth in networks of law firms that serve employers.** Because increasingly complex laws, such as the Family and Medical Leave Act and the Americans With Disabilities Act, affect state workers compensation statutes, employers need attorneys with a broad, sophisticated understanding of employment and labor law. Failure—or even the perceived failure—to comply with the law when hiring, promoting or firing employees can be costly in both time and money. Violations of the ADA have risen 31% in just two years. One attorney has estimated that 20% of all civil suits are filed by disgruntled employees or former employees.

Because each state's laws are so different, a national employer needs legal counsel who possesses state-specific knowledge. In a legal network, independent local practitioners affiliate with a large law firm. With such a network in place, it becomes simple for an employer to find an employment law expert in New Mexico or New Hampshire.

While employers need local counsel to handle traditional defense work such as fighting dubious workers compensation claims, it is more important that they find experts who can take a proactive role. A competent employment attorney can coach employers in safe hiring and termination practices. A lawyer with a broad grasp of employment law can keep employers out of trouble by reviewing areas such as interviewing and employee selection standards, disciplinary procedures, and the handling of contentious employees and the problems they create.

• **More employee lawsuits based on gossip and innuendo.** In a more competitive and downsized workplace, some people don't play fair, and unwary employers and co-workers can get sued when an employee or supervisor slanders a co-worker.

In general, the workplace has become a more rancorous place. To ensure their survival in the next round of layoffs, some people take the strategy, whether consciously or not, of spreading innuendo about co-workers. Even managers can fall into this trap, with results that can be disastrous for employers. Today's employees are quick to fight back when they feel they've been treated unjustly, by hauling their former co-workers, supervisors and employers into court. Even if the gossip was entirely the doing of a co-worker, the employer may be sued too, on the theory that it did nothing to prevent or control such slander.

To protect itself, every employer should have a written policy saying it won't tolerate malicious gossip and backstabbing. Besides reducing legal risks, the policy helps boost worker morale and makes for a more productive workplace.

• **An upsurge in union activity.** Unions hadn't had many victories until last year's Teamsters' win over United Parcel Service of America Inc. That has changed the landscape. With continuing downsizings and layoffs, we have an insecure and angry work force, and unhappy workers are more apt to welcome unions.

Now, with a low unemployment rate, power is starting to shift from employers to employees. Unions are stepping up their efforts to recruit service workers. Part-time and leased employees promise to be a fertile ground for union recruiting.

Unionized companies pose special challenges for companies striving to control workers' compensation and disability costs. Employers with return-to-work programs—or those that are planning to create such programs—must earn the cooperation of unions. They must take care to promote return-to-work programs as a real benefit to workers and not let unions portray such programs as another instance of management infringing on worker rights. BI

Rebecca S. Bruce is counsel in the employment practice group of the Wethersfield, Conn., law firm of Mayo, Gilligan & Zito. She also is former president and chief executive officer of Aon Management Institute in Glastonbury, Conn.

How to prepare for 'common crises'

"The Crisis Counselor: The Executive's Guide to Avoiding, Managing and Thriving on Crises That Occur in All Businesses"
By Jeffrey R. Caponigro
Published by Barker Business Books Inc.
4000 Town Center, #900
Southfield, Mich. 48075
248-208-3090
$24.95

By Kevin M. Quinley

EVERY BUSINESS—and risk manager—has problems that, if not managed properly, can turn into crises. A new business management book, "The Crisis Counselor," provides practical advice that can be applied by any risk manager, according to the book's author, Jeffrey Caponigro, a Michigan public relations executive.

Most businesses are sorely unprepared for crises, argues Mr. Caponigro, who has helped clients manage more than 100 crisis situations during his 19-year public relations career. A common mistake is thinking that crises are only those disasters reported in the newspapers or on the pages of *Business Insurance*—such as plane crashes, workplace shootings or product tamperings.

Most businesses, Mr.Caponigro believes, fail to prepare for the more common crises, such as lawsuits, employee layoffs, quality problems and poor financial performance. It takes years to build a solid reputation in business, the author believes, and that reputation can be destroyed in minutes by a poorly managed crisis.

Mr. Caponigro is president and chief executive officer of Caponigro Public Relations Inc., based in Southfield, Mich. The book's aim is to help any business, from a start-up venture to a Fortune 500 company. It offers a mind-set to risk managers that encourages advance planning, fixing small problems before they turn into crises, and helping businesses insulate themselves from crisis situations.

Although this book was not written with risk managers in mind as the core audience, they should be a receptive market for its message.

"The Crisis Counselor" is a veritable risk manager toolbox, offering:

- Seven steps to effectively prepare for and manage crises.
- Examples of 15 crises that can happen in any business.
- Ten mistakes most businesses make in grappling with crises.
- Ten outcomes of mismanaged crises.
- Four benefits of well-managed crises.
- More than 30 examples of crisis situations—with lessons learned—for each.
- Bulleted answers and advice for more than 100 questions.

Many risk managers respond to crises by focusing on the insurance and loss financing ramifications. This is understandable, but it is a narrow, piecemeal approach to crisis management. Conversely, Mr. Caponigro provides a holistic system. He emphasizes that it is also vitally important to conduct ongoing public relations in order to build a company's goodwill and to cushion it from the impacts of future crises.

Consensus opinion offers Johnson & Johnson's handling of the Tylenol tampering case as an example of a well-managed crisis. Another example Mr. Caponigro draws upon is when Chrysler Corp. Chairman Lee Iacocca learned that officials were disconnecting odometers for test drives in unsold cars. Mr. Iacocca went on prime-time television to admit his company's error, to apologize and to promise to make it up to American car buyers.

To paraphrase a popular bumper sticker, "stuff happens." Perhaps better than anyone, risk managers know this. When the bad stuff hits the proverbial fan, however, risk managers who have read and heeded "The Crisis Counselor" can step to the forefront and help guide their organizations successfully through the ordeal. BI



Kevin M. Quinley is senior vp-risk services for MEDMARC Insurance Co. Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. He holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.



DOCTORS DEFEAT POLIO: 1955
PAPERWORK DEFEATS DOCTORS: 1997

(ONE-FORM PROCAP COVERAGE CREATED: 1997)

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Continued from page 24

Services: Retail pharmacy network, mail-order distribution, claims processing*, online claims processing, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, patient education.

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

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

Service area: Nationwide.

Billing methods: Fee per claim. Volume discounts to employers.

Officers: Robert E. Marks, president; Doug Boodjeh, chairman; Tom McConnell, CFO; Jim Wallace, vp-sales; Cheryl Sforzo, director-administration.

Contact: Robert E. Marks or Jim Wallace.

* *Subcontracted.*

International Pharmacy Management Inc.

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

1997 revenues

Total gross revenues	$5,000,000
PBM gross revenues	$5,000,000
PBM unbundled revenues	$5,000,000

PBM clients

Total	64
Employer/group plans with direct service	7

Lives covered

Group Health:	
Total	1,750,000
Active enrollees	350,000
Through employers	65%
Through third-party vendors	35%
Workers Compensation:	
Active enrollees	250,000
Through employers	100%

Retail network

Pharmacy locations	50,000

Mail-order services

Percent of prescription volume	12%

Generic usage

Percent of prescription volume	43%

Staff

Total	30
Professionals	28

Includes: 2 registered pharmacists

PBM services since: 1995

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including 137 locations nationwide.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization; 20 standard reports available.

Service area: Gulf Coast, Midwest, Northeast, Southeast.

Billing methods: Capitated rate, fee per claim. Volume discounts to employers.

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

Contact: Greg Stein.

INTEQ

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

1997 revenues

PBM gross revenues	$3,100,000

PBM clients

Total	1,000
Employer/group plans with direct service	250

Lives covered

Group Health:	
Total	1,300,000
Active enrollees	1,100,000
Through employers	30%
Through third-party vendors	65%
Through Medicare/Medicaid	5%
Workers Compensation:	
Active enrollees	100,000
Through employers	40%

Retail network

Pharmacy locations	43,000

Mail-order services

Percent of prescription volume	14%

Generic usage

Percent of prescription volume	43%

Staff

Total	40
Professionals	35

Includes: 3 registered pharmacists

PBM services since: 1993.

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

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

Service area: Nationwide.

Billing methods: Capitated rate, fee per claim. Volume discounts to employers.

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

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

1997 revenues

PBM gross revenues	$12,000,000,000

PBM clients

Total	1,300

Lives covered

Group Health:	
Total	51,000,000

Retail network

Pharmacy locations	55,000

Staff

Total	11,000

Includes: 1,500 registered pharmacists

PBM services since: 1983.

Parent: Merck & Co. Inc.; primary business: drug manufacturer.

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

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

Service area: Nationwide; also serves Puerto Rico and certain international regions.

Billing methods: Capitated rate, fee per claim. Volume discounts to employers.

Officers: Per Lofberg, president.

MIM Health Plans Inc.

1 Blue Hill Plaza, 15th Floor,
Pearl River, N.Y. 10965;
888-818-3939; fax: 914-627-6614
www.mimcorp.net

1997 revenues

PBM gross revenues	$75,000,000

PBM clients

Total	59
Employer/group plans with direct service	18

Lives covered

Group Health:	
Total	1,700,000
Active enrollees	1,200,000
Workers Compensation:	
Active enrollees	50
Through employers	100%

Retail network

Pharmacy locations	39,000

Mail-order services

Percent of prescription volume	1%

Generic usage

Percent of prescription volume	66%

Staff

Total	185

Continued on page 32



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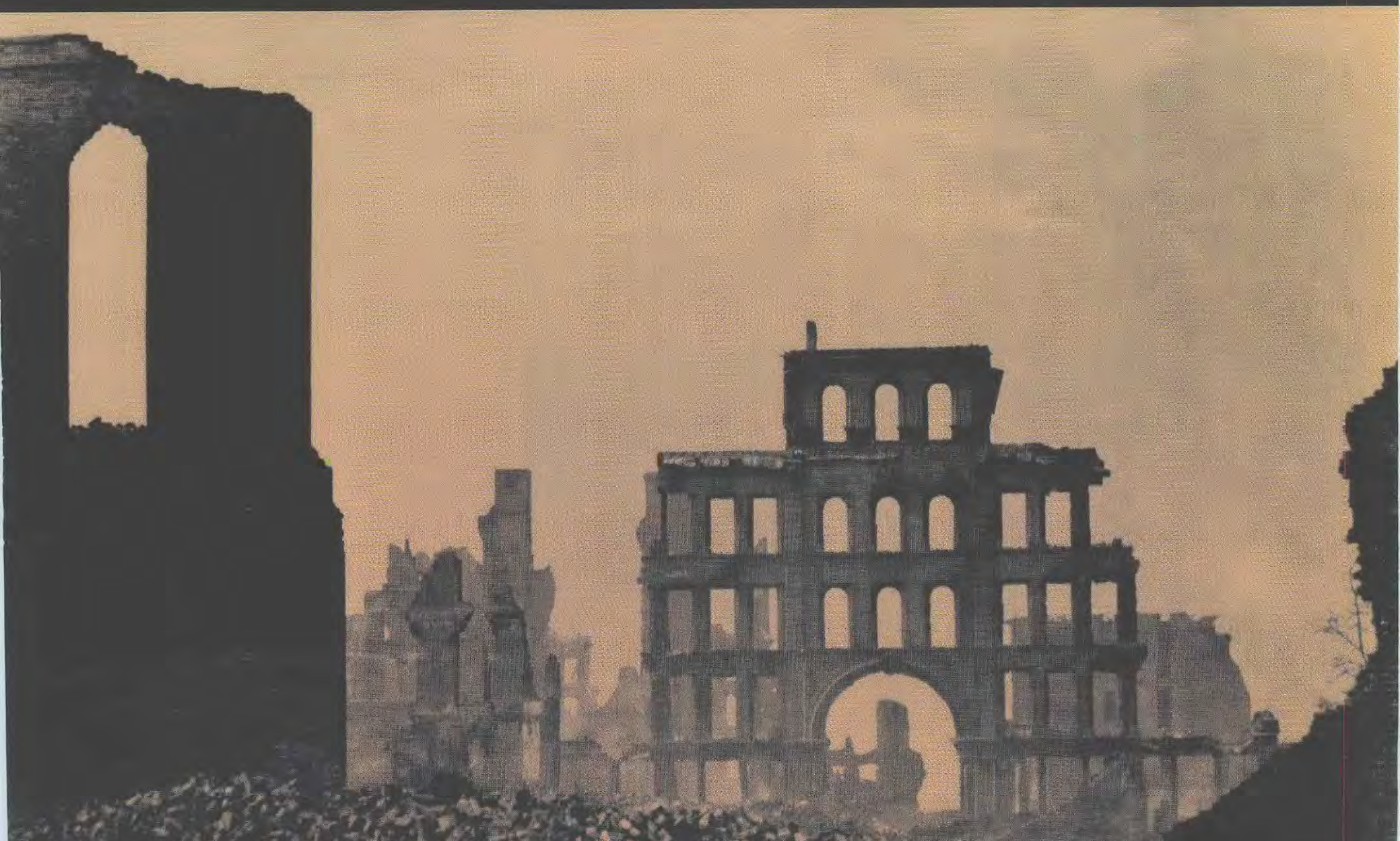
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Continued from page 30

Professionals....170
Includes: 29 registered pharmacists

PBM services since: 1993.

Parent: MIM Corp.; primary business: pharmacy management.

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

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

Service area: Nationwide.

Billing methods: Capitated rate, fee per claim, shared savings.

Officers: Richard H. Friedman, CEO; Scott Yablon, president/COO; Rick Pellokat, vp-sales/marketing; Barry Posner, executive vp/general counsel.

Contact: Joe DeMarte, vp-marketing/sales operations.

National Pharmaceutical Services

14748 W. Center Road,
Omaha, Neb. 68144;
800-546-5677; fax: 800-458-1646

1997 revenues

Total gross revenues....$28,000,000
PBM gross revenues....$5,000,000
PBM unbundled revenues....$5,000,000

PBM clients

Total....700
Employer/group plans with direct service....700

Lives covered

Group Health:
Total....300,000
Active enrollees....110,000
Through employers....100%

Workers Compensation:
Active enrollees....30,000
Through employers....100%

Retail network

Pharmacy locations....45,000

Mail-order services

Percent of prescription volume....10%

Generic usage

Percent of prescription volume....83%

Staff

Total....20
Professionals....13
Includes: 7 registered pharmacists

PBM services since: 1992.

Parent: Pharmaceutical Technologies Inc.; primary business: software.

Services: Retail pharmacy network, mail-order distribution, claims processing, online claims processing, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient education, demographic trends for group analysis.

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including Albertsons, Kmart, Med Man, Rite Aid, Walgreens and Wal-Mart.

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

Service area: Nationwide, principally western and southwestern states.

Billing methods: Capitated rate, fee per claim. Volume discounts to employers.

Officers: Douglas M. Pick, CEO/president; Angela Pieper, CFO; Cindy Waterman, network director; Mike Heskin, vp-mail order; Dan Cutler, information director.

PCS Health Systems Inc.

9501 E. Shea Blvd.,
Scottsdale, Ariz. 85260-6719;
602-391-4600
www.pcshs.com

1997 revenues

PBM gross revenues* $1,792,000,000

PBM clients

Total....1,208
Employer/group plans with direct service....930

Lives covered

Group Health:
Total....56,000,000
Through employers....30%
Through third-party vendors....70%

Retail network

Pharmacy locations....54,000

Generic usage

Percent of prescription volume....40%

Staff

Total....2,400

PBM services since: 1969.

Parent: Eli Lilly & Co.; primary business: drug manufacturer.

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including CVS, Eckerd, Walgreens, Wal-Mart.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, claims history, drug utilization review, network performance, customized reports.

Service area: United States, Puerto Rico.

Billing methods: Capitated rate, fee per claim.

Officers: Jean-Pierre Millon, president/CEO; John Voris, executive vp; Thomas Garrity, executive vp/CFO; Elizabeth Dichter, executive vp-strategic marketing; Mitch Henry, executive vp/chief information officer.

Contact: Public relations, 602-391-4501.

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1100 N.E. 51st St.,
Oakland Park, Fla. 33334;
800-774-2002; fax: 954-938-7984
www.rxmail.com

1997 revenues

Total gross revenues....$23,000,000
PBM gross revenues....$4,000,000
PBM unbundled revenues....$2,300,000

PBM clients

Total....362
Employer/group plans with direct service....164

Lives covered

Group Health:
Total....483,000
Active enrollees....338,000
Through employers....53%
Through third-party vendors....40%
Through Medicare/Medicaid....7%

Workers Compensation:
Active enrollees....72,000
Through employers....35%

Retail network

Pharmacy locations....40,000

Mail-order services

Percent of prescription volume....40%

Generic usage

Percent of prescription volume....59%

Staff

Total....41
Professionals....11
Includes: 5 registered pharmacists

PBM services since: 1983.

Parent: Managed Healthcare Systems Inc.; primary business: PBM and mail order prescription services.

Services: Retail pharmacy network, mail-order distribution, claims processing, online claims processing, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient education, liquid unit dosage for institutions.

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

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

Service area: Nationwide.

Billing methods: Fee per claim. Volume discounts to employers.

Officers: Ken Sack, CEO; Stan Freedman, pharmacy director; Gina Hunt, PBM director; Cathy Cox-customer service director; Martin Duberstein, marketing director.

ProVantage Inc.

13555 Bishops Court, Suite 201,
Brookfield, Wis. 53005;
800-784-0881; fax: 414-641-3770
www.provantageinc.com

1997 revenues

Total gross revenues....$56,500,000
PBM gross revenues....$50,100,000

Continued on next page

Continued from previous page

PBM clients

Total 3,500
Employer/group plans with direct service 750

Lives covered

Group Health:
Total 4,500,000
Active enrollees 750,000
Through employers 35%
Through third-party vendors 60%
Through Medicare/Medicaid 5%

Retail network

Pharmacy locations 50,463

Mail-order services

Percent of prescription volume 5%

Generic usage

Percent of prescription volume 45%

Staff

Total 370
Professionals 280
Includes: 28 registered pharmacists

PBM services since: 1994.

Parent: Shopko Stores Inc.; primary business: retail/health services.

Services: Retail pharmacy network, mail-order distribution, claims processing, online claims processing, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient education, clinical prior authorization, health care therapeutics management, ProVRx online decision support tool.

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including CVS, Eckerd, Longs, Osco, Rite-Aid, Shopko and Walgreens.

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

Service area: Nationwide.

Billing methods: Fee per claim, gainshare, per month per member. Volume discounts to employers.

Officers: Jeffrey Jones, executive vp/COO-ProVantage Inc.; Glen C. Laschober, executive vp/COO-ProVantage PBM/VMB; Lee Morse, president-PharMark Inc.; Joseph A. Coffini, vp-managed care services; Dr. Peter Hoffman, vp/chief medical officer-ProVantage Inc.

Contact: Matthew J. Zirpoli, vp-sales.

RESTAT

724 Elm St., West Bend, Wis. 53095;
800-926-5858; fax: 414-338-5767

1997 revenues

PBM gross revenue $6,000,000

PBM clients

Total 122

Lives covered

Group Health:
Total 1,815,303

Retail network

Pharmacy locations 49,000

Mail-order services

Percent of prescription volume 4%

Generic usage

Percent of prescription volume 49%

Staff

Total 65
Professionals 58
Includes: 5 registered pharmacists

PBM services since: 1985.

Parent: The F. Dohmen Co.; primary business: prescription benefit management.

Services: Retail pharmacy network, claims processing, online claims processing, concurrent utilization review, retrospective utilization review, benefit design consulting, formulary management/review*, monitoring of physician prescribing practices.

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including Osco, Revco and Walgreens.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, mail vs. retail detail reports, executive summary, pharmacy billing summary, claim detail.

Service area: Nationwide.

Billing methods: Fee per claim, per member per month.

Officers: Michael W. Clark, president; David Kwasny, vp-sales/marketing; John Bergan, vp-information systems; Ann Larkin, controller.

** Subcontracted.*

United Drugs

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

1997 revenues

Total gross revenues $8,000,000
PBM gross revenues $100,000

PBM clients

Total 20
Employer/group plans with direct service 10

Lives covered

Group Health:
Total 200,000
Active enrollees 200,000
Through employers 25%
Through third-party vendors 75%

Retail network

Pharmacy locations 12,000

Mail-order services

Percent of prescription volume 10%

Generic usage

Percent of prescription volume 70%

Staff

Total 35
Professionals 8
Includes: 2 registered pharmacists

PBM services since: 1989.

Parent: American Associated Druggists; primary business: independent pharmacy cooperative.

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

Formularies offered: Restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, utilization review by therapy class, top drugs by dollar volume/number of prescriptions.

Service area: Nationwide.

Billing methods: Fee per claim. Volume discounts to employers.

Officers: Michael Huston, CEO; Elizabeth Schrader, vp-finance/operations; Bruce Semingson, vp-managed care sales; Frank Taylor, vp-marketing.

Contact: Bruce Semingson.

** Subcontracted.*

York Prescription Benefits

1 Church St., Fifth Floor,
New Haven, Conn. 06510;
203-781-3411; fax: 203-946-3591
www.yorkpbm.com

1997 revenues

Total gross revenues $21,000,000
PBM gross revenues $9,000,000
PBM unbundled revenues $7,500,000

PBM clients

Total 53
Employer/group plans with direct service 51

Lives covered

Group Health:
Total 77,039
Active enrollees 51,028
Through employers 64%
Through third-party vendors 16%
Through Medicare/Medicaid 20%
Workers Compensation:
Active enrollees 2,359

Retail network

Pharmacy locations 40,392

Mail-order services

Percent of prescription volume 10.3%

Generic usage

Percent of prescription volume 41.3%

Staff

Total 75
Professionals 23
Includes: 4 registered pharmacists

PBM services since: 1995.

Parent: Yale New Haven Health.

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains.

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

Service area: Nationwide.

Billing methods: Capitated rate, fee per claim, per member per month. Volume discounts to employers.

Officers: Lily Khodadoost-Kamvar, director-clinical services; James Bigl, general manager, York; Michael Hajdun, director-operations, York.

Contact: Karen Bradbury, business development manager, 203-781-4875. BI

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Free information on benefit products and services

EMPLOYEE BENEFITS

■ The American College offers a descriptive guide about the Registered Employee Benefits Consultant and Registered Health Underwriter **professional designations**. Request item **2300**.

■ A newsletter from Aon Consulting discusses temporary tax regulations impacting midyear **cafeteria plan** elections. Request item **2301**.

■ A report from the International Foundation of Employee Benefit Plans examines the feasibility of **economically targeted investing** through the partnership of public and private pension funds. Request item **2302**.

■ **Employee benefit provisions in the Taxpayer Relief Act** are explained in a fact sheet presented by Buck Consultants Inc. Request item **2303**.

■ A paper providing information on the impact of the **Americans with Disabilities Act** on employers, employees and insurers is available from CNA. Request item **2304**.

■ CorporateFamily Solutions offers an article outlining the benefits to both employees and employers by being a **family-friendly company**. Request item **2305**.

■ **Human resources and benefits** issues are explored in a newsletter offered by Aon Consulting. Request item **2306**.

■ Developments and corporate solutions to problems associated with **work/life benefits** are discussed in a newsletter published by CorporateFamily Solutions. Request item **2307**.

■ A catalog with information regarding the **Certified Employee Benefit Specialist designation program** is available from the International Foundation of Employee Benefit Plans. Request item **2308**.

■ A series of pamphlets discussing major **life events** and choices facing individuals in these situations is available from MetLife. Request item **2309**.

■ MetLife provides a booklet that answers questions about how the **Family and Medical Leave Act** may relate to employee benefit programs. Request item **2310**.

■ A booklet available from Sedgwick Noble Lowndes provides a checklist for employers to ensure **compliance** with current-year employee benefit rules. Request item **2311**.

■ The Segal Co. supplies an annual reporting and disclosure calendar that indicates general **reporting and disclosure** requirements applicable to employee pension and welfare benefit plans. Request item **2312**.

■ Sedgwick Noble Lowndes offers a survey of senior corporate executives that measures opinions on topics such as **Medicare, managed care and 401(k) investor education**. Request item **2313**.

■ The Self Insurance Exchange Inc. provides a guide for **third-party administrators** and their marketing departments about adapting to a changing marketplace. Request item **2314**.

■ A study offered by Intracorp explores the attitudes and perspectives of the American worker regarding **personal health**. Request item **2315**.

■ A handbook offered by Sedgwick Noble Lowndes interprets some of the more vexing **COBRA** laws for plan sponsors. Request item **2316**.

■ A study aimed at employers that identifies strategic issues relevant to employer **health benefit spending** is offered by Towers Perrin. Request item **2317**.

■ A quarterly newsletter from the International Society of Certified Employee Benefit Specialists explores **employee benefit issues and trends**. Request item **2318**.

■ An article discussing key considerations in **voluntary payroll deductions for benefit products** is available from Monumental Life Insurance Agency. Request item **2319**.

■ A pamphlet from the International Foundation of Employee Benefit Plans lists publications and materials designed to assist employers with the **communication of benefits**. Request item **2320**.

■ **Social Security and Medicare program benefits** are summarized and criteria explained in an annual fact sheet published by BNA Books. Request item **2321**.

■ Child & Elder Care Insights Inc. offers a booklet aimed at employers and employee assistance providers that gives an overview of **dependent care** benefits. Request item **2322**.

Continued on next page

The Information Resource section on employee benefit products and services is an editorial compilation of current informational and educational materials on topics of interest to corporate risk management, employee benefits and financial executives.

The listings are published as an editorial service by *Business Insurance*; there is no charge to list materials in the section.

All of the materials may be obtained free by *BI* readers. To receive any of the materials listed in this section, please write the item numbers of those materials on the reader service coupon printed in the section. Fill out the remainder of the coupon and mail it to:

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VIRTUAL SPIDERS HELP CURE ARACHNOPHOBIA.

If eight-legged creatures give you the creeps, now there's a new high-tech therapy to help you overcome your fear. Researchers at Clark Atlanta University have developed a virtual-reality program that allows arachnophobes to get up close and personal with a real-looking spider. By learning to be comfortable with virtual spiders, patients can eventually come to grips with their irrational fears.* Of course, if you also suffer from technophobia, this may not be the right therapy for you.

SCIENTISTS GROW NEW KNEES IN LABORATORY.

A group of green-thumbed scientists have invented a method for cultivating human kneecaps in test tubes. In this new procedure, called Carticel, doctors remove healthy cartilage from a patient's injured kneecap. Then the specimen is sent to a lab, where cells are cultured in test tubes. Weeks later, millions of farm-fresh cartilage cells are returned and implanted into the patient's knee.* Who knows, maybe someday you'll be able to get new knees in the produce section of your supermarket.

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Continued from previous page

■ A disk that helps users connect with **benefits-related World Wide Web sites** is available from Midwest Legal Services. Request item **2323**.

■ Aetna International Group Benefits presents an annual **international manual** of the usual and customary benefits offered in 44 countries. Request item **2324**.

■ A bulletin published by Baker & McKenzie highlights global labor, **employee benefits** and employment issues. Request item **2325**.

■ A newsletter produced by Globex International discusses **international** events and developments involving benefits and related subjects. Request item **2326**.

■ A paper offered by T.E. Brennan addresses self-insurance and ways that employers can reduce **health costs**. Request item **2327**.

■ A newsletter highlighting new developments for **health plan professionals** is available from Corbel. Request item **2328**.

■ A booklet available from ENCOMPASS Health Management Systems addresses frequently asked questions of **benefits managers**. Request item **2329**.

■ A brochure from Insurance Claims Auditing and Professional Services Inc. explains how to determine if a self-insured health or other benefit plan needs a **claim audit**. Request item **2330**.

■ A Self Insurance Exchange Inc. pamphlet for vendors interested in reaching **self-insured workers compensation and benefit programs** highlights key marketing tips, including product and buyer information. Request item **2331**.

■ A directory of companies that provide products and services for **self-insured employee benefits or workers compensation plans** is available from the Self-Insurance Institute of America Inc. Request item **2332**.

■ Strategic Recovery Partnership Inc. offers a newsletter discussing congressional initiatives that may affect **self-funded health care plans**. Request item **2333**. BI

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Information Resource

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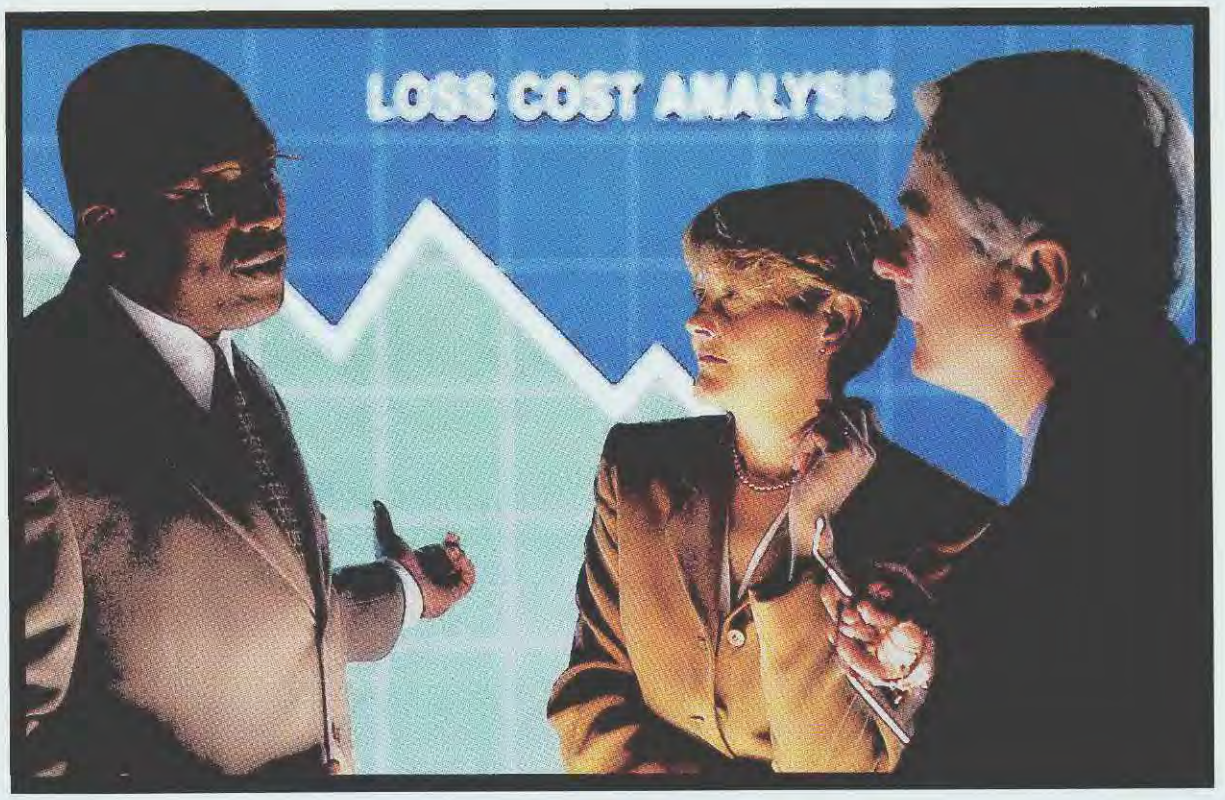
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California

Continued from page 2

with Orrick, Herrington & Sutcliffe in San Francisco. He filed a brief in the case on behalf of The Employers Group, which represents 2,500 California companies. "I think this is a victory for every person employed in the state of California as a manager," said Mr. Klein.

The decision is not expected to decrease litigation. "I don't think it's going to cut back on the number of suits," said Mr. Klein. Instead, it will just "cut back on the number of suits where an employee is named along with the company," he said.

Kimberly Reno, a pediatric nurse employed by a now-defunct nurse registry who claims she was fired in 1992 after her employer learned she suffers from cancer, filed the suit. She sued Marijo Baird, who had been the registry's principal owner as well as her supervisor, on charges that included employment discrimination and discharge in violation of public policy.

The Supreme Court overturned a lower court decision and ruled that Ms. Reno could not sue Ms. Baird as an individual. In doing so, it agreed with a 1996 appellate court decision, *Janken vs. GM Hughes Electronics*.

Harassment, such as slurs or derogatory drawings, involves conduct that is avoidable and unnecessary, but a manager cannot refrain from conduct that could later lead to a discrimination claim, said the high court's decision.

Managers should not be subject to the "ever-present threat of a lawsuit each time they make a personnel decision," said the court.

"By limiting the threat of lawsuits to the employer itself, the entity ultimately responsible for discriminatory actions, the Legislature has drawn a balance between the goals of eliminating the discrimination in the workplace and minimizing the debilitating burden of litigation on individuals."

Managers should not be subject to the 'ever-present threat of a lawsuit each time they make a personnel decision,' said the California Supreme Court ruling.

Managers guilty of discrimination will not go unpunished, though, says the court. "They will merely escape the cost of defending suit. Supervisors guilty of engaging in unlawful discrimination, and thus causing their employer to incur monetary liability, will often suffer demotion or unemployment. Their reputation with potential future employers will also be affected," the ruling stated.

Even though the decision is about individual employees, it is significant for their employers, "because they call upon their supervisors to make employment decisions," said George W. Abele, of Los Angeles-based Paul, Hastings, Janofsky & Walker, which had filed a brief in the case on behalf of an employers group, the California Employment Law Council.

Had the court concluded that managers could be held personally liable, those individuals "would likely make a decision based on who is less likely to sue them, rather than what's best for the company," said Mr. Abele. A supervisor, for instance, "might keep someone who's less worthy of being kept on, simply because that person is more likely to sue if they were let go or disciplined."

Insurer attorneys say there are other implications to the decision.

David Miller of Walnut Creek, Calif.-based Hoyt, Miller & Angstadt, which represented the defendant, said the decision "takes away a tool of the plaintiff lawyer—basically, to force settlements out of individuals."

In addition, the decision means companies will not have to take on the sometimes significant cost of defending individual employees in addition to the corporation, said Patricia Gillette of Heller Ehrman White & McAuliffe in San Francisco.

Attorneys warn, however, that the decision also represents a potential danger to employers.

"The challenge for employers in this is making sure their employees don't take this to mean they don't have to still toe the line when it comes to enforcing the employer's policies about discrimination in the workplace, because one of the ways you make supervisors pay attention is to tell them it's going to hit their pocketbook," said Ms. Gillette.

The decision "sends the wrong message to people inclined to discriminate. Ultimately, the decision will hurt not just victims of discrimination but business as well," because managers will feel freer to discriminate, which will lead to more suits, said Phil Horowitz of Lawless, Horowitz & Lawless in San Francisco, who represented the plaintiff.

This is the "only area of the law I've heard of (where) someone can commit an illegal act and get off scot-free," charged Joseph Posner, an Encino, Calif.-based solo practitioner who filed a brief in the case on behalf of the California Employment Lawyers Assn., an organization of plaintiffs attorneys.

"I maintain that the fear of liability is what keeps most people on the straight and narrow. If you have to think about the consequences of your action because you might be held responsible, then that's a good thing," said Mr. Posner.

The court incorrectly assumes that managers who discriminate always face punishment, said Mr. Posner. "I don't think the court's living in the real world," he said. "It sure doesn't happen in the cases that I have."

More typically, the company "forms the wagon in a circle" and claims the individual at fault is as "pure as the driven snow," he said.

Mr. Posner also said the "court treats this matter of personnel decisions as somehow sacrosanct, but I've seen many instances where personnel decisions are made to harass someone."

However, Mr. Horowitz said individuals will continue to be named in suits, but "it'll be under other legal claims," such as defamation and intentional infliction of emotional distress.

•

Kimberly Reno, plaintiff and appellant, vs. Marijo Baird, defendant and respondent, No. S06547, in the Supreme Court of California.



to plan recruiting strategies

evaluate incentive options

brief senior management

design training classes

review family-care benefits

and make time to read

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INTERNATIONAL

Global Briefs

Stephen J. Bensinger has been appointed chairman and CEO of **Archer Group Holdings P.L.C.** and Archer Managing Agency Ltd. He also retains his position as president of Chartwell Re Corp. Stamford, Conn.-based Chartwell Re owns Archer Group, and Mr. Bensinger's appointment needs Lloyd's approval. Archer Group's previous CEO, Stephen Wenman, left the organization as the announcement was made last Monday. . . .Aon Insurance Managers in London, a captive management division of Aon Corp., has appointed Jim Boyd and John Perham as executive directors. Mr. Boyd, previously managing director of Willis Corroon Management (Isle of Man) Ltd., will remain in the Isle of Man, where he will head AIM's European operations and its global business development. Mr. Perham, formerly a senior executive in Johnson & Higgins' Captive Management Group, will be based in Dublin, Ireland, and focus on global business development. . . .Anthony Medniuk, managing director of British Aviation Insurance Group, and Stephen Riley, managing director of Swiss Re UK Ltd., have been elected deputy chairmen-designates of the **International Underwriting Assn.** of London. The IUA, due to start up early in 1999 as the world's largest international insurer and reinsurer association, is being created by the merger of the London International Insurance & Reinsurance Market Assn. and the Institute of London Underwriters. . . .Lloyd's of London has introduced a **disaster recovery system** into the computerized Lloyd's Insurance Network in order to help users to continue trading in the event of computer equipment at its London headquarters being inactivated by a disaster. LIN allows networks throughout the Lloyd's community to communicate and connect to other services. The disaster recovery system depends mainly on the installation of additional backup equipment at a separate site. . . .**Bayerische Ruck** is investing £10 million ($16.4 million) in the Wellington Group, one of the largest underwriting groups at Lloyd's of London. . . .A survey of U.K. corporate pensions by London-based market analyst Datamonitor concludes that one of the key trends over the past few years has been the increasing **popularity of defined contribution pension plans**, led by the U.K. subsidiaries of U.S. companies. This change also is attracting more overseas players into the U.K. pensions market, particularly from the United States, says the survey, Corporate Pension Fund Management. . . .Ice storms in Canada, floods in Britain and Year 2000 compliance costs have impacted heavily on the first-half financial results for 1998 of British insurer **Guardian Royal Exchange P.L.C.** Pretax profit for the six months to June 30 was £451 million ($752.1 million), down 8.7% from the prior-year period. Costs included £15 million ($25.1 million) from Canadian ice storms (*BI*, Jan. 19), £15 million from U.K. floods (*BI*, April 20), and £10 million ($16.7 million) on internal Year 2000 compliance. John Robins, group chief executive, said the underwriting environment remains competitive everywhere. . . .Losses from a **fire at a printing factory** operated by Germany's largest newspaper, Bildzeitung, will exceed 150 million deutsche marks ($84.6 million), said an underwriter. A spokesman for Hamburg, Germany-based Iduna/Nova Group, the lead insurer of a property insurance consortium, said insured property losses would likely exceed 100 million deutsche marks ($56.4 million) from the July 14 blaze in Essen-Kettwig, Germany. The extent of business interruption losses is unknown, but the spokesman said such losses likely will exceed the 50 million deutsche marks ($28.2 million) already reserved by Gerling A.G., the lead insurer on the business interruption loss, and others on the program. Investigators said arson was the likely cause. It is the worst fire in Germany since the Dusseldorf airport fire in April 1996 (*BI*, April 15, 1996).

Merger mania grips Lloyd's

Angerstein Underwriting Trust and Murray Lawrence agree to terms

By SARAH GODDARD

LONDON—The big are getting bigger at Lloyd's of London, as merger activity reduces the number of players in the market.

Angerstein Underwriting Trust P.L.C. is the latest Lloyd's spread investor to merge with an agency, with the announcement last week that it has agreed to terms with ML (Bermuda) Ltd., the holding company for Murray Lawrence.

Angerstein's merger follows an announcement by LIMIT P.L.C., the largest single investor at Lloyd's, that it was buying the remaining portions of Bankside Insurance Holdings Ltd. and Janson Green Ltd. it did not already own. The purchase effectively converts the spread investor into a Lloyd's-dedicated insurance company. LIMIT last week issued proposals to acquire £536 million ($880.2 million) of capacity on the nine syndicates in the group, paying from 1 pence per pound (1.6 cents) of capacity on syndicate 1036 to 32 pence per pound (52.6 cents) on syndicate 386. The agencies will merge next year.

Angerstein's move will have a similar effect. If the deal—currently awaiting regulatory and shareholder approval—goes through, Angerstein will become an integrated insurance group, rather than an investment company.

This is not Angerstein's first Lloyd's-related acquisition. Three years ago, it bought a rival Lloyd's spread investment company, Delian Lloyd's Investment Trust P.L.C. More recently, it took over Stace Barr Holdings Ltd., P.B. Coffey (Underwriting Agency) Ltd. and J.E. Mumford (Underwriting Agencies) Ltd. Angerstein has already said it will merge P.B. Coffey and J.E. Mumford.

The breadth of Murray Lawrence's business interests would expand Angerstein's business outside Lloyd's for the first time. The Whittington Group, part of Murray Lawrence, provides various specialist services, such as claims management and runoff for both insurance companies and Lloyd's-related businesses. It recently opened a unit in San Francisco to extend its services to U.S. clients.

At the beginning of this year, Angerstein

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

U.K. to disband broker regulator

Standards may fall amid shift to self-regulation, association warns

By SARAH GODDARD

LONDON—Business standards among U.K. brokers may weaken following a government decision to disband the authority that regulates them, an industry association warned last week.

Economic Secretary Helen Liddell early last week told Parliament that the U.K. government intends to repeal the Insurance Brokers (Registration) Act 1977, dissolving the Insurance Broker Registration Council, in a prelude to introducing draft legislation on U.K. financial services regulation late last week.

A British Insurance & Investment Brokers' Assn. spokeswoman said disbanding the IBRC could lead to "a rapid fall in standards."

Ms. Liddell said the combination of the 1977 Act and the Assn. of British Insurers' general business code of practice for selling insurance resulted in an incomplete and outdated framework of regulation, a view reinforced by responses during a recent consultation period on broker regulation (*BI*, April 27). She called for increased self-regulation by brokers.

"Our consultation has reaffirmed my view that a case for continuing statutory regulation through the registration of insurance brokers has not been made," said Ms. Liddell.

The IBRC regulates all organizations that use the title of insurance broker. Repealing the 1977 act would mean a lifting of restrictions and regulation of businesses wanting to call themselves insurance brokers.

"I now look to the industry itself to put the desired standards on a soundly established footing from which they will command widespread support," said Ms. Liddell.

But until that footing is reached, broker

See **Regulate** *on page 40*

Doctors get dose of risk management

U.K. medical council prescribes insurance, steps to minimize liability

By CAROLYN ALDRED

LONDON—The General Medical Council, the self-regulatory body responsible for British doctors, is advising physicians to obtain adequate professional indemnity insurance and to deal honestly and promptly with patients when things go wrong.

The risk management advice forms part of the updated "Duties of a Doctor," the GMC's ethical guidelines, published July 15.

"In your own interests and those of your patients, you must obtain adequate insurance or professional indemnity cover for any part of your work not covered by your employer's indemnity scheme," the GMC advises doctors.

Currently, most hospital doctors are covered by Crown Indemnity, a government-funded arrangement for medical negligence claims introduced in 1990 in response to an increased number of claims and higher court awards. However, Crown Indemnity does not cover disciplinary and criminal proceedings, and family doctors—the U.K. equivalent of general practitioners—generally are not covered by the government.

Medical insurers have welcomed the advice.

"This guidance has been needed for some time," said medical insurance officials Dr. Peter Schutte, deputy head of advisory services of the London-based Medical Defence Union Ltd.

"Up to now, there has been no legal or ethical requirement for a doctor to be a member of a medical defense organization. This is not in the interests of the doctor or the patient. The GMC's guidance means all doctors will have to have personal professional indemnity. Doctors take an unnecessary risk in relying on (National Health Service) indemnity alone," said Dr. Schutte.

New advice from the GMC also includes what doctors should do "if things go wrong."

As a doctor, "you have a professional responsibility to deal with complaints constructively and honestly," the GMC states.

"If a patient under your care has suffered serious harm, through misadventure or for

See **Doctors** *on page 40*

Waves leave wake of destruction

By YVETTE HIGGINS

PORT MORESBY, Papua New Guinea—Papua New Guinea's insurance industry expects few property/casualty claims for damage caused by three large waves that devastated fishing villages in the Sanduan Province in the northwest part of the country.

The waves, caused by an earthquake last month, destroyed remote villages in a 19-mile area close to the Irian Jaya border. Government officials have confirmed that 1,600 people have been killed and 2,000 are still missing.

David Macrae, executive director of Port Moresby, Papua New Guinea-based broker Kila Marsh & McLennan Pty. Ltd., said the financial loss was "substantial, even though only basic houses were destroyed." But few, if any, owners of those homes would have insurance, Mr. Macrae said.

Lyall McEwin, Papua New Guinea manager of Port Moresby-based General Accident Insurance Asia Ltd., said his company had received no commercial claims from businesses in affected areas as of July 22 and had received only one domestic house and contents claim.

See **Waves** *on page 40*



PHOTO: REUTERS

Three seismic sea waves last month destroyed fishing villages in Papua New Guinea, killing at least 1,600 people, but few losses were insured.

Lloyd's

Continued from previous page

put up £188 million ($310.4 million) of capacity to underwrite at Lloyd's, down from the £197 million ($337.4 million) it put up for 1997 because of deteriorating market conditions. Angerstein's board has stated that it wants an increasing amount of its capacity supporting group-managed syndicates.

Currently, it manages two: syndicate 902, with £38 million ($62.4 million) of capacity; and syndicate 1141, with £77 million ($126.4 million) of capacity. Angerstein's members agency Stace Barr looks after the interests of members that supply Lloyd's with around £522 million ($857.2 million) capacity this year—more than 5% of the £10.13 billion ($16.64 billion) capacity throughout Lloyd's.

As one of the leading underwriting groups, Murray Lawrence also controls substantial amounts of capacity.

'This merger will strengthen substantially our insurance business and, we believe, will create a strong and secure platform to continue' excellent performance, says Richard Keeling.

At the beginning of this year, it merged its six syndicates under a single umbrella syndicate, 2001, which has £530 million ($870.4 million) spread across the six units. Combining the two organizations will mean the new company—yet to be named, but unlikely to carry either "Angerstein" or "Murray Lawrence" in its title—will have £644 million ($1.06 billion) on its syndicates in 1998.

The merged group will have a capital base of £210 million ($344.9 million), and it aims to increase the share of the capacity it contributes to its syndicates from the current £158 million ($259.5 million). As part of this effort, Angerstein will scale down the amount of capacity it puts on non-group syndicates.

Richard Keeling, executive chairman at Murray Lawrence, will become chief executive officer of the new organization. "This merger will strengthen substantially our insurance business and, we believe, will create a strong and secure platform to continue achieving excellent returns and significant value for both sets of shareholders," he commented.

Angerstein's CEO, John Stace, will become deputy CEO of the new entity.

Although the proposed merger needs shareholder approval, already almost three-quarters of Murray Lawrence shareholders, including its three main institutional investors—State Farm Fire & Casualty Co., Fund American Enterprises Holdings Inc., and Lehman Brothers Holdings Inc.—have approved the deal.

State Farm currently owns 40% of Murray Lawrence Corporate Ltd., along with Fund American, and it supplies £116 million ($190.5 million) of capacity. Almost 20% of the new business will be owned by Murray Lawrence and Angerstein employees. BI

B.A.T, Zurich deal on track

LONDON—The merger of the financial services operations of B.A.T Industries P.L.C. and Zurich Group is on course for completion in September or October, B.A.T Chairman Lord Cairns said last week.

Speaking as the London-based tobacco and financial services group unveiled interim results, Lord Cairns said the target date should be met, "provided that regulatory consents continue to be achieved as expected."

The merger's target date should be met 'provided that regulatory consents continue to be achieved,' say Lord Cairns.

Commenting on the pretax profits for the six months to June 30, 1998, which were 14% lower than in the same period last year at £1.06 billion ($1.77 billion), Lord Cairns said one reason for the decline was a £55 million ($91.7 million) charge for demerger and restructuring costs.

Pretax profits also were lower because of a £152 million ($253.5 million) charge to cover U.S. tobacco settlements by its U.S. subsidiary, Brown & Williamson Tobacco Corp. The legal settlements were in Texas, Florida, Mississippi and Minnesota; they relate to the cost of treating smokers under Medicaid. B.A.T warned that there will be further charges for settlement costs in the remaining quarters of 1998 and that further amounts are payable each year by the U.S. tobacco industry from 1999 onward.

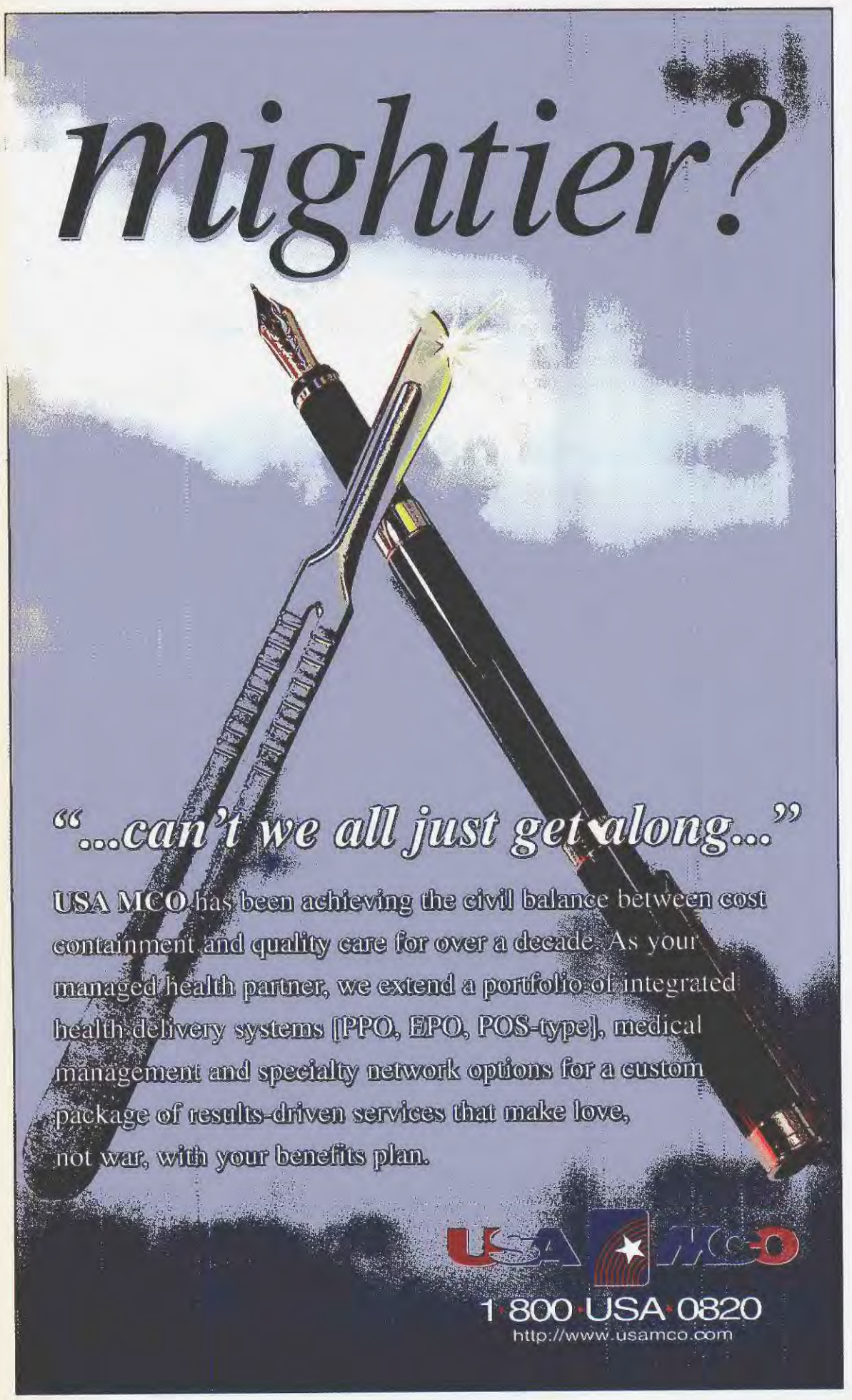
However B.A.T's results benefited from a one-off recovery after court action in Brazil of £78 million ($130.1 million) of tax on sales levied as social contributions.

Trading profit—the profit on trading activities before tax and excluding investment income—from B.A.T's financial service operations improved by 2% to £584 million ($973.9 million).

Underwriting results at Eagle Star Holdings P.L.C., B.A.T's principal U.K. multiline insurance subsidiary, deteriorated to a loss of £116 million ($193.5 million) against a £61 million ($101.7 million) loss last year. But compensating in part was a 10% rise in profit at Farmers Group Inc. to £351 million ($585.4 million).

B.A.T and Swiss insurance giant Zurich Group had announced the merger of their financial services operations last October. The new company will be called Zurich Financial Services Group, owned 53% by Zurich Group and 47% by B.A.T. It will have gross written premiums of approximately $40 billion, more than $340 billion in assets under management and 66,000 employees internationally.

—By Edwin Unsworth





1994 gold mine explosion brings subrogation

By KATE TILLEY
and YVETTE HIGGINS

SYDNEY, Australia—A trial date may be set soon to determine whether an Australian explosives contractor was an insured party under a construction all-risks policy for the Porgera gold mine in Papua New Guinea.

At a hearing set for late last week in New South Wales Supreme Court, Judge Bob Hunter was expected to set a date for a trial on the $28.1 million subrogation claim by the mine's insurers and owners against Sydney, Australia-based Dyno Nobel Asia Pacific Ltd., a Norwegian-owned company.

Dyno Nobel Asia Pacific Ltd. was the onsite explosives contractor at the mine when an Aug. 2, 1994, explosion killed 11 men and caused major damage at the mine, 373 miles northwest of Port Moresby.

The mine's owners at the time of the accident and their insurers are seeking compensation from Dyno, alleging Dyno was negligent and caused the explosion. Because the cause of the explosion has not been determined, the owners and insurers are relying on the principle that the explosion speaks for itself. Dyno disputes the claim, saying it was not negligent and regardless of fault should be covered under the Porgera joint venture's contract works policy. The policy has an extension for up to $20.0 million to allow for contractors' liability.

Porgera, which is the largest gold mine outside South Africa, was owned at the time of the 1994 accident by a joint venture of Sydney-based Placer Pacific Ltd.; Sydney-based Renison Goldfields Consolidated Ltd.; Highlands Gold Ltd., a subsidiary of Brisbane, Australia-based mining company MIM Holdings Ltd.; and the Papua New Guinea government.

The joint venture partners placed coverage with a Papua New Guinea-based insurer, Nuigini Insurance Corp., which fully reinsured the risk with Munich Reinsurance Co. The broker was Papua New Guinea-based Kila Marsh & McLennan Ltd., a unit of J&H Marsh & McLennan Inc.

Mark Sheller is an attorney with the Sydney law firm of Phillips Fox, which represents Dyno Nobel Asia Pacific Ltd.'s liability underwriter, Vesta Forsikring A/S, based in Bergen, Norway. He said Nuigini, after paying, took a subrogation action on the joint venture's behalf against Dyno seeking reimbursement of its $11 million material damage claim payment to the owners, while the Porgera joint venture partners also sought damages from Dyno for $17.1 million in uninsured losses.

Mr. Sheller said the insurer, reinsurer and the joint venture partners argued that Dyno Nobel Asia Pacific Ltd. was responsible for the loss.

Dyno's policy with Vesta covers it only for liabilities over and above any claims met by the underlying insurance, the Porgera joint venture's contract works policy, Mr. Sheller confirmed.

Court documents show the claim includes $13.6 million for repairs and reinstatement to buildings and equipment; $25,897 in workers compensation payments; $158,888 for payments to villagers for personal injury and property damage; and other payments, including repayment of sums paid by Nuigini to Dyno Nobel Asia Pacific Ltd. to replace its equipment.

There are also business interruption losses, including $4.6 million in lost profits, and interest on those losses, totaling $9.9 million.

Peter Robinson, an attorney with the Brisbane law firm of Carter Newell Lawyers, represents Nuigini. Mr. Robinson said the total claim is for the recovery of insured losses and payment for uninsured losses. Only $11.0 million of the $13.6 million material damage claim for repairs and reinstatement is covered under the joint venture's contract works policy, he said.

Mr. Robinson said policy deductibles are low, but he would not disclose them. Nor would he disclose policy limits, saying only that "the entire value of the site was covered."

Papua New Guinea law requires insurance to be placed with Papua New Guinea companies, but large risks are frequently 100% reinsured (*BI*, Aug. 15, 1994).

Mr. Robinson said Nuigini is a "front insurer" for the Porgera joint venture "to satisfy Papua New Guinea insurance requirements."

Mr. Sheller said Dyno has lodged public liability claims through Vesta's Stockholm, Sweden, office and also with its Papua New Guinea liability insurer, Port Moresby-based General Accident Insurance Asia Ltd.

The Vesta Forsikring A/S policy "operates on a global basis," and the General Accident Insurance Asia Ltd. policy "operates entirely within Papua New Guinea," but there is "a degree of overlap," he said. "The Vesta policy operates after all other policies have been exhausted."

Both Vesta's and General Accident's policy conditions require Dyno to first seek indemnity under the Porgera joint-venture's contract works policy, he said.

Mr. Sheller would not disclose more details of the policies.

Carter Newell Lawyers' Mr. Robinson said the case is being heard in New South Wales because Dyno Nobel Asia Pacific Ltd. and Placer Pacific Ltd., the mine operator, have headquarters in Sydney.

Mr. Sheller said a trial originally was set for June 9 after mediation in April failed. On May 27, the Porgera joint venture partners sought an extension; Judge Hunter was expected to set the trial date last week.

While attorneys involved in the case will not estimate the potential legal costs, other sources involved with the case suggest that if the litigation continues to a full trial, legal costs are likely to be about $6.3 million.

The Porgera mine is now owned 50% by Placer Pacific Ltd., a unit of Canadian mining company Placer Dome; 25% by Sydney-based Renison Goldfields Consolidated Ltd., 15% by Sydney-based mining company Orogen Minerals Ltd., and 10% by PNG landowners. Placer Pacific operates the mine for the joint venture partners.

The partners have just announced a discovery of more reserves at the mine. In the first three months of this year, the mine's output was 209,000 ounces of gold. BI

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Waves

Continued from page 37

He said the company had received and agreed to pay a 25,000 kina ($10,625) domestic house and contents policy claim from the owner of a mission house at Aitape, one of the villages destroyed.

Mr. Macrae said Kila Marsh & McLennan Pty. Ltd. has no business in the area.

Mr. McEwin said commercial and domestic property coverage against such waves is rare, but some insurers, including General Accident Insurance Asia Ltd., provide coverage selectively to some businesses and homeowners. He said he expects claims to be made only by church organizations and forestry operations that had property in the affected area.

Mr. McEwin said many church organizations in Papua New Guinea have commercial property coverage but no business interruption coverage. Mr. Macrae said that because they are in very remote areas and the buildings are simple structures, missions in the villages are unlikely to be covered. Mr. McEwin said it is possible some forestry operators could make commercial property and business interruption claims, but insurers would have to determine whether policies included coverage for the seismic sea waves.

Mr. Macrae said few, if any, villagers bought insurance. "I guess most villagers and traders would not have insurance because they can't afford it—it is really subsistence living."

Another Port Moresby broker, who declined to be identified, said traditional houses such as those in the destroyed villages were uninsured.

During a visit to the devastated area last week, U.S. Secretary of State Madeleine Albright announced an aid package of more than $1 million for rescue efforts and a seismic early-warning system to prevent similar disasters in the future. BI

Regulate

Continued from page 37

clients may lose confidence because of the resulting hole in the regulatory framework, said the BIIBA spokeswoman.

BIIBA meanwhile has extended its membership criteria to admit currently unregulated intermediaries as well as IBRC-regulated brokers. BIIBA estimates this could double the association's current membership of 2,500 organizations.

"Our concern is that the government is repealing the IBRA without putting in place statutory requirements," said Mike Williams, BIIBA's chief executive.

"This could cause a dilution of professional insurance standards for the industry. . . .We urge IBRC firms and non-regulated intermediaries to join us to ensure that during the transition period before the new regulatory body is put into place high professional standards are maintained," he said.

In contrast, the ABI welcomed Ms. Liddell's statement as an early indication of the draft legislation for financial services regulation. ABI Director General Mark Boleat said the association was particularly pleased that self-regulation will become the standard regime in the industry.

Repealing IBRA could cause 'a dilution of professional insurance standards,' says BIIBA's Mike Williams.

"The insurance industry must work together now to ensure that self-regulation works well in practice and provides good consumer protection," he said. "The industry is fully committed to ensuring the ABI general business selling code works effectively and gives the required consumer protection."

The ABI immediately showed it intends to enforce its sales code by warning 150 independent U.K. intermediaries last week that they have 28 days in which to file an annual review form or risk losing their agency appointments. The ABI uses the form to keep track of certain intermediaries doing business with the association's member insurers.

"Action we are taking today shows that self-regulation can have real teeth with disciplinary action to support it," said Mr. Boleat. BI

Doctors

Continued from page 37

any other reason, you should act immediately to put matters right, if that is possible. You should explain fully to the patient what has happened and the likely long- and short-term effects. When appropriate, you should offer an apology," the GMC advises.

Meanwhile, "subject to your right not to provide evidence which may lead to criminal proceedings being taken against you, you must cooperate fully with any formal inquiry into the treatment of a patient. You should not withhold any relevant information," the GMC adds.

The MDU has long accepted the merits of apologies and being honest with patients, an MDU spokesman said. Doing so without admitting liability might prevent litigation.

The new advice comes as compensation claims against the medical profession continue to escalate.

The MDU alone paid out £48 million ($79.2 million) in compensation for medical accidents in 1997, double the amount paid out just two years earlier in 1995. The MDU is the United Kingdom's largest medical mutual insurer, with 160,000 member doctors, dentists, nurses and other health care professionals worldwide.

Separately, the National Health Service could face up to £2.3 billion ($3.38 billion) in medical negligence liabilities, the government's National Audit Office announced last week.

While the Department of Health paid out £300 million ($493.1 million when converted at a current exchange rate) for medical negligence claims for April 1, 1996, to March 31, 1997, outstanding liabilities for known claims are £1 billion ($1.64 billion), and liabilities related to as yet unreported incidents could amount to another £1 billion, according to Sir John Bourn, head of the National Audit Office. BI

Scam artist gets prison

Mother and son slip-and-fall team convicted of fraud

TUCSON, Ariz.—A 20-year prison term was imposed on the junior partner in a well-traveled mother and son team of slip-and-fall con artists whom Arizona insurance fraud authorities nabbed last year.

A judge ordered seven years' probation for the man's mother, who has cancer.

The pair was arrested for defrauding the liability insurers of several Arizona businesses. However, the Arizona Insurance Department fraud unit investigator who tracked down the team suspects the pair similarly scammed businesses and insurers in 10 other states across the South. The pair's favorite targets were fast-food chains, large discount store chains and truck stops, said the investigator, Mitch Rea (*BI*, Sept. 8, 1997).

Robert J. Benge and Mary Alessi faked injuries at the businesses and then duped the liability insurers into making quick settlements to avoid litigation. The pair, who often used aliases and fake Social Security numbers, usually netted settlements of $1,000 to $8,000, according to Mr. Rea.

Only a few persistent insurance adjusters scared off the pair, he said. Those adjusters did not readily dismiss inconsistencies in the pair's names and Social Security numbers.

A Pima County Superior Court jury in Tucson, Ariz., convicted Mr. Benge in May of four counts of fraud and three counts of attempted fraud.

The trial judge on July 20 sentenced Mr. Benge, 27, to four 20-year terms and three 11-year terms, all to be served concurrently.

Mr. Benge also faces three years of probation when released.

Mr. Rea said a 20-year prison term in a case like this one is significant.

Ms. Alessi, whose age in court documents is listed as 56 or 58, pleaded guilty to six counts of fraud and two counts of attempted fraud. A judge earlier last month allowed Ms. Alessi to serve her probation in Virginia, where she will obtain medical treatment, according to court officials. The judge also ordered her to pay almost $113,500 in restitution.

—By Dave Lenckus

NCQA

Continued from page 1

The reports available next year will be the first to integrate NCQA's Health Plan Employer Data and Information Set measures with accreditation information. Additionally, they will be the first reports to convey data audited to standards launched by NCQA last year. The accreditation score also will reflect the results of consumer surveys administered by NCQA-certified vendors. NCQA has merged its HEDIS Member Satisfaction Survey with that of the federal Agency for Health Care Policy and Research to have a standardized industry survey covering commercial, Medicare and Medicaid products.

"Today, we believe, marks the start of a new era of accountability in managed care, which will have a profound effect in the years to come on the 80 million Americans enrolled in HMOs," NCQA President Margaret E. O'Kane said at a July 28 news conference.

Traditionally, NCQA's HEDIS and accreditation programs have been separate. Accreditation involved reviewing an HMO's structure and processes, examining issues such as grievance procedures, physician credentialing and the way decisions are made for medically appropriate care.

HEDIS is a set of report card-type performance measures. Revised HEDIS measures will be released this month, and those that initially will be incorporated into Accreditation '99 are related to effectiveness of care, access to care and member satisfaction (*BI*, April 27).

Combining the two programs offers a complete review that can tell consumers a plan has good systems in place and is performing well, Ms. O'Kane said. "It's a much more coherent way of telling the story."

According to the NCQA, many employers, unions, consumer groups and other organizations have publicly supported Accreditation '99. Employer representatives at the news conference who have worked with NCQA said the audited data and new report will help them in their missions to provide quality, cost-effective care to their employees.

Lee Saviola, human resources director of AT&T Corp. in New York, said the new report "translates technical and clinical data into usable consumer information."

Barbara Brickmeier, manager of health benefits programs at Armonk, N.Y.-based International Business Machines Corp., said that "adding performance measures to the accreditation process gives a complete picture of how the plan is operating." Having such data, she said, enables IBM to "keep drilling down" into its layer of employees not yet in managed care. Of IBM's 220,000 active employees and retirees covered by health benefits, almost 88,000 are in managed care, Ms. Brickmeier said.

Dr. Cary Sennett, NCQA executive vp, said that of the five measures the new report will show, "the single most important category quantitatively is access and service." The combined HEDIS and accreditation score in this category will account for 40% of the weight in the overall accreditation decision.

Access and service provides a "global view" of a plan, reflecting NCQA's evaluation of systems and key performance measures. This category answers the general questions of whether health plan members have access to the care and service they need. It also factors in how members rate service and whether they have problems getting care.

Terms previously used, such as "credentialing" and "utilization management," are meaningful "for those of us inside the industry," Dr. Sennett said, "but we learned these are not terms that consumers understand."

The new terms were developed in conjunction with the Foundation for Accountability, a Portland, Ore.-based employer group, and tested on focus groups. "It's very clear to us that this is how people think about quality," Dr. Sennett said.

Among the accreditation categories, "excellent" will be reserved for plans that are considered benchmarks because of consistent delivery of the highest levels of care and service that far exceed NCQA requirements. About 10% of accredited plans will earn this designation, Dr. Sennett said. "Commendable" will signify that the plan exceeds NCQA requirements, "accredited" will mean that a plan meets NCQA requirements, and "provisional" will mean the plan is in partial compliance with standards but that there is, in NCQA's judgment, no deficiency that poses a significant risk to care. "Denied" will signify a seriously flawed plan. The current categories are: full, one-year, provisional and denied.

Plans with an initial review in July 1999 or later will be able to earn the "excellent" designation. Plans that received full accreditation prior to the 1999 launch of the new categories and that have at least one year before another review can try to move into the "excellent" category by submitting audited HEDIS data. In the first year of the program HEDIS measures will be used only to help, not hurt, an accreditation decision.

The American Assn. of Health Plans welcomes the changes. "Both payers and health plans will benefit by getting better access to reliable and accurate information," according to a spokesman for the Washington-based association. The new accreditation terminology "better expresses the benchmarking process," and from a health plan perspective, the audited data "will help level the playing field." Plans will be more willing to participate because they will know that the data competitors are submitting is audited, the spokesman explained. BI

Vehicle safety urged

WASHINGTON—Employers must take steps to reduce job-related motor vehicle accidents, the National Institute for Occupational Safety and Health says.

In a report released last week that reflects the insights of business and labor groups, NIOSH recommends that employers, among other measures, conduct driver's license background checks on prospective drivers; establish and enforce written policies requiring drivers and passengers to use seat belts; train drivers in safe driving practices and the use of vehicle safety features; establish schedules that allow drivers to obey speed limits and limit drivers' hours according to regulations; and purchase vehicles equipped with safety features such as antilock brakes and daytime running lights.

Employers developing traffic safety programs must analyze internal data and target the problems that will reduce accidents, NIOSH said in its report, the first that looks at workplace motor-vehicle accidents across all industries.

The report, "Preventing Worker Injuries and Deaths from Traffic-Related Motor Vehicle Crashes," states that traffic-related motor vehicle crashes are the leading cause of on-the-job fatalities, claiming the lives of more than three workers daily. From 1990 to 1992, the average annual fatality rate associated with motor vehicle crashes was 0.7 per 100,000 workers. The actual number of fatalities is higher than indicated in the report, because death certificates do not capture more than 83% of work-related fatalities from motor vehicles, according to NIOSH.

The data from this period is consistent with more recent data collected by other government agencies, a NIOSH spokesman said.

—By Roseanne White

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Merger

Continued from page 1

company, in terms of cost efficiency and capacity," said Peter Kellogg, assistant vp at A.M. Best Co. Inc. in Oldwick, N.J.

"The acquisition of IRI by GE perhaps added a sense of urgency and may have added impetus to this movement," said Allen Murray, senior credit officer with Moody's Investors Service Inc. in New York. Employers Reinsurance Corp., which is owned by GE Capital Services Inc., bought 99.5% of Industrial Risk Insurers late last year. The move strengthens IRI, a pool that competes with the Factory Mutual companies for HPR business (*BI*, Dec. 22, 1997).

Executives of the merging insurers agreed the move will make them stronger competitors.

"In a fast-changing business environment, the opportunity costs of delaying the realization of such powerful benefits is too high. This is an excellent time for the Factory Mutual companies to merge," said William J. Poutsiaka, president and CEO of Waltham, Mass.-based Arkwright.

"The market is both intensely competitive and also filled with many great opportunities. Industry leaders remain industry leaders because they don't take competition for granted," he said.

"We've been here 163 years," said Shivan S. Subramaniam, chairman, president and CEO of Johnston, R.I.-based Allendale. Without pointing to the IRI deal directly, Mr. Subramaniam, who will be president and CEO of the new company, said "always, always never take your competition for granted."

The merger of the three Factory Mutual companies into a single mutual insurer completes a process of consolidation that stretches back decades. At the turn of the century, 20 insurers belonged to the Associated Factory Mutual Fire Insurance Cos. Those 20—as well as an additional 22 mutual insurers that existed at one time or another during the Factory Mutual system's history—gradually consolidated into the three remaining companies.

"Policyholders and employees will realize many benefits from the creation of this exciting new company. First, we will have a simpler and more consistent message in the marketplace by presenting our products and services as one company, said Arkwright's Mr. Poutsiaka.

The merger would also provide "a superior corporate structure for organization change and individual improvement. This will allow us to achieve better integration of engineering and insurance services," he said.

The new company will allow more effective use of the individual companies' global distribution channels and risk-taking capacity, while also "combining our best practices," said Mr. Poutsiaka.

Based on 1997 results, the combined insurance company would have assets of about $5.3 billion and policyholder surplus of $2.33 billion, the insurers reported.

Allendale is the largest of the companies, with year-end 1997 net earned premiums of $433 million, compared to $326 million for Arkwright and $253 million for Protection Mutual. Allendale also had the largest surplus at $1.02 billion, compared to Arkwright's $819 million and Protection Mutual's $488 million.

The three HPR insurers jointly own Factory Mutual, a Norwood, Mass.-based loss prevention engineering and research entity, and FM Insurance Co. Ltd., a London-based insurer. Both of the joint ventures will be integrated into the new company.

In addition to greater financial strength and expertise, the proposed merger should bolster the individual companies' overseas operations, said James Black, who has been named chief operating officer of the new company. He currently is president and CEO of Park Ridge, Ill.-based Protection Mutual.

"We've been overseas since 1963, so being there is not new to us," he said.

Mr. Black said the merger would allow the new company to better focus internationally while giving it more flexibility in where to direct its efforts. "We just feel it will make us a much stronger global competitor," he said.

"At the end of the day, we will have an intellectual talent pool second to none. If we do this correctly, we should be able to provide solutions superior to any other organization in our area of expertise," said Mr. Black.

Continued on next page

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PJ Singer
Joint Liquidator
14 July 98

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Circulation Breakdown
Commercial Consumers

Administrative:
CEO's, Presidents, and Owners, ...2,710
Vice Presidents, General Managers and
Other Administrative Personnel 5,122

Financial:
Chief Financial Officers and Vice Presidents
of Finance 5,429
Secretaries, Treasurers, controllers and
other Financial Personnel 4,145

Risk/Employee Benefits:
Vice Presidents, Directors, Managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/
labor relations 14,748

Sub-total 32,154
Associations 286
Government, Unions and
Educational Institutions 1,019

Commercial Consumers
Sub-total 33,459
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Insurance Companies 6,933
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Attorneys & Consultants 2,705
Adjusters, Appraisers, TPA's, Captive Managers
& Health Care Providers 1,578
Others Allied to the Field 757

Total Qualified 53,525
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TOTAL CIRCULATION 53,556

★ *Source Business/Occupational breakdown of qualified circulation, November 24, 1997 Issue, as submitted to BPA for December 1997 BPA Publisher's Statement*

Business Insurance Online **www.businessinsurance.com**

Merger

Continued from pervious page

Allendale's Mr. Subramaniam added that the merger would "reduce the confusion in some of these overseas markets" because there will be only one Factory Mutual company providing service and insurance worldwide.

Arkwright's Mr. Poutsiaka said risk managers "will see the benefits of the efficiencies that we hope to achieve with the merger. Ultimately we would like to have an expense structure that is similar to firms that sell insurance without the leading risk management services for which we are known throughout the world. The combination will be a vastly improved menu of products and services at what we believe will be at a very competitive and lower price."

Risk managers agree.

"I think it's good," said Stephen M. Wilder, vp-risk management at The Walt Disney Co. in Burbank, Calif. "My perception is that it will create one larger company that is more efficient."

The merger should streamline some of the administrative tasks the three companies performed individually, and "over time that should reduce our costs," Mr. Wilder said.

Disney has purchased property coverage from Allendale for the entertainment company's U.S. risks for the past 50 years, Mr. Wilder noted.

Mr. O'Toole of A.O. Smith, a Protection Mutual policyholder, said his company will benefit from "tremendous economies of scale that will allow them to operate more efficiently and effectively."

The merger actually would solve a problem for The Budd Co., a Troy, Mich.-based automotive parts company.

Budd, an Arkwright policyholder, is trying to consolidate the insurance programs of its sister companies that also have coverage with Factory Mutual insurers, explained Louis J. Drapeau, manager-insurance and risk management.

"Poof. This makes the problem go away," Mr. Drapeau said, now that Budd's various operations will be dealing with one Factory Mutual insurer.

Mr. Subramaniam said there obviously will be some duplication of functions as a result of the merger, which will mean a reduction in force. "The intent is to end up with a single culture," he said.

"We will look at that very carefully during the next several months."

He added that the merger is not necessarily a precursor to demutualization.

Mutual companies can absorb greater variations in loss costs than stock companies generally can, Mr. Subramaniam said. Demutualization "doesn't have a lot of economic appeal for us," he explained.

John A. Luke Jr., an Arkwright director who is president, chairman and CEO of New York-based Westvaco Corp., will serve as chairman of the new company's board.

No decision has been made about where the new company's headquarters will be located.

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Michael Bradford in New Orleans contributed to this report.

CIGNA

Continued from page 1

month period of silence after the Commonwealth Court's ruling was appealed. At the time of its erroneous orders in June, the court had taken twice as long to rule in the matter as called for under its self-imposed guidelines.

CIGNA policyholder attorney John N. Ellison said the latest order was "better than sitting in suspense forever."

But, he said he "is a little bit disappointed" the high court took so long to act. "I expect now we'll hear the argument from CIGNA that it can't undo the restructuring because the case has taken this long," said Mr. Ellison, a partner with Anderson, Kill & Olick P.C. in Philadelphia.

"If they win on the merits, they win. But, it's not fair that we had to wait around so long for a decision," he said.

A CIGNA spokesman said that potentially reversing the restructuring is a "hypothetical situation" and that the insurer expects the Supreme Court will rule that no additional hearings are necessary, making the issue moot.

Noting that CIGNA's appeal raised questions relating only to procedural issues surrounding the department's public hearings, the spokesman said: "We're pleased that the Supreme Court found the questions we raised about the appellate order were important enough to warrant a review by the full court. . . .We believe the Commonwealth Court opinion was wrong."

After the Commonwealth Court vacated the reorganization approval order, opponents of the plan argued that CIGNA had no regulatory authorization to keep its new structure in place.

CIGNA said, however, that the Commonwealth Court did not order the insurer to revert to its prior organization.

"Nothing has changed the fundamental nature of the restructuring," said the CIGNA spokesman.

Attorneys for CIGNA's opponents said the high court's refusal to hear their cross-appeals was not surprising, considering that the Commonwealth Court did not rule on those issues.

Attorneys for the opponents contend the high court's decision to review the case does not automatically spell trouble for them.

"At least as many cases that go up to the Supreme Court are affirmed as are reversed," Mr. Ellison said.

The protracted legal battle stems from CIGNA's reorganization to recognize its long-tail liabilities and maintain its A- rating from A.M. Best Co. for its active operation. Attaining that rating was crucial for the operation's financial future; without it, the company would not have been able to retain and attract quality risks, CIGNA officials have said.

Some observers have said, though, that improvements in CIGNA's reserves and lower estimates of the insurance industry's long-tail liabilities mean the reorganization may not be necessary today to earn a high rating.

The reorganization allowed CIGNA to fence off most of its liabilities—including 80% of its environmental and asbestos liabilities—in a separately capitalized runoff operation.

CIGNA executed that strategy by using a unique Pennsylvania corporate division law to split its Insurance Company of North America subsidiary in two. CIGNA allocated most of INA's liabilities to one segment and then merged it and some other small units to form a new company. CIGNA next merged that company into an existing licensed company in the runoff operation.

The other segment, which retained INA's name, handles the active business.

CIGNA officials have said that under the reorganization the insurer has fully funded its long-tail liabilities three times over. CIGNA officials estimated that the runoff facility would have more than $7 billion of assets, including investment income over the life of the runoff, to pay claims.

The CIGNA spokesman said the facility has exceeded expectations. As of year-end 1997, the facility had $4.6 billion of statutory assets and $3.9 billion of invested assets, he said.

In February 1996, then-Insurance Commissioner Linda S. Kaiser approved the restructuring, first proposed in 1995.

In the preceding months, Ms. Kaiser had held three public hearings on the reorganization. She allowed only 15 minutes of prepared testimony from each witness, and she did not permit either side to cross-examine witnesses.

Opponents of the plan argued that this structure meant they were unable to ask CIGNA officials and actuaries questions about the strength of the runoff facility's reserves. That adequacy is a concern, critics say, because CIGNA contends its active operation would not be responsible for financially bailing out the runoff facility if its liabilities were to deplete all of its assets.

The Supreme Court's decision to review the case prevents any additional policyholders from joining the approximately three dozen current opponents of the reorganization. Some additional policyholders are interested in joining, though, if the court eventually orders the case back to the Insurance Department for a new round of hearings, said Mr. Ellison and John Osborne, a partner with Zevnik Horton Guibord McGovern Palmer & Fognani L.L.P. in Washington. Each attorney represents about a dozen policyholders now.

CIGNA contends that the security of the runoff facility is not the key issue for its critics, but that they have ulterior motives for fighting the reorganization.

The policyholders are using the litigation in an attempt to leverage their positions in ongoing coverage disputes with CIGNA, its spokesman said.

Most of the policyholders either currently have or once had claims against CIGNA. Many of those claims resulted in litigated coverage disputes, of which many are ongoing.

The policyholders' attorneys deny CIGNA's assertion. Several have said they would not object to the reorganization if CIGNA produced proof that policyholders are better protected under the insurer's new organization.

"We know what they've told us," Mr. Osborne said.

"Our clients took steps to protect their rights under existing contracts," he said, referring to CIGNA moving the policyholders' coverage to the runoff facility without their prior approval. CIGNA contends this was unnecessary.

The five rival insurers opposing the reorganization do not want CIGNA to develop into a stronger competitor, the CIGNA spokesman said.

Those insurers have reinsured and been reinsured by CIGNA, have coinsured risks with CIGNA and are CIGNA creditors, according to attorney Lawrence T. Hoyle Jr. of Hoyle, Morris & Kerr of Philadelphia. Mr. Hoyle represents three CIGNA policyholders and four of the rival insurers.

The Commonwealth Court had ruled that insurers that only reinsured CIGNA lack standing in the case. Its 1997 ruling had ordered the Insurance Department to sort out the insurers' business relationships with CIGNA and ultimately determine which insurers could remain in the case.

Given the schedule for filing briefs to the Supreme Court, the court is not expected to hear oral arguments until at least next February. BI

Court orders pollution ruling depublished

By DAVE LENCKUS

SAN FRANCISCO—A general liability insurer has won California court approval to invoke a total pollution exclusion to deny covering a restaurant that contributed to a sewage backup at a neighboring business, but other insurers cannot rely on the ruling as legal precedent.

The California Supreme Court's July 8 order to depublish the opinion signals that the court is uncomfortable with the prospect of insurers using pollution exclusions to deny coverage for losses resulting from routine business operations, policyholder attorneys said.

Insurer attorneys, though, emphasized that the state's highest court still allowed an insurer to use its total pollution exclusion to bar coverage for a loss stemming from a routine business practice.

The depublication leaves California with little or no case law on the issue of whether insurers can use absolute or total pollution exclusions to deny coverage for third-party property damage or bodily injuries when the substances involved were part of routine business operations and did not cause environmental damage.

Several state supreme courts have ruled in favor of policyholders in such cases (*BI*, Dec. 1, 1997; Nov. 10, 1997). Lower courts nationwide are split on the issue.

The California case developed in August 1995 when a pressurized sewage drain pipe leading away from a Panda Express restaurant in a San Francisco shopping mall burst, damaging a neighboring business. The business, Visionary Toys & Games, in 1996 sued the restaurant's owner, Panda Management Co. Visionary sought between $750,000 and $1 million of damages, including various fees, according to insurer attorney Bryan Barber, a partner with Zelle & Larson L.L.P. in Los Angeles. Mr. Barber represents Panda Management's commercial general liability insurer, Wausau Underwriters Insurance Co. of Wausau, Wis. Wausau wrote $1 million of limits, Mr. Barber said.

Visionary argued that the restaurant's routine disposal of cooking oil and grease in the restaurant's sink and floor drains clogged the sewer system. The clog ultimately caused the sewage pipe to burst, Visionary argued.

Wausau denied Panda a defense and coverage, citing the liability policy's total pollution exclusion. The exclusion, which is broader than the absolute pollution exclusion, bars coverage for bodily injury or property damage that "would not have occurred in whole or part but for the actual, alleged or threatened discharge, dispersal, release or escape of pollutants at any time."

A California appellate court in March affirmed a trial court's September 1996 summary judgment for Wausau.

The appellate court determined:

- The waste material in the drain pipe was a pollutant—as defined by Panda's liability policy—that is excluded from coverage.
- The restaurant's disposal of cooking oil into the sewer system amounted to a "discharge" and "release" of pollutants—an act for which the liability policy excluded coverage.
- An endorsement in Panda's property policy that assured the restaurant of coverage in the event of a sewage backup does not create an ambiguity in the restaurant's CGL policy.

Attorneys speculated that the case was "too fact-specific" to support a sweeping state Supreme Court decision on the breadth or limitations of the absolute and total pollution exclusions in losses involving routine business practices and no environmental damage.

"If the court had ruled on it, more than anything, it may have led to some confusion," said insurer attorney Otis D. Wright, a partner with Wilson, Elser, Moskowitz, Edelman & Dicker L.L.P. in Los Angeles. "It probably was wise of the Supreme Court to take this one out of the books."

But, even though Panda lost this coverage battle, policyholders in California won, said Panda attorney David Gauntlett of Gauntlett & Associates in Irvine, Calif.

He said the depublication means the Supreme Court basically disapproves of the appellate court's reasoning in the case. He said insurers should be cautious about making the same arguments in future cases.

The Supreme Court may have depublished the case instead of reviewing and then reversing it because it was the most efficient way for the busy court to extinguish a "one-alarm fire" while it awaits a "three-alarm fire" on the issue, he said.

Policyholder attorney Dorn Bishop, a partner and head of the insurance practice in the San Diego office of Latham & Watkins, suspects the high court depublished the decision for several reasons.

He said the appellate court's decision would have set bad precedent for policyholders because it defined pollutants and discharges too broadly. He said he thought the high court may have been troubled by the finding that disposing of an "everyday" substance in a sewer drain was a pollution discharge. "Do they really want that on the books?"

Policyholder attorney Kirk Pasich, a partner with Troop Meisinger Steuber & Pasich L.L.P., said he agrees. He said courts should consider the point of the original discharge, which in the Panda case was into a sewer system. That should not constitute a pollution release, he said.

Mr. Bishop also suspected the high court may have been troubled by the appellate court's standard of review of insurance contracts and its refusal to interpret the policy as an objective, reasonable layperson would have.

But, insurer attorneys said courts do not have to review a contract under that standard if they find the contract's language clear.

Insurer attorneys said policyholders did not come away with any victory in the case.

"Our claims handling has been upheld. We'll do it again," said Mr. Barber, Wausau's attorney.

Insurer attorney Jeffrey Kaufman of Kaufman & Logan L.L.P. of San Francisco said the depublication probably had little to do with the outcome of the case. "My own speculation is that it was not because of the result but because of a procedural concern or language" in the appellate court's decision with which the high court did not approve.

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Panda Management Co. vs. Wausau Underwriters Insurance Co., California Court of Appeal; No. B107856.

Brokers

Continued from page 1

services to its middle-market clients (*BI*, July 27).

Warren, N.J.-based Chubb Corp. asked not to be identified as one of USI's investors in USI's announcement due to its limited investment but did confirm last week that it was "a very small participant" in the consortium.

Observers say the vertical integration is part of the ongoing consolidation of the brokerage marketplace, where J&H Marsh & McLennan Inc. and Aon Group Inc. now dominate. By investing in other brokers, namely Willis, which was frequently cited as a potential acquisition target, insurers are ensuring they will not be dependent on just a few players to distribute their products.

"There is tremendous concern that the increasing market share held by brokers has given that segment too much control over access to the customer," said Scott K. Lange, director of risk management at Microsoft Corp. in Redmond, Wash.

"Naturally, insurers are attempting to preserve some degree of control, and it appears they are concerned enough to purchase their own distribution channels," he said.

Jay Cohen, who tracks brokers as a vp with Merrill Lynch & Co. in New York, agrees. "Insurers are somewhat concerned about the size of large brokers and how much business they control and the possible shift in the balance of power," he said. These insurers "may be examining ways to control more of the distribution."

'Naturally, insurers are attempting to preserve some degree of control, and it appears they are concerned enough to purchase their own distribution channels,' says Scott K. Lange.

Mr. Cohen said he views Willis' deal as similar to that of American International Group Inc.'s 1994 $200 million cash infusion into then-struggling Alexander & Alexander Services Inc. At that time, AIG said it wanted to invest in A&A to enable it to remain independent, and A&A was clear that AIG was making a passive investment and that any favoritism toward AIG by any of its producers would result in immediate termination (*BI*, July 18, 1994).

The five insurers proposing to invest $317.3 million in Willis—Guardian Royal Exchange P.L.C., Royal & SunAlliance Insurance Group P.L.C., Chubb Corp., Hartford Financial Services Group Inc. and Travelers Property Casualty Corp.—are doing so "not so much to control the broker, but to make an investment in the broker," Mr. Cohen contends.

He added, however, that it would be interesting to have compared A&A's production for AIG before and after the cash infusion.

At a time when potential conflicts of interests in broker relationships with insurers have been heightened by a resurging controversy over contingent commissions and whether megabrokers are wielding clout with insurers due to their size, risk managers are concerned over whether the investments have strings attached in terms of where their business will be placed.

"Day to day, I think the deals are not a significant event for the industry," said Timothy J. Cunningham, a principal in Chicago with Insight Management Group. "In the longer term for larger buyers, however, it has to give them pause in terms of where the brokers' allegiance shakes out. . .to their clients or to the insurers they have some link to?"

Kenneth Pinkston, chairman of Willis Corroon Corp. in Nashville, Tenn., and group executive director of Willis Corroon Group, said: "We've tried to be quite clear that it's not a means to an end to get more business to the carriers. The objective is to remain independent and to preserve choice for risk managers."

A spokeswoman for USI said the broker's seven new insurer investors—Chubb, CNA Financial Corp., Equitable Cos., Orion Capital Corp., Provident Cos. Inc., Travelers Insurance Cos. and Zurich Centre Investments Inc.—will not dictate where business will flow.

"It is true that we do have solid relationships with all the carriers," she said. "But there is no contract requirement to place business with the carriers as part of the investment. The investment is strategic, that's true, but it's not quid pro quo."

"Our job as brokers is to identify the right opportunity for clients to evaluate. We will make sure we do that," she said.

For the most part, risk managers are taking a wait-and-see attitude.

"I was very nervous when AIG made its investment years ago in Alexander & Alexander, but give them credit, as AIG went to great lengths to assure the risk management community that it was an investment made for the economics and to support the brokerage industry as a whole by keeping a number of players involved," said Stephen M. Wilder, vp-risk management at The Walt Disney Co. in Burbank, Calif. "To the extent that the current investments in Willis are to ensure that at the end of the day the brokerage industry remains competitive, it is good. If the investment is made to exert any control over the placing of business, then I think risk managers will object."

Mark DeLillo, vp-risk management for Celotex Corp. in Tampa, Fla., and president of the Risk & Insurance Management Society Inc., said he personally is not concerned "because of the relationship I have with my brokers, but in general I am" concerned over potential conflicts of interest in various broker/underwriter relationships.

Whether the Willis deal creates such a conflict of interest remains to be seen, he said. "I'm not sure if the investment is an opportunity to exert control of the delivery mechanism of insurance products or simply an investment," Mr. DeLillo said.

If it is the latter, it would "be great for the industry," he added. "If Willis was in a position of non-growth because of financial resources, the investment opportunity gives them those resources, which adds to the competition within the industry," he said.

Stephen Finley, risk manager for Denver Public Schools, said he is concerned over where the risk manager fits into the equation.

"A typical broker arrangement is that a broker works for me," he said. "I don't know if a broker can be owned by a major underwriter and still work for me."

"It's really going to become part of the job to find out who owns whom," Mr. Finley said. "I'm not interested in becoming an expert in that."

While any effect from the insurers taking financial stakes in the brokers will be seen in time, observers say more vertical integration and various other strategic alliances will take place.

"The reality in today's marketplace is that primary insurers and reinsurers are truly starved for premium. No other time have you seen greater interest on the part of primary insurers and reinsurers in controlling the flow of business at the fountainhead," said John Wicher, managing director for Russell Miller Inc. in San Francisco.

"Disintermediation has been going on for at least 15 years," Mr. Wicher said, referring to the blurring of the lines between brokers and underwriters. Willis' and USI's deals are "two more transactions neither of which in and of themselves are defining events, but rather events continuing to underscore a trend of integration and rationalization of the insurance distribution system," he said.

"I think vertical integration will continue for a while because there is a disproportionate amount of power in the marketplace with two large brokers," said Microsoft's Mr. Lange. "I think we'll see all kinds of reactions and countermoves," whether they are affiliations with regional brokers or technology-based distribution, he said.

Mr. Cohen of Merrill Lynch said he also expects more integration, but "it will happen in a very measured fashion," he predicts.

"I don't expect, for example, AIG to buy Aon or Marsh & McLennan or for Chubb to buy (Arthur J. Gallagher & Co.)," he said. Instead, "we might see more investments in MGAs, or we might see some select investments in some good regional brokers." BI

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Commentary

New experience for world traveler

I'm not at all the woman of the world I thought I was.

I came to this disappointing conclusion last week at the end of a 10-day trip to France. My husband and I went there to visit friends and spend some time in the countryside on our own.

Although my French is just about non-existent beyond a few short phrases of pleasantry and menu reading, I've never felt too cut off or frustrated by that in the past. No matter where I am, I have thought I could manage quite well, blend in and feel almost at home.

Several recurring events during this trip force me to reassess my perception of myself as a seasoned world traveler.

For one, I am not the driver I thought I was. On the auto route in France, the equivalent of a tollway in the United States, I simply could not keep up with traffic. I did not hang in the right lane with the trucks, but I couldn't spend much time in the middle lane, let alone the left lane at the posted speed limit of 130 kilometers per hour (80.6 mph) for good weather.

Despite the posted speed limits, the European drivers were careening down the auto route at speeds far faster than 130 kilometers per hour. And they would climb right up to our rear bumper at those tremendous speeds before passing, and then cut right back in front of us as soon as their rear wheels passed our front bumper. They didn't single us out for that treatment; it's just a different approach to driving than in the United States.


Kathryn J. McIntyre

Also, we found ourselves lost more than once. It was quite frustrating to realize that it would be useless, even in our broken French, to ask for directions, because we would not understand the answer. We eventually found our way to our desired destinations without trying to ask anyone, but drove in circles for half an hour trying to find the rental car return facility at the train station in Lyon. Our frustration growing and the time running out to catch our train, I agreed to ask for directions, but in English so as not to suggest I could understand the answer in French. A lovely man helped, in his limited English, and we finally returned the car properly, just in time to make our train to Paris.

But the most revealing experience for me was my reaction to warnings about the danger of having our luggage lifted at the Paris train station and our wallets lifted at Charles de Gaulle Airport.

We were making plans to leave Lyon for Paris via the TGV, the fast train, when fellow American travelers heard our request for information from the concierge at the hotel. They volunteered that we should be very careful in the Paris train station because they had been relieved of one of their suitcases there just the day before.

All the way to Paris I envisioned bands of people trying to steal my luggage upon arrival.

Of course, no one tried, at least as far I could tell. I was still very grateful and relieved to see the smiling face of a friend from Paris who met us as we walked off the train.

The next day, upon departing the cab at the airport, the driver suggested that we carefully watch our wallets because, while there is little crime in Paris, "there are pickpockets."

For the 30 minutes it took to check in, get to our gate and board the plane, I held onto my purse and bags for dear life.

I finally relaxed when we were aboard the flight.

With relaxation, I reflected upon how foolish I had been to be upset at all, especially by the warnings of potential theft. Yes, I was right to listen carefully and heed warnings. But for goodness sake, I live in downtown Chicago and fly in and out of the world's busiest airport without such nervous concern for my safety or that of my purse and luggage.

I also have had my wallet lifted in New York and have fought off a pickpocket just blocks between my office and home in Chicago. I got over those incidents quickly enough not to see a robber at every corner.

Clearly, I overreacted to the kind warnings in France because I am not as comfortable in a country I don't know as well as my own, in addition to the fact that I foolishly studied Latin instead of French.

No, sadly, I am not a citizen of the world—yet.

Publisher and Editorial Director Kathryn J. McIntyre and Editor Paul D. Winston publish columns on alternate weeks.

Reinsure

Continued from page 2

ling a more substantial reinsurer in a market that emphasizes size, and Life Re will give Swiss Re a solid U.S. life reinsurer to add to its existing life portfolio, Ms. Vogel said.

Gerling's U.S. operations now will have $700 million in capital, said Mr. Troiano. Its 1998 combined gross premium income will increase to about $800 million, with $600 million derived from Constitution Re and $200 million from Gerling, he said.

The two reinsurers write similar business, and both strive to lead the programs they participate in, Mr. Troiano said. "And there certainly is a marketing advantage to having financial flexibility," he said.

Constitution Re and Gerling will merge their operations in the United States, though the Constitution name will be retained for some business areas, Mr. Troiano said. Bard Bunaes, chairman of Constitution Re, will become vice chairman of the combined operations.

The purchase of Life Re will increase Swiss Re's North American life and health reinsurance gross premiums to $2.7 billion. Its worldwide life and health gross premiums will increase to $4.9 billion.

Swiss Re already writes a substantial amount of life reinsurance. In August 1996, it bought Mercantile & General Reinsurance Co. P.L.C. in London for $2.7 billion.

Last week A.M. Best Co. in Oldwick, N.J. put Constitution Re's A+ rating under review with negative implications. It also put the A rating of Gerling under review with developing implications. BI

Koskinen

Continued from page 2

administration's National Campaign for Year 2000 Solutions, said many companies have information about fixing the computer bug but have been advised by their attorneys to keep mum for two reasons.

The first is fear of antitrust law violations, a fear Mr. Koskinen said the Justice Department had pretty much laid to rest. Mr. Koskinen and Jacob J. Lew, acting director of the Office of Management and Budget, told congressional leaders in a July 27 letter accompanying the bill that the Justice Department already has informed the securities industry that "competitors in an industry who merely share information on Y2K solutions are not in violation of antitrust laws." That applies to other industries as well, wrote Messrs. Lew and Koskinen.

The second is fear of liability for good-faith information that fails to produce the desired results. The administration bill attempts to quell that fear by providing liability immunity for statements made in good faith that ultimately turn out to be inaccurate. The bill covers statements made between July 14, 1998, and July 14, 2001. The bill does not deal with liability that arises from actual system or device failures due to Y2K problems.

In contrast, Rep. Dreier's bill would limit the liability of virtually every party involved in the manufacture or use of software or hardware that might be affected by year 2000 problems.

The Year 2000 campaign stresses collaboration between federal agencies and industries, says John Koskinen.

Under Rep. Dreier's bill—the Y2K Liability and Antitrust Reform Act—computer hardware and software designers, developers and manufacturers would have to make fixes available to their customers for Year 2000 problems to limit their liability to customers' "consequential business losses and costs of repair." For products introduced after Dec. 31, 1994, the fixes would have to be provided free.

Computer systems users would enjoy similar liability limitations if they made all reasonable efforts to protect their systems against Year 2000 failure, tested the systems by July 1, 1999, and notified customers and the President's Council on Year 2000 Conversion of their efforts. The bill also calls for a limited antitrust exemption for information sharing.

The measure has been referred to the House Judiciary Committee, which did not consider it immediately.

Mr. Koskinen did not discuss the Dreier bill during his appearance at the Press Club. Rather, he spent most of his time outlining the new Year 2000 campaign. The campaign's goal is "basically to promote public and private action" on the Year 2000 problem, he said, adding that the effort cannot require anybody to do anything in particular about it. Instead, the campaign emphasizes collaboration between federal agencies and industries to minimize Y2K disruptions, he said.

As part of the effort, the council is maintaining a World Wide Web site that provides links to Y2K information from various economic sectors and governmental areas. The site's address is http://-www.y2k.gov. BI

Co-author rejects AIG D&O report

By GAVIN SOUTER

COLUMBUS, Ohio—An attorney who specializes in directors and officers insurance issues is distancing himself from a white paper he co-authored on the Year 2000 problem.

In a letter sent to some brokers and insurers, Dan A. Bailey, a partner at Arter & Hadden L.L.P. in Columbus, Ohio, asserts that most standard D&O policies will cover claims related to Year 2000 problems.



The assertion is in marked contrast to an executive summary of the white paper, which was commissioned by a unit of American International Group Inc. and sent to AIG policyholders. The white paper stated that standard D&O policies may not cover Year 2000 claims (*BI*, July 13).

Mr. Bailey's letter adds to a growing controversy surrounding AIG and its position on Year 2000 coverage.

Mr. Bailey would not comment on the letter or the white paper summary. However, copies of both documents, which *Business Insurance* obtained, show contrasting views.

The executive summary sent out by National Union Fire Insurance Co. of Pittsburgh, Pa., an AIG unit, stated that D&O policies silent on the Year 2000 issue "will rarely (and poorly) serve the best interests of the board of directors."

Mr. Bailey said in his letter that he does not agree with the portion of the white paper regarding D&O coverage. He states in his letter, dated July 15: "We do not believe there (are) likely to be significant coverage defenses unique to Year 2000 claims under standard D&O insurance policies offered by insurers today. Thus, D&O policies that are silent regarding coverage for Year 2000 exposures are generally not deficit for that reason."

Mr. Bailey goes on to say there may be a "marginal" advantage in obtaining confirmation of Year 2000 coverage from an insurer through a letter or policy endorsement; such actions will ensure that insurers do not deny coverage for Year 2000 claims by arguing that the millennium is a "fortuitous event" not covered by insurance.

However, Mr. Bailey states further, "Because we suspect the vast majority, if not all D&O insurers, are unlikely to raise that coverage defense in any event, we do not view that coverage clarification as essential for insureds, but potentially helpful."

National Union recently launched its D&O Gold policy, which expressly covers Year 2000 liabilities (*BI*, May 25).

Mr. Bailey's letter concludes, "Even in the absence of such a coverage clarification, though, we believe it is likely that Year 2000 claims generally will be covered under an insurer's standard D&O insurance policy to the same extent as other types of similar claims."

Other authors of the white paper were Milbank, Tweed, Hadley & McCloy of New York; Coopers & Lybrand L.L.P. of New York; and John V. Guttag, professor of computer science and engineering at the Massachusetts Institute of Technology. Listed as providing additional assistance are New York law firms Cahill, Gordon & Reindel, and Cravath, Swaine & Moore.

When the contents of the white paper were revealed, National Union stated that it had only commissioned the report and did not necessarily endorse its findings. However, in a letter accompanying the executive summary, the insurer said the report "offers practical suggestions for protecting your organization and its management."

The management of Year 2000 problems requires dialogue among insurers, brokers and policyholders, National Union President John Cavoores said in a statement in response to Mr. Bailey's letter.

"It also requires educational efforts such as the white paper and is not an issue that can be summed up as simply as Mr. Bailey does in his letter," he said.

Also, the white paper was not intended to establish coverage positions regarding Year 2000 exposures, he said.

The letter by Mr. Bailey adds another element to what is becoming a controversial issue for AIG. Earlier, AIG had sent a letter to policyholders on the Year 2000 issue that said little about insurance coverage, but some observers said it could signal AIG's intention to deny Year 2000-related claims made on commercial liability policies (*BI*, June 29).

Additionally, AIG's near-silence on D&O coverage for Year 2000 claims is in contrast to competitors Chubb Corp. of Warren, N.J., and Reliance National Insurance Co. of New York. The two insurers earlier this year stated they would treat Year 2000 D&O claims like any other D&O claims. BI

Settlement

Continued from page 2

The bill calls for a 50% excise tax on the difference between the total value of the annuity payments and the discounted lump sum the factoring company pays for them. An exclusion would be allowed only in hardship cases authorized by a court order.

Lawmakers have "grave concerns that these factoring transactions directly undermine the policy of the structured settlement tax rules," Rep. Shaw said when introducing the bill.

The bipartisan bill would supersede a Treasury Department request this spring for a 20% excise tax on the transactions.

"Swift passage of this bill is vital to the continued protection of seriously injured persons from the usurious discount rates and high-pressure sales tactics common in this 'gray market' industry," said Randy Dyer, executive vp of the Washington-based National Structured Settlement Trade Assn.

For employers and insurers, however, "the big fear" is that if Congress begins to view settlement resales as just another marketplace practice, it could jeopardize the current tax-free status of structured settlements, a tax policy that benefits both injured persons and insurers, Mr. Dyer said.

Current law lets the injured person receive the benefits tax-free, though a recipient cannot accelerate, defer, increase or decrease payments.

Many employers and insurers like using structured settlements because they are far less costly than lump-sum settlements. Structured payments are funded by buying an annuity based on the present value of future periodic payments, factoring in future income from interest.

Structured settlements, which are voluntary arrangements often negotiated prior to a hearing, also can help reduce litigation costs by resolving cases more quickly.

Passage of the bill may create some special concerns for employers, cautioned Lance J. Ewing, chairman of the Risk & Insurance Management Society Inc.'s External Affairs Team and loss control administrator for the Philadelphia Public School System.

"I believe that plaintiffs' attorneys and factoring companies may join forces so the plaintiffs' attorneys will ask for larger settlements to offset the new excise tax," he said. As a result, "employers may be less willing to go the structured settlement route and may want to push for lump-sum settlements, although they may not be in the best interests of the claimant," Mr. Ewing said.

In addition, claimants whose settlements provide that all additional related medical care will be paid separately might be encouraged to try to attribute any medical malady to the original injury, he said.

Nationally, 'very little case law exists about the propriety of settlement resales,' says Michael Goodman.

From a claimant's perspective, though, settlement resales provide greater flexibility and discounted lump-sum cash, said Michael Goodman, executive vp and chief operating officer of Philadelphia-based J.G. Wentworth & Co. Inc., a factoring company. "When life changes, everyone should have the right to determine what's best for his life," especially to accept a new business opportunity, or meet medical, housing or tuition requirements, he said.

Since 1995, the company has completed 12,000 structured settlement resales, with a present value of about $250 million.

The company, an affiliate of Dutch financial conglomerate ING Barings Group, bundles these settlement resale agreements and periodically resells them in the financial market.

In a typical resale arrangement, an injured person agrees to sell to Wentworth his or her rights to a portion of a structured settlement for a lump sum that is discounted at about 19%, though the rate changes monthly, Mr. Goodman said. He denied critics' allegations that discounts can be as high as 60%, especially in cases where a claimant repeatedly sells portions of a settlement.

After a sale, checks for the periodic payments are routed first to Wentworth, so the company can take its agreed-upon cut before it passes the remainder on to the injured person, a practice critics say skirts anti-assignment clauses in annuity contracts.

An injured person also signs a "confession of judgment," which is designed to allow Wentworth to seek court approval to garnish the injured person's income if the person seeks to "commit fraud" by failing to live up to the terms of the resale agreement, as 2% to 3% of claimants attempt, Mr. Goodman said. Such fraud may include attempts to reassert full ownership of the payments with the annuity company.

However, a typical resale arrangement also can contain other controversial legal practices, factoring companies' critics say.

For example, a state court judge in Louisville, Ky., on June 20 denied Wentworth's motion to garnish the incomes of four injured persons who had previously entered into settlement resales with Wentworth. The judge's assessment of their settlement resale arrangements was, "Wentworth has attempted to accomplish by sleight of hand what it is prohibited from doing directly."

Wentworth is reviewing the decision and considering an appeal, Mr. Goodman said. Nationally, though, "very little case law exists about the propriety of settlement resales," he said.

Congress is not the only forum for legislation to curb factoring companies; states also have considered related action. During the past year, Connecticut, Illinois and Kentucky have enacted laws designed to curb settlement resales, according to the structured settlement trade group.

Illinois law requires court approval for companies holding the settlement annuity from making payments to anyone other than the designated recipient. BI

Blues' enrollee threshold barred

By MICHAEL PRINCE

LANSING, Mich.—Michigan's insurance commissioner has barred the state's largest health insurer from imposing a minimum participation requirement on some employer clients.

Benefit consultants say that minimum participation rules are one of several strategies that health plans employ to minimize the risk of winding up with a preponderance of high-cost enrollees.

In an order dated July 22, Insurance Commissioner E.L. Cox said the Blue Cross & Blue Shield of Michigan policy violates Michigan's Non-Profit Health Care Corporation Reform Act.

The policy under attack required that 75% of an employer's workforce be enrolled in a Blues plan—either an indemnity plan or a health maintenance organization—or the Blues would not offer its traditional indemnity health plan to the group.

The Michigan commissioner's order rejected the Blues' contention that its policy fits under the law's exceptions.

"Giving legislative intent respecting access to health care services its full import, and giving appropriate weight to comparable provisions in the Code and the Act, all lead to the conclusion that the participation requirements violate" the state law, the commissioner's order states.

The Michigan Blues plan adopted its current policy in July 1993. Previously, the insurer's policy was that 75% of an employer's workforce had to be enrolled in any health plan or it wouldn't offer its traditional plan.

A spokeswoman for the Michigan Blues explained that its policy applies only to employers with fewer than 100 employees and said it was needed to help "the company achieve a mixed pool of members."

The spokeswoman for the Michigan Blues said the company is reviewing the order for possible appeal to the state's courts. "We think the action goes against our opinion of equity," she said.

In a statement, BC/BS of Michigan said that the order, if left standing, could mean higher rates for community-rated group customers.

Minimum participation rates are common in Blues plans across the country, said a spokeswoman for the Blue Cross & Blue Shield Assn. in Washington.

Participation rules are not uncommon, but a required level of 75% is unusually high, according to Rich Sinni, health care practice leader in the New York office of Watson Wyatt Worldwide. "I believe it's quite unique," he said.

Despite the Blues' policy, many health plans do not have minimum participation levels and typically accept whatever percentage of employees enroll in the plan, whether it's 1% of the population or 99%, he said.

Health plans use minimum participation requirements to prevent the adverse selection that would occur if only high-cost employees enrolled in a plan, benefit consultants say. By requiring a minimum participation level, the plans hope to pool the risk of high-claims participants with low-claims enrollees.

Another way health plans avoid adverse selection, is to require employers to pay all or most of the premium, which creates a financial incentive for a larger percentage of employees to enroll in the plan, said Helen Darling, practice leader-group benefits and health care in Watson Wyatt Worldwide's Stamford, Conn., office.

Without such incentives for enrollment, "people who take it will be high users," she said.

Alternatively, insurers wishing to avoid adverse selection may require employers to offer a selection of health care plans, so that enrollees have multiple options and high users get spread among them, she said.

Although she had not heard of another state acting to bar minimum participation provisions, as Michigan did, Ms. Darling said the move did not surprise her. Such action, she said, shows a growing trend by state officials and legislatures to intervene in health care. "It's a much more activist period" by all levels of government, she said. BI

Updates

Indiana to appeal ruling

Continued from page 2

The state sued tobacco makers to recover the costs of treating smoking-related illnesses.

The basis of the state's appeal will be formed in the coming weeks, said a spokesman for Indiana Attorney General Jeffrey A. Modisett.

U.K. drafts regulatory reform

LONDON—Insurers and risk managers in Britain are studying a draft bill published late last week that would bring U.K. insurers, Lloyd's of London and other financial services companies under the purview of the Financial Services Authority.

The Assn. of British Insurers and the Assn. of Insurance & Risk Managers have reserved judgment on the proposal as they assess its implications for their members.

Lloyd's welcomed the bill. It said FSA's proposed oversight of Lloyd's would be in line with the market's expectations.

The draft Financial Services and Markets Bill would make the FSA one of the most powerful regulators in Britain, with broad powers to investigate and punish offenses by banks, insurers and securities traders. Currently, these powers are dispersed, with insurance companies coming under the control of the Treasury.

Although the FSA would supervise the conduct of financial services companies, it would not regulate their products.

Birth control bill passes Senate

WASHINGTON—The U.S. Senate voted last week to join the House in expanding drug benefits for federal employees by requiring that their health plans cover prescription contraceptives or devices.

The measure is designed to end the unfair treatment of women, who now pay "68% more for out-of-pocket health care costs then men, largely because of costs surrounding reproductive health care," said Sen. Harry Reid, D-Nev., who co-sponsored the provision in a Treasury Department bill.

Of the approximately 375 health plans covering federal employees, 81% do not cover all five leading reversible methods of contraception, and 10% have no coverage of contraception, his staff said.

Nationally, surveys show that prescription benefit coverage for oral contraceptives varies, according to Lincolnshire, Ill.-based Hewitt Associates L.L.C. About 85% to 90% of fully insured plans, such as HMOs, provide some coverage for oral contraceptives. However, only 50% to 55% of less-insured plans, such as PPOs and indemnity plans sponsored by self-insuring employers, provide some coverage of oral contraceptives.

However, "it's too soon to tell whether employers with self-insured plans will decide to follow the government's lead," said Bridget Eber, a pharmacist and consultant with Hewitt.

The willingness of health plans generally to provide coverage for Viagra, a life-enhancing drug for men with impotence problems, underscored the inequities faced by women using contraceptives, Sen. Reid said in a statement.

Briefly noted

A unit of Stamford, Conn.-based GE Capital Corp. is investing $6 million in claims manager **Ward North America Inc.** in return for a 35% interest in the company. In addition, Hartford, Conn.-based Conning & Co. has made a $1 million investment, increasing its interest in Ward North America to 25%. . . .**American International Group Inc.** is investing $1.35 billion in The Blackstone Group, a New York investment firm. Of the money, $150 million will buy AIG 7% of the company, and the remaining $1.2 billion will be used to invest in funds managed by Blackstone. . . .Support is growing for a moratorium on state legislative changes as a way to help insurers face unexpected **Year 2000 computer glitches**. The National Conference of State Legislatures recently approved such a respite from programming system changes between July 1, 1999, and June 30, 2000, as proposed by the National Assn. of Independent Insurers. The National Conference of Insurance Legislators recently approved a similar measure, and the National Assn. of Insurance Commissioners is considering one (*BI*, July 6). . . .Santa Monica, Calif.-based **Fremont General Corp.** has agreed to buy UNICARE Specialty Services Inc., the workers compensation insurance subsidiary of Woodland Hills, Calif.-based WellPoint Health Networks Inc., for about $100 million in cash. . . .Underwriters Reinsurance Co. is buying **Venton Holdings Ltd.** for $313 million in cash and letter of credit assumptions from a group of investors that includes Trident Partnership L.P., X.L. Insurance Co. Ltd. and Risk Capital Reinsurance Co. Venton has operations in Bermuda and London, where it owns a Lloyd's underwriting agency. . . .The House and Senate have passed a bill providing **protection from liability** for suppliers of raw materials used for medical implants. The bill's sponsor in the House, Rep. George Gekas, R-Pa., said the law is necessary as the number of raw material suppliers has dwindled in the past few years over fears of product liability suits. President Clinton has expressed support for the bill. . . .The **Pension Benefit Guaranty Corp.** is taking over a pension plan sponsored by Ernst Home Center Inc., a Seattle-based chain of hardware and home improvement stores in bankruptcy liquidation. The plan has about 3,000 participants and $6 million in unfunded benefits. . . .The California state appellate court in San Francisco has upheld a $1.3 million jury award, including $800,000 in punitive damages, against San Francisco-based Bechtel Corp. in an **age discrimination suit** in *Keiffer vs. Bechtel*. . . .**Cendant Corp.** has extended its $67 per share tender offer for 51% of American Bankers Insurance Group Inc. until Sept. 1 from today. Executive changes last week at Cendant will not affect its plans to make the acquisition. . . .The stock-for-stock merger of Boston-based child care facility designer **Bright Horizons** and work/life consultant **CorporateFamily Solutions** of Nashville, Tenn., has been completed. The combined entity, known as Bright Horizons Family Solutions, has operations in 35 states.

Cold fact: heat wave causing losses

By MICHAEL BRADFORD

It's hot.

Ask risk managers in the southern half of the United States how things are going in their neck of the woods, and that's the answer. Not much else; it's just plain hot.

As they limp into the dog days of summer, employers across the South are continuing the fight to protect man, beast and property from the relentless summer sun.

A heat wave that found a home in north Texas has baked Dallas with high temperatures above 100 degrees Fahrenheit for more than three weeks. From Florida to Colorado, incessant heat and drought conditions have ruined crops and left forests tinder-dry and burning from wildfires. The heat is blamed for more than 100 deaths across the South.

Employers are keeping their workers cool by urging outdoor workers to drink enough fluids and take breaks in the shade. Risk managers have to be especially careful about the risk of fire when landscaping near facilities is bone dry. Zoos are making sure their animals and workers are protected from the searing sun.

Keeping workers cool is the biggest concern employers have during a prolonged heat spell.

Most manufacturing processes are done inside, where materials are protected by climate-controlled environments. While the leather and other materials used to make boots at Justin Industries Inc.'s footwear operations are unaffected by what's going on outside, many of the Fort Worth, Texas-based company's workers at its brick- and block-making plants are subject to the weather's ill effects.

The heat is "a concern to those of us who have employees working in non-environmentally controlled climates," said Jim Green, risk manager at Justin. "We are taking extra precautions" to make sure workers who spend time outdoors get enough water and replacement-fluid drinks, he noted.

Mr. Green said that as of last week no Justin workers had suffered heat-related illnesses.

Employees of Carlo Ditta Inc. also have held up well, according to John J. Uhl, vp at the New Orleans concrete company. "Most of these guys are pretty tough. Generally speaking, if a man is in good physical shape, he shouldn't have any problem."

Carlo Ditta employees get periodic reminders at safety meetings to stay hydrated in the heat, Mr. Uhl said

Other employers issue similar warnings. "We've had several meetings on the heat," said Guy Albanese, safety manager for T.D. Industries, a Dallas-based construction subcontractor.

"We go over the signs and symptoms" of heat-related illness and "make sure people can determine when others are in trouble," he added. "Construction workers are kind of macho," Mr. Albanese said, and some tend to overwork unless a co-worker urges them to slow down.

T.D. Industries issues its workers special collars that can be soaked in water and worn around the neck. Water-soaked pads also can be inserted into hard hats. Work starts at 6 a.m. for most T.D. Industries workers and ends around 2:30 p.m. Roof work always is stopped at noon.

"We supply (workers) with cotton shirts, which are cooler," said Bob Lowe, vp and production manager at T.D. Industries. "And we've purchased lots of fans," which are taken to construction sites and can be used in closed or other hot areas.

Some operations—concrete companies, for example—have to account for the heat in their production processes.

Carlo Ditta is mixing an icy concrete cocktail in its trucks as a way to keep the product from drying too fast. "The heat affects the product quality," explained Mr. Uhl. "The setting time is accelerated a lot."

To cool things down, the company mixes ice with the concrete on some jobs and on long hauls in the hot sun. "We make 75 tons of ice a day," according to Mr. Uhl, adding that the ice mixture is a common practice among concrete companies during hot summers.

Droughts are producing conditions that put property at risk for some businesses, an insurer points out. When forests and landscapes dry out, fire becomes a concern for property owners, according to Fred Palmer, vp and manager of staff operations at Factory Mutual in Norwood, Mass. Any business that stores lumber or any type of material that will burn outside should "make sure it is well away from the building," Mr. Palmer advised.

He pointed out that droughts strain water supplies, and that risk managers should bear in mind that low water pressure could mean sprinkler systems will not operate properly. If water pressure is low, any operations involving work that could spark a fire should be halted, Mr. Palmer advised.

In Fort Worth, strains on water supplies have been blamed for two major breaks on the same water main. Increased demand meant pressure built until the line broke. And in Dallas, more lines have broken this year than during a normal summer, according to Robert Gardner, assistant director of Dallas Water Utilities.

While the breaks in Dallas have not been as dramatic as those in Fort Worth, they, too, are occurring because of increased demand, said Mr. Gardner. Dallas' water lines have pumped record amounts this year, up to 696 million gallons per day. "As pumpage goes up, it requires more pressure to get the water through the pipes," Mr. Gardner explained. Pipes then began to "pull apart and break at the joints," he said.

The heat and drought are costing farmers and ranchers billions of dollars. The Texas Agricultural Extension Service estimates the crop damage and loss of profits on livestock in the state total about $1.5 billion.

Texas cotton farmers are hardest hit, losing $500 million so far. Corn losses have reached $225 million, and sorghum losses are at $140 million.

Federal crop insurance is available to farmers, "so farmers do have some insurance," said Carl Anderson, an agricultural economist with Texas A&M University in College Station, Texas. However, he added, the coverage usually pays far less than total losses.

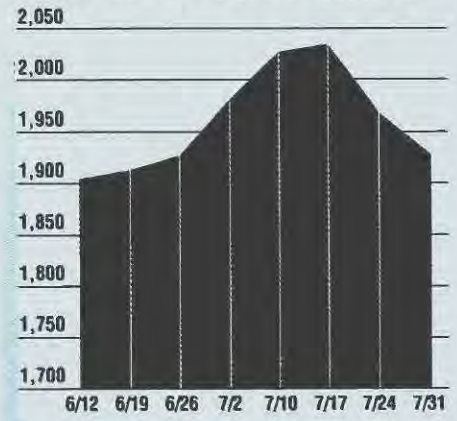
Ranchers losing money because of reduced prices for underfed cattle and additional feedstock costs probably aren't covered for those losses. For livestock, "there's not much insurance that I'm aware of," Mr. Anderson said.

But animals at the Audubon Zoo in New Orleans are getting special treatment during the hot summer days. "We've given them open house, where they can be in their night houses if they prefer," said a zoo spokeswoman. "We have sprinklers on, so they can get wet if they want to."

"We also offer them frozen treats," she said. Primates get frozen treats made of electrolyte drinks. "The carnivores get frozen chicken and meat; we call them 'blood pops.' "

Zoo workers are wearing new hats this year that can be worn wet. BI

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: *Nordby International Inc.* (nordby.com) Boulder, Colo.

PCS catastrophe options

As of July 31

Call spread	Price bid/ask
National Annual 1998	
40/60	6.0/12.0
100/120	3.5/—
120/140	NA
Southeastern September 1998	
40/60	2.3/—
Northeastern September 1998	
100/150	NA
Florida September 1998	
40/60	1.0/2.4

Call spread	Price bid/ask
California Annual 1998	
150C	0.8/—
Western Annual 1998	
40/60	1.4/—
80/100	1.0/2.0
150C	0.9/—
Eastern September 1998	
20/40	3.0/—
40/60	2.3/3.5

Total volume: 0 Total open interest: 19,555

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.
Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high-low
Gdn Royal Exch	333	5.3	12.1	3.3	495-266
Legal & Gen	747	21.3	13.3	2.2	785-400
Royal & Sun	666	18.2	22.8	3.3	825-488
Brokers					
Lmbrt Fenchurch	99	7.9	5.7	7.0	138-99
Lloyd Thmpson	178	12.0	10.0	7.0	194-151
Sedgwick Grp	159	12.9	7.0	4.8	171-115
Willis Corroon	199	22.8	6.9	4.3	199-116

Note: Prices are July 31 closings; other numbers from July 30.

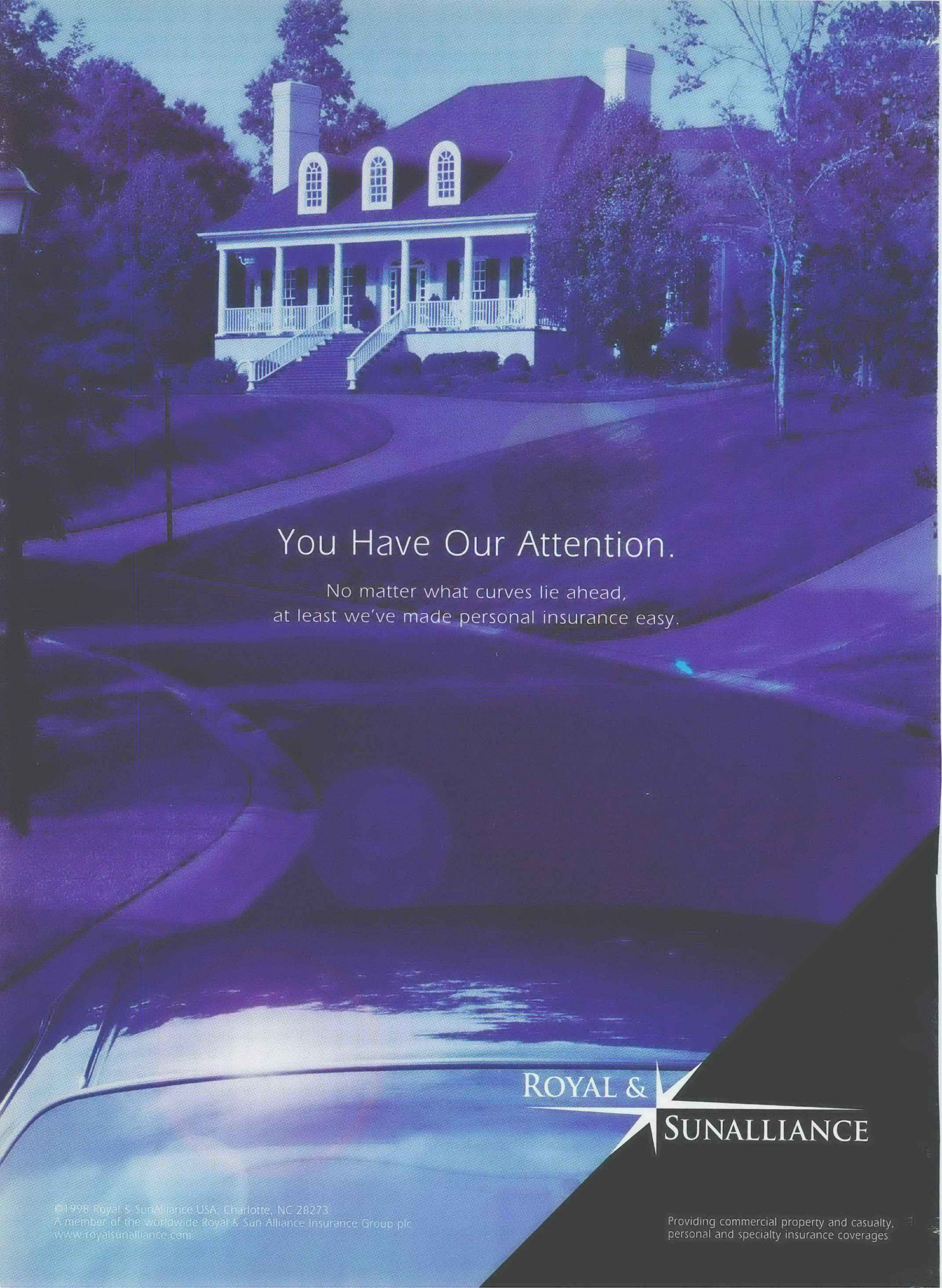
Source: *Nordby International Inc.*(nordby.com) Boulder, Colo.

BI Industry Stock Report JULY 27, 1998, THROUGH JULY 31, 1998

BROKERS		Price	Weekly % change	Year to date % change	52-week High	52-week Low	Vol.(000)
Aon Corp.	NYS	68.00	-1.98	15.99	75.56	50.00	1490
E.W. Blanch Holdings Inc.	NYS	37.31	3.11	8.35	38.75	27.94	121
Gallagher Arthur J. & Co.	NYS	39.19	-6.70	13.79	46.56	33.56	152
Hilb, Rogal & Hamilton	NYS	18.63	1.02	-3.56	19.63	15.38	139
Kaye Group Inc.	NDQ	7.25	3.57	9.43	9.00	6.13	20
Marsh & McLennan	NYS	61.06	2.41	22.84	64.31	44.00	3404
Poe & Brown	NYS	41.50	2.79	39.50	42.50	23.88	19
Sedgwick Group PLC	NYS	13.63	8.46	10.66	14.44	9.38	47
Willis Corroon Corp.	NYS	16.25	-0.76	31.98	16.44	9.75	662
BROKERS	AVERAGE		1.74	16.62			
INSURERS/REINSURERS							
ACE Ltd.	NYS	36.69	-4.40	14.05	43.00	26.38	2661
Acceptance Insurance Cos.	NYS	22.13	-5.10	-6.53	28.63	21.13	636
AEGON N.V.	NYS	91.75	-12.10	104.74	111.31	34.00	410
Aetna Life & Casualty	NYS	69.31	-4.81	-1.77	118.13	66.31	2894
AFLAC Inc.	NYS	34.38	-1.96	34.47	38.25	22.13	1802
Allied Group Inc.	NYS	47.13	0.13	64.63	47.19	25.00	479
Allstate Corp.	NYS	42.44	-6.73	-6.22	52.38	35.44	17938
AMBAC Indemnity Corp.	NYS	58.25	-6.71	26.63	65.94	38.94	1707
American Bankers Ins.	NDQ	60.31	4.32	31.29	66.06	32.38	889
American Financial Group	NYS	39.81	-2.15	-1.24	49.25	34.56	539
American General	NYS	68.31	-3.45	26.36	75.69	46.56	1648
American Heritage Life Ins.	NYS	24.13	-1.53	34.03	26.06	17.06	61
American Indemnity/Fin'l	NDQ	12.50	9.29	-9.91	15.50	9.50	27
American International	NYS	150.81	3.47	38.68	153.50	93.75	6249
American Safety Insurance	NDQ	11.25	-2.17	-8.63	15.06	10.93	186
Argonaut Group	NDQ	30.63	1.24	-9.59	38.13	29.00	70
AXA-UAP Group	NYS	67.44	1.41	72.92	71.25	31.69	206
Baldwin & Lyons Inc.	NDQ	22.25	-7.29	-7.77	28.75	18.50	4
Berkley W.R. Corp.	NDQ	33.50	-9.31	-23.65	49.88	33.50	706
Berkshire Hathaway Inc.	NYS	70105.00	-2.77	52.40	84000.00	41300.00	3
Capital RE Corporation	NYS	33.00	-8.17	6.34	38.69	24.94	155
Capitol Transamerica Corp.	NAS	20.81	-3.20	-2.35	28.13	19.00	48
Centris Group Inc.	NYS	11.25	-5.76	0.84	14.81	9.69	121
Chartwell Re	NYS	28.88	-3.75	-14.44	36.25	28.25	48
Chubb Corp.	NYS	73.38	-5.78	-2.98	88.81	63.50	3801
CIGNA Corp.	NYS	66.06	-3.56	14.97	74.50	45.63	3927
CNA Financial Corp.	NYS	39.63	-4.95	-6.95	53.25	36.44	572
CNA Surety	NYS	13.38	-2.73	-13.36	16.75	12.88	327
EMC Insurance Group Inc.	NDQ	13.31	3.90	0.47	15.88	12.25	42
ESG Re Limited	NDQ	22.25	0.00	-5.32	28.88	19.88	111
Enhance Financial Services	NYS	31.38	-6.52	5.46	37.56	22.75	358
Everest Reinsurance	NYS	38.44	2.50	-6.82	45.25	33.00	1430
Executive Risk Inc.	NYS	48.44	-16.13	-30.62	75.75	48.44	719
EXEL Ltd.	NYS	78.06	-1.34	23.18	84.00	52.75	2527
Fremont General Corp.	NYS	57.19	-1.40	4.45	62.13	36.75	303
Frontier Insurance Group	NYS	17.75	-9.55	-22.40	35.69	16.94	1326
Gainsco Inc.	NYS	6.06	1.04	-28.68	10.19	5.75	515
General RE Corp.	NYS	237.00	-2.67	11.79	275.00	191.00	1888
Gryphon Holdings	NDQ	16.00	4.07	-4.48	19.38	14.75	210
Harleysville Group	NDQ	23.38	3.31	-2.60	28.50	18.75	231
Hartford Steam Boiler	NYS	51.94	-3.48	41.17	59.56	33.25	265
HCC Insurance Holdings	NYS	20.25	-5.54	-4.71	32.25	15.63	324
ING Groep N.V.	NYS	74.88	-0.17	76.96	76.75	38.88	236
IPC Holdings Ltd.	NDQ	26.50	-3.20	-17.67	33.25	26.50	107
Hartford Financial Services	NYS	52.06	-1.19	11.29	60.00	39.25	2871
LaSalle Re Holdings Ltd.	NYS	35.00	-2.44	-1.06	42.94	30.50	92
Life Re Corp.	NYS	91.19	2.46	39.88	92.94	49.75	3092
Lincoln National	NYS	95.88	1.32	22.72	96.38	64.63	1308
MAIC Holdings Inc.	NYS	27.00	-1.37	0.80	30.38	22.44	82
Markel Corp.	NYS	170.75	-4.31	9.37	187.00	135.00	38
MBIA Insurance Group	NYS	67.38	-5.11	0.84	80.94	56.50	1677
Meadowbrook Insur. Group	NYS	28.81	-2.33	10.55	35.00	21.88	9
Mid Ocean Ltd.	NYS	79.00	-1.56	45.62	84.88	52.75	438
MMI Cos. Inc.	NYS	20.13	-7.20	-19.90	27.88	20.13	62
Mutual Risk Mgmt. Ltd.	NYS	38.13	6.83	27.35	39.94	22.63	536
NAC Re Corp.	NYS	51.44	1.23	5.38	55.88	43.50	315
Navigators Group	NDQ	18.13	0.00	-3.49	22.50	17.00	27
Nobel Insurance Ltd.	NDQ	0.66	10.53	-95.00	1.00	0.40	7
NYMagic Inc.	NYS	28.00	-1.10	1.59	34.25	22.38	25
Ohio Casualty Corp.	NDQ	42.63	-4.21	-4.48	51.75	41.50	248
Old Republic Int'l	NYS	26.75	-4.04	7.90	32.25	22.38	1041
Orion Capital Corp.	NYS	48.75	-9.20	4.98	59.25	39.06	809
Partner Re Ltd.	NYS	49.75	-0.25	7.28	52.50	39.44	290
Penn-America Group Inc.	NDQ	13.25	6.00	-35.37	23.00	12.25	25
Pennsylvania Manufacturer's Co	NDQ	20.00	-0.31	19.40	23.75	16.25	16
Philadelphia Cons. Holding	NDQ	18.88	-8.21	6.34	24.38	15.50	89
PXRE Corp.	NYS	27.00	-10.19	-18.64	35.25	27.00	91
Reliance Group Holdings	NYS	17.31	-5.14	22.57	19.81	11.63	753
Reliastar Financial Corp.	NYS	49.63	-2.22	20.49	52.44	33.63	1191
RenaissanceRe Holdings Ltd.	NYS	44.69	4.23	1.27	50.75	38.19	186
Risk Capital Holdings	NDQ	24.88	0.00	11.80	25.50	19.75	35
RLI Corp.	NYS	42.31	-3.84	6.18	45.63	28.81	33
St. Paul Companies	NYS	36.19	-5.39	-11.81	47.19	35.00	5667
SCOR	NYS	70.13	2.84	46.86	72.75	39.25	7
SAFECO Corp.	NDQ	45.06	-0.41	-7.56	56.00	41.81	4160
SCPIE Holdings Inc.	NYS	29.63	-9.89	2.38	38.38	25.50	NA
Seibels Bruce Group	NDQ	7.25	3.57	-3.33	8.94	6.63	96
Selective Ins. Group	NDQ	19.38	-9.88	-28.24	29.25	18.50	255
Terra Nova Insurance Co. Ltd.	NYS	32.00	6.22	21.90	35.00	22.25	106
TIG Holdings	NYS	20.69	-4.89	-37.66	36.56	20.13	1338
Tokio Marine & Fire	NDQ	50.38	-2.18	-12.77	66.00	41.25	304
Torchmark Corp.	NYS	44.00	-0.71	4.30	49.81	34.81	1741
Transatlantic Holdings	NYS	90.38	5.55	26.40	90.56	67.44	212
Travelers Property Casualty	NYS	43.25	-1.98	-1.70	46.06	34.88	1374
Travelers Corp.	NYS	67.25	1.13	24.83	73.50	42.00	20521
Trenwick Group Inc.	NDQ	34.75	1.09	-7.64	41.75	33.38	211
Unico American Corp.	NDQ	14.50	-3.33	18.37	18.13	10.75	45
United Fire & Casualty	NDQ	38.75	-2.52	-12.43	47.00	37.88	2
Unitrin	NDQ	65.25	0.00	0.97	74.13	56.25	556
UNUM Corp.	NYS	52.69	0.00	-3.10	59.63	40.69	3898
Vesta Insurance Co.	NYS	15.00	-18.64	-74.74	64.75	15.00	798
Zenith National Ins.	NYS	26.81	-4.88	4.13	30.50	24.50	49
INSURERS/REINSURERS	AVERAGE		-2.22	6.10			
HEALTH MAINTENANCE ORGANIZATIONS							
Foundation Health Systems Inc.	NYS	20.63	-4.07	-7.30	33.94	20.25	1625
Humana Inc.	NYS	27.19	0.93	31.02	32.13	18.44	4779
Oxford Health Plans	NDQ	8.06	-11.64	-48.19	86.00	7.38	15715
Pacificare Health Sys.	NDQ	68.25	-7.77	35.82	88.88	46.75	130
Safeguard Health Enter.	NDQ	5.63	-14.29	-58.33	14.88	5.63	27
Sierra Health Services	NYS	18.00	-10.00	-19.70	27.75	18.00	813
United Healthcare Corp.	NYS	56.50	-0.44	13.71	73.94	42.44	6470
Wellpoint Health Networks	NYS	61.31	-12.02	45.12	75.00	38.63	6985
HMOs	AVERAGE		-7.41	-0.98			
ALL COMPANIES	AVERAGE		-2.63	7.25			

Top advancing issues: Nobel Insurance Ltd., American Indemnity/Fin'l, Sedgwick Group P.L.C. Leading decliners: Vesta Insurance Co., Executive Risk Inc., Safeguard Health Enter. Most active issue: Travelers Corp. The *BI* Index declined 2.0%; the Dow Jones 30 Industrials fell 0.6%; the S&P 500 decreased 1.8% and the NYSE Composite fell 1.9%. Average P/E: Brokers, 25.1; Insurers/reinsurers, 17.5; HMOs, 23.3.

Source: *Nordby International Inc.* (nordby.com), Boulder, Colo.


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