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Updates

Fed Ex insured for jet crash on last day of policy period

NEWARK, N.J.—The fiery crash of a Federal Express Corp. jet last week occurred on the final day of the freight carrier's 1996-1997 aviation insurance coverage, but the crash will not alter the company's renewal program, a Fed Ex risk management official said.

Fed Ex locked in its renewal about a month ago, said Phil Williams, a senior risk analyst with Fed Ex in Memphis, Tenn.

Fed Ex has about $1 billion of liability insurance to cover the value of cargo that was

See **Updates** *on next page*

Tax bill benefits employers, retirees

By JERRY GEISEL

WASHINGTON—For the second year in a row, employers and employees have reason to welcome tax legislation awaiting President Clinton's signature.

The measure, on which congressional conferees put their finishing touches last week, contains a slew of employee benefit provisions that would help employers and workers.

Among other things, the bill would overhaul the payment structure for so-called Medicare risk health maintenance organizations, a change that would open up HMOs to millions of Medicare-eligible retirees, give those retirees better benefits and reduce health care costs for their former employers.

The measure also would reduce employers' pension administration hassles. Employers, for example, would be able to remove from their pension rolls former employees with small benefits. Companies no longer would have to file certain employee benefit reports with the federal government, and public employers' pension plans would be exempt from non-discrimination rules.

In addition, employers would not feel the wrath of the Internal Revenue Service if their pension plans—through no fault of their own—accepted new employees' pension rollovers from plans that unbeknownst to employers were disqualified by the IRS.

The pact also would put federal regulatory agencies on track to let employers use electronic information systems to provide employee benefit notices.

Employers aren't the only ones welcoming the pact. Workers, for example, would be the beneficiaries of provisions permanently repealing a federal excise tax on big pension distributions. Employees also would benefit from provisions that would: extend the tax-favored status of employer-provided educational assistance plans through May 2000; greatly

See **Tax bill** *on page 57*

Address tobacco issues: Senator

By MARK A. HOFMANN

WASHINGTON—The chairman of the Senate Judiciary Committee wants to move quickly on the proposed $368.5 billion global tobacco settlement, though testimony last week revealed that considerable disagreement remains.

Sen. Orrin Hatch, R-Utah, said last week that when Congress returns from its August recess, lawmakers will have to consider two questions regarding the settlement proposal: First, if Congress does nothing, is there an acceptable alternative to the proposal? And, second, can lawmakers afford to "fritter away" the opportunity to reduce smoking by youths that the proposal provides?

Sen. Hatch's assessment came after a pair of Senate hearings last week, one in the Judiciary Committee, the other in the Senate Commerce Committee.

At both hearings, senators heard an intellectual tug of war between witnesses who insisted the settlement must undergo significant changes or be scuttled and those who insisted with equal conviction that any significant changes would scuttle the settlement.

The proposal already has been attacked for allegedly relieving cigarette makers of liability without adequately punishing them (*BI*, July 21).

A group of state attorneys general and tobacco manufacturers hammered out the proposed settlement as a means to settle state suits seeking to recover the costs of Medicaid payments that covered tobacco-related ailments (*BI*, June 23).

See **Tobacco** *on page 59*



AP/ WIDE WORLD PHOTOS

Mobile homes and campers were ruined by the flooding in Fort Collins.

Colorado losses to rise as floodwaters recede

By MICHAEL BRADFORD

FORT COLLINS, Colo.—Colorado floodwaters that killed at least five people and injured dozens more also left a muddy swath of destruction and property damage that will cost tens of millions of dollars to restore.

The flooding began last week in Fort Collins, Colo., when heavy rains forced Spring Creek over its banks. It destroyed two mobile home parks, damaged dozens of homes and washed away hundreds of vehicles.

The biggest commercial losses are likely to come from Colorado State University, which suffered extensive property damage, including the loss of thousands of textbooks in the campus bookstore.

Fort Collins retailers and business owners were regaining access to their property late last week and beginning to assess damages.

Colorado Gov. Roy Romer de-

See **Colorado** *on page 58*

Paying part of legal tab

Policyholder required to repay part of defense costs: Court

By DAVE LENCKUS

LOS ANGELES—In a potentially costly defeat for policyholders facing liability lawsuits, the California Supreme Court has ruled that general liability insurers' duty to defend policyholders does not mean insurers are responsible for the entire defense.

Upholding a state appellate court ruling, the Supreme Court on July 24 ruled that insurers that defend their policyholders against all allegations in a lawsuit later may seek reimbursement from policyholders for the cost of defending claims that their policies potentially do not cover.

Policyholder attorneys said the court, normally a pro-policyholder forum, has weakened insurers' duty-to-defend obligation under comprehensive and commercial general liability policies.

One insurer attorney said the decision merely affirms a longstanding practice by insurers in California to allocate defense costs, though she was not sure how readily policyholders have swallowed some of those costs in the past.

And at least one other state, Washington, allows insurers to defend policyholders against only the portions of lawsuits that allege potentially covered claims, said the attorney, Laura Foggan, a partner with Wiley Rein & Fielding in Washington, D.C.

Several insurer attorneys, though, said the allocation process is too expensive and difficult to pursue in most cases.

Appeals court rejects defense allocation to self-insurer..... Page 42

And, "The reality is, insurers are not going to seek reimbursement from policyholders that can't afford it," said insurer attorney Elizabeth A. McIntyre of San Francisco-based Kaufman & Logan, which filed an amicus brief in the case.

As a result, the ruling will not open a floodgate of defense cost allocations after underlying lawsuits have been resolved, insurer and policyholder attorneys agree.

In the few cases in which allocations are relatively easy, however, insurers stand to recoup significant sums, insurer attorneys acknowledged.

But, policyholder attorneys fear the decision

See **Defense** *on page 42*

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NEWSPAPER



Updates

Fed Ex renewal unaltered

Continued from previous page
destroyed, Mr. Williams confirmed.

The flight originated in Singapore and stopped in Malaysia, Taiwan and Anchorage, Alaska, before continuing on to Newark International Airport. Immediately after landing there about 1:30 a.m. local time on July 31, the jet flipped and burned. Two crew members and three passengers escaped with only minor injuries.

The jet was carrying 145,000 pounds of cargo, a Fed Ex spokesman said. About 400 pounds of cargo was "routine hazardous materials," like perfume and pressurized household cleaners, which are flammable or potentially explosive, he said. Fed Ex was unsure whether any cargo could be salvaged.

The MD-11 jet, manufactured by McDonnell Douglas Corp., was destroyed. Aviation sources estimated its value at about $115 million.

The National Transportation Safety Board last week could not say with certainty why the plane crashed. However, the agency's early investigation was focusing at least in part on the jet's fuel balancing system, an agency spokesman confirmed.

The jet was damaged three years ago during a hard landing in Anchorage, but it was repaired and returned to service within 48 hours, the Fed Ex spokesman said. A different flight crew was involved in the earlier incident, he said.

U.S. Department of Transportation documents and sources indicate that London insurance markets lead Fed Ex's coverage. Underwriters at Lloyd's of London and members of the Institute of London Underwriters participate on the risk.

Other insurers involved in the placement include La Concorde Group, through La Reunion Aerienne; Skandia International Insurance Group; CIGNA Corp. subsidiary Insurance Co. of North America; Assurance France Aviation Group; New York Marine & General Insurance Co.; members of Somerset Aviation Inc.; American Home Assurance Co.; and AXA Marine & Aviation (U.K.) Ltd. Aon Alexander & Alexander of Texas Inc. in Dallas placed the coverage.

Acordia MBO investors named

INDIANAPOLIS—Knightsbridge Capital L.L.C. and Wand Partners Inc. are the lead investors backing Acordia Inc. management's buyout of the broker from Anthem Insurance Cos. Inc., *Business Insurance* has learned.

The definitive agreement, signed early last Friday, calls for the equity group, which includes two other smaller investors and Acordia's management, to pay Anthem $320 million, including the assumption of about $40 million of debt and a $10 million contingent payment based on future operating earnings.

The transaction is expected to close at the end of August.

Acordia's management last month announced its plans to buy out the property/casualty brokerage operations from Anthem, after months of speculation over its future (*BI*, July 21). Anthem, which in February announced its plans to focus exclusively on health and managed care, had retained Credit Suisse First Boston to explore the possible sale of Acordia's property/casualty brokerage business.

The $320 million purchase price is less than the buyer's original indication of interest of $335 million, but Anthem had expected the price to be lower (*BI*, July 7). In 1996, Acordia reported $343.9 million in gross revenues.

New York-based Knightsbridge Capital is the general partner of Knightsbridge Capital Fund 1 L.P., an investment fund affiliated with PennCorp Financial Group Inc., which makes equity or equity-linked investments in the insurance industry. Wand Partners is a private equity investment firm that is an active investor in such industry areas as insurance and information software.

In addition to Acordia's management, the other investors are High Ridge Capital Partners L.P., a private equity fund that invests exclusively in the property/casualty industry, and NationsBank Capital Investors, the direct investing group of NationsBank Corp.

The senior debt facility will be underwritten and arranged by NationsBank Capital Markets Inc. and The Chase Manhattan Bank.

Bruce W. Schnitzer, chairman of Wand Partners, is the new non-executive chairman of Acordia, and Frank C. Witthun is president and chief executive officer.

Firing not age bias: Court

SANTA ANA, Calif.—California employers can fire and replace higher-paid older employers with younger employees without violating age discrimination laws if it is done for economic reasons, says a ruling by the California Court of Appeal, 4th Appellate District.

The appellate court ruled in *Michael J. Marks vs. Loral Corp.* that "price-based business decisions should not be held to constitute illegal age discrimination."

The focus of the 42-page decision was jury instructions in the case of Mr. Marks, who lost an age discrimination and retaliation lawsuit against his former employer, the New York-based Loral Corp.

Mr. Marks' attorney, James J. Guziak, an Orange, Calif.-based sole practitioner, said that while federal courts have split on this particular issue, this is the first California case to his knowledge to deal with it.

He said the ruling will be appealed, though a decision has not yet been made whether to ask for a rehearing before the appellate court or to petition the California Supreme Court for review.

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Legislation would boost recoveries in air crashes

By DEBORAH SHALOWITZ COWANS

Families who have lost a relative in an airline disaster occurring over international waters would be able to seek damages for grief and sorrow under a bill introduced last week in Congress.

The measure, designed to increase compensation to families of victims of TWA Flight 800, is now in the Senate.

Currently, death cases stemming from an airline disaster three miles or more from shore are governed by the 77-year-old Death on the High Seas Act. The act supersedes the Warsaw Convention in these accidents.

The Death on the High Seas law allows spouses, parents, children or dependent relatives of those killed in international waters to seek pecuniary damages, which include loss of financial support; loss of inheritance; loss of nurture, care and guidance for minor children and children with special needs; loss of services; and funeral expenses.

The Death on the High Seas Act

See **Crash** *on page 57*

Recall cover sits on shelf

Demand low for product recall insurance, in spite of risks

By BRUCE KELLY

Splash Off Water Rockets were meant to be a blast, but not the kind that some users of the toy experienced.

So Ohio Art Co. last month permanently grounded some 68,000 of the rockets, which consist of a 16-inch, clear plastic tube with a rounded rubber nose that promised to shoot up to 60 feet in the air.

This was the first product recall for the Bryan, Ohio-based manufacturer, which began making toys in 1917 with a galvanized toy windmill and has made the Etch-A-Sketch since 1960.

U.K. risk managers more aware of recall risks.....Page 55

In the weeks leading up to the July 17 recall, the Consumer Product Safety Commission and Ohio Art had received reports that 37 of the rockets had malfunctioned. They exploded during the rocket lift off, which was fueled by the water pressure of a garden hose, or broke apart upon its crash to earth.

Three people were cut, one on the hand, another on the forehead and one more on the shoulder.

The faulty rockets were traced

See **Recall** *on page 49*

Policies don't always follow

California ruling may limit coverage after acquisitions

By RODD ZOLKOS

OAKLAND, Calif.—Unless it is overturned, a recent California Appeals Court ruling could limit corporate successors' ability to tap the insurance coverage of predecessor companies.

By suggesting that passage of tort liability to a successor company does not imply that insurance coverage follows as a matter of law, the June ruling by the appellate court could have particularly serious implications for the coverage of companies whose ownership has changed, such as through mergers or acquisitions.

Western MacArthur Co. today was to petition California's Supreme Court to review the decision. The Appeals Court's decision came in an appeal by a group of insurance companies of a state Superior Court judge's denial of their motion for summary judgment in a coverage dispute with Western MacArthur.

In the underlying coverage litigation, filed in 1993, Western MacArthur claimed that as liability insurers for its predecessor company—Western Asbestos Co.—General Accident Insurance Co. of America, United States Fidelity & Guaranty Co. and Argonaut Insurance Co. were responsible for paying for Western MacArthur's defense and indemnifying the company for liabilities

See **Liability** *on page 45*

Former National Heritage officer, others charged in asset fraud

By DOUGLAS McLEOD

ORLANDO, Fla.—A former top officer of the defunct National Heritage Life Insurance Co. and four other men are facing charges that they bilked the insurer of $47 million in a complex series of investment schemes.

While purporting to arrange $23 million in capital contributions to the insurer's parent company, the defendants secretly diverted National Heritage assets totaling more than twice that amount, funneling some of the money back to the company and diverting the rest to their own benefit, a federal indictment charges.

The defendants also produced a variety of bogus documents to conceal the fraud from regulators, prosecutors charge. The schemes effectively inflated the assets and surplus of Delaware-domiciled National Heritage, which was ordered liquidated in 1995 after regulators charged that $200 million of the company's assets were missing.

Named in a 91-count fraud and money laundering indictment are:

- Patrick C. Smythe, former chief operating officer of National Heritage and president of its parent company, Maitland, Fla.-based LifeCo Investment Group Inc.
- Michael D. Blutrich, a New York lawyer who acted as outside counsel to LifeCo and National

See **Heritage** *on page 58*

Inside

- Employers must remain vigilant to ensure their voices on benefit issues are heard after a relatively successful year in Congress, this week's editorial says. **PAGE 8**
- A new Bermuda Commodities Exchange now is scheduled to begin next month, with a delay resulting from trying to expand membership. **PAGE 51**
- The Home Insurance Co. decided to make a dividend payment to its holding company, enabling the holding company to make an interest payment to bond holders. **PAGE 58**

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PBMs shift marketing attention to HMOs

Case maintenance gains importance

By JOANNE WOJCIK and SALLY ROBERTS

After a flurry of acquisitions in the prescription benefit management market, PBMs now are rethinking their marketing strategies.

Most PBMs are increasingly directing their marketing efforts toward health maintenance organizations rather than toward employers, as more and more companies move their employees into managed care plans.

Many PBMs also are fine-tuning their data collection to create more worthwhile disease management programs.

The search for new approaches to serve health care buyers does not indicate that PBMs are in trouble, despite Eli Lilly & Co.'s second-quarter $2.4 billion writedown of PCS Health Systems Inc., industry sources say (*BI*, June 30).

Lilly paid $4 billion for the former McKesson Corp. unit in 1994.

The writedown, which devalued the asset on Lilly's balance sheet to $1.6 billion, was not unexpected by industry experts (*BI*, June 30).

Lilly's writedown of PCS is indicative of two things, contends Mike Barberi, principal and managed pharmacy practice leader for William M. Mercer Cos. Inc. in New York.

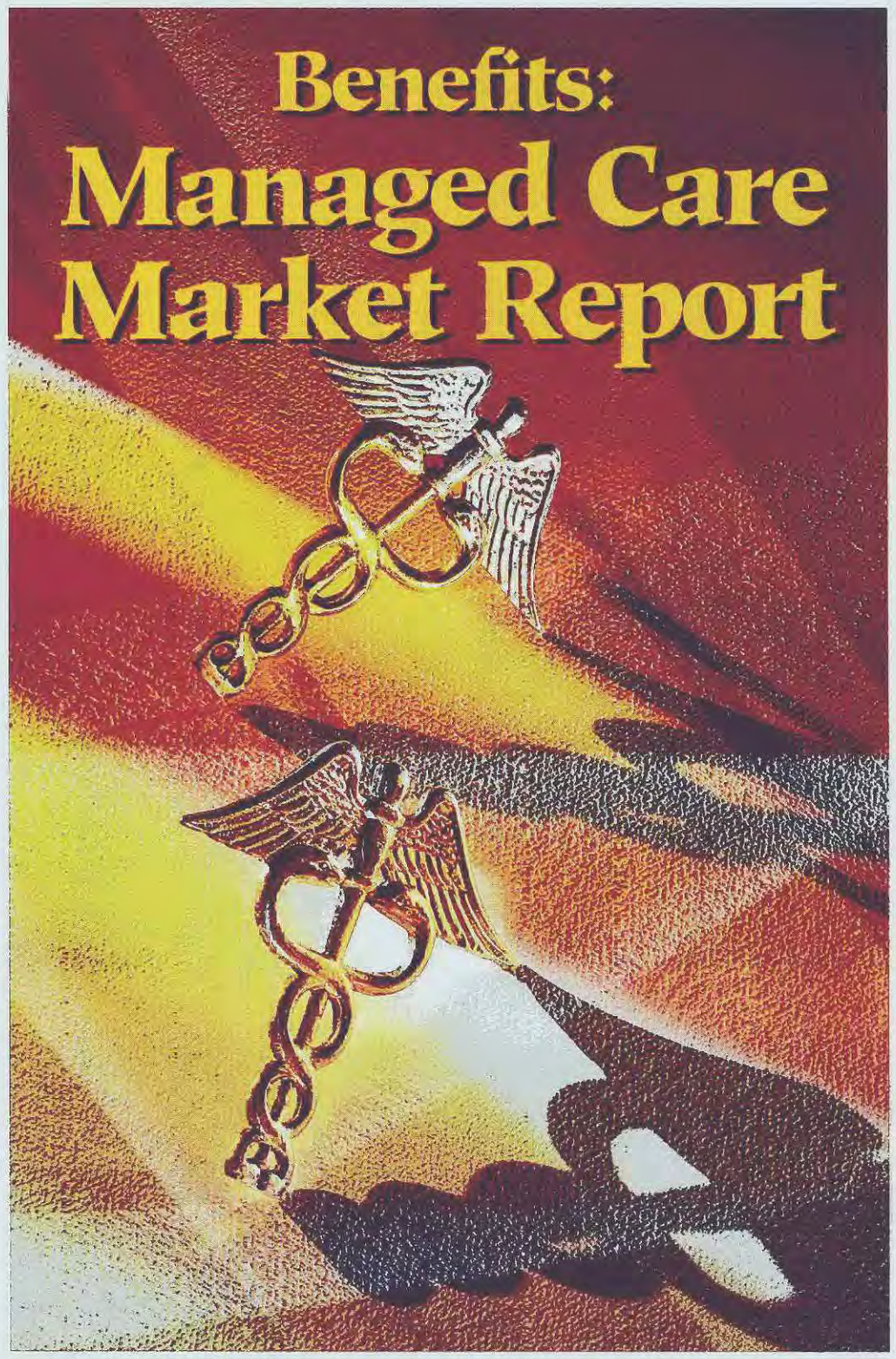
First, Lilly paid too much for PCS, Mr. Barberi said. And second, "Lilly probably had misguided assumptions of how much value PCS would deliver in relation to Lilly's objective in moving market share of its own drugs."

PCS isn't the only PBM gobbled up in the past few years by pharmaceutical manufacturers at what observers say was too high a price.

"Merck paid too much for Medco," said Howard Tarre, a senior consultant with The Kwasha Lipton Group in Fort Lee, N.J. Merck acquired Medco in 1993 for $6.6 billion.

"I think the word on the street now is that (prescription drug) companies taking over PBMs is dumb," Mr. Tarre said.

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Spotlight Editors:
Jerry Geisel, Robert Kazel

Mandates often manage delivery

Higher costs may be result

By MICHAEL PRINCE

Managed care organizations are learning there is a downside to the dominant role they've assumed in health care.

Their lessons, though, could cost employers.

Perceived public ire over managed care practices has prompted legislative mandates. Because many of the mandates only recently have been enacted, their financial impact on managed care plans have not been felt—yet. Still, experts think mandates will mean higher premiums.

"If you legislate certain procedures, it will increase costs," said Lee Exton, a consultant with Watson Wyatt Worldwide in Los Angeles.

Said Jonna Kurucz, director-health care policy for Prudential HealthCare in Roseland, N.J., "It will ultimately be felt by the consumers and buyers." She added that expected rate hikes by some HMOs for 1998 are related to these new laws.

Premiums now rising in the single digits could go up by double digits next year (*BI*, July 7).

Managed care companies' shift away from a single-minded focus on cost-cutting is taking place despite widespread criticism of the new laws from experts and health maintenance organizations themselves and evidence that people like their HMOs.

Many factors have spawned the backlash against managed care. And managed care entities, while making improvements, are working to change how they operate and how the public perceives them.

HMOs have come under more scrutiny as their enrollments have surged in recent years.

"They were unprepared to manage and unprepared for the responsibility of being mainstream medicine," said

See **Backlash** *on page 14*

Enrollment in HMOs hardly a risk for retirees

By JERRY GEISEL

Traditional indemnity plans' stronghold on the retiree health care market is crumbling as more employers and retirees discover the cost-saving advantages of Medicare risk health maintenance organizations.

During the past 11 months, nearly 1 million retirees have moved into Medicare risk HMOs and out of the traditional Medicare program. That has swelled enrollment in risk HMOs to about 4.8 million of the nearly 37 million people Medicare covers.

More than 13% of those eligible for Medicare now are enrolled in risk HMOs. With enrollment rising at a clip of a million a year, more than 20% of the Medicare population is likely to be receiving health care benefits through risk HMOs by 2000, experts say.

And that estimate could be conservative if tax legislation, which was expected to receive final approval last week, is enacted.

That legislation would overhaul the payment rates the federal government provides and allow risk HMOs to be established in many parts of the country where they have not been fiscally possible.

"The program should become more widely available than ever before," said Chip Kerby, a principal with William M. Mercer Inc. in Washington.

"We should be able to offer coverage in some areas, especially rural areas, where the rates have been too low," said Craig Schub, senior vp of marketing at Cypress, Calif.-based PacifiCare Health Systems Inc., whose Secure Horizons program is the nation's largest Medicare risk HMO with about 1 million enrollees.

That is good news for employers with retiree health care plans that supplement the traditional Medicare program. As retirees move out of Medicare into risk HMOs that typically offer far richer benefits than Medicare, they no longer need employer supplemental coverage and can drop that coverage, saving employers a considerable amount of money, a point not lost on employers.

"Every day, more employers are beginning to work on how they can get more retirees into risk HMOs," said Joseph Martingale, a principal with Towers Perrin in New York.

Even in the absence of legislation, enrollment in Medicare risk HMOs is surging for an obvious reason: Coverage in the program is too good a deal for retirees to pass up.

Medicare risk HMOs are so named because the HMOs contract with the federal government to provide benefits to Medicare-eligible retirees at a fixed payment rate. The HMO assumes the risk that it can provide what is often greater coverage at less cost than its payment from the government.

In some parts of the country, such as South Florida and

See **HMOs** on page 6

PBM industry consolidation:

1993: Merck buys Medco for $6.6 billion

1994: SmithKline Beecham buys Diversified Pharmaceutical Services for $2.3 billion

1994: Eli Lilly buys PCS for $4 billion

1995: ValueRx buys Diagnostek for $216 million

1996: MedPartners/Mullikin acquires Caremark for $2.5 billion

1997: Columbia/HCA signs definitive agreement to aquire Value Health Inc. and its prescription benefit management operation Value Rx for 1.3 billion

GRAPHIC BY TONY BUCCINI

PBMs

Continued from previous page

Joe Schiesl, president of Plymouth, Minn.-based ValueRx Inc., agreed that "when those transactions were completed, there was some concern that the values were inflated."

"Now the market has cooled off," he said, and current PBM pricing is more in line with the companies' values.

For example, in a still pending deal announced earlier this year, Columbia/HCA is paying $1.3 billion for Value Health, ValueRx's parent company. ValueRx's PBM gross revenues for 1996 totaled $1.6 billion *(BI*, Jan. 20).

The Columbia-ValueRx deal is a veritable bargain compared with the $2.5 billion price MedPartners/Mullikin paid last year for Caremark, which is about half the size of ValueRx with 1996 revenues of just $888 million.

It had been suggested that drug companies were buying PBMs to ensure the manufacturers' drugs are given preferred treatment and not sold at too much of a discount.

"The assumption was that the drug companies would be able to get more business for more drugs," said Craig Stern, president of Pro Pharma Pharmaceutical Consultants Inc. in Northridge, Calif.

But drug companies say they didn't take over PBMs solely to be a conduit for delivering their products to the marketplace.

"We realized our expectations when we purchased Medco," said Wayne Gattinella, senior vp of marketing for Merck-Medco Managed Care L.L.C. in Montvale, N.J. "Our objective was to get closer to the end user—the patient," he said. "We wanted to make sure the drugs were taken appropriately."

The combination of drug maker and PBM also is enabling Merck-Medco to develop better disease management and patient education programs, according to Mr. Gattinella.

"We still see significant opportunities for disease management," he said.

Because of the time needed to determine a cause-and-effect relationship between treatment and outcomes, many of these programs are still in the incubation stage, Mr. Gattinella explained.

"Providers like ourselves are investing significant dollars in fertilizing those programs," he said.

So far at least one of those programs has produced enough data to show that regular monitoring and administration of insulin can reduce the cost of hospitalization and doctor's office visits for diabetics by an average of $500 per year, according to Mr. Gattinella Merck-Medco also is working on disease management programs in several other areas, including hypertension, cholesterol, smoking cessation, women's health and depression.

While disease management has been a buzzword among PBMs in recent years, employers haven't been asking for it, according to Mary Harrison, director of client services in Stamford, Conn., for The MEDSTAT Group, a Minneapolis health care information and consulting firm.

Instead, "they are being inundated with drug companies and PBMs coming to them and saying, 'We have a program and wouldn't you like to get involved?' Savvy employers say 'Let me look to see if I have a problem first,' " she said.

"Many buyers are skeptical of specific disease management programs," agreed Mr. Schiesl of ValueRx.

That's understandable, he said, because "our industry has had a difficult time showing measurable results."

ValueRx hopes to set a new standard for disease management programs through its affiliation with hospital giant Columbia/HCA.

ValueRx is building a repository of data to show the efficacy of prescription drug use in three distinct settings: outpatient, inpatient and long-term care.

Called "knowledge systems" the databases will be used to show how drugs work in various treatment settings, cross-referenced by diagnosis and support services provided, he explained.

"Our strategy is to become the leader in medication management—in every outlet of medical care," he said.

Mr. Barberi compared the growth of disease management programs to that of managed care in general.

"Years ago when managed care was still new, Allied Signal was the first to put managed care in, and other employers sat back and were skeptical. And look what happened. Disease management is the same thing. Conceptually, it is still not completely proven, but the business case for it is being built, and it's getting stronger. We're starting to see companies implement it."

See **PBMs** *on page 6*

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Spotlight report

PBMs

Continued from page 4

The fact is, benefit managers are going to have to "take a much stronger role to help PBMs achieve the results they are looking for," Mr. Barberi said.

He suggests benefit managers move toward gradually closing formularies to a specific number of drugs and offer disincentives, like higher copayments, for drugs not on the formulary.

When that occurs, manufacturers will give larger rebates that are eventually passed on to employers, because the chance their drug is not on the formulary increases, he said.

"In order to really cut costs and improve quality, benefit managers cannot just have 50 million drugs (in a formulary). They need to give the PBM the ability to go back to the drug manufacturer to manage the health plan by getting better formulary programs," he said.

In general, prescription drug formularies are becoming more fashionable, experts agree.

Todd Swim, a principal and health actuary at Buck Consultants Inc. in Chicago, said he is seeing increased use of closed formularies—a list of 300 to 400 drugs for which reimbursement is provided to plan participants. Drugs not on the list come with penalties, like higher copayments. Closed formularies "are becoming more prevalent because they've proven to be a more effective way to control costs," Mr. Swim explained.

The drugs on the list are carefully chosen and are the best drugs in their respective classes, so in most cases, no additional drugs are needed and the patient is cured as quickly as possible.

While the PBM industry's growth in recent years may be compared to that of the managed care industry, its future expansion will likely come from that market, industry observers say.

Employers that in the past had carved out their prescription drug benefits to cut costs are less likely to do so today.

Instead, many employers—like Coors' Brewing Co.—are handing over prescription drug management to the HMOs with which they contract.

"Our HMOs handle prescription drug management," said Elaine Allison, benefits administration supervisor at the company's Golden, Colo., headquarters.

Oxford Health Plan's decision to contract with PCS for pharmacy management is another indication that this trend is starting.

"As the market shifts to HMOs from indemnity plans, the PBMs are directing their marketing toward these customers," said Mr. Schiesl of ValueRx.

In the past, many HMOs attempted to manage drug utilization themselves, "now they're realizing that this requires an increasing commitment of resources," said Mr. Gattinella of Merck-Medco.

But HMOs are feeling competitive pressure, too, and need to cut these costs as close to the bone as possible, he said.

Mr. Gattinella predicts the end result will be a trend toward outsourcing pharmacy management to what he considers the experts—PBMs.

•

Robert Kazel contributed to this report.



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HMOs

Continued from page 3

Southern California, the government's payment rates to risk HMOs are so high—roughly $750 a month for each retiree that leaves the traditional Medicare program—that HMOs can offer far richer benefits than the traditional Medicare program and charge little if any premiums.

For retirees, especially those without employer-provided health care coverage, the cost advantages of Medicare risk HMOs compared with a combination of traditional Medicare and a supplemental Medigap policy can be immense.

In many parts of Florida, for example, retirees buying Medigap policies supplementing Medicare pay anywhere from $100 to $125 a month for the Medigap policies. And those policies typically don't provide prescription drug coverage, often a vital benefit for retirees.

By contrast, risk HMOs in the state typically do not charge retirees premiums, yet offer rich benefits. For example, in the Tampa area, a $1,000-a-year prescription drug benefit is standard, while in the Miami area, risk HMOs are offering unlimited prescription drug benefits.

"Retirees are getting better benefits and lower costs," said Dwight Frank, director of group Medicare sales at Louisville, Ky.-based Humana Inc., whose Medicare risk HMO product Humana Gold Plus, has 390,000 enrollees, including 220,000 in Florida.

The economics of enrollment in risk HMOs aren't lost on retirees, who are voting with their feet. For example, enrollment in a Medicare risk HMO product offered by Blue Cross & Blue Shield of Florida over the past 12 months leaped to about 87,000 from 59,000, nearly 48%, said Bill Simek, segment director for BC/BS in Jacksonville, Fla.

Much of this growth, Mr. Simek noted, has occurred as the Blues' Florida risk HMO product, Medicare & More, has moved into new areas of the state, allowing retirees with expensive indemnity plan coverage to join its risk HMO.

Just as more retirees are seeing the economic advantages of risk HMOs, so are employers, who in many cases are giving their retired workers financial incentives to join risk HMOs and drop traditional Medicare and supplemental company-provided Medigap coverage.

For example, Los Angeles County pays premiums charged by risk HMOs for coverage, which average $13 a month, as well as the current Medicare Part B premium—currently $43.80 per month—for retirees who select coverage in risk HMOs.

Even though it picks up those costs, the county still saves more than $1,000 a year for each retiree who enrolls in a Medicare risk HMO compared with what it would spend if the retiree enrolled in the county's traditional retiree indemnity health care plan.

In fact, since 1992, when the county began to offer risk HMOs, it has saved nearly $24 million in retiree health care costs.

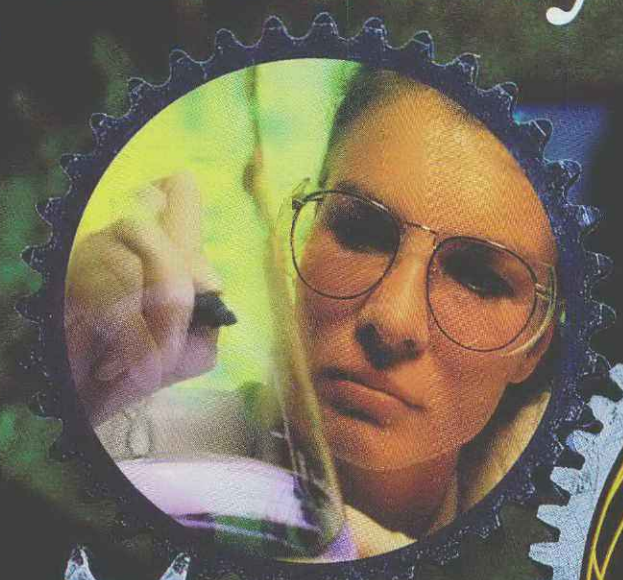
"This has been a very good program," said Kathy Migita, director of health care benefits at the Los Angeles County Employees Retirement Assn. in Pasadena, Calif.

Paying for retirees' Part B premium is only one of several incentives employers may offer to encourage their former workers to move into risk HMOs and out of their Medigap plans.

Another popular strategy is to negotiate with HMOs to offer enriched benefits to retirees—such as a high limit of prescription drug benefits—with the company absorbing the additional premium cost of the benefit upgrade.

See **HMOs** *on page 10*

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Opinions

Finally, a beneficial budget bill

FOR YEARS, JUST HEARING the words "tax legislation" or "budget bills" has been enough to make benefit managers grimace—and for good reason.

While more than a decade has passed, veteran benefit managers still can recall the Section 89 debacle. That was in 1986, when congressional and administration staffers closed the door to outside input and assembled a bewildering and unjustified set of non-discrimination rules for health care plans as part of a tax bill. An embarrassed Congress repealed Section 89 three years later amid a tidal wave of employer protest.

There also was COBRA, a law with a sound public purpose, but one that gave employers an impossibly short time to be in compliance in spite of administrative complexities.

And there have been many miscues since then, among them the misguided Medicare Data Bank, which was part of a 1993 budget law. The Data Bank was a ludicrous federal mandate that would have required the nation's employers to file millions of health care coverage reports each year with bureaucrats, who never would have been able to read those reports. It, too, was later repealed.

Last year, however, we saw the glimmer of a possibility that lawmakers were changing their act when it came to tax/budget legislation and employee benefits.

The 1996 tax law included provisions—long sought by the employer community—that began to peel away layers of complex and unnecessary pension rules that had accumulated over the years.

The relief in the 1996 tax law, it now seems, was no fluke. Tax and spending measures now on their way to President Clinton contain numerous benefit provisions that employers and employees will welcome.

As we report this week, the legislation will, by getting rid of an irrational payment structure, greatly increase the availability of health maintenance organizations for Medicare beneficiaries. That will mean employers in many more parts of the country will have a new weapon to hold down their health care costs, while retirees in many cases will receive greater benefits than they now receive.

Other provisions also make a lot of sense, including those that will allow employers to give lump-sum payments and remove from their pension rolls more former employees with very small benefits. The cost of administering such small benefits is exorbitant relative to their value.

Perhaps best of all, the legislation contains no provisions that make us shake our heads and say: "How awful. That is going to cause no end of problems."

How has such a positive change come about? Certainly, a booming economy has helped. With the government flush with tax receipts, benefits no longer are the easy target they once were for revenue raiders.

But that isn't the only reason. We think the Clinton



health care reform disaster of 1993-1994 has made both the administration and Congress more sensitive to the vital role that employer-provided benefits play and the need to deal with them carefully.

Last, but certainly not least, is that employer trade groups and individual employers are getting more active in the legislative process. Employers used to complain how they were blindsided by legislative changes affecting their benefit programs. Today, more than ever, instead of complaining after the fact, employers have taken action to stop bad ideas from becoming law.

Case in point: a provision in the Senate's tax bill that would have required employees to obtain written spousal consent before they could make withdrawals from their 401(k) plans. Employers launched a massive lobbying campaign to tell legislators and their staffs that the measure not only would increase administrative costs, but also could dampen participation in the plans. They argued that employees would be reluctant to contribute to retirement accounts knowing that access to those funds would be restricted. Those arguments won the day, and the provision was dropped from the bill that now is before President Clinton.

While an era of benefits goodwill may prevail today, it is uncertain how long it will last. Tough decisions are ahead for federal programs such as Medicare and Social Security, which are intertwined with employee benefit plans.

Employers must keep their eyes—and mouths—open in Washington. If they don't, their current smiles could become grimaces again.

Letters

Pollution endorsements a first step

To the editor: As someone who has followed the changes in the pollution exclusion since it was introduced, I find the new endorsements described in your May 19 article, "New CGL Endorsements Limit Pollution Exclusion," show a new flexibility by the Insurance Services Office Inc. At the same time, I agree with the critics that these endorsements do not go far enough.

The most useful of these endorsements appears to be the provision of coverage for events lasting less than 48 hours and reported within 14 days. Covering such limited events for named perils only, as provided by a second endorsement, also would be feasible. The requirement in this endorsement that a pollution event cannot be identical to another event that occurred within the past 12 months should be applicable only if the policyholder failed to take corrective action after the initial event, however.

The "specified pollutant" endorsement would appear to be the least useful of the three. It could be applied only where a policyholder is concerned about a single toxic substance, such as chlorine in a swimming pool, carbon monoxide in a heating system or use by a manufacturer or processor of a single dangerous chemical in its operations.

None of these endorsements addresses the greatest abuse of the absolute pollution exclusion, which is its application to incidents causing no damage to the environment.

No single endorsement can address every exposure. Broadly speaking, pollution risks can be divided into three categories. Those that are an integral part of a business should be covered by environmental impairment liability policies tailored to the operation they are designed to cover. Businesses with limited pollution exposures could be covered for brief, sudden and accidental events or for specified pollutants as provided in the new ISO endorsements or manuscript wording. Finally, risks with no known pollution hazards would not require any pollution exclusion except for violation of environmental laws or regulations.

I hope that the new endorsements will open the way to an era of cooperation rather than confrontation between insurers and policyholders.

Harry Cylinder
Philadelphia

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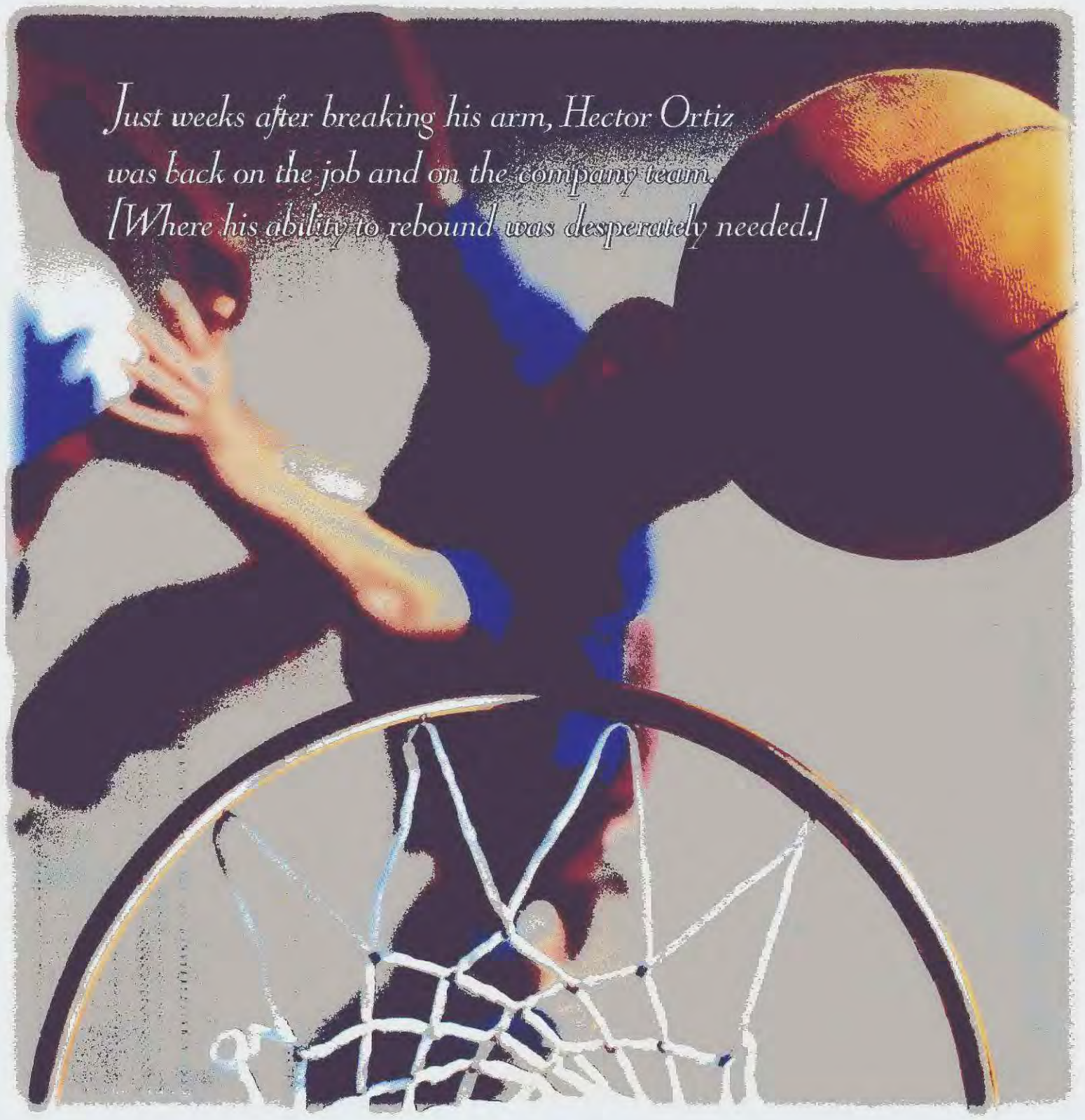
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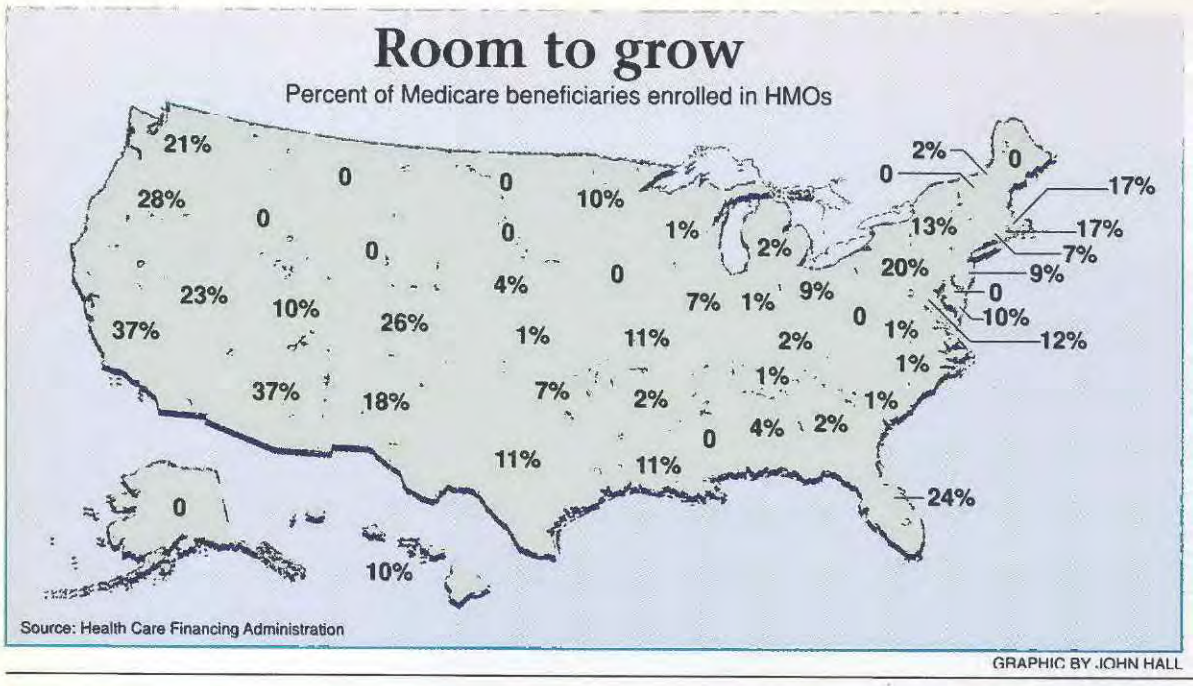


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GRAPHIC BY JOHN HALL

HMOs

Continued from page 6

"If your indemnity plan cost had been $200 a month, paying $50 a month for an enriched benefits package is well worth it for an employer," if significant numbers of retirees move into risk HMOs, said Eileen Settineri, a health care consultant with Buck Consultants Inc. in New York.

Economic incentives, while important, aren't the only way employers are encouraging retirees to move into risk HMOs. Communicating how Medicare risk HMOs work to a population of retired workers that may have had little experience with managed care also is vital, experts say.

For example, Bethlehem Steel Corp. has conducted meetings to explain how Medicare risk HMOs operate.

"Medicare HMOs can be very confusing to retirees. They want to know what rules to follow and how to use primary care physicians. They need some hand-holding," said Thomas Broderick, Bethlehem's manager of benefits administration in Bethlehem, Pa.

Those educational efforts, along with economic incentives, such as typically paying any premiums charged by risk HMOs, are paying off. Since Bethlehem first began to offer risk HMOs in 1995, enrollment has climbed to more than 10,000 retirees from 4,400, saving the big steel manufacturer several million dollars a year in retiree health care costs.

Employers' educational efforts are necessary for another reason: Many retirees distrust any program connected to the federal government.

Clearly informing retirees of risk HMOs benefits can ease that suspicion. "The No. 1 sales point for retirees tends to be the richness of the benefits," said Jack Doerr, national practice leader for Sedgwick Noble Lowndes in Chicago.

In some cases, retirees are approaching employers about offering Medicare risk HMOs. For example, in 1992, AlliedSignal Inc. first began to offer Medicare risk HMOs after retirees in the Phoenix area expressed an interest in the program because of their own positive experiences with managed care as active employees, noted Stacey Houston, a health and welfare specialist with AlliedSignal in Morristown, N.J.

Since that initial rollout in Phoenix five years ago, AlliedSignal now offers Medicare risk HMOs to retirees in 14 states. About 20% of AlliedSignal's Medicare-eligible population is enrolled in risk HMOs.

And that percentage is likely to increase as AlliedSignal adds risk HMOs to areas in which it already offers them as well as offering them in parts of the country where they are not yet an option.

"Risk HMOs fit well in our philosophy that managed care works well, be it for employees or retirees," Ms. Houston said.

Just as employers are encouraging retirees to consider and enroll in risk HMOs, the plans themselves are offering new programs to attract retirees.

For example, earlier this year United HealthCare Corp., which has about 450,000 retirees in risk HMOs it owns or operates, launched a new program geared to so-called snowbirds. Under that program, dubbed Passport, retirees can enroll in one United HealthCare HMO and receive coverage from another United HealthCare HMO for up to nine months. That allows them to spend part of the year in other places, such as Sunbelt states during the winter.

Offering a portable benefits program is striking a responsive chord with retirees. One retiree in a United HealthCare risk HMO in Chicago was thrilled to learn she could live part of the year in Florida without giving up coverage, said Tom Anderson, vp of Medicare programs for United HealthCare in Minneapolis.

And Congress is doing its part to expand enrollment in Medicare risk HMOs by overhauling what many health care experts say is a severely flawed payment structure.

Under a 1982 law, risk HMOs receive from the government 95% of the cost Medicare thinks it would have to pay to provide Medicare benefits to retirees living in a given county. The basic community rate then is adjusted for the age and gender of each retiree.

In coming up with payment rates for HMOs, Medicare looks at its own costs on a county-by-county basis over the previous five years in providing coverage to retirees.

That basis of rate-setting, critics of the current formula say, has a terrible public policy result: HMOs in areas of

See **HMOs** *on page 12*

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Medicare HMO saves retiree thousands while increasing benefits

Talk to Howard Loadman Jr., a 72-year-old retired executive, and it is easy to understand why enrollment growth in Medicare risk health maintenance organizations has been so explosive.

As Mr. Loadman's situation illustrates, the financial savings of enrolling in an HMO and moving out of the traditional Medicare program can be enormous.

A little over a year ago, Mr. Loadman, a former vp in Europe with Airborne Freight Corp., now Airborne Express Corp., paid about $3,000 a year in premiums to Prudential Insurance Co. of America for Medigap policies for himself and his wife, Betty.

In addition, Mr. Loadman, a diabetic, paid about $2,000 a year for prescription drugs, which the Prudential policy did not cover.

Mr. Loadman, who now lives in Sarasota, Fla., said he read several newspaper stories and ads about HMOs that provided rich benefits and charged no premiums for Medicare-eligible retirees.

"It sounded almost too good to be true," Mr. Loadman said.

It wasn't an illusion. Mr. Loadman and his wife enrolled in Humana Gold Plus Plan, the Medicare Risk HMO product offered by Humana Inc.

The Humana plan provided rich medical and hospital benefits as well as a $1,200-a-year prescription drug benefit. The premium for the health care benefits package: $0.

"Literally, I am saving thousands of dollars a year," Mr. Loadman observed.

Mr. Loadman is candid in acknowledging that not all of his experiences with the HMO have been positive. For example, he was skeptical about the results of a test taken by an HMO physician, which detected blockage in the carotid arteries. The results showed a much higher blockage than earlier tests.

Mr. Loadman went outside the network to have a new test taken, which showed a much smaller blockage. He showed the new results to his HMO primary care physician, who agreed that an operation to reduce the blockage was not necessary.

But on the whole, Mr. Loadman said he is satisfied with care delivered through the HMO. He and his wife are especially pleased that many of the medical specialists they used prior to joining the HMO are in the Humana network.

And he says he has recommended the HMO to others.

"We have a number of friends we already have recommended it to. The dollar savings are just so great," he said.

—By Jerry Geisel

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HMOs

Continued from page 10

the country that have done the leas to control costs receive the highes rates, while HMOs operating in part of the country that have been mos successful in holding down costs re ceive the lowest rates.

That, in turn, means HMOs i high-payment areas can provide rich array of benefits, charge no pre miums and still make a profit, whil HMOs in low-payment areas can even enter the Medicare market.

"This is virtually the only progran where the benefits provided ar based on ZIP code. Two seniors ca have the same income and the sam status. One lives in Dade County an the other lives in Chippewa, Minn The government says the retiree i Dade County is worth $748 a mont (to a risk HMO), while the retiree i Chippewa is worth only $227," com plains Tom Lehman, director of leg islative affairs with Blue Cross & Blue Shield of Minnesota in St. Paul.

"In some areas HMOs get so muc and can offer so much. In other areas there is no economic incentive fo HMOs to enter the Medicare marke because the rates are so low. If yo are a senior, whether you are a win ner or loser depends on ZIP code," Mr. Lehman adds.

"We acknowledge the curren model is broke and needs to b fixed," said Dick Anderson, vp health policy at Kaiser Permanent in Oakland, Calif.

Congress is about to do something about the rate system. Instead of bas ing payment rates to risk HMOs sole ly on Medicare costs on a county by county basis, the rates would becom a blend of Medicare's local and na tional costs. By 2004, the payment rate would be a 50-50 blend of loca and national costs. In addition, a minimum monthly rate of $36 would be set in 1998.

These changes would produce three effects:

- Rates in extremely low payment areas, such as rural areas, would immediately climb by more than 50%.
- Rates in areas of the country where costs are somewhat lower than the national average also would gradually increase.
- Rates in high-payment areas would increase, though the increases would be much smaller compared with current law.

The next effect of these changes will be an expansion of risk HMOs to areas of the country where low payment rates kept HMOs out of the Medicare market.

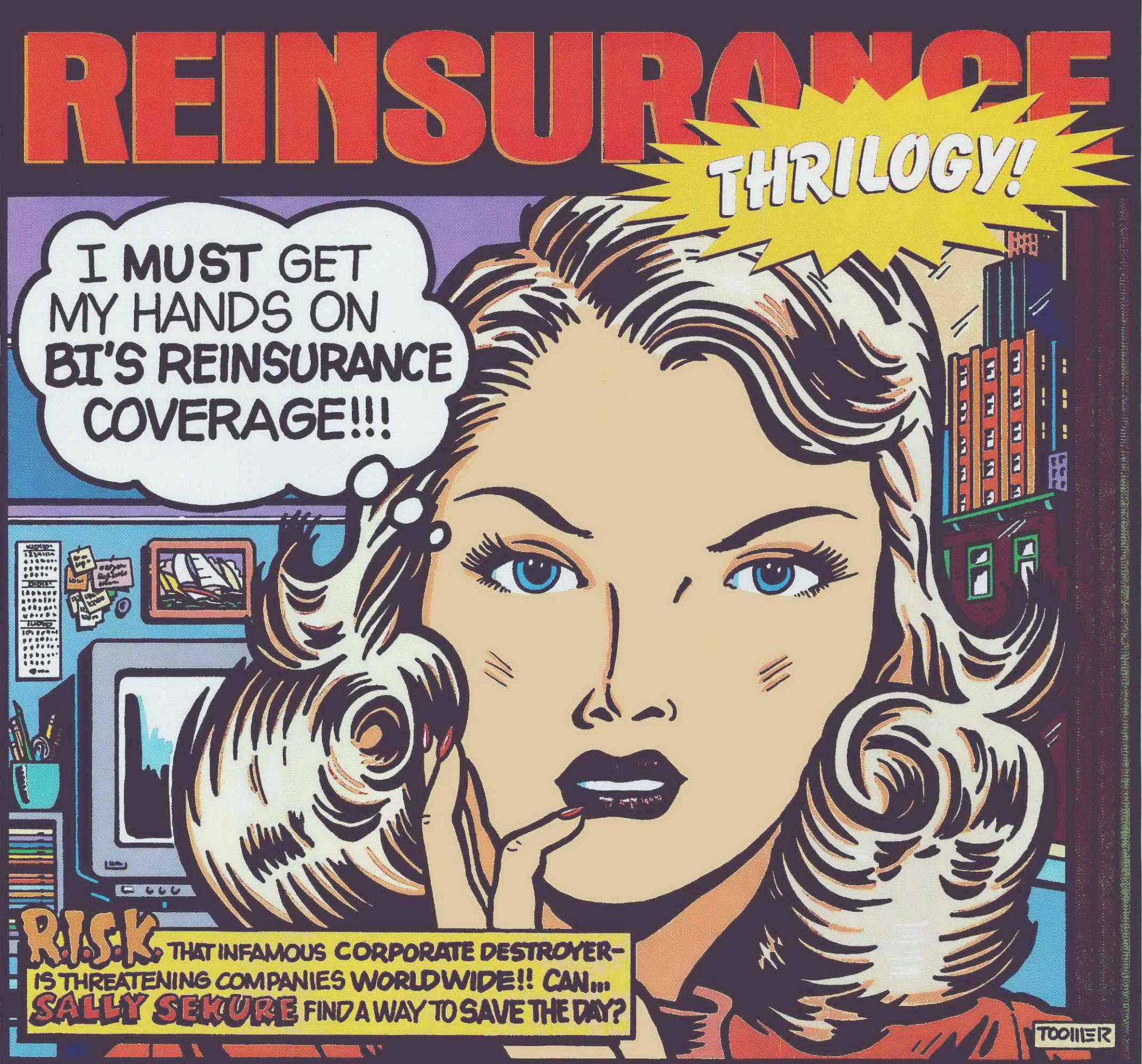
"In many areas of the country, risk HMOs will become a reality because the payment rates will be sufficient," said Susan Foote, president of Durenberger/Foote, a Washington-based health policy consulting firm.

"This is a step in the right direction. There were so many areas of the country where we and others could not enter because the rates were so low," said Eugene Scanzera, director of National Medicare Managed Care Networks for Blue Cross & Blue Shield Assn. in Chicago.

While risk HMOs in high-payment areas will receive smaller rate increases than under current law, they still should be able to offer rich benefit packages.

"There may be some trimming of benefits or slight premium increases but they will be viable and attractive" to retirees, said Mary Harrison director of client services at The MEDSTAT Group in Stamford Conn.

And with so many current employees already most likely covered by managed care plans, many of them will want to stay in HMOs when they retire, assuring even more growth for risk HMOs. BI



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Spotlight report

Backlash

Continued from page 3

Michael Millenson, a consultant with William M. Mercer Inc. in Chicago.

Tom Billet, vp-national practice for The MEDSTAT Group in Stamford, Conn., said, "As more and more people get into managed care, it will continue to attract the attention of federal and state regulators, and we will see more regulation than we have today."

Also, managed care reforms are easy for lawmakers to support in light of stories about HMOs denying people care.

"Politicians are looking for ways to capture the interest of the public and represent causes that are public," Mr. Exton said.

"It's win-win for politicians to represent their causes and bring those issues to the Congress for a vote. They come out looking like the good guy," he said.

"The threat of impending legislation has provided some impetus to HMOs to look at quality," he said.

The backlash has approached a whipping. So far, 33 states have adopted some sort of comprehensive approach to regulating managed care, according to figures compiled by the Health Policy Tracking Service of the National Conference of State Legislatures.

Also, 48 states have either adopted or are considering legislation to outlaw so-called gag clauses, which prevent HMO providers from discussing more expensive treatment options with patients. In addition, 11 states outlawed "drive-through mastectomies," and 26 have adopted laws allowing obstetrician/gynecologists to be classified as primary care physicians, the Tracking Service reports.

Both HMOs and employers say the legislation is not a reasoned response to any concerns.

"It's a matter of thinking rather than reacting emotionally to a perceived threat," said Susan Laudicina, director of research for the Blue Cross & Blue Shield Assn. in Washington.

"Sometimes lawmakers seek simple solutions because they are easy to understand and are popular. But the easy solutions, such as mandates, do not make health care better," she said.

A large part of the HMOs' efforts have gone toward defeating "any willing provider" legislation. These laws open HMOs to all providers who meet the HMOs' requirements. Such laws cause HMOs to "lose control over the coordination of care," said Fran Tracy, vp of government affairs at Blue Cross & Blue Shield of Maryland in Owings Mills, Md., and "would significantly damage the cost-effectiveness of managed care."

Any-willing-provider laws "will eventually throw us back to the 1970s," Mercer's Mr. Millenson said, referring to a time when fee-for-service was the dominant health care model.

Critics of HMOs, including the public, tend to forget the numerous problems that existed under the fee-for-service system that led to the growth of managed care, experts say.

"The myth of a lost 'Golden Age' of medicine before the advent of managed care should be rejected," wrote Mr. Millenson in a report entitled "Beyond the Managed Care Backlash: Medicine in the Information Age." "Marcus Welby isn't just dead; he never lived in the first place," the report says.

Twenty-three states have passed some form of any-willing-provider legislation, according to figures compiled by the Health Policy Tracking Service. The vast majority of these apply to pharmacies or allied health professionals, such as optometrists, chiropractors and podiatrists, but four—Idaho, Indiana, Kentucky and Wyoming—have laws covering a broad array of providers, including physicians.

But to date, the most common legislation is mandates, which employers generally oppose.

Legislation protecting consumers already exists but is not strictly enforced, said Helen Darling, manager, international compensation and benefits for Xerox Corp. in Stamford, Conn. "All the legislation needed is there. You don't have to pass any more laws; all you need is to enforce the ones that are already there," she said.

The laws "send the message to everybody, including the bad apples in the industry, they will be punished," Ms. Darling of Xerox said. The good HMOs won't suffer but "the ones that make money by doing less will be driven out of business," she said.

Said Laurel Pickering, executive director of the New York Business Group on Health: "Most employers are thinking (legislation is) not a good idea. It has the potential to increase health care costs."

Rather than having government control health care, she said employers prefer using the market to cull out the weak HMOs from the strong by "holding their health care plans more accountable," she said.

One such company is The Dow Chemical Co. in Midland, Mich. The company now requires all HMOs it contracts with to provide HEDIS data and receive accreditation by the National Committee on Quality Assurance in order to get the best quality care at the best price, said the company's director of employee benefits, Dr. Geof Kusch. HEDIS is a collection of standardized performance measures that allows comparisons among managed health care plans and is marketed by the Washington-based NCQA.

Dr. Kusch said Dow will drop an HMO from its roster for failing to provide the data or if its quality of care drops too low. Factors including employee complaints are weighed in deciding whether to retain an HMO. This type of market-driven approach will create competition among the HMOs, he said, and make them find the best way to provide quality at a low cost.

"Employers need to make managed care organizations accountable for quality and present the quality information to the employees so they can make an informed choice," he said.

Despite the criticism, the laws have helped correct some problems with the managed care industry. "There's a lot that can be improved" with HMOs, said Joseph Martingale, a principal with Towers Perrin in New York. "You cannot defend managed care in its entirety. There are good ones and lousy ones with the majority somewhere in between."

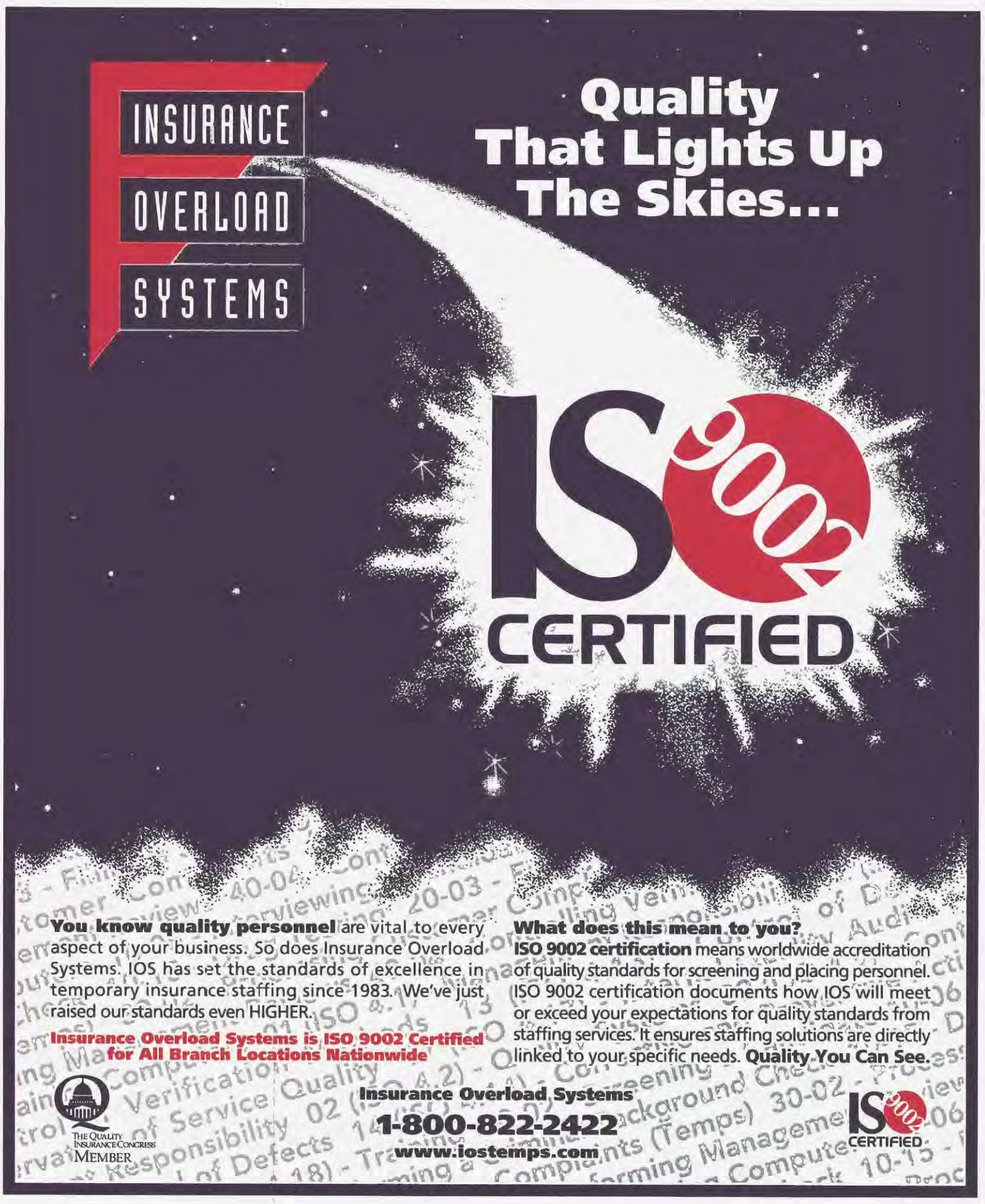
In the past two to three years the performance of HMOs has improved, said Mr. Millenson. "In that respect, the managed care backlash has been good," he said.

And the laws have made HMOs look beyond costs. "Maybe some groups thought of other than the well-being of the patients," said Richard Sinni, a principal with Buck Consultants Inc. in New York. "And that is now being addressed."

HMOs are making changes and trying harder to get their message out. But one thing that perplexes many is that while managed care seems to suffer in the area of public opinion, one new survey shows the opposite.

A recent Towers Perrin study found that 68% of enrollees in Medicare HMOs are extremely or very satisfied

See **Backlash** *on page 18*



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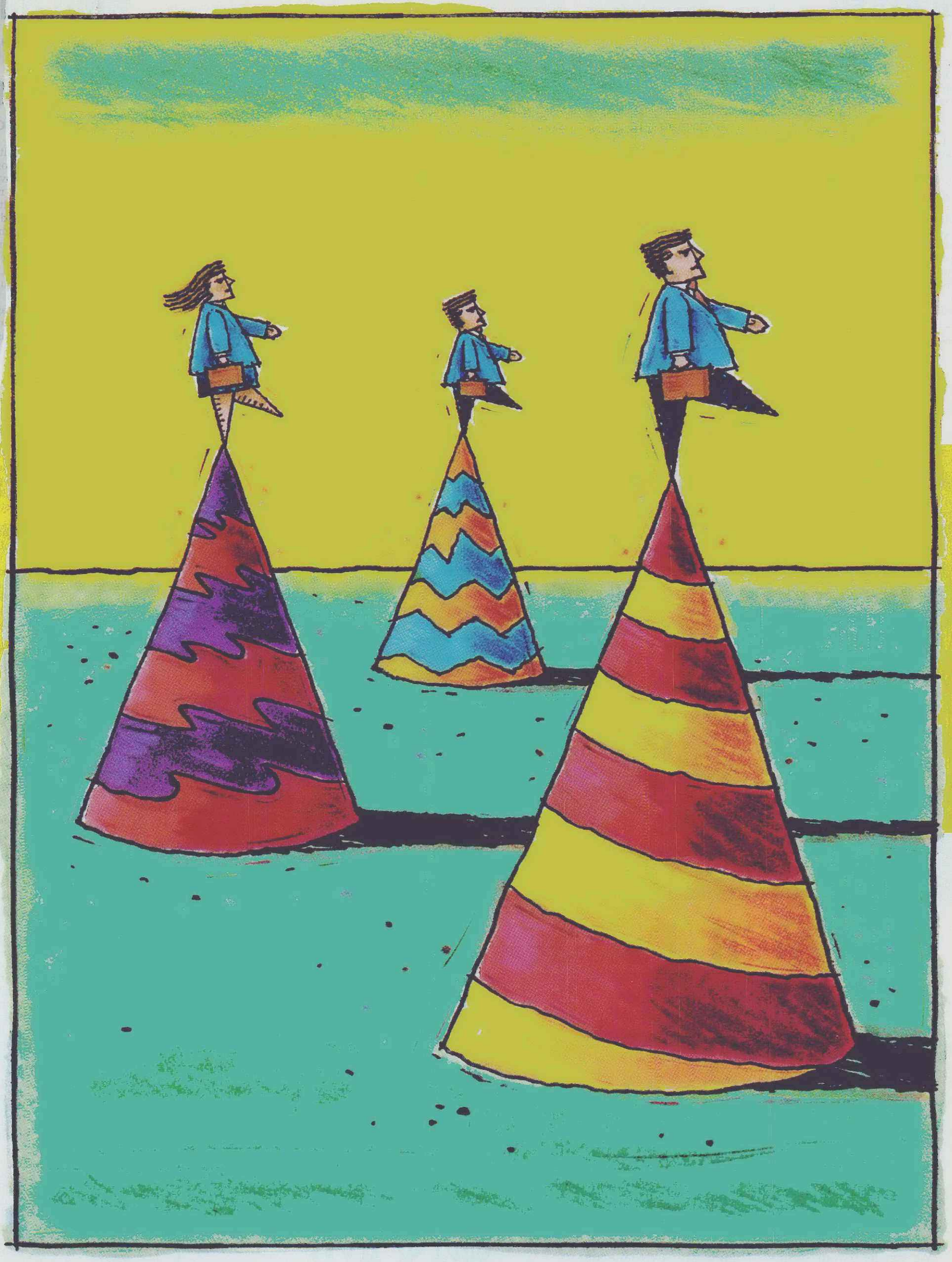
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Spotlight report

Backlash

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with their health plan. Of the 5,932 people surveyed, only 6% indicated they would not re-enroll in the HMO.

"People don't make noise when they're happy. They make noise when they're unhappy," Mr. Martingale said.

Ms. Laudicina said HMOs are adopting a three-pronged strategy to build trust with enrollees.

The first area is working with legislators, providers and consumer groups to draft legislation that the managed care industry considers reasonable.

As an example, Minnesota this year enacted a comprehensive law that among other items banned gag clauses and provided for disclosure of how HMOs reimburse providers.

Also, health plans have signed agreements with providers that open to enrollees details of the relationships between providers and HMOs. For example, enrollees can learn if doctors are paid on a capitated basis, in which they receive a fixed fee to provide care for a set number of patients. Such agreements address public concerns while preventing legislation from becoming enacted. "That keeps overly intrusive laws and regulations from being written," she said.

The third aspect of the HMO response is a more aggressive effort to publicize the benefits of managed care and counter the stream of stories depicting the HMOs as care-deniers.

To further their goal of promoting the positive aspects of HMOs, the American Assn. of Health Plans is promoting its "Putting Patients First" program. Put out in early 1996, all members of the AAHP have agreed to uphold these guidelines designed to both improve communication between managed care organizations, providers and enrollees and promote higher standards of accountability for health plans.

"The challenge for our community is to look at what there is yet to be done to improve quality and service to all audiences: employers, patients and physicians," an AAHP spokeswoman in Washington said.

Managed care brought the backlash on itself, one benefit manager said.

"They are getting a backlash because they went too far," said Ash Kilada, director of risk management and benefits for Sbarro Inc. in Comack, N.Y. He said that in his experience, managed care companies have cut their services in order to keep their costs low and compete with each other on price. Mr. Kilada says that decreases the quality of care.

And although benefit managers generally agree that the government can't legislate better care, they can act as a watchdog, many said. Fred Hamacher, vp of compensation and benefits for Dayton Hudson Corp. in Minneapolis, said he could envision an organization patterned after the Securities and Exchange Commission that oversees how HMOs grade and promote themselves to the public.

Mr. Exton of Watson Wyatt agrees. He sees government as a third party helping to balance HMOs between quality of care and lowering costs. This can be accomplished by facilitating the gathering and dissemination of information on HMO's performance and other measures of quality.

"The managed care backlash presumes there are obvious good guys and bad guys," Mercer's Mr. Millenson said. "In fact, everyone, the medical community, the managed care companies and consumers, all bear some responsibility for the problems we have in the system and all bear some responsibility for solving them." BI

HMO role in research debated

By HOLLY SIMPSON

As more health maintenance organizations get involved in medical research, some health care buyers and physicians say that involvement may compromise the care HMOs provide.

HMOs' involvement with medical research was addressed in a series of articles in the July 16 issue of the Journal of the American Medical Assn. that questioned managed care organizations' willingness to pay for routine patient care as well as clinical research.

The question, according to some employers and physicians, is not where the money is coming from, but if managed care companies should participate in clinical research at all.

"Research has the potential for leading to considerably improved quality; that's why it's worth supporting," said Helen Darling, manager of international compensation and benefits for Xerox Corp. in Stamford, Conn. However, "there is just as much potential for doing harm."

There are two kinds of harm, she said. From the perspective of a health care buyer trying to select the most cost-effective plans, she is concerned that money spent treating terminal patients with experimental technologies may be diverted from the preventive screening and routine care of other patients who may achieve a much greater and longer-term health advantage from the procedures.

"If you look at a disease like cervical cancer, the women with the biggest problems come in too late," Ms. Darling said.

Second, aggressive treatment for some terminal diseases, such as cancer, also can put the patient at great risk, she said.

"Research has given us modern miracles," said Ms. Darling. "It's worth it, but there are tradeoffs."

Barbara Lardy, director of the medical affairs department for the American Assn. of Health Plans in Washington, said an investment in research is cost-effective in the long run.

"The overall research enterprise will benefit by working with managed care," Ms. Lardy said. "Research leads you to innovations (to find) the best way of providing care."

Ms. Lardy explained that when HMOs work with the National Institutes of Health, a key organization in funding medical research, the cost of the routine patient care associated with studies is covered by the plans themselves. The NIH provides the money to support the research side.

The question, she said, is " 'How do you define routine patient care?' That term often must be defined in the context of a particular patient," she said.

Some observers say managed care organizations should not fund any medical research.

"I don't know whether it makes sense to ask the managed care industry to solve the broader public problem of assuring adequate clinical research or medical education," said Dr. Arnold Milstein, medical director of the Pacific Business Group on Health, an employer purchasing coalition and a principal with William M. Mercer Inc. in San Francisco. "These are broad national needs that need to be systematically thought through and solved at a national level

See **Research** *on page 20*

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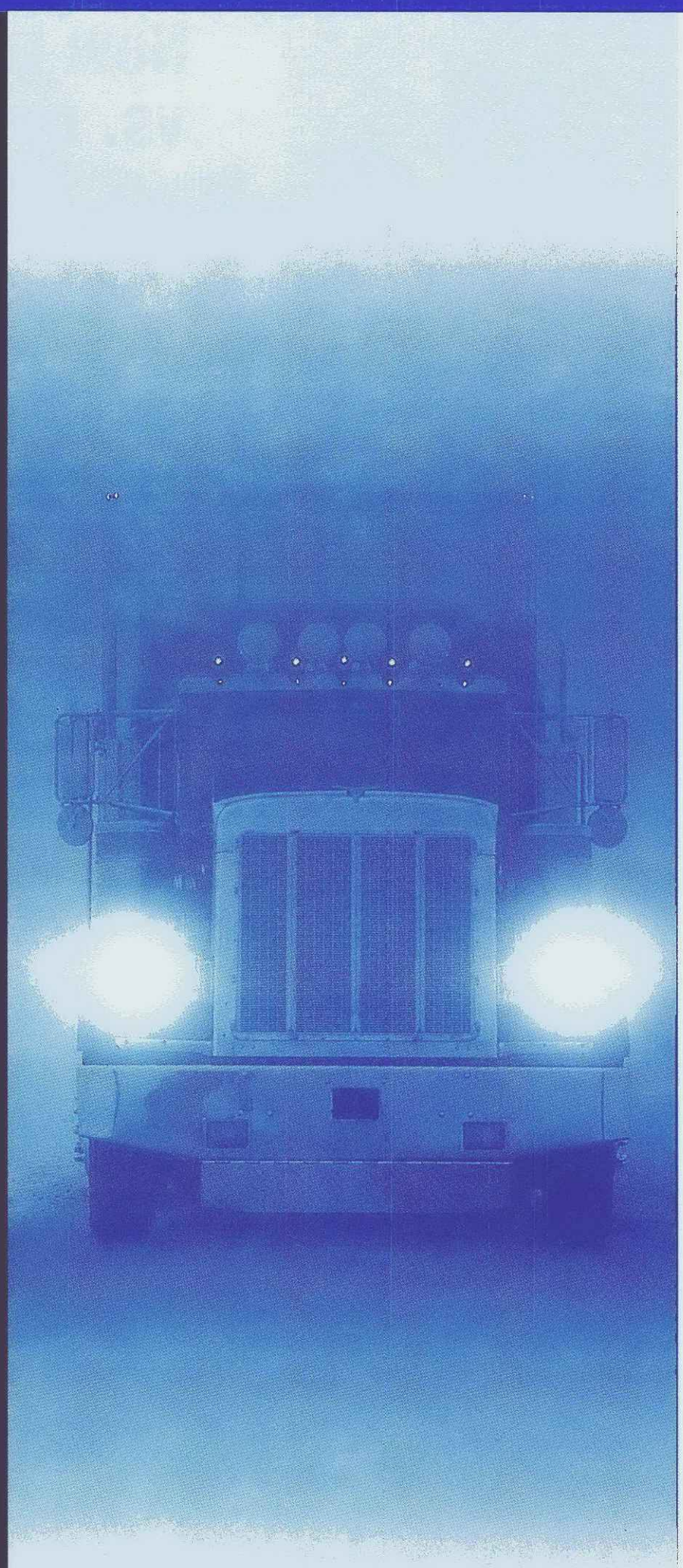
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Research

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rather than through exhorting the managed care industry to do more."

Steve Wetzell, executive director of policy and public affairs for the Buyers Health Care Action Group in Minneapolis, said research "isn't an issue just related to managed care. . .it's an issue of public policy and how we fund clinical research."

Mr. Wetzell said that while it is the coalition's policy to pay for treatment believed to benefit the patient, basic research should be funded with public money, not necessarily by health care plans.

"You still want to advance the science, and it takes money to (do so)," he said. "The problem is you don't know whether you're paying for something that will advance medical technology. How do you make the appropriate allocation?"

Dr. Milstein said, "Value improvement in health care lies not with progress in biotechnology, but rather in more consistently delivering the benefits of our existing technology."

He said the medical community does better at discovering new therapies than in learning how to utilize their potential benefit for the covered populations.

"We just don't pay any attention to delivery," Dr. Milstein said.

In the meantime, some managed care companies have initiated their own research programs. Several HMOs would not comment on their research.

Dr. Mary Durham, vp for research for Kaiser Foundation Hospitals in Portland, Ore., said Kaiser has been investing in research for the past 35 years.

"We have a great interest in doing research which identifies large groups of people, like women with breast cancer, or women with osteoporosis, or people with Alzheimer's," said Dr. Durham. "(Our research) is based on clinical trials, and many are large, randomized studies."

Kaiser "builds bridges" with academic medical centers, forming a partnership through which research can be performed, Dr. Durham said. She acknowledges that obtaining money is "much more difficult" nowadays. Of the $25 million Kaiser will spend on research this year, 60% comes from the NIH, about 30% is from private foundations, such as the Robert Wood Johnson Foundation, and Kaiser finances the remainder.

"I can't imagine anything else more cost-effective, especially something that's a social benefit as well," said Dr. Durham. BI

New technology vs. cost control

Balancing utilization, costs is seen as key

By MEG FLETCHER

Managed care's emphasis on controlling the cost of health care is increasing the importance of cost-effectiveness in the development and reimbursement of new medical technology.

"If you look at the health care environment over the 1960s, 1970s and 1980s, (the paradigm) was one of better patient care at any cost. Managed care has basically put in a different paradigm, which is better patient care through lower cost," said Patrick Sullivan, president and chief executive officer of Cytyc Corp. in Boxborough, Mass., which develops medical technology.

The challenge is to get improved results at lower overall cost, without reducing quality of care or increasing hidden costs to employers, such as lost time due to employee sick leave or physician office visits.

Meeting that challenge is complicated by several factors, including that the procedure for analyzing the cost-effectiveness of new technology "is still in its infancy," said Dr. Paul Schyve, a senior vp at the Joint Commission on the Accreditation of Healthcare Organizations in Oakbrook Terrace, Ill.

In addition, using cost-effective technology still can increase health care costs because studies show that physicians tend to extend new, less invasive procedures, like laparoscopic surgeries, to patients who might otherwise have received a more invasive type of operation.

In the past, several research studies have shown that "technological change is responsible for half of the rise in (health care) costs," said Daniel Mendelson, a consultant and vp with The Lewin Group in Fairfax, Va.

The challenge is to get improved results at lower overall cost, without reducing quality of care.

However, "if utilization is directed properly, new technology should lower the cost of health care," he said.

While most employers don't contract with hospitals and health care providers directly, companies should make sure that managed care organizations are concerned about providing quality care and appropriate reimbursement for cost-effective treatment.

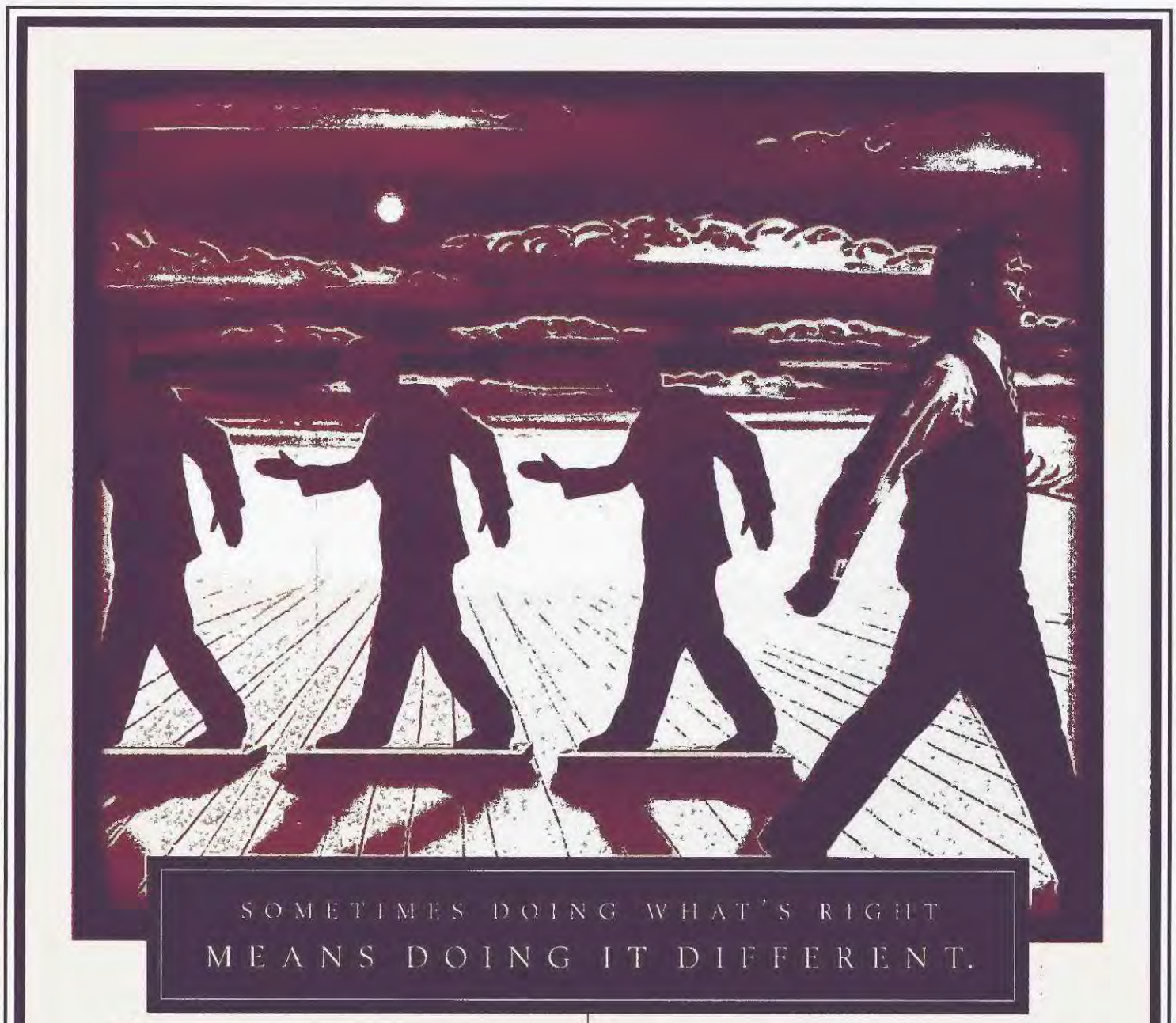
New technology should be able to improve the quality of health care as well as patients' lives through quicker diagnoses and less invasive treatment, thereby reducing recovery time.

For example, "polio was very costly to treat until a vaccine was developed, and then merely cost pennies," said Bill Maloney, a principal and head of health care information practices in the Phoenix office of William M. Mercer Inc.

Technology—including procedures, devices and drugs, experts say—is giving health care providers new options in treating patients.

For example, one of the newest uses for radiological equipment is "magnetic resonance angiography," which lets a physician use magnetic resonance imaging equipment to see blocked blood vessels. This procedure eliminates the need to inject a patient with

See **Technology** on page 24



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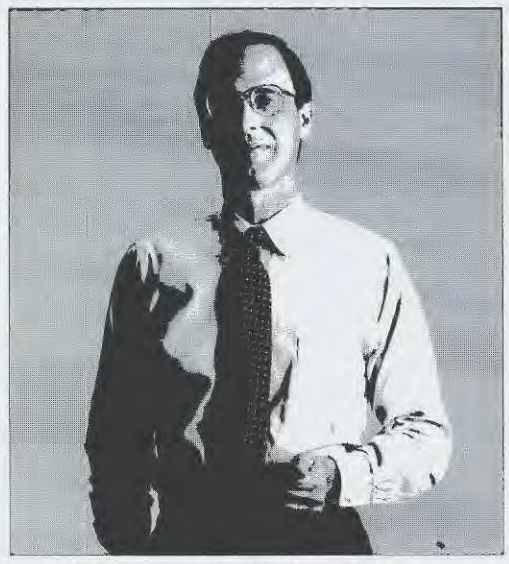
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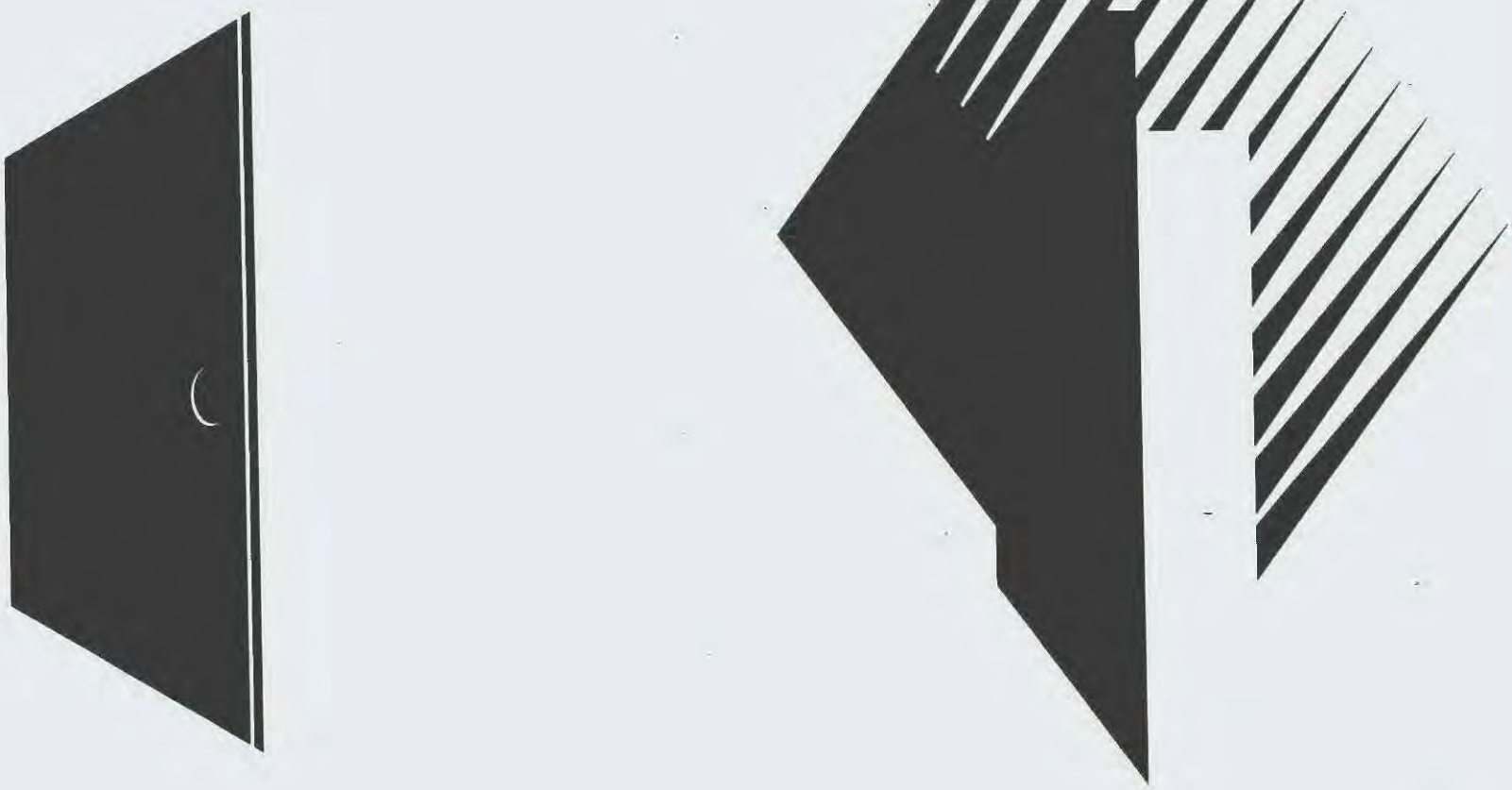
[1]The Center for Healthcare Industry Performance Studies is a healthcare data information and analysis firm.

[2]HCIA, a healthcare information company and William Mercer, a human resources management consulting firm, cooperatively published a 1996 study: "100 Top Hospitals: Benchmarks for Success."

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Spotlight report

Technology

Continued from page 20

dye, which sometimes triggers an allergic reaction, said Dr. Carole Flamm, senior consultant with the Blue Cross & Blue Shield Assn.'s Technology Evaluation Center in Chicago. The center advises Blues plans and other health care plans about the efficacy of new medical technology.

Nuclear cameras enable physicians to diagnose malignant tumors more quickly by imaging cancerous cells as the cells consume "radioactively labeled sugar," said Dr. Kenneth Bartholomew, who practices at the Medical Center of Bowling Green, Ky. Implementing that approach, which required purchasing $400,000 worth of equipment, is considered more cost-effective than using a positron emission tomography scanner costing millions of dollars more, he said.

In addition, hospitals and clinics are buying moderately priced ultrasounds, which cost $50,000 to $100,000, along with higher-quality units costing $220,000 to $300,000, said Bill Carrano, marketing director for general imaging with Acuson Corp. in Mountain View, Calif.

Researchers also are analyzing the effectiveness of "minimally invasive coronary artery bypass grafting," in which surgeons use specialized instruments to make a small incision under a patient's rib rather than saw through the breastbone.

Also, a new ThinPrep Pap Test is designed to improve cervical cancer screening. Instead of using the 50-year-old procedures of smearing cells on a slide, the physician uses a tiny, brush-type collection device to collect cells and places them in a vial of preservative solution that is sent to a laboratory for analysis.

"Manufacturers are selling a lot less equipment than in the past, says Jeffrey Lerner of ECRI.

The procedure yields a cleaner sample without the mucus, blood and inflammation of conventional smears that can result in inconclusive findings. A cleaner sample also reduces the frequency of inconclusive findings, which make patients anxious and require retesting.

Finally, new drugs, such as those that treat depression, can help a patient avoid an extensive hospital stay and return to work sooner.

When it comes to such medical technologies, "everybody across the board is interested in cost-effectiveness," said a spokesman for the National Committee for Quality Assurance in Washington.

Some payers even are willing to pay more for a better test.

For example, United HealthCare Corp. in Minneapolis announced last year that it would cover the ThinPrep Pap smear test because it has been demonstrated to be significantly more effective than the traditional method.

Depending on a reimbursement arrangement, the new test adds about $15 to $30 to the $6-to-$38 cost of a traditional test, said Cytyc's Mr. Sullivan. However, the more accurate sampling procedure also saves money by reducing costs associated with retesting.

But, even a cost-efficient procedure or test can increase overall costs if physicians use it more often.

A recent study of radiological services, which was prepared last month for *Business Insurance*, found that "the clear message is that while the unit costs of most imaging diagnostic tests are flat or down over the past few years, the use of such procedures continues to increase every year," according to Tom Billet, vp-national managed care practices in the Stamford, Conn., office of The MEDSTAT Group in Ann Arbor, Mich.

The study, which tracked services provided during 1992-1995 to more than 7 million individuals covered by large employers' health care plans, found that payments for magnetic resonance imaging dropped each year during that period to $666.78 from $795.86, in 1997 dollars. However, the utilization rate increased from 17 to 24 per 1,000 covered lives.

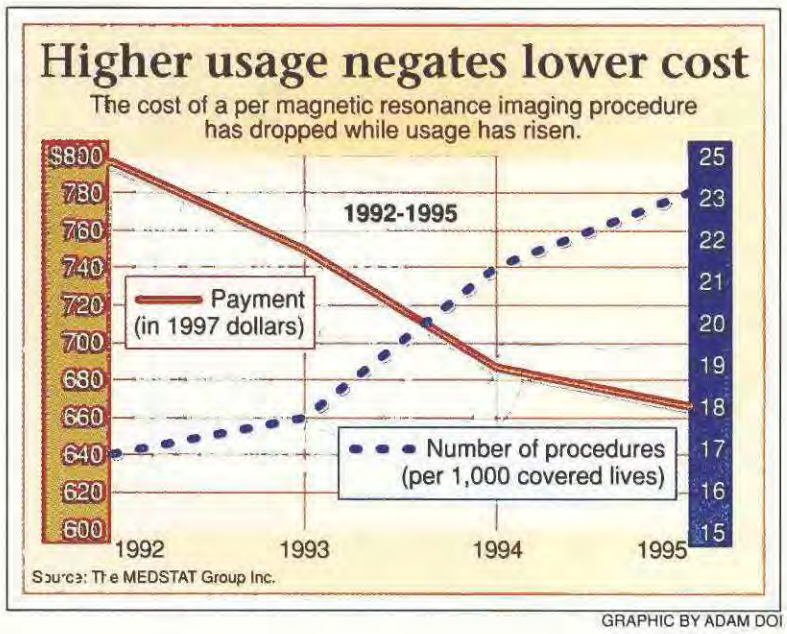
"The tighter health care dollar has caused all health care providers to carefully evaluate the need and pay back for new technology," said Michael Engelhart, a partner with the Deloitte & Touche Consulting Group in Chicago.

Hospitals are making surprising progress, he said.

"Manufacturers are selling a lot less equipment than in the past," said Jeffrey Lerner, vp for strategic planning with ECRI, a non-profit organization that evaluates medical technology in Plymouth Meeting, Pa.

By becoming more efficient, hospitals boosted their median operating profit margin to 3.88% in 1995, compared with 3.42% in 1994, according to an annual comparison of U.S. hospital opera-

Continued on next page



GRAPHIC BY ADAM DOI

A company that manages every medical aspect of catastrophic injury from any point in the life of the claim, anywhere in the country. That actually manages cost by ensuring high-quality treatment and uncompromising medical management,

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Technology

Continued from previous page

tions prepared by ECRI and HCIA Inc., a Baltimore-based health care information company.

Hospitals and clinics are extending that drive for efficiency to include their use of medical technology.

Previously, duplication of services and equipment within a given marketplace was a huge problem, several experts agree.

Health care facilities used new equipment to attract high-quality physicians. That practice continued unchecked after the failure of a public program in the 1980s that required health care facilities to get a certificate of need from a health care regulatory agency before making expensive equipment or other capital improvements.

"Under the old fee-for-service climate, hospitals charged on a cost-plus basis. Now they negotiate to be paid on a per diem basis or per case basis. They often get a fixed fee and they have to control and bring down costs so they can make money," said Mr. Billet.

As a result of the new reimbursement system, most community hospitals and clinics now have a greater incentive to cooperate.

Cooperative efforts by hospitals include mounting MRI machines on tractor trailers and rotating them among small, neighboring hospitals, often in rural areas.

Hospitals also are cooperating to establish and share a specialized unit, such as pediatrics. In addition, hospitals and clinics are continuing to contract for services such as sophisticated laboratory analysis and to lease equipment.

Employers that choose managed care services that deal directly with providers need to make sure that managed care organizations share their goal of providing quality care for employees, including appropriate reimbursement for cost-effective treatment.

"Employers have an obligation to ask more of their managed care organizations than they have in the past. What we see now is more of an interest in quality but not nearly enough," said Lewin Group's Mr. Mendelson.

Employers need to ask for outcomes' information, including reports about lower infection rates in surgery, lower percentage of Caesarean section deliveries and fewer readmissions for illnesses, said Deloitte & Touche's Mr. Engelhart.

"Employers are interested in employees getting well and getting back to work," he said. BI

Managed care Southern style

Despite obstacles and rural settings, managed care makes inroads in Dixie

By MICHAEL BRADFORD

Managed care isn't spreading like kudzu through the South, but managed care plans are taking root in the region as more Southern employers embrace the concept.

In the South, health care cost pressures have not been as great as in the West or Northeast, where managed care has made significant inroads. In addition, Southern providers have fought to continue offering care in traditional ways.

At the same time, managed care plans have found less financial incentive for setting up shop in a region with vast stretches of rural communities than in more densely populated regions of the country.

Nevertheless, managed care is now making steady inroads into Dixie.

A survey by A. Foster Higgins & Co. Inc. released earlier this year indicates that managed care programs are replacing traditional indemnity plans in Southern workplaces.

It showed 31% of Southern employers offered traditional indemnity plans in 1996, down from 41% the year before.

The survey also indicates that point-of-service plans are growing faster among employers than other forms of managed care in the South.

The data showed that 15% of Southern employers were offering point-of-service plans in 1996, which was more than double the 7% that had the plans in place the year before.

Fifty-two percent had preferred provider organizations, compared with 45% in 1995. Twenty-two percent listed health maintenance organizations among their 1996 offerings, up from 18% the year before.

While encouraging, the numbers have to be taken with a grain of salt, according to Dave Hollis, a principal and health and welfare practice leader for the South unit at William M. Mercer Inc. in Atlanta.

"You could be led to believe that managed care has made as many inroads in the South as anywhere else. I would still question that a little bit."

Others agree that managed care hasn't penetrated the South as deeply as it has other parts of the country.

"It's my perception that the South has lagged behind but is doing its best to catch up," said Jane Freedman, senior consultant at Watson Wyatt Worldwide in Atlanta.

"It does lag behind for a lot of reasons," suggested Jonathan Newpol, director of The MEDSTAT Group in Atlanta.

One reason is city size, he noted. "Obviously, managed care is stronger in large metropolitan areas. The South has much more rural and small city concentrations."

Mr. Newpol pointed out that managed care is "way behind" in places with few or no major markets, such as Mississippi, Alabama and most of Louisiana. The lack of large employers with large employee populations in those states gives managed care providers less incentive to operate there.

Ms. Freedman agreed that "the degree to which a marketplace is mature in the context of managed care has more to do with size

See **South** *on next page*

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Spotlight report

South

Continued from previous page

rather than the area of the country. In most of the major metropolitan areas, it's the businesses that are driving it."

However, plans are beginning to find ways to expand into rural areas.

Employers with operations in multiple communities are asking plans to tie together the far-flung locations in a network that will provide consistent benefits to all workers, explained Harvey Ludlam, president of Prudential Health Care Plan of Georgia Inc. in Atlanta.

Banks, for example, may have a number of employees in cities throughout a state and want to provide the same level of benefits to employees at all locations, he said. "Pressure is coming from these kinds of clients to offer statewide plans."

Plans are responding by putting together statewide networks of PPOs and POS plans, Mr. Ludlam said. "We have embarked on a statewide POS program," he said of Prudential Health Care's efforts to satisfy employers with statewide operations.

POS programs have caught on because, while they resemble HMOs, they offer patients provider choice that HMOs do not.

Mr. Hollis pointed out that in many cases, a POS plan is put in place as a "second phase," when an employer thinks HMO enrollment has peaked.

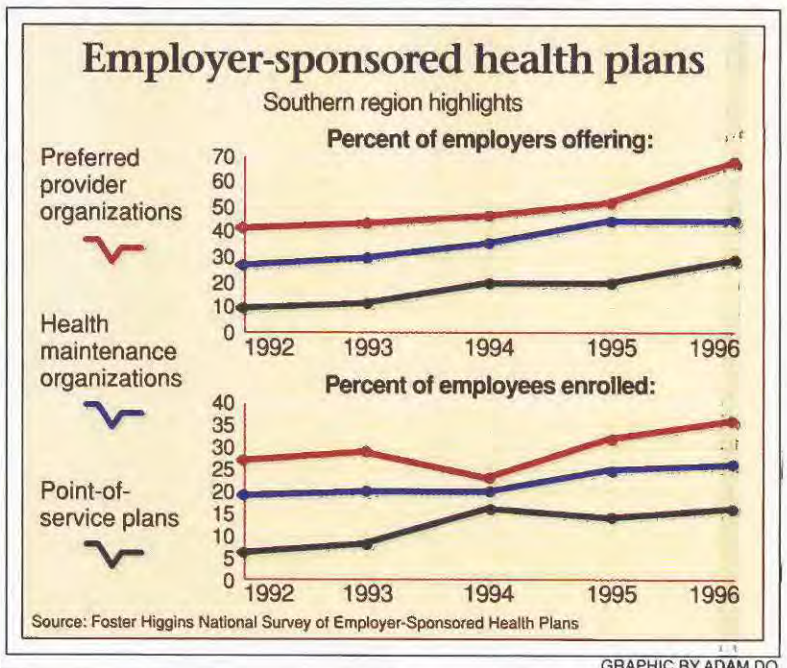
But HMOs are becoming more popular, according to figures compiled by InterStudy Publications in St. Paul, Minn.

InterStudy tracks HMO enrollment in regions established by the U.S. Bureau of the Census.

HMO enrollment in the East South Central region—Alabama, Kentucky, Mississippi and Tennessee—grew almost 50% from July 1995 to July 1996, according to InterStudy. HMOs in that region covered 15.6% of the population as of July 1996.

InterStudy's figures show enrollment in the South Atlantic region—Delaware, the District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia and West Virginia—grew by 29% for the period. HMOs cover 19.4% of that region's population.

"In spite of the rapid growth, it is not the most highly penetrated part of the country," said Richard Hamer, director of InterStudy. The Northeast and West Coast are still "quite a bit higher in HMO penetration," he added.



GRAPHIC BY ADAM DO

According to a 1996 Foster Higgins survey of employers with at least 500 employees, 51% of eligible employees in the West were enrolled in HMOs, while among Northeast employers, 44% of eligible employees were enrolled in HMOs.

The South has lagged behind other regions in managed care partly because Southern employers have a tradition of waiting until a concept is proven before implementing it, Mr. Hollis pointed out. In many cases, he said, they have waited to watch managed care mature in the Northeast and West before joining the bandwagon.

Provider resistance has been another barrier to managed care in Southern states.

"The medical community has not been anxious to get in," Mr. Hollis said. "That has slowed the growth of managed care."

"Significant pockets" remain in the South where health care providers are "adamant against managed care," he said, explaining that many physicians worry that their incomes will drop and their livelihoods could be threatened if managed care becomes entrenched.

In some parts of the South, health care costs haven't risen enough to push employers to the concept. In fact, costs have been so low in some areas that managed care has been "a solution looking for a problem," noted David Foster, a Mercer associate and member of its managed care advisory group in Atlanta.

Florida is a managed care dichotomy.

In the southern half of the state, where the retiree population is large and health care is more costly, managed care is well-entrenched, Mr. Foster pointed out.

Not so in the northern half of the state, he said, where the population is younger and health care costs are lower.

Apart from South Florida, some hot markets for managed care can be found in North Carolina, pointed out Mr. Newpol of MEDSTAT. Population growth in Charlotte and the Research Triangle area has heated up competition among managed care marketers.

In many other areas, however, expansion likely will be slow.

"I don't foresee strong expansion," said Mr. Newpol, predicting instead "low to moderate growth" in the South.

Instead of expanding, Mr. Newpol thinks the "infrastructure," or operations, of managed care will improve among plans already in the South. BI

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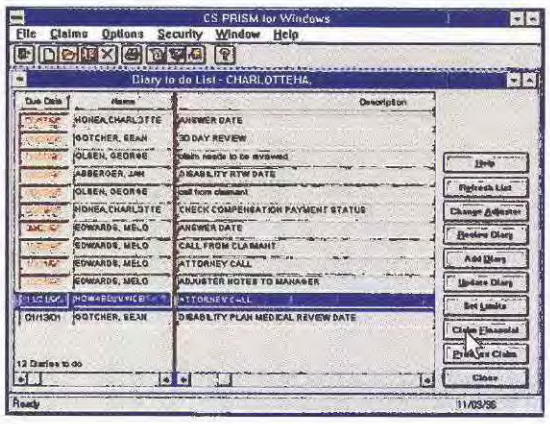
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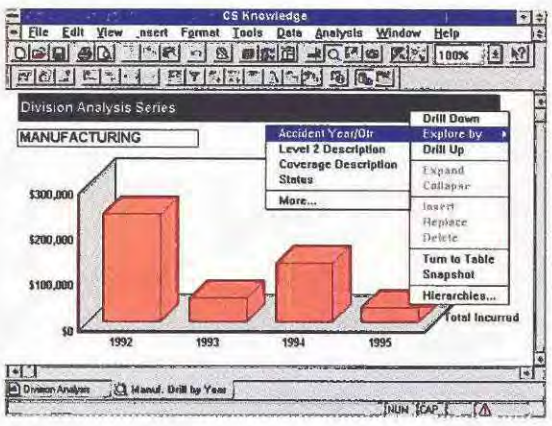
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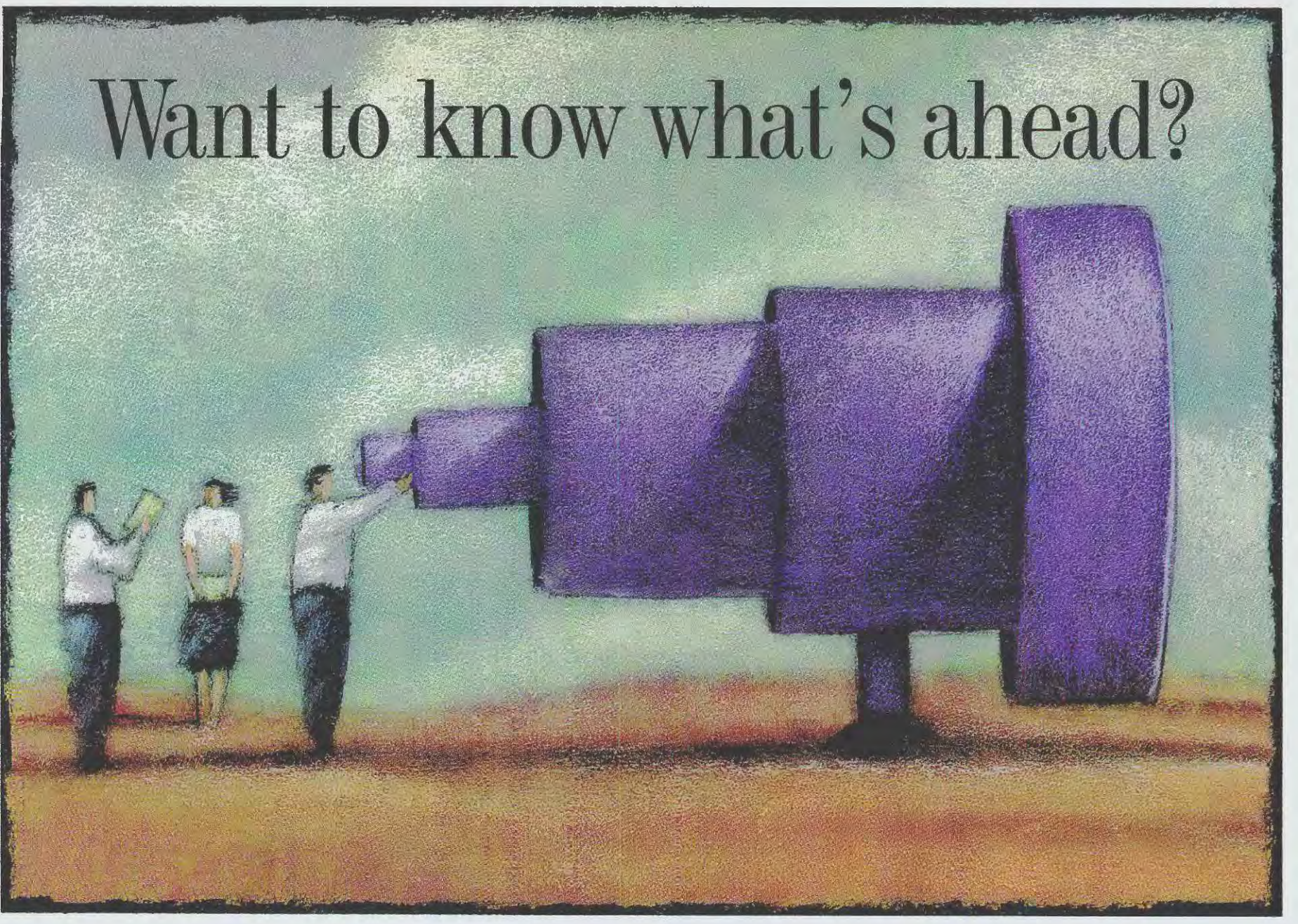
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Aug 11	*Distribution: ARIA*		Jul 30
Aug 18	Property Loss Control RS *Directory: Property Loss Control Consultants*	IT Government Relations	Aug 6
Aug 25	Ward's 50 Benchmark Results		Aug 13
Sep 1	Reinsurance: International Markets RS *Directory: Leading Reinsurers Worldwide* *Distribution: Monte Carlo Rendez-Vous*	ABT Leaders in Productivity GLOBAL FOCUS	Aug 20
Sep 8	*Distribution: Canadian RIMS*		Aug 26
Sep 15	Surplus Lines RS *Directory: Surplus Lines Insurers & Wholesalers* *Distribution: IIAA; IUMI; NAMIC; NAPSLO*	IT Employee Recruiting & Training	Sep 3
Sep 22	Reinsurance: Rendez-Vous Report *Distribution: HMIS; NAIC*		Sep 10
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RS: Reader Service, SS: Starch Study

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Annual directory of prescription benefit managers

A

ABC Healthcare Solutions

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

1996 revenues

Total gross revenues	$152,000
PBM gross revenues	$152,000
PBM unbundled revenues	$152,000

PBM clients

Total	5
Employer/group plans with direct service	5

Lives covered

Group health:

Total	80,000
Through employers	100%

Retail network

Pharmacy locations	45,000

Mail-order services

Percentage of prescription volume	2%

Generic usage

Percentage of prescription volume	45%

Staff

Total	8
Professionals	2

PBM services since: 1994.

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

Formularies offered: Open.

Pharmacies contracted: Independently owned, retail chains.

Reports provided: Generic vs. name brands dispensed analysis, employee utilization, utilization by age group.

Service area: Mountain, Northwest and Southwest regions; Florida, Kansas, Louisiana, Mississippi, Nebraska, Oklahoma, Texas.

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

Officers: Gary Michael, CEO; Dick King, president; Craig Olson, CFO; Carl Pennington, senior vp-operations; Mark Shadle, vp-pharmacy.

** Subcontracted.*

APB America

P.O. Box 27000, Jackson, Wyo. 83001; 800-733-2722; fax: 307-733-4211

1996 revenues

PBM gross revenues	$5,300,000

PBM clients

Total	1,632

Lives covered

Group health:

Total	120,000
Through employers	80%
Through third-party vendors	20%

Retail network

Pharmacy locations	45,000

Mail-order services

Percentage of prescription volume	75%

Staff

Total	25
Professionals	20

Includes: 1 registered pharmacist

PBM services since: 1994.

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

Formularies offered: Open, closed.

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: Chris Osmers, president/CEO; Don Beste, George Merchant, senior vps; Tony Cerdan, director-marketing; Michael Pruett, director-national operations; Jennifer Lenz, director-client services.

Contact: Tony Cerdan.

** Subcontracted.*

American Associated Druggists Inc. dba United Drugs

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

1996 revenues

Total gross revenues	$500,000,000
PBM gross revenues	$22,700,000
PBM unbundled revenues	$1,400,000

PBM clients

Total	30
Employer/group plans with direct service	6

Lives covered

Group health:

Total	260,000
Through employers	25%
Through Medicare/Medicaid	75%

Retail network

Pharmacy locations	15,000

Mail-order services

Percentage of prescription volume	10%

Generic usage

Percentage of prescription volume	55%

Staff

Total	40
Professionals	8

Includes: 3 registered pharmacists

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.

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including Albertsons, Kmart, Kroger, Safeway and Wal-Mart.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization pharmacy provider, member utilizations drug utilization.

Service area: Western states.

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

Officers: Bob Coulter, president; Greg Mitchell, president elect; John Saliba, treasurer; James Hills, secretary; Michael Huston, CEO.

Contact: Bruce A. Semingson, national sales manager-managed care.

** Subcontracted.*

C

Caremark Prescription Services

2211 Sanders Road, Northbrook, Ill. 60062; 847-559-4700; fax: 847-559-5256

1996 revenues

Total gross revenues	$888,000,000
PBM gross revenues	$888,000,000

PBM clients

Total	1,300
Employer/group plans with direct service	663

Lives covered

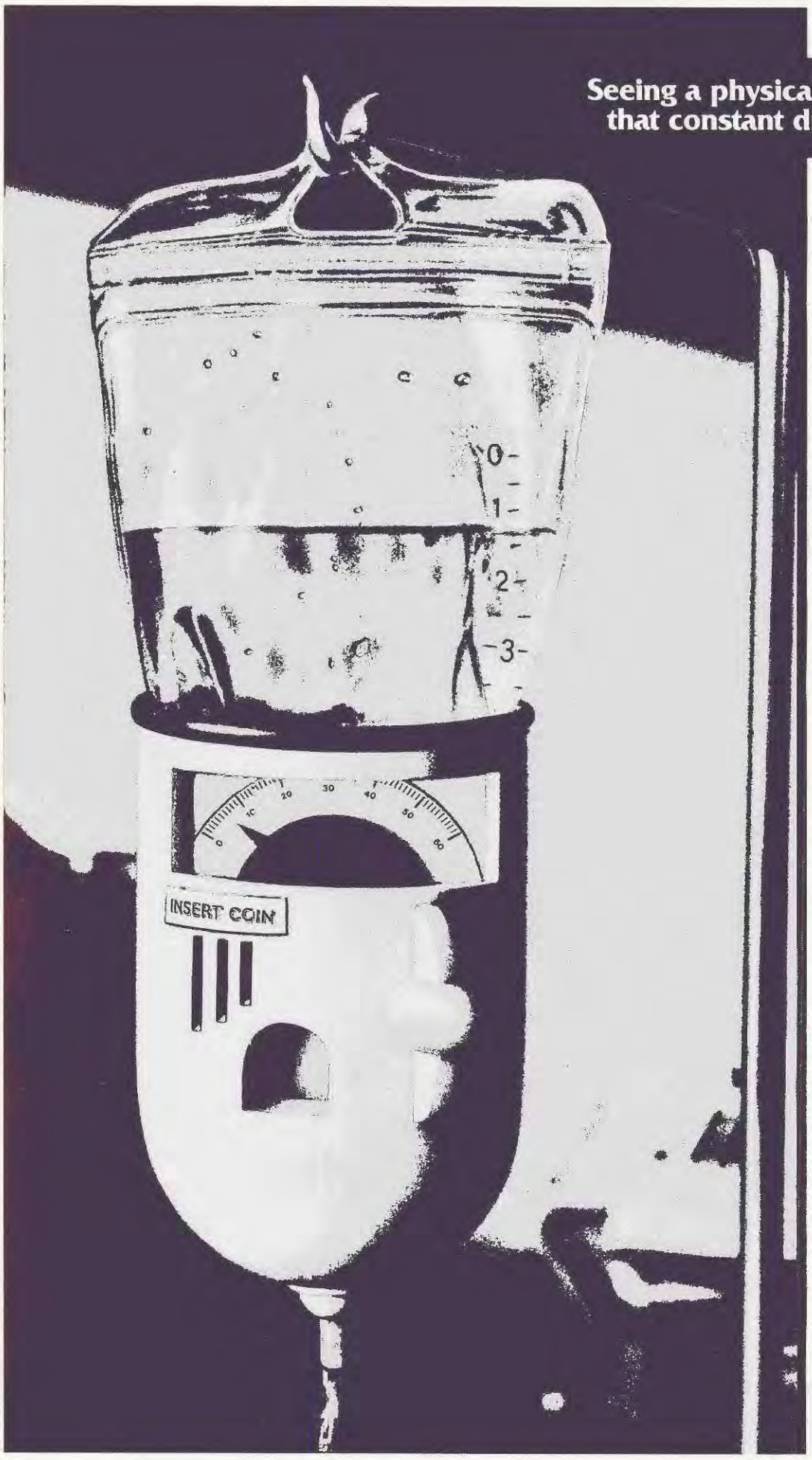
Group health:

Total	15,000,000
Through employers	75%
Through third-party vendors	15%
Through Medicare/Medicaid	10%

Retail network

Pharmacy locations	5*,000

Continued on page 32



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Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Government relations

Agents have high hopes on legislative issues

Agent/Broker Topics

Agents hope for legislative turn for the better



By REGIS COCCIA

Following some disappointments in Washington last year, agents and brokers are hopeful that legislation favorable to their business can be passed in the current session of Congress.

Priorities for the insurance industry in 1996 included tort reform, Superfund liability reform and regulation of banks selling insurance. Although several bills addressing those issues were introduced, none was enacted and President Clinton vetoed a tort reform bill.

In June of this year, however, agents and brokers were cheered by the inclusion of a proposed agent/broker licensing clearinghouse in a House banking bill, the Financial Services Competitiveness Act.

The proposal, which would create a clearinghouse run by a new National Assn. of Registered Agents & Brokers, would enable agents and brokers to operate more freely on an interstate basis, proponents say (*BI*, July 7).

Although NARAB would not grant a federal insurance license, the clearinghouse would streamline the licensing process by establishing uniform requirements and allowing agents and brokers to obtain multiple state licenses from a single source.

Currently, agents and brokers that wish to do business in more than one state must meet requirements that may vary widely. For example, while some states mandate that an agent reside there to receive a license, others do not. In addition, licensing application forms and the information that producers are required to file differ from jurisdiction to jurisdiction.

Brokers allocate a great deal of resources to licensing, which reduces their productivity, pointed out Barbara Haugen, senior vp and director of federal affairs at the National Assn. of Insurance Brokers in Washington. "Anything that is going to make things more uniform is going to help brokers' productivity," she said.

Under the legislation, all state-licensed agents and brokers that meet continuing education and other currently recognized standards would be eligible for membership in NARAB.

Among the provisions of H.R. 10, NARAB would collect licensing fees on behalf of the states. Member agents and brokers would be exempted from state residency requirements and other regulations.

In June, the House Banking Committee approved the bill. Before going to the House floor, the measure also must win the approval of the House Commerce Committee.

However, passage will take time, Washington observers note.

"We're under no illusions that we're going to be sitting at a Rose Garden ceremony at its signing in 1997," said Joel Wood, vp-government affairs for the Council of Insurance Agents & Brokers in Washington.

But, the Council is making progress on the legislation, he said. "Our members have told me this (the licensing provision) is their biggest priority. We're going to do everything we can to continue banging that drum."

"We're a long way from seeing final action on a banking bill," Ms. Haugen said. "There is a sort of rhythm to Washington; things happen in time."

Still, recent action on Capitol Hill signals good news, she said.

Legislation aimed at balancing the federal budget, on which the White House and Congress agreed last week, contains a provision on the tax treatment of foreign business that could benefit brokers operating internationally.

"I'm astounded at what happened on the tax bill," Ms. Haugen said. Despite "all of my 25 years of watching this town, I was surprised" to see Republicans and Democrats reach agreement on previously contentious issues.

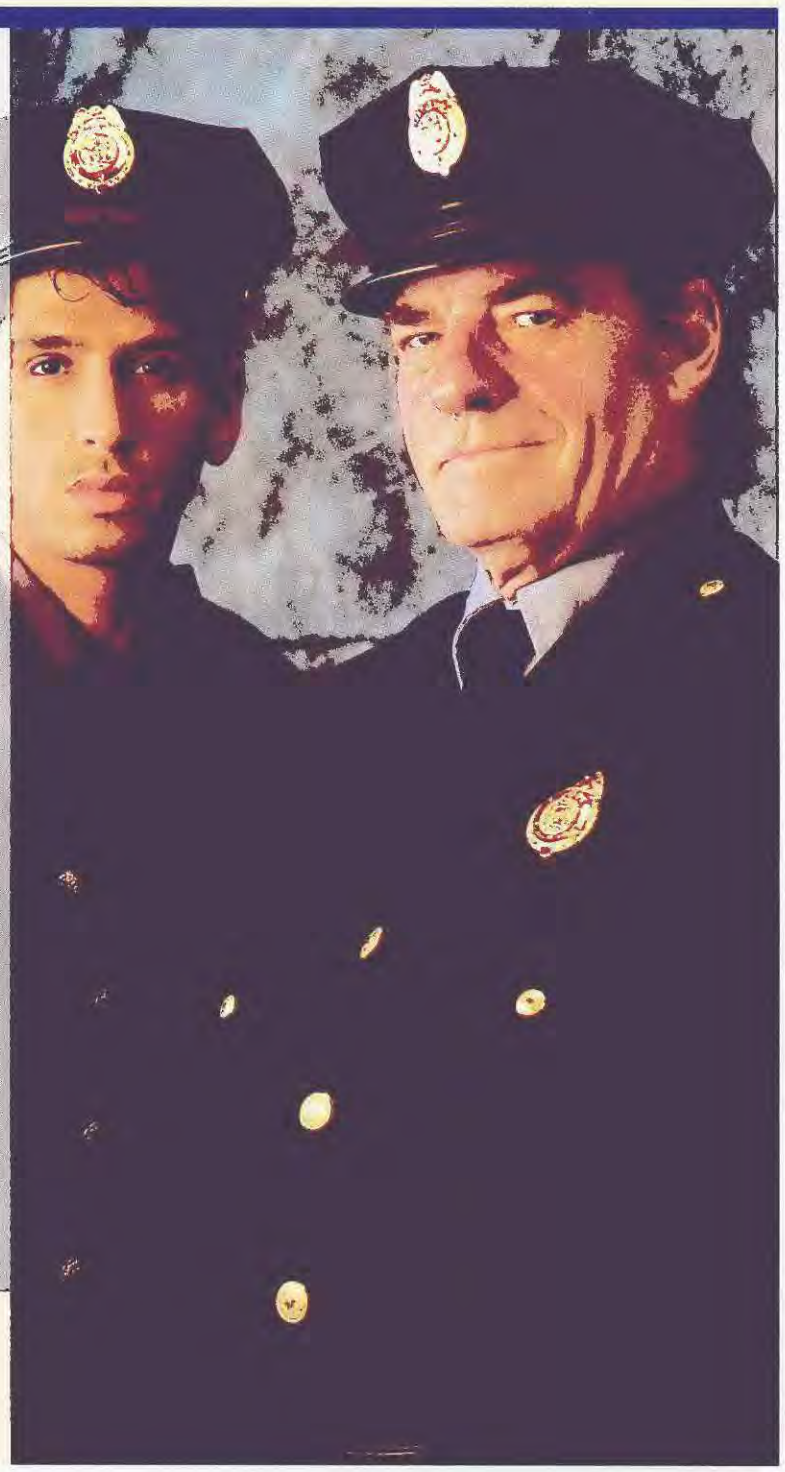
"I think there's hope for a lot of other stuff," Ms. Haugen said. Although the NAIB is not seeing "a lot of action on the broad issues affecting the industry," such as Superfund reform and product liability reform, "I don't think anything is dead yet that's important to the industry," she said.

"The toughest on the list is probably banking," Ms. Haugen said. "It's very hard to make compromises in which everybody feels good."

That can require both the in-

See **Government** *on page 30D*

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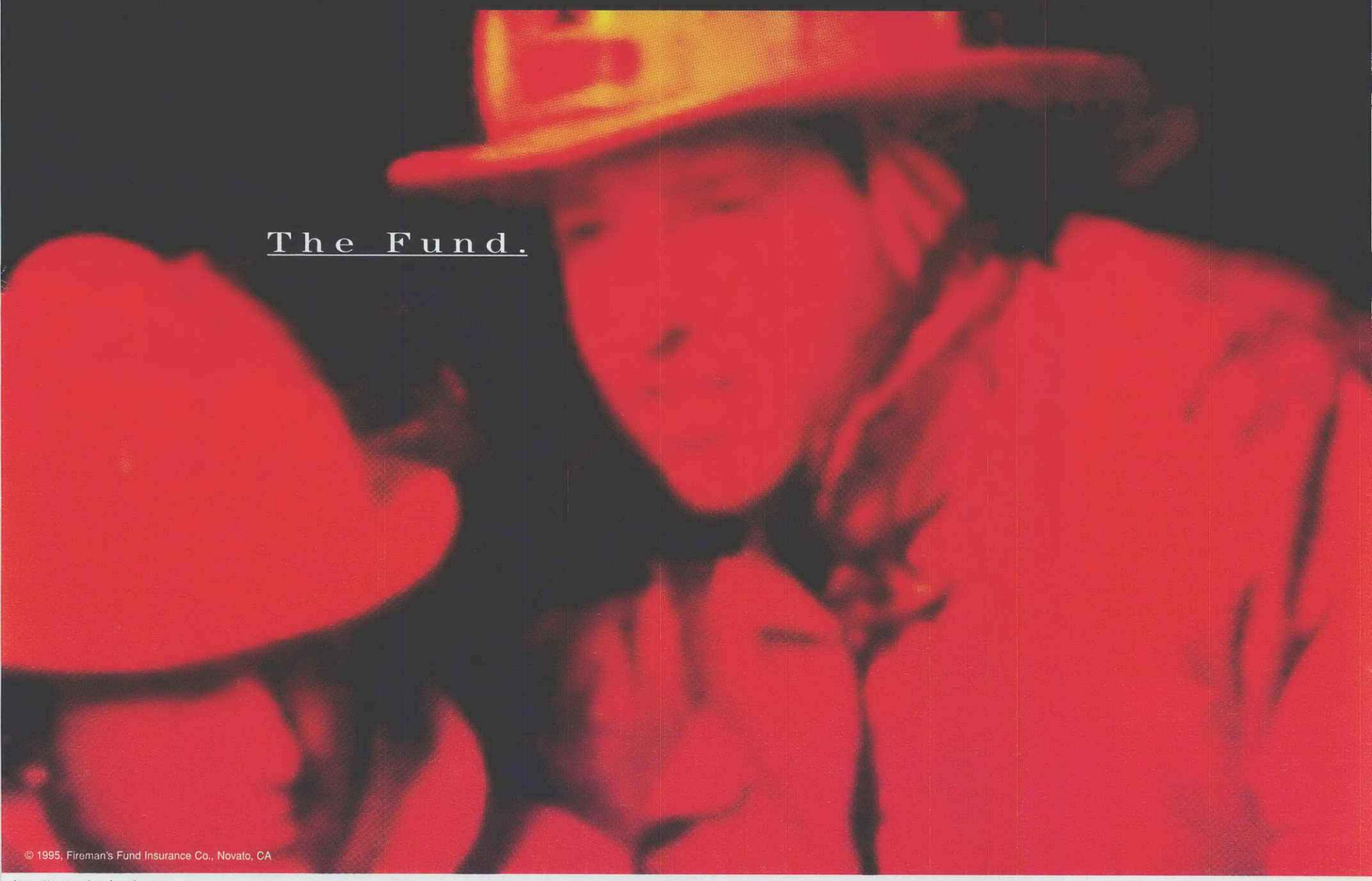
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Government

Continued from page 30B

surance industry and lawmakers to make some sacrifices to achieve their respective goals. "When you're working with legislation, you have to constantly re-evaluate" one's position, she said. "What you're willing to give up changes on the industry side, too."

Agents are monitoring a host of legislative issues, but four items are taking priority, said a spokesman in Washington for the Independent Insurance Agents of America:

• Financial services reform.

Bank sales of insurance have long been of concern to agents, and the IIAA is watching the pending banking bill closely to ensure "a level playing field," the spokesman said.

• Natural disaster response.

The Big I is supporting a natural disaster response bill that would improve the availability of insurance protection to homeowners and small businesses in catastrophe-prone areas. H.R. 219, introduced in January, would establish a federal reinsurance program to help catastrophe pools in states such as California, Florida and Hawaii, which have large exposures but limited means to cover disaster losses, the IIAA spokesman said. The bill is in the House Banking and Financial Services Subcommittee on Housing and Community Opportunity.

The Council also hopes natural disaster legislation is enacted to protect the industry against huge contingent liabilities. "Our argument is that these liabilities are on the books whether you want them there or not," Mr. Wood said.

• Small-business tax reform.

Two of the IIAA's goals, a capital gains tax cut and an increased exemption for inheritance taxes, are part of the tax bill agreement that Congress reached last week, the spokesman said. Both measures would benefit agents in operating and perpetuating their businesses.

"Many small, independent agencies end up closing on the death of the owner because they can't afford to pay the taxes," he said. The proposed inheritance tax exemption increase, to $1 million from $600,000, would help smaller agencies.

• Crop insurance.

Agents won a battle against a proposed cut in the federal subsidy to insurance companies writing crop insurance, the IIAA spokesman said. The Clinton administration proposed cutting the reimbursement level to 24% from 28% of crop insurance premiums, which would have meant lower commissions for agents handling that business.

"We fought that issue tooth and nail," he said, explaining that agents were able to raise the funding level to 27% in the House and back to 28% in the Senate. The measures are pending resolution in conference committee.

Another area that brokers are watching closely is regulation of electronic commerce. "We're very interested in the electronic commerce issue," the NAIB's Ms. Haugen said. "That's a very big issue for us."

A group of the world's largest brokers launched the World Insurance Network last month in an effort to promote electronic insurance transactions (*BI*, April 21). "Obviously, they're devoting significant resources to this issue," Ms. Haugen said.

Earlier this year, the White House recommended that Congress let industry take the lead on electronic commerce and not create barriers to electronic business transactions, she noted.

The NAIB is "quite pleased with the direction the White House is taking on this," she said. "You don't want artificial barriers set up or tariffs" on international electronic commerce. "When those things happen, they're going to add costs, which aren't productive."

Meanwhile, the industry associations say they will continue to make agents' and brokers' voices heard on the Hill.

"Being a state-regulated industry, there's not as much familiarity on Capitol Hill with the workings of our members," the Council's Mr. Wood said.

Ms. Haugen agreed: "With every Congress there are new members and there's an education part of the job. You have to teach them about your business." BI

Yates, Equale promoted to new roles at IIAA

In moves it says will increase its emphasis on core activities, the Independent Insurance Agents of America has promoted two veteran employees.

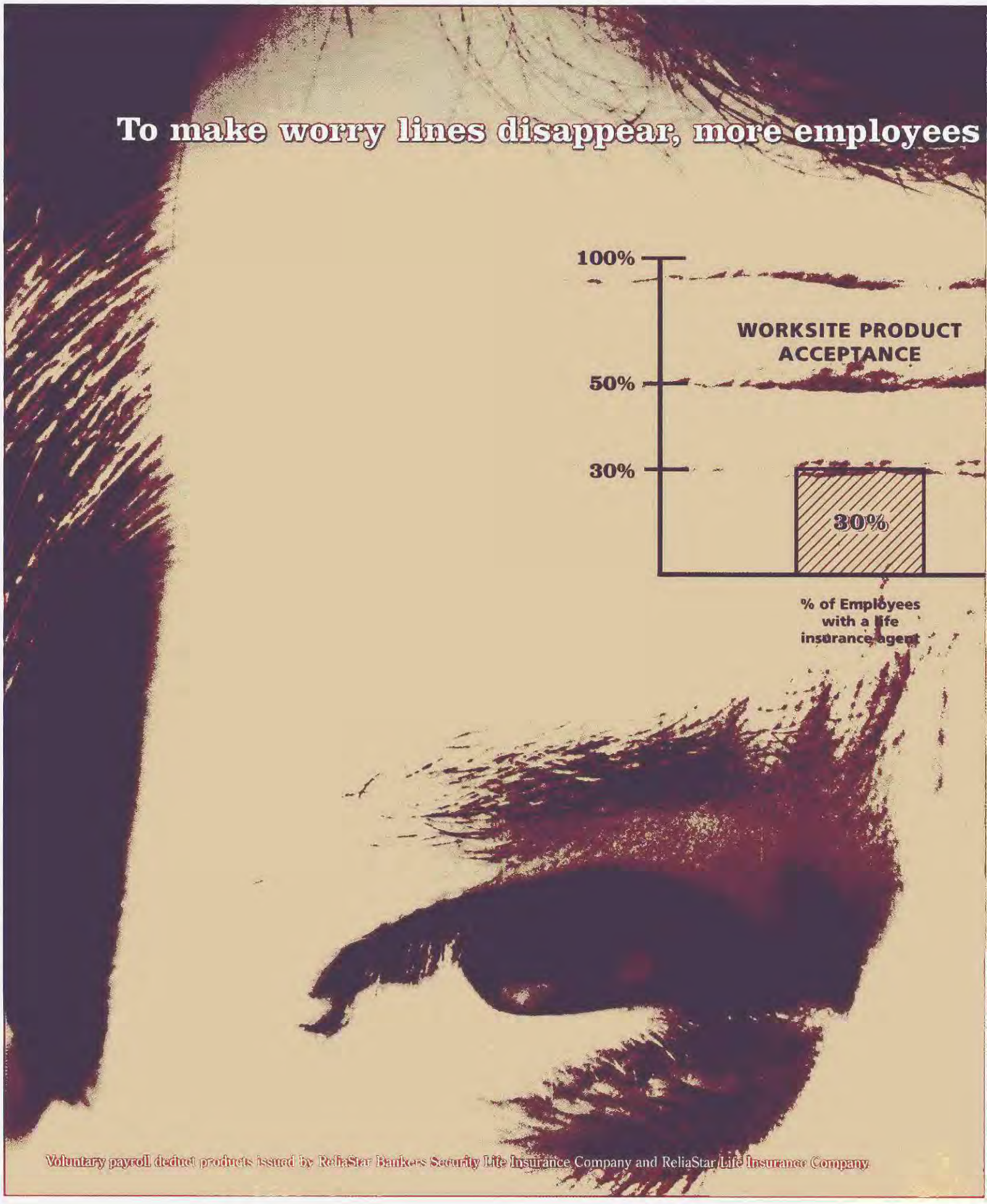
Jeffrey M. Yates has been made senior executive vp and general counsel, while Paul A. Equale has been promoted to executive vp of public affairs for the Alexandria, Va.-based association, which represents about 300,000 agents and agency employees.



Mr. Yates

In a release, IIAA President Ronald Smith said the IIAA made the staff moves in part to address the future needs of some programs and initiatives.

See **IIAA** *on next page*



IIAA

Continued from previous page

"We will have a tighter emphasis on IIAA's core activities: government affairs, company-industry advocacy, promotion of independent agents and the Big "I" logo, best practices, information and generation of non-dues revenue to support those activities," Mr. Smith said in the release.

A recent survey of state associations affiliated with the IIAA confirmed the importance of those issues, he said. "This keen focus also will provide us with more synergy between national and state IIAA activities and programs," according to the statement.



Mr. Equale

Mr. Yates, who had been executive vp and general counsel, will be responsible for overall staff operations. He is in his 22nd year with the IIAA.

Mr. Equale, who joined the IIAA in 1982, had been senior vp of government affairs. He now will be responsible for the association's government affairs, communications and information technology divisions.

The association said that as part of his new role, Mr. Equale will aim to enhance the IIAA's use of emerging technology and the Internet.

Another senior vp position has not been filled. That person will be charged with creating a profitable business entity within the association to help the group remain financially strong, the IIAA said.

More attention to its for-profit businesses will help the IIAA hold on to its industry leadership position and advocacy work, Mr. Smith said in the statement. BI

A/BT Products & Services

Reference guide

EXTON, Pa.—A revised reference on how to sell environmental insurance is available from underwriting manager ECS Inc.

"The Guide to Selling Environmental Insurance" is intended for agents and brokers who want background on environmental exposures for various industries, insurance coverages, sales techniques for new markets and tips for the bid submission process.

A new section explains opportunities for insuring brownfields redevelopment, the cleanup of contaminated property. ECS says it expects the size of such markets may double in the next five to seven years.

The 300-page guide is $95, which includes a year's updates to the manual. For more information, contact Lisa Mertz at ECS, 800-327-1414, ext. 2606.

Liability book

WASHINGTON—A booklet is available to help agents and brokers stay current on trends in professional liability when an insurer becomes insolvent.

"Agent/Broker Liability for Insurer Insolvency" was written by lawyers Scott Sinder and Ann M. Kappler, who are counsel for the Washington-based Council of Insurance Agents & Brokers.

The new edition, like the one published five years ago, focuses on insurers' financial health and how future solvency can be best achieved, the Council said in a release.

Since 1992, many states have revised their statutes or enacted new ones dealing with the allocation of duties and liability when an insurer is declared insolvent, according to the release.

The 34-page booklet is available for $15 to Council members and $50 for non-members. To order it or any other Council publication, call Wendi Slagle, 202-783-4400.

Reference guide

LANGHORNE, Pa.—A free guide is available to help agents, brokers and others evaluate and use electronic marketing media.

The guide, "Electronic Media Production Notes," covers selection, production and estimated costs of media such as radio, television, videotapes, CD-ROMs and audio programs, according to the Langhorne, Pa.-based Lighthouse Strategic Projects Group, an electronic marketing organization.

Lighthouse Principal Jerry Mainardi said in a release that "The guide was created to help industry marketers select the appropriate media based on the nature of the product or service, the offer, and the profile of the target market.

To get a free copy, contact Lighthouse Strategic Projects Group, 2080 Cabot Blvd. W., Suite 203, Langhorne, Pa. 19047, 215-750-4544; fax: 215-750-9795; e-mail: lighthou@pond.com

Web site

PHILADELPHIA—A new site on the World Wide Web is targeted to agents and brokers who want to learn more about opportunities in the alternative market.

Commonwealth Risk Management Inc. and the International Business Forum announced the site, http://www.producersforum.com.

The site will provide information such as upcoming Forum events and topics specific to the alternative market, The Producers' Forum said in a statement. BI



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Agent/Broker Topics

Following simple edicts can lead to success

By MICHAEL BRADFORD

Hire the best employees available, pay them well and concentrate on underwriting.

Those are a few of the keys to success for a couple of insurers that are among the Top 50 property/casualty insurers identified by Cincinnati-based Ward Financial Group (*BI*, Aug. 26, 1996).

Ward's annual benchmarking of insurers provides performance comparisons among companies and gives insurers an idea of best practices that can be utilized to improve operations.

"The lessons learned from this analysis," said John Ward, chairman of Ward Financial Group, "is that companies that focus on the fundamentals. . .are more likely than not the top performers."

Mr. Ward was moderator of a panel discussion at the Seventh Canadian Insurance Congress this spring in Charlottetown, Prince Edward Island. He emphasized that the "overall message" delivered by the annual benchmarking is that any company can become a high performer by working on business fundamentals.

Executives from Erie Insurance Group and AVEMCO Insurance Cos., two insurers that were among the Top 50 last year, joined Mr. Ward at the session.

"I believe the key reason for our success is centered around our stability, our consistency and our culture," said Stephen Milne, president and chief executive officer of Erie Insurance Group in Erie, Pa.

"We've understood our basic mission, and we've stuck to it, through thick and thin, through all the underwriting cycles, even this 10-year cycle that seems it will never end," he said.

For the most part, change at Erie has been "very conservative and slow," he emphasized. However, in 1990 the primarily personal lines underwriter instituted a reinsurance department. "We write $68 million in reinsurance; it's been extremely profitable. But that was a major change for us," he said.

Mr. Milne maintains the insurer has not changed its underwriting philosophy much since he joined the company in 1973.

"Our idea of a good risk—notwithstanding things like pollution and lead and things of that nature—is the same today as it was back then."

Ray Hall, president of Frederick, Md.-based AVEMCO, said there is no compromise when it comes to underwriting at his company. "Underwriting profitability is a given at AVEMCO," he said. "We rarely discuss it. It goes without saying."

AVEMCO, a direct writer, depends on its force of "sales underwriters," stationed throughout the United States and Canada, to produce business, Mr. Hall explained. The network of underwriters is supported through computer technology that ties them into the home office.

Erie depends on independent agents for business. Those agents know they can count on the insurer's stability, a quality that's becoming rare in the current marketplace, Mr. Milne said. In return, the insurer wants a stellar underwriting effort from agents, who have binding authority. "We stress underwriting to the extreme," Mr. Milne said.

He pointed out that Erie picks its agents carefully.

"When we went into New York state in 1995, we interviewed over 300 agencies to appoint 30," he said. "We're extremely selective relative to our agents' appointments."

When an agent is selected, generally after five interviews and six months of gathering and checking references, Erie wants a commitment that it will be the top insurer in that agency within a "reasonably short period of time. If they're not open to that, then we won't appoint the agency," Mr. Milne said.

Agents who turn in subpar underwriting results are required to go through Erie's "agency review process" each March to determine how such results can be reversed.

Mr. Milne pointed out that in-house relations also are an important part of maintaining a successful culture for an insurance company.

In its 72-year history, the insurer has never had a layoff. "That's an internal corporate guideline that I think is critical to our success," Mr. Milne stated.

Erie's workers are paid well, about 13% more than they would get at a competitor, he pointed out. "If you pay good people, if you get good people, you win."

Erie's culture is "extremely people-oriented," according to Mr. Milne. "That includes all three of our constituencies, which are our policyholders, our employees and our independent agents."

Another key to success for insurers, according to AVEMCO's Mr. Hall, is speedy claims handling.

"All of our claims are handled as expediently and liberally as humanly possible," he said. "It's really the only way to go."

A weekly claims review looks at claims that aren't closed quickly, Mr. Hall said. "We've found that claims rarely get better with age," he noted, so an ongoing effort is under way to put them to rest.

Also on the panel was Peter R. Kensicki, professor of insurance at Eastern Kentucky University in Richmond, Ky. BI

No end in sight on M&A front

Industry consolidations driven by several factors: Report

By HOLLY SIMPSON

Brokers can expect mergers and acquisitions among their ranks to continue, according to a recent report.

The insurance industry also can expect increasing influence of financial services companies and more catastrophe losses, especially in the Eastern and Southeastern United States, according to the report, "Insurance Market Trends and Developments," from Memphis, Tenn.-based broker Sedgwick Inc., a unit of Sedgwick Group P.L.C.

Charles Fiske, senior vp of Sedgwick Inc., said he thinks that it is too early to tell what effect the megamergers of the past year will have on insurance markets.

Opportunistic buyers looking for sellers weakened by losses, buyers trying to enter niches and the increasing need to operate globally will drive the consolidations, the report says.

Ken Crerar, president of the Washington-based Council of Insurance Agents & Brokers, agreed that M&A activity will continue.

"I think we will continue to see consolidation on the agent/broker side as much as we have in the last 18 months," Mr. Crerar said. "I think it will continue at a faster rate in part because of financial services entering the industry. It bodes well for a lot of mergers."

Mr. Fiske said insurance is the only piece of business that banks are missing, and their increasing involvement in property/casualty insurance will have a great impact in rural areas and smaller cities.

"Insurance companies make joint ventures with banks to produce policies on small businesses. It's really nothing new," he said. "They've been doing it for years, selling life and disability insurance to banks."

Mr. Crerar said that while part of the rapid changes in the marketplace are a result of financial services moving into insurance, the insurance industry can learn some lessons by watching the banking industry.

"It's more a movement of insurance as a financial service than it is a movement of financial services into insurance," he said. "Banks are moving into our business in a big way . . . .It's a different perspective, and it will have an impact in the long run. The way to get bigger is to buy."

"This industry is going through its maturing process," he said of brokers, adding that other industries are undergoing the same. "It's good for our industry, and it's ultimately good for the client."

As competition continues to reduce insurance costs, attracting new customers grows more difficult.

Mr. Fiske said new business is harder for insurers to obtain, because though the incumbent can almost always match competitors' offers, customers are demanding incentives and lower prices.

Another trend the Sedgwick report looked at is cat loss protection.

The report warned that catastrophes, particularly along the East Coast from Cape Cod to Florida, will increase over the next several years, partially as a result of heightened development in coastal areas.

"I think, for example, in Florida, you'll see (hardening of). . .catastrophe markets for wind and flood," said Mr. Fiske.

"I know that the commissioner of insurance in Florida is working hard to see that people have the protections they need for hurricanes," he said. But, if it doesn't happen quickly enough, it's going to affect the market in Florida, decreasing the competition and making coverage harder to come by if catastrophe programs aren't put together as in California, Mr. Fiske added.

In September, the state of California launched the California Earthquake Authority, a catastrophe pool for homeowners. The CEA's organizers had considered using the capital market to finance high layers of coverage, but in the end went with traditional reinsurance (*BI*, Nov. 25, 1996).

"I think it takes a huge burden off the domestic carriers to provide needed protection for the clients of that state," said Mr. Fiske. "It's only going to be good for the consumers, because they'll have more choices. It's more competitive, and I think in the end, both carriers and consumers win."

Increased catastrophes would tighten the property/casualty market, said the Council's Mr. Crerar, who added it's time to look at mitigating issues as a way to reduce potential losses in susceptible areas.

Natural disaster response legislation now pending in Congress would create a federal reinsurance program to help state catastrophe pools, a step Mr. Crerar said is necessary to provide the needed coverage.

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Broker pleads not guilty to theft charges

Charges spur review by other public entity clients

By JULIE JOHNSSON
Crain News Service

An insurance broker and claims administrator who specializes in state and local government entities is under intense scrutiny by a growing number of his public-sector clients.

Frank Rousseau faces an Oct. 20 trial on charges that he stole $140,000 between 1994 and 1996, while administering property and casualty insurance claims for Will County, Ill.

Mr. Rousseau, of Bolingbrook, Ill., has pleaded not guilty and will ask the court to dismiss the case.

However, the charges prompted the Kendall County, Ill., board last week to drop its health care contract with Mr. Rousseau. And the Illinois State Toll Highway Authority is auditing all of its health care claims processed by Mr. Rousseau over the past two years.

Meanwhile, regulators in Nevada also are investigating Mr. Rousseau's dealings as a third-party administrator of municipal health care claims, according to a spokeswoman for the Nevada Department of Insurance.

Nevada has temporarily suspended Mr. Rousseau's third-party administrator license and barred his company from soliciting new business in the state.

Mr. Rousseau manages health care contracts of self-insured municipalities in Illinois, Nevada and California.

Mr. Rousseau also used to administer property and casualty insurance contracts in Illinois, typically subcontracting with another firm to perform the actual claims processing.

However, Mr. Rousseau is legally barred from performing these services because his Illinois insurance license lapsed in 1996, according to Will County prosecutors.

Douglas Roller, Mr. Rousseau's attorney, charges that the widening inquiries into his client's dealings are "all orchestrated from Will County."

Mr. Rousseau has pleaded not guilty to the four criminal and two misdemeanor counts pending against him in Will County, and will file a motion in early August to dismiss the charges, Mr. Roller says.

He attributes the funds allegedly misappropriated by Mr. Rousseau to "sloppy bookkeeping and a misunderstanding of the process by the Will County Board."

Will County fired Mr. Rousseau as claims administrator for its $1 million property/casualty program last October, after discovering that the Bolingbrook broker's state insurance license had lapsed in May 1996, said Jonathon Dopkeen, risk manager for the county.

A subsequent audit showed that Mr. Rousseau billed the county $160,000 annually to administer the contracts, subcontracted these services to Chicago-based Martin Boyer Co. for about $90,000 and allegedly pocketed the $70,000 difference, according to Mr. Dopkeen.

A 1994 county resolution limited Mr. Rousseau's administrative fees for all services to 10% of the roughly $900,000 in the county's annual policy premiums, or $90,000—which was far less than the $160,000 billed by one of Mr. Rousseau's companies, Rousseau Insurance Management Corp., Mr. Dopkeen said.

"There was no way to argue this was an appropriate commission on a fee," he said.

The May 21 grand jury indictment charged Mr. Rousseau with "misrepresenting the total dollar amount of the Martin Boyer Co.'s fees for administering the county of Will's general liability and workers compensation plans."

The four-count indictment spurred the county to launch a massive audit of the roughly $6 million in annual preferred provider organization claims processed between 1987 and 1994 by Mr. Rousseau's Bolingbrook, Ill.-based Suburban Health Care Benefits. That company changed its name to L&H Administrators Inc. earlier this year.

Meanwhile, other government entities are also taking a close look at Mr. Rousseau's business dealings.

The board of Kendall County, Ill., voted earlier this month to terminate Mr. Rousseau's PPO contract as soon as a replacement can be found. The county also is considering auditing the health care claims processed by Mr. Rousseau over the past six years, said Tim McCann, Kendall County state's attorney.

This action is prompted by "concern over the indictments in Will County and the actions taking place in Nevada," Mr. McCann added. "There's no documentation that there has been any impropriety in Kendall County's (claims) handling at all."

The Illinois State Toll Highway Authority, meanwhile, has launched an internal audit of health care claims handled by Mr. Rousseau, said a spokesman. For now, L&H remains the toll authority's third-party administrator, but the agency will review that contract when it expires in October.

Nevada is examining whether another Rousseau company transferred $800,000 to an out-of-state account and commingled funds from several self-insured employers, according to court documents.

At an Aug. 12 hearing, Nevada's Department of Insurance will decide whether to permanently suspend Mr. Rousseau's third-party administrator license. BI

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A/BT Briefs

Assessing reinsurers

MONTE CARLO, Monaco—How to measure the quality of reinsurers is the topic of a seminar during this year's Rendez-Vous de Septembre.

The annual reinsurance meeting, which attracts insurers, reinsurers, brokers, consultants, attorneys and others, will be held in Monte Carlo Sept. 8-13.

"In recent years, the 'quality' of reinsurance companies has been predominantly discussed by their financial strength, premium volume and other financial criteria. . . .Although financial stability is still of paramount importance, a trend toward a supplementary assessment of so-called 'soft factors' can be observed," the conference's organizers state.

The seminar on how to measure reinsurer quality will be held Sept. 9 and will feature several speakers:

- Michael Muth, a director of McKinsey & Co. in Munich, Germany.
- Bernd Michaels, president of the German Insurance Assn. and chairman of Provinzial Feuerversicherungsanstalt der Rheinprovinz in Bonn, Germany.
- Denis Kessler, deputy chairman of AXA-UAP Group in Paris.
- John Kriz, managing director of Moody's Investors Service Inc. in New York.

For more information on the Rendez-Vous, contact Le Bureau des Rendez-vous de Septembre, Centre de Congres Auditorium de Monte-Carlo, Boulevard Louis II, Monte Carlo, MC 9800 Monaco; phone 377-92-16-6050; fax: 377-92-16-6135.

BIPAR officers

BUDAPEST, Hungary—A global broker association has elected two members of the Council of Insurance Agents & Brokers to serve three-year terms as vice presidents.

The new BIPAR vps are:

- Charles R. Adams, the first non-European to reach officer level, according to the Council. Mr. Adams is president of Adams & Son Inc., an Auburn, N.Y.-based brokerage.
- Hugh D. Goverey, managing director of corporate brokering for Coyle Hamilton Ltd. in Dublin, Ireland. Coyle Hamilton last year became the first international firm to belong to the Council.

The two broker executives will serve on committees of the Bureau International des Producteurs des Assurances, whose membership comprises 51 associations, the CIAB said. BI

Brokers form network to boost performance

A group of highly productive independent agents and brokers has formed a new network called RiskProNet International.

The approximately 25 companies involved represent about $1.5 billion in written premium and have an average revenue per employee of about $105,000, said Steve Tanner of Tanner Insurance Brokers in Pleasanton, Calif.

Mr. Tanner, along with John Langsfeld of Merritt & McKenzie Agency in Atlanta and Michael Flynn of Diversified Risk in Emeryville, Calif., founded the network. The idea is about a year and a half old, Mr. Tanner said.

Insurers and consultants were contacted to get ideas on high-performing agencies that might make good members, Mr. Tanner said.

He said such a network of strong partnerships is needed in order for agencies such as his to serve their clients as the major brokerages do. He noted that the Assurex International brokerage network is a "good model for where we are going."

Each member put up an equal amount of capital to launch the network, though Mr. Tanner declined to disclose the amount.

The RPN network will be connected through a unique and proprietary software program now operational and available to the founding members.

"We are extremely excited about the ability to directly communicate with each other on all kinds of issues," Mr. Langsfeld said in a statement.

The intranet software will allow members to deal with a host of issues in different states, including underwriting, marketing, product distribution, countersignature and new product development. Because the agencies are in different regions of the country, they are not competing directly.

"Eventually, we expect to have up to 30 agents located in key designated cities throughout the United States," said Mr. Flynn of Diversified Risk in the statement. "And we believe this network will give us a competitive edge in the future and will allow client access for service delivery and risk management assistance."

Membership, which is by invitation only, will not be limited to the United States. In fact, a large Montreal-based brokerage, B.F. Lorenzetti & Associates Inc., already has agreed to join the new organization as a founding member.

"During the next 12 months, we also expect to build a very strong network internationally," Mr. Tanner added in a statement. "And when we do, we will be a significant competitor in the marketplace, able to communicate with other members on a worldwide basis in order to serve our clients more effectively."

The network has a Web site at www.riskpronet.com. BI

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2. Number of employees:
1 ❑ 150 or less 2 ❑ 151 - 499 3 ❑ 500 - 999 4 ❑ 1,000 - 4,999 5 ❑ 5,000 or more 6 ❑ Unknown

3. My title is best defined as:
A ❑ Administrative Mgt B ❑ Financial Mgt C ❑ Risk Mgt D ❑ Benefits Mgt E ❑ Loss Prevention Mgt F ❑ Other_____

4. My purchasing involvement for the requested products is to:
1 ❑ recommend only 2 ❑ specify 3 ❑ approve

5. Do you now receive a personally addressed copy of *Business Insurance*?
A ❑ Yes B ❑ No, so please send subscription info

Circle the numbers below that correspond to the companies listed on our Advertiser Index for the **August 4, 1997** issue. Cards with more than 20 items circled will not be processed. This card expires **September 29, 1997**.

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16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
31 32 33 34 35 36 37 38 39 40 41 42 43 44 45
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Company_____
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Phone ( )_____



"I didn't want a one-size-fits-all program."

Barbara, 33, Human Resources Manager,
mid-size company, Houston, TX

When Barbara's CEO decided to upgrade the company's mental health coverage, she looked for a program that would accommodate her employees' individual needs and fit her budget. With Merit, Barbara discovered that she could create a tailored program that offered a range of service and provider options. Merit's unique flexibility gave her exactly what she required — value, choice and high quality care.

Tailor-made and well-suited for Barbara and her employees.

MBC Merit Behavioral Care Corporation
1-800-436-4111 ▪ www.mbc-ret.com

Continued from page 30

Mail-order services

Percentage of prescription volume 36%

Generic usage

Percentage of prescription volume 45%

Staff

Total 6,000
Professionals 2,000
Includes: 300 registered pharmacists

PBM services since: 1984.

Parent: MedPartners; primary business: physician practice 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, case 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.

Service area: Nationwide.

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

Officers: Michael Cannizzaro, president; Todd Martin, senior vp-field management; Richard Scardina, senior vp-operations management; Jay Messeroff, senior vp-clinical services/trade relations; Mark Thierer, vp-marketing/field operations; John Moss, vp-quality assurance/regulatory affairs; Cliff Berman, vp-legal.

Contact: Todd Martin.

CLAIMSPRO Health Claims Services Inc.

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

1996 revenues

Total gross revenues $5,092,008
PBM gross revenues $4,837,407
PBM unbundled revenues $3,309,805

PBM clients

Total 7,000
Employer/group plans with direct service 800

Lives covered

Group health:
Total 900,000
Through employers 75%
Through third-party vendors 23%
Through Medicare/Medicaid 2%

Retail network

Pharmacy locations 40,000

Mail-order services

Percentage of prescription volume 3%

Generic usage

Percentage of prescription volume 40.5%

Staff

Total 35
Professionals 18
Includes: 1 registered pharmacist

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.

Pharmacies contracted: Independently owned; retail chains, including Arbor Drugs, Eckerd, Kmart, Kroger, Meijer, Revco, Rite-Aid, Walgreens and Wal-Mart.

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

Service area: United States, nationwide; Puerto Rico; Virgin Islands.

Billing methods: Capitated rate, fee per claim.

Officers: Ron Klein, executive vp; Bruce Liebowitz, president; Jeff Pultorak, vp-information systems.

Contact: Ron Klein.

** Subcontracted.*

Eckerd Health Services

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

Continued on page 34

Who gives Kaiser Permanente its annual checkup?

the answer is Deloitte & Touche

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Explanation of terms used in this directory

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

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

Listings begin with the company name, address, phone number and fax number. The category **1996 revenues** includes total gross revenues, gross revenues generated from PBM services and gross revenues from unbundled PBM services. The **PBM clients** section specifies total clients for which prescription benefit management services were provided, as well as the number of employer/group plans who contracted directly with the company in 1996.

Lives covered includes total **group health** plan lives (both eligible and active), active group health enrollees and active **workers compensation** enrollees in 1996. Active enrollees are defined as those participants who actually received prescriptions through the plan. 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 is also provided.

Retail network information includes the number of pharmacies who participate in the company's network. The percentage of prescriptions filled through **mail-order services** and the percentage of prescriptions filled with **generic** equivalents is listed next.

Staff information, given in full-time equivalents for 1996, details the total number of staff members, as well as the total number of professionals, assigned to prescription benefit management services (not including sales or marketing staff).

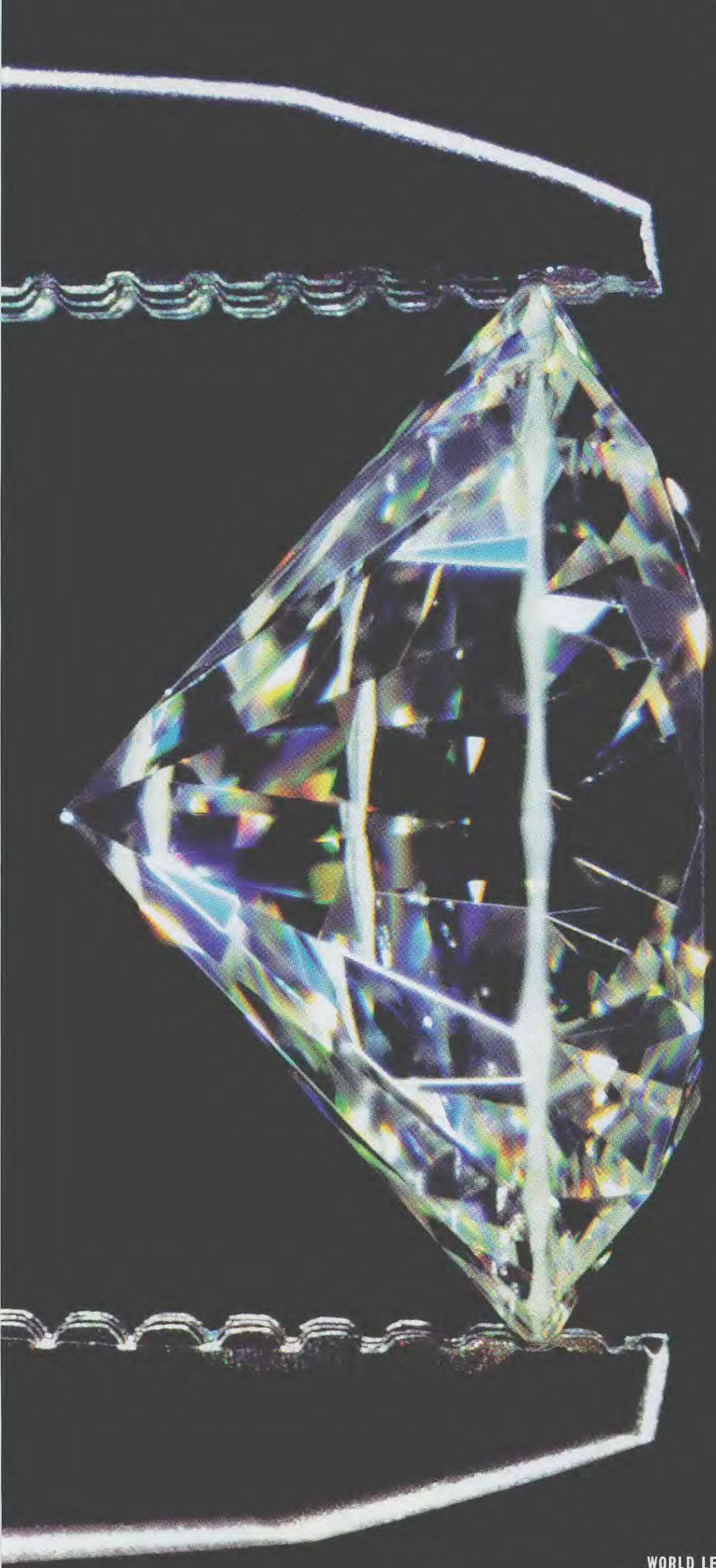
PBM **services** offered by the company are identified next, and services provided through a subcontracted organization are indicated with a footnote.

Network design specifies the type or 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 and names, if provided, of **pharmacies** participating in the network, the types of **reports** provided to the client and the **service area** and **billing methods** offered. If volume discounts are given to employer clients, it is so noted.

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

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



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WORLD LEADERS IN INSURANCE AND FINANCIAL SERVICES

American International Group, Inc., 70 Pine Street, New York, NY 10270

AIG

Continued from page 32

1996 revenues

Total gross revenues	$591,000,000
PBM gross revenues	$9,000,000

PBM clients

Total	170
Employer/group plans with direct service	135

Lives covered

Group health:

Total	2,000,000

Retail network

Pharmacy locations	48,100

Staff

Total	1,000
Professionals	102

Includes: 14 registered pharmacists

PBM services since: 1994.

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, network pharmacy utilization, disease state management.

Service area: Nationwide.

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

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

Contact: George Watt, 412-967-2323.

The directory begins on page 30. An explanation of terms used in this directory is on page 32.

F

FFI Health Services

8536 Crow Drive, Macedonia, Ohio 44056; 216-467-9898; fax: 216-468-3847

1996 revenues

Total gross revenues	$15,000,000
PBM gross revenues	$15,000,000
PBM unbundled revenues	$15,000,000

PBM clients

Total	2,000

Lives covered

Group health:

Total	600,000
Active enrollees	400,000*
Through employers	90%
Through third-party vendors	10%

Retail network

Pharmacy locations	28,000

Mail-order services

Percentage of prescription volume	2%

Staff

Total	40
Professionals	5

Includes: 3 registered pharmacists

PBM services since: 1993.

Parent: First Florida Int'l Holdings INc.; primary business: TPA

Services: Retail pharmacy network, claims processing, online claims processing, concurrent utilization review, benefit design consulting, formulary management/review.

Formularies offered: Open, restricted/customized.

Pharmacies contracted: Independently owned, retail chains.

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

Service area: Nationwide.

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

Officers: Paul Wutz, president; John Puls, senior vp; James J. Mindala, executive vp.

Contact: Jim Mindala.

** Estimate.*

First Health Services Corp.

4300 Cox Road, Glen Allen, Va. 23060; 800-884-2822; fax: 804-527-6849

1996 revenues

Total gross revenues	$248,000,000
PBM gross revenues	$40,000,000
PBM unbundled revenues	$15,000,000

PBM clients

Total	900
Employer/group plans with direct service	850

Lives covered

Group health:

Total	8,000,000
Active enrollees	7,000,000
Through employers	25%
Through third-party vendors	45%
Through Medicare/Medicaid	30%

Retail network

Pharmacy locations	46,000

Mail-order services

Percentage of prescription volume	10%

Generic usage

Percentage of prescription volume	45%

Staff

Total	350
Professionals	110

Includes: 35 registered pharmacists

PBM services since: 1972.

Parent: HealthCare COMPARE Corp.; primary business: HMO/PPO.

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, risk sharing. Volume discounts to employers.

Officers: Teresa R. DiMarco, president; James G. Council, vp/corporate counsel; David W. Norton, senior vp-pharmacy operation.

Contact: Thomas Fagan, director-marketing support.

** Subcontracted.*



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G

GenPlus Managed Care Inc.

80 Marcus Drive, Melville, N.Y. 11747; 516-845-8460; fax: 516-845-8488

1996 revenues

Total gross revenues	$50,000,000
PBM gross revenues	$5,000,000

PBM clients

Total	32
Employer/group plans with direct service	22

Lives covered

Group health:

Total	150,000
Through employers	70%
Through third-party vendors	30%

Retail network

Pharmacy locations	46,000

Mail-order services

Percentage of prescription volume	20%

PBM services since: 1996.

Parent: Genovese Drug Stores; primary business: retail drug stores.

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.

Pharmacies contracted: Independently owned, retail chains.

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

Service area: Connecticut, New Jersey, New York.

Billing methods: Fee per claim.

Officers: Wayne Nash, president; Eileen Rainis, vp-administration; Chris Noonan, controller; Gene Wexler, vp/legal

Continued on page 36

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Continued from page 34

counsel; Kerry Benson, vp-sales.
Contact: Kerry Benson, 516-845-8650.
** Subcontracted.*

Integrated Pharmaceutical Services

3400 Data Drive, Rancho Cordova, Calif. 95670; 916-853-8758; fax: 916-853-5225

1996 revenues

Total gross revenues	$300,000,000
PBM gross revenues	$275,000,000
PBM unbundled revenues	$15,000,000

PBM clients

Total	125
Employer/group plans with direct service	25

Lives covered

Group health:	
Total	12,000,000
Active enrollees	10,000,000
Through employers	35%
Through third-party vendors	40%
Through Medicare/Medicaid	25%
Workers compensation:	
Active enrollees	25,000

Retail network

Pharmacy locations	45,000

Generic usage

Percentage of prescription volume	37%

Staff

Total	125
Professionals	35

Includes: 30 registered pharmacists

PBM services since: 1994.

Parent: Foundation Health Systems; primary business: HMO/PPO.

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: Michael Cartier, president/CEO; Barry Katz, vp-managed care services; Kevin Nagle, vp-sales/marketing; Dr. James Bonnette, vp/medical director.

Contact: Kevin Nagle.
** Subcontracted.*

INTEQ

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

1996 revenues

PBM gross revenues	$5,000,000

PBM Clients

Total	600
Employer/group plans with direct service	150

Lives Covered

Group health:	
Total	1,000,000
Active enrollees	800,000*
Through employers	40%
Through third-party vendors	55%
Through Medicare/Medicaid	5%
Workers compensation:	
Active enrollees	200,000
through employers	100%

Retail network

Pharmacy locations	43,000

Mail-order services

Percentage of prescription volume	12%

Generic usage

Percentage of prescription volume	42%

Staff

Total	40
Professionals	35

Includes: 2 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-administration/finance; John Teichgraeber, vp-sales/marketing; Patti Carr, vp-pharmacy operations.

Contact: John Teichgraeber.
** Estimate.*
*** Subcontracted.*

Managed Pharmacy Benefits Inc.

1100 N. Lindbergh Blvd., St. Louis, Mo. 63132; 314-585-5051; fax: 314-872-5500

1996 revenues

Total gross revenues	$500,000
PBM gross revenues	$500,000

PBM clients

Total	362
Employer/group plans with direct service	36

Lives covered

Group health:	
Total	1,700,000
Active enrollees	1,300,000
Through employers	20%
Through third-party vendors	80%
Workers compensation:	
Active enrollees	1,000
through employers	10%

Retail network

Pharmacy locations	45,000

Mail-order services

Percentage of prescription volume	7%

Generic usage

Percentage of prescription volume	49%

Staff

Total	35
Professionals	20

Includes: 7 registered pharmacists

PBM services since: 1989.

Parent: Cardinal Health Inc.; primary business: prescription drug distribution.

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 Albertsons, City Market, King Sooper, Kmart, Medicine Shoppe, Leader Drug Stores, Payless United Drug, Revco, Thrift and Wal-Mart.

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

Service area: United States, nationwide; Puerto Rico.

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

Officers: Kent Friedman, vp/general manager; Dan Schneider, Hugh Mugfor, Rod McCann, managers-regional sales/marketing; Janet Rodgers, manager-administrative services; Dean Nicholson, controller.
** Subcontracted.*

Merck-Medco Managed Care L.L.C.

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

1996 revenues

PBM gross revenue	$8,100,000,000

PBM clients

Total	2,000

Lives covered

Group health:	
Total	49,200,000

Retail network

Pharmacy locations	55,000

Staff

Total	11,000

Includes: 1,200 registered pharmacists

PBM services since: 1983.

Parent: Merck & Co. Inc.; primary busi-

Continued on page 38

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(ONE-FORM PROCAP COVERAGE CREATED: 1997)

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Continued from page 36

ness: 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.

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

Service area: United States, nationwide; Puerto Rico.

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

Officers: Per Lofberg, president.

A detailed explanation of the terms used in this directory can be found on page 32.

National Pharmaceutical Services

14748 W. Center Road, Suite 325,
Omaha, Neb. 68144; 402-334-2677;
fax: 402-334-4475

1996 revenues

Total gross revenues	$2,500,000
PBM gross revenues	$1,500,000
PBM unbundled revenues	$1,500,000

PBM clients

Total	450
Employer/group plans with direct service	450

Lives covered

Group health:	
Total	350,000
Active enrollees	47,000
Through employers	65%
Through third-party vendors	35%

Retail network

Pharmacy locations	47,000

Mail-order services

Percentage of prescription volume	10%

Generic usage

Percentage of prescription volume	83%

Staff

Total	12
Professionals	7

Includes: 5 registered pharmacists

PBM services since: 1994.

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

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including CVS, Eckerd, Long's, Osco, Publix, Revco, Tom Thumb, Vons, Walgreens and Wal-Mart.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, per member per month projections, top prescription providers by cost/prescription volume.

Service area: Midwest, South, West.

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

Officers: Mike Makoid, CEO; Douglas M. Pick, president/COO; Angela Pieper, CFO; Bill Fleming, medical director; Melissa Schreifels, director-HMO/pharmacy.

Contact: Douglas M. Pick.

Pharmacy Services Group of Florida

1100 N.E. 51st St.,
Fort Lauderdale, Fla. 33334;
954-938-9980; fax: 954-938-7984

1996 revenues

Total gross revenues	$7,000,000
PBM gross revenues	$4,000,000
PBM unbundled revenues	$3,000,000

PBM clients

Total	175
Employer/group plans with direct service	10

Lives covered

Group health:	
Total	400,000
Active enrollees	170,000
Through employers	20%
Through third-party vendors	80%

Retail network

Pharmacy locations	40,000

Mail-order services

Percentage of prescription volume	30%

Generic usage

Percentage of prescription volume	60%

Staff

Total	30
Professionals	5

Includes: 3 registered pharmacists

PBM services since: 1983.

Parent: Managed Healthcare Systems Inc.; primary business: 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, prescription software.

Formularies offered: Open, closed, restricted/customized.

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

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: Kenneth Sack, CEO; Gina Hunt, director-client services; Stanley Friedman, director-professional services; Martin Duberstein, director-marketing.

Contact: Kenneth Sack.

Pro-Mark Holdings Inc.

33 North Road, Peace Dale,
R.I. 02883; 401-782-0702;
fax: 401-788-9909

1996 revenues

PBM gross revenues	$283,159,000

PBM clients

Total	353
Employer/group plans with direct service	5

Lives covered

Group health:	
Total	1,100,000
Through employers	1%
Through third-party vendors	5%
Through Medicare/Medicaid	94%
Workers compensation:	
Active enrollees	15

Retail network

Pharmacy locations	36,545

Mail-order services

Percentage of prescription volume	1%

Generic usage

Percentage of prescription volume	73%

Staff

Total	129
Professionals	115

Includes: 22 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.

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including American Drug, Brooks, Fred's, Kmart, Safeway, Walgreens and Wal-Mart.

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

Service area: Nationwide.

Billing methods: Capitated rate, fee per claim, risk sharing.

Officers: John Klein, CEO; Richard Friedman, CFO/COO; E. David Corvese, president; E. Paul Larrat, executive vp-op

Continued on next page

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Continued from previous page

erations; Richard Stader, vp-sales/marketing.

Contact: Robert Tamburro, manager-business administration.

** Subcontracted.*

RESTAT

724 Elm St., P.O. Box 758,
West Bend, Wis. 53095-0758;
800-926-5858; fax: 414-338-5767

1996 revenues	
Total gross revenues	$10,832,211
PBM gross revenues	$10,832,211
PBM unbundled revenues	$7,946,621
PBM clients	
Total	140
Employer/group plans with direct service	2,574
Lives covered	
Group health:	
Total	1,800,000
Active enrollees	897,571
Through employers	40%
Through third-party vendors	40%
Through Medicare/Medicaid	20%
Workers compensation:	
Active enrollees	60,000
Through employers	95%
Retail network	
Pharmacy locations	48,600
Mail-order services	
Percentage of prescription volume	40%
Generic usage	
Percentage of prescription volume	40%
Staff	
Total	67
Professionals	59

Includes: 3 registered pharmacists

PBM services since: 1985.

Parent: F. Dohmen Co.; primary business: drug wholesaler.

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: Fee per claim.

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

Contact: David Kwasny or Adam Holzman.

** Subcontracted.*

ValueRx

4700 Nathan Lane N., Plymouth,
Minn. 55442; 800-440-1486
or 612-509-2835; fax: 612-509-2841

1996 revenues	
PBM gross revenues	$1,589,599,783
PBM clients	
Total	3,000
Employer/group plans with direct service	2,818
Lives covered	
Group health:	
Total	27,000,000
Through employers	67%
Through third-party vendors	33%
Retail network	
Pharmacy locations	48,341
Generic usage	
Percentage of prescription volume	72%
Staff	
Total	1,300
Professionals	1,023

Includes: 94 registered pharmacists

PBM services since: 1985.

Parent: ValueHealth Inc.

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, physician/patient education, auditing services.

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.

Service area: Nationwide.

Billing methods: Capitated rate, fee per claim.

Officers: Kevin Roberg, president/CEO; Joseph Schiesl, president-PBM services division; Michael Flagstad, senior vp/CCO; Steve Michurski, president-pharmaceutical trades; Gary Blackford, executive vp/COO.

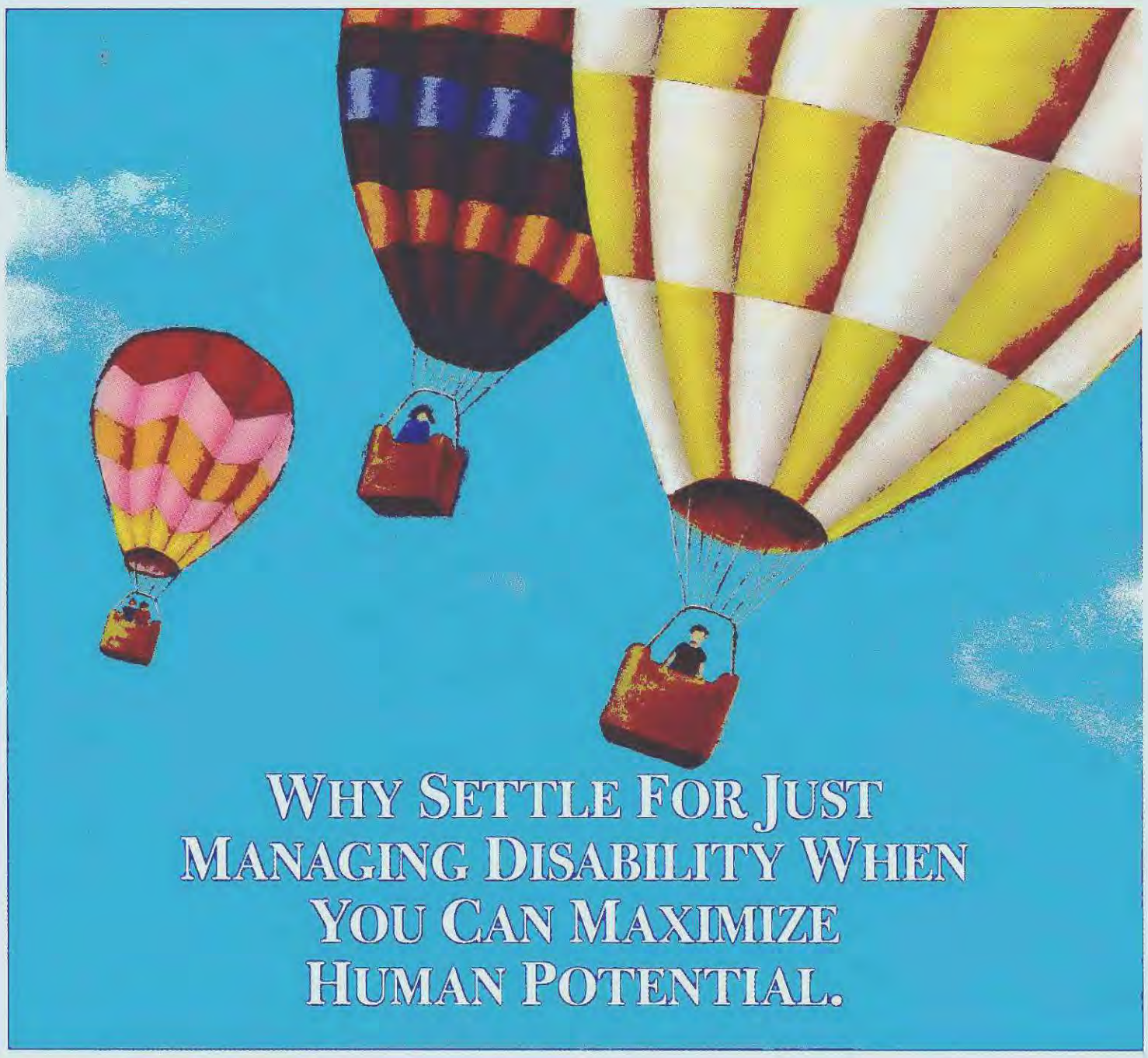
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• DIRECTORIES •

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Information on employee benefit products and services

EMPLOYEE BENEFITS

■ Watson Wyatt Worldwide offers a newsletter that covers regulations, policy and research about **employee benefits and retirement issues**. Request item **3501**.

■ The International Foundation of Employee Benefit Plans supplies a newsletter that examines **trends in voluntary benefits**. Request item **3502**.

■ The pitfalls of **ambiguous plan language** are examined in an article from The Kwasha Lipton Group. The article focuses upon the distinctions between "employees" and "independent contractors." Request item **3503**.

■ A flier from Disability Services Group discusses **voluntary payroll deduction disability programs**. Request item **3505**.

■ A paper on **medical benefits subrogation** and the financial opportunity it represents for all health care claim payers is available from Strategic Recovery Partnership Inc. Request item **3506**.

■ An approach for conducting a **work/life needs assessment** is provided by The Kwasha Lipton Group. In addition, the article details a methodology for **calculating the cost of work/life-related turnover**. Request item **3507**.

■ A flier from Disability Services Group illustrates the high **cost of delaying the purchase of long-term care insurance**. Request item **3508**.

■ A brochure from Watson Wyatt Worldwide explains how targeted communication can affect **savings rates and participation in 401(k) plans**. Request item **3509**.

■ An article from Self-Insurance Marketing Services provides an overview of the **self-insurance marketplace**, as well as suggestions as to how a claims administrator can successfully reach that market. Request item **3510**.

■ A primer that examines the principal issues involved in **designing or modifying supplemental executive retirement plans** is available from The Kwasha Lipton Group. Request item **3511**.

■ An article from The International Foundation of Employee Benefit Plans illustrates **the need to restructure benefits** due to the increasing number of contingent workers. Request item **3512**.

■ The basic issues of **extending benefits to employees' domestic partners** are examined in a research brief from Aon Consulting. Request item **3513**.

■ An article from The Kwasha Lipton Group explores **how to use excess assets from defined benefit plans** to provide additional benefits to plan participants. Request item **3514**.

■ A newsletter focusing on **health care policy language** and providing suggestions on drafting policy language is available from Strategic Recovery Partnership Inc. Request item **3515**.

■ The history of **audits conducted by the Internal Revenue Service and the Department of Labor** is analyzed in a booklet supplied by The International Foundation of Employee Benefit Plans. Request item **3516**.

■ Survey results suggesting **projected changes in cash balance plans** are examined in an article from The Kwasha Lipton Group. Request item **3517**.

■ A brochure from Watson Wyatt Worldwide evaluates **pension simplification** provisions in the Small Business Job Protection Act. Request item **3518**.

■ Disability Services Group provides a paper that explains what employers should look for when **selecting a disability insurer**. Request item **3519**.

■ An overview of **dependent care benefits** is featured in a brochure from Child Care Insights Inc. Request item **3520**.

■ A booklet from Watson Wyatt Worldwide shows how successful companies implement **strategic rewards programs**. Request item **3521**.

■ Six essential **issues of daily valuations** that plan sponsors should consider are set forth in an article from The Kwasha Lipton Group. Request item **3522**.

■ A guide to **self-funded benefit programs and services** is available from VISTA Administrators Inc. Request item **3523**.

■ VISTA Administrators Inc. provides a brochure for self-insured employers with an overview of **Section 125 plans**, including reasons to adopt a flexible benefits plan. Request item **3525**.

■ Aon Consulting provides a research brief for 501(c)(3) charitable organizations that discusses the advantages and disadvantages of **replacing a 403(b) plan with a 401(k) plan**. Request item **3526**.

■ Marketing and sales tips for **targeting the self-insurance market** are outlined in an article from Self-Insurance Marketing Service. Request item **3527**.

■ Several pamphlets supplied by MetLife are designed to help an employer's workforce better understand the issues and **choices involved in major life events**. Request item **3528**.

■ Watson Wyatt Worldwide provides a booklet that surveys the salaries of chief executive officers at top companies and examines **trends in executive pay practices**. Request item **3529**.

■ Information Products explains an **interactive voice response system** in a brochure that details how benefit administrators can utilize this technology. Request item **3530**.

■ An article from Disability Services Group addresses the financial shortfalls of **group long-term disability**. Request item **3532**.

■ Information on the **usual and customary benefits** in more than 40 countries is detailed in a book from the Aetna/Generali Network. Request item **3533**.

■ The American Institute for CPCU and the Insurance Institute of America provide a flier explaining an **Associate in Automation Management** designation program. Request item **3534**.

Continued on next page

The guiding star...

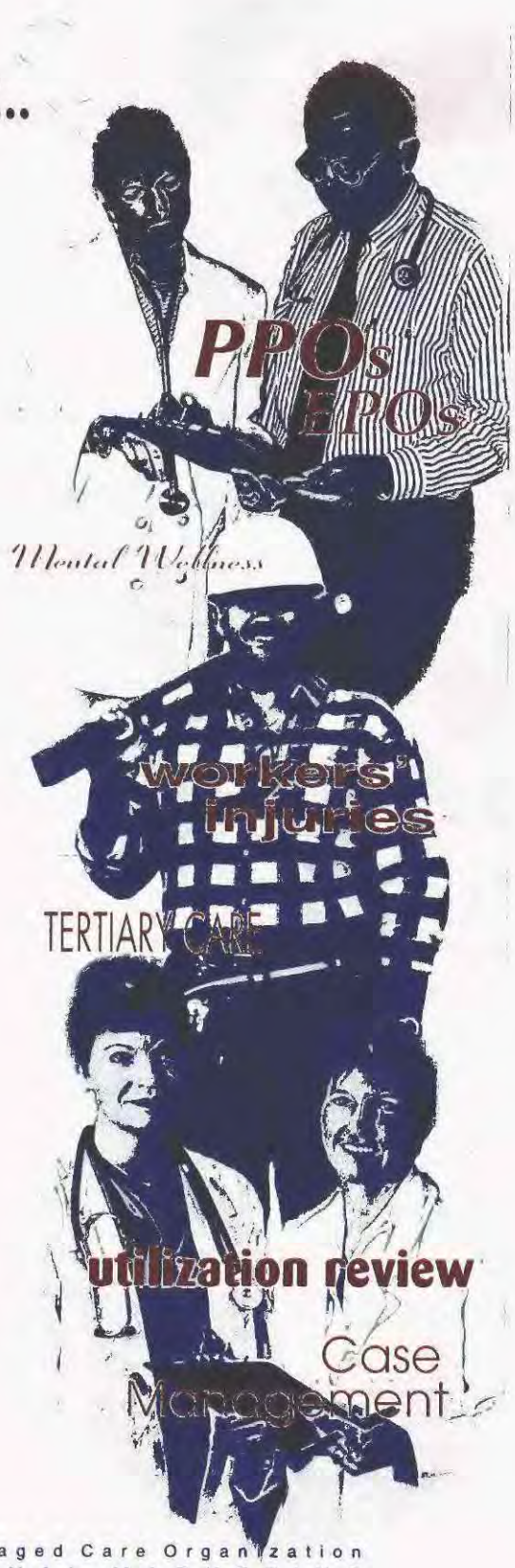
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The listings are published as an editorial service by *Business Insurance*.

There is no charge to list materials in the section; and the materials may be obtained free of charge to *Business Insurance* readers.

To receive any of the free materials listed in this special information resource section, please write the key numbers of the desired items on the reader service coupon that is printed along with the section.

Fill out the remainder of the coupon and mail it to:

Business Insurance
Reader Service Center, 650 S. Clark St., Sixth Floor, Chicago, Ill. 60605-1702

All requests must be received before Sept. 29 to be processed.

Continued from previous page

■ BNA Books presents a fact sheet that summarizes employee benefits under **Social Security and Medicare programs.** Request item **3535**.

■ A course catalog with information regarding the **Registered Health Underwriter and Registered Employee Benefits Consultant designations** is available from The American College. Request item **3536**.

■ **Converting unused vacation time into 401(k) contributions** is examined in a bulletin from the Kwasha Lipton Group. Request item **3537**.

■ D'Ancona & Pflaum presents an article that examines **employee benefit provisions in 1996 legislation**. Request item **3538**.

■ Disability Services Group presents a paper discussing why **long-term care insurance** should be considered an integral part of employees' financial planning. Request item **3540**.

■ **Major employee benefits issues** are analyzed in a newsletter provided by the International Society of Certified Employee Benefit Specialists. Request item **3541**.

■ An **Associate in Insurance Accounting and Finance** program is described in a flier provided by the American Institute for CPCU and the Insurance Institute of America. Request item **3542**.

■ A catalog with information regarding the **Certified Employee Benefit Specialist designation program** is available from the International Foundation of Employee Benefit Plans. Request item **3543**.

■ A **COBRA compliance review checklist** is available from Aon Consulting. Request item **3544**.

■ Approaches that allow plan sponsors to **integrate defined benefit and defined contribution retirement plans** are discussed in a bulletin from The Kwasha Lipton Group. Request item **3545**.

■ Reasons for **performing a claims audit of a third-party administrator** are outlined in a flier from Meridian Resource Corp. Request item **3546**.

■ A comparative analysis of **the differences in the ways benefit values accrue** among various retirement plan designs is available from the Kwasha Lipton Group. Request item **3548**.

■ The Segal Co. offers a **1997 annual reporting and disclosure calendar** for benefit plans. Request item **3549**.

■ A newsletter on **self-funded health care benefits** is available from VASA Brougher Inc. Request item **3550**.

■ An article that discusses **the importance of considering an organization's business objectives** when developing a benefit plan design is available from The Kwasha Lipton Group. Request item **3551**.

■ How employers use **self-service human resources technology** to achieve their business objectives is reported in this study conducted by Watson Wyatt Worldwide. Request item **3552**. BI

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2. Number of employees:
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Allocation

Continued from page 1

plants the seeds for a thicket of other defense problems for policyholders.

For example, merely by threatening an allocation lawsuit, insurers might coerce policyholders into agreeing at the inception of an underlying lawsuit to shoulder a portion of their defense costs.

"The much more realistic threat is the Damoclean sword that carriers will try to foist on policyholders," said policyholder attorney Dorn Bishop, head of the insurance practice at Latham & Watkins in San Diego.

"I suspect allocations could be a cottage industry in and of itself, either after the fact or before the fact," said policyholder attorney Roger W. Simpson, a partner with law firm Cotkin & Collins of Los Angeles.

Both attorneys filed amicus briefs in the case.

Policyholder attorneys also are concerned that the decision by the influential California Supreme Court could sway courts elsewhere, few of which have ruled on this issue.

The policyholder in the case has not decided whether to ask the court to review its decision, but such a request is unlikely, said David M. Roberts, a partner with Paul, Hastings, Janofsky & Walker L.L.P. in Los Angeles. Mr. Roberts represents the policyholder in the case.

The court's 6-1 decision clears up what had been a muddled position on defense cost allocation in the state. California courts, including the Supreme Court, have reviewed the issue in a handful of cases over the past three decades. But none of those decisions fully spelled out when an insurer that has provided its policyholder a defense in a case involving potentially covered and uncovered claims is entitled to a reimbursement of defense costs.

'The much more realistic threat is the Damoclean sword that carriers will try to foist on policyholders,' says policyholder attorney Dorn Bishop.

The latest case, which attracted numerous amicus briefs from policyholders and insurers, stemmed from a contractual dispute between H&H Sports Inc. and Los Angeles sports mogul Jerry H. Buss.

Attorneys think H&H was dissolved years ago, after it settled its dispute with Mr. Buss. The company is not listed in the Los Angeles phone directory.

Mr. Buss owns the Los Angeles Lakers professional basketball team and the Great Western Forum, the home arena for the Lakers and some other Los Angeles-area sports teams as well as the site of other special events.

Mr. Buss also owns cable television networks.

By contract, H&H for years had been Mr. Buss' exclusive agent for obtaining advertising for the Forum and for one of his cable networks. But in 1988, Mr. Buss terminated that exclusivity arrangement.

H&H in 1989 sued Mr. Buss and other individuals and organizations connected to him, eventually charging them with 27 allegations of wrongdoing. The allegations included breach of contract, fraud, conspiracy and conversion, which Mr. Buss' CGL policies did not cover.

But, the suit also contained one allegation—a defamation charge—that CGL policies do cover.

Mr. Buss asked three of his CGL insurers to defend him, but only Irving, Texas-based Transamerica Insurance Co., now TIG Insurance Co., consented.

One of the other insurance companies, Landmark Insurance Co., a subsidiary of American International Group Inc., later settled with Mr. Buss.

In a 1995 summary judgment, a trial court found that the third insurer, Fireman's Fund Insurance Co. of Novato, Calif., had no duty to defend Mr. Buss, because the defamation allegedly occurred after the insurer's policy had terminated.

Mr. Buss settled with H&H, which had sought $297 million of damages, for $8.5 million in December 1991.

TIG, as well as the other insurers, refused to contribute to it.

While TIG agreed it owed Mr. Buss a defense because the defamation claim was potentially covered, H&H did not provide much evidence that it had been defamed, explained TIG's attorney, James E. Gibbons.

As a result, the settlement did not consist of any insured damages, said Mr. Gibbons, a partner with Haines, Brydon & Lea P.C. in Long Beach, Calif.

In a flurry of litigation that followed the settlement, a trial-level court agreed TIG did not have to contribute to the settlement and that the insurer could seek reimbursement for most of its defense costs from Mr. Buss.

The defense costs exceeded $1 million, with only $22,000 to $56,000 attributable to defending Mr. Buss against the defamation claim, the lone potentially covered claim in H&H's lawsuit, according to TIG.

The appellate court affirmed the decision last year (*BI*, March 18, 1996).

The Supreme Court's decision, written by Justice Stanley Mosk, said an insurer has a duty to defend a policyholder against the entire action it faces, even when only some of the claims are potentially covered.

"To defend meaningfully, the insurer must defend immediately. To defend immediately, the insurer must defend entirely," Justice Mosk wrote.

When all of the claims are potentially covered, the insurer must pay for the entire defense, Justice Mosk wrote.

But, California courts have established that when policyholders face suits in which none of the claims are covered, their insurers have no duty to provide a defense, the justice wrote.

"It follows" that in lawsuits alleging both covered and uncovered claims that an insurer has the right to seek reimbursement for the costs that the insurer incurs defending its policyholder against uncovered claims, Justice Mosk wrote.

"With regard to defense costs for those claims, the insurer has not been paid premiums by the insured. It did not bargain to bear those costs," the justice explained.

Even if the policy language were unclear, a policyholder "could not have an objectively reasonable expectation that it was entitled to what would in fact be a windfall," he wrote.

The court also ruled that insurers must prove their defense cost allocations are sound by a preponderance of evidence.

In a 1970 ruling, the court held insurers to the much more difficult "undeniable evidence" standard. But, Justice Mosk explained that the stricter standard did not apply in this case. Among other reasons, the 1970 court invoked the standard against an insurer that wrongfully refused to provide its policyholder any defense, Justice Mosk wrote.

"What I found sort of refreshing is the extent to which the California Supreme Court said it would enforce the terms of the policy," observed Ms. Foggan, who filed an amicus brief for insurers in the case.

But, several policyholder attorneys criticized the court for "paying lip service" to CGL policy language but then not addressing two key policyholder arguments: Policies require insurers to defend "any suit," not just any potentially covered claim, and CGL policies do not explicitly allow insurers to allocate defense costs to policyholders.

"If the policy says, 'defend any suit,' I would expect that is a reasonable expectation" by policyholders, Mr. Simpson said.

"If they wanted to defend only covered claims, the policy should say that," agreed Mr. Roberts. Mr. Buss' attorney.

The court's majority "didn't seem to focus on the language of the policy, and our arguments were given short shrift," he said.

Dissenting Justice Joyce Kennard concurred, pointing out that title insurers, for example, include such language in their policies.

Ms. Foggan said the majority's detractors are taking the "defend any suit" language out of context. The remainder of the provision, as well as "common sense," dictate which defense risks insurers assume, she said.

The decision raises several

See **Allocation** *on page 44*



Carvill

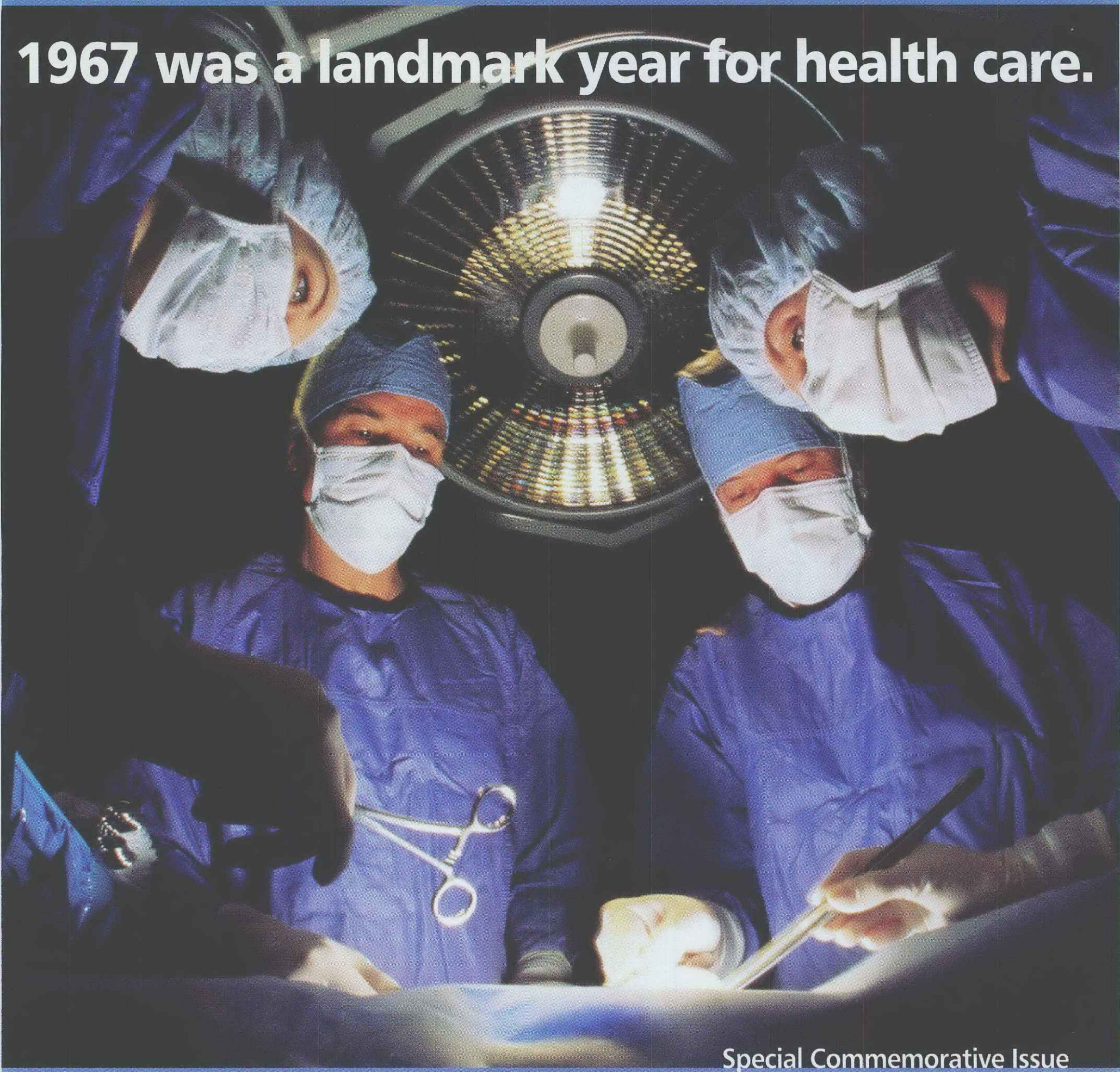
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Allocation

Continued from page 42

potentially thorny defense-related problems for policyholders.

Mr. Roberts said insurers may use this ruling to pressure policyholders at the beginning of a liability lawsuit that alleges some uncovered claims to assume a portion of their defense costs in exchange for a waiver of their insurers' rights to seek reimbursement later.

But, in the ruling, Justice Mosk said there is nothing wrong with two parties to a contract agreeing to such a provision. However, he said that scenario is unlikely, because the court has affirmed insurers' duty to defend any lawsuit in its entirety if the action alleges at least one potentially covered claim.

Mr. Roberts and other policyholder attorneys also lamented that the court's ruling creates potential conflict-of-interest issues between insurers and policyholders.

Those issues could hurt a policyholder's defense in underlying litigation and spark additional litigation between policyholders and insurers, the attorneys said.

For example, will insurance companies direct a policyholder's attorney to focus on only covered claims? Or, to avoid paying any defense costs, will insurers direct the attorneys to focus on the uncovered claims?

Justice Mosk and insurer attorneys discounted those concerns, though.

"It's up to the insured's lawyer to provide the best case possible," said Mr. Gibbons, TIG's attorney. After that, he said, if the policyholder has to reimburse its insurer a portion of the defense costs, "that's what he bargained for in the contract."

The decision also may further complicate pollution coverage disputes, Mr. Simpson said.

For defense cost purposes, insurers typically consider pollution liability allegations against a policyholder as a single claim, even if the pollution spanned many years and the policyholder was uninsured in some years.

Mr. Simpson also questioned whether insurers in California now might break down those pollution liability claims by year of coverage and allocate to policyholders the defense costs related to the years the policyholder was uninsured.

The case now heads back to the trial court, where TIG must show it has allocated its defense costs properly.

•

Jerry H. Buss et al. vs. the Superior Court of Los Angeles, Califcrnia Supreme Court; No. S052844.

Self-insurer not liable for defense costs: Court

By JUDY GREENWALD

SAN DIEGO—A self-insurer cannot be treated as an insurer when it comes to contributing to defense costs,a California appellate court ruled in an environmental case.

The state appellate court in San Diego ruled in *Pacific Indemnity Co. vs. County of San Bernardino* that while the county was self-insured for much of the relevant period, it was "not an insurer for purposes of allocation of costs of defense of the underlying actions."

Los Angeles-based Pacific Indemnity Co., a Chubb Corp. unit, plans to appeal the decision to the California Supreme Court, said Kenneth E. Goates, an attorney with Lewis, D'Amato, Brisbois & Bisgaard in San Diego, which represents the insurer in the litigation.

According to the decision, which was issued July 8 and certified for publication July 21, Pacific Indemnity had provided the county with primary comprehensive general liability insurance for more than 25 years, until it became self-insured in 1973. The county operated a landfill beginning while Pacific's policies were in effect and continuing after their expiration.

More than a decade after Pacific's policies expired, owners of adjacent land filed two lawsuits against the county for property damage caused by toxic gases emitted from the landfill.

Pacific provided a defense under reservation of rights, but demanded that the county as a self-insured entity pay a portion of its defense costs.

Under a stipulated judgment, both sides agreed Pacific would pay half of reasonable defense costs. Pacific then appealed the portion of the judgment declaring it had a duty to provide the county with a defense, while the county appealed the portion that said it was responsible for half the defense costs.

Ruling in the county's favor, the appellate court said while defense costs may be allocated among insurers, this "does not apply to deny a policyholder its contractual right to a complete defense where the policyholder was not insured at all times."

A self-insured entity 'should have a reasonable expectation to defend claims that occur during the time it has no insurance,' says Kenneth E. Goates.

And although the county was self-insured, it was not an insurer for purposes of allocating defense costs, the court decided. As a result, "Pacific remains contractually obligated to provide the county with a complete defense of those underlying actions, not simply a 'share' of such defense."

Commenting on the decision, Mr. Goates said if a self-insured entity "acts like an insurance company" and "walks like an insurance company," especially if it is a government entity that has set up its own claims-handling facility, "it should have a reasonable expectation to defend claims that occur during the time it has no insurance."

However, the county's attorney, Barry J. Shotts of Lathem & Watkins in San Diego, said Pacific Indemnity's policy "clearly obligates them to defend the entire suit against them. That's in the contract." Nothing the county did once the contract expired changed that, said Mr. Shotts.

While there is a clause in the standard CGL policy that calls for allocating defense costs among multiple insurers, the fact that the county decided not to renew its policy is "not insurance. It's the opposite of insurance because it does not involve transfer of risk from one entity to another," said Mr. Shotts.

Mr. Shotts said the case is significant because though it "simply extends" long-standing principles of insurance law, "it's one of the very few cases that actually deals with this particular argument, that a county somehow becomes an insurance company by not buying a policy."

•

Pacific Indemnity Co., defendant/appellant/cross-respondent, vs. County of San Bernardino, plaintiff/respondent/cross-appellant, Court of Appeal fourth appellate district, division one, state of California, D020939.

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Liability

Continued from page 2

emerging from Western Asbestos' products.

In their motion for summary judgment, however, the insurers argued that the company's suit confused tort liability with the contractual relationship between insurer and policyholder.

The lower court judge denied the insurers' motion, ruling that Western Asbestos' insurance coverage did transfer to Western MacArthur as a matter of law because of successor tort liability.

But the California Appeals Court reversed that finding June 25 in *General Accident Insurance Co. of America et al. vs. The Superior Court of Alameda County*, deciding that the passage of tort liability to a successor company does not suggest that insurance coverage also passes to the successor as a matter of law.

The appellate court subsequently rejected Western MacArthur's petition for rehearing on the issue, prompting its appeal to the state Supreme Court.

"From our perspective it clearly doesn't make any sense at all, because then the company that ends up picking up the liability doesn't have access to the one set of insurance policies that specifically apply to the liability," said Tom Freeman, a partner with Brobeck, Phleger & Harrison in San Francisco who represents Western MacArthur.

The attorney for the insurers, though, had nothing but praise for the ruling.

"The opinion is a very well-researched, very thoughtful analysis of the issues associated with insurance coverage and successorship," said Paul E.B. Glad, a partner with Sonnenschein Nath & Rosenthal in San Francisco. "It also recognizes the importance of the differences between the public laws underlying tort law and insurance contract law."

Western Asbestos Co. was formed in the early 1900s and in the 1930s became a distributor of asbestos products. But faced with financial difficulties in the 1960s, the company was acquired by St. Paul, Minn.-based MacArthur Co., which became the parent to Western MacArthur Co. Western MacArthur later was held liable for Western Asbestos' product liability torts as a successor corporation.

Today, Western MacArthur says it faces 2,000 open asbestos-related injury claims and has settled as many as 10,000, with more than $93 million in related costs for those settlements.

"Western MacArthur blew through its own insurance program entirely paying for the Western Asbestos liabilities," said Mr. Freeman, the company's attorney.

Subsequently, Western MacArthur sued the insurers, claiming Western Asbestos' liabilities should be covered by comprehensive general liability policies in place from 1948 to 1967.

In arguing that insurance coverage must transfer along with its successor liability for product liability claims, Western MacArthur cited the 9th U.S. Circuit Court of Appeal's 1992 ruling, *Northern Insurance Co. of New York vs. Allied Mutual Insurance Co.*, which held that when a company purchases the assets of its predecessor, and subsequently acquires its pre-transfer liabilities as a matter of law, insurance coverage for those liabilities follows as well.

The Superior Court cited the 9th Circuit ruling in denying the insurance companies' summary judgment motion. But the California Appeals Court panel declined to follow *Northern Insurance*.

While direct impact of the appellate ruling, if upheld, may be limited to California, insurer attorney Mr. Glad predicted the ruling ultimately could expand beyond the state.

"We believe that the case will have important implications with regard to a wide array of long-tail claims ranging from asbestos to environmental claims," he said. "It will mean that insurance companies will have greater assurance that they need only confront the risks which they agreed to underwrite."

A consultant who specializes in uncovering insurance policies of predecessor companies says she is skeptical the ruling will have a broad impact.

"It's a very narrow set of circumstances," said Sheila Mulrennan, president of Insurance Archaeology Group in New York.

The case is far from over, said Ms. Mulrennan, who noted Western MacArthur is pursuing other arguments for coverage.

"There's certainly the possibility that the policyholders will be able to access coverage," Ms. Mulrennan said. "I don't think by any means they won't be able to get at it."

'The opinion is a very well-researched, very thoughtful analysis of the issues,' says insurer attorney Paul E.B. Glad.

In this sort of case, the terms of the original policies are particularly significant, Ms. Mulrennan added. "So it seems that to do the most thorough search possible to find the policies or do whatever is necessary in terms of insurance archaeology is more important than ever."

Mr. Freeman said he thinks the ruling could be significant "if it was expanded to other jurisdictions."

However, he added, "I would hope that somebody somewhere, a judge or panel of judges, would look at it and say, 'This just doesn't make sense.' "

That somebody could be the justices of the California Supreme Court.

Even if the Supreme Court upholds the ruling, the coverage dispute will go back to the Alameda County Superior Court, where Western MacArthur has contested the insurers' request for summary judgment on two other points.

Western MacArthur claimed there was an express assignment of Western Asbestos policies to Western MacArthur under a 1967 security agreement, and that the Western Asbestos takeover was in fact a "de facto merger." The company contends that courts have largely held that insurance coverages do transfer to the successor company in merger situations.

"It's possible that this won't have that much impact if the judge does wind up ruling in our favor on de facto merger or express assignment," Mr. Freeman said of the appellate ruling.

•

General Accident Insurance Co. of America et al. vs. The Superior Court of Alameda County, Western MacArthur Co., Real Party in Interest; Court of Appeal of the State of California, First Appellate District, No. 076084

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PROGRAM AGENDA

MONDAY, OCTOBER 27

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

3:00 PM
EARLY REGISTRATION

4:30 - 5:30 PM
EMPLOYERS PRIVATE ROUNDTABLE

Moderator:
Kathryn J. McIntyre
Business Insurance

5:30 - 6:30 PM
COCKTAIL RECEPTION:
Hosted by Liberty Mutual Group

TUESDAY, OCTOBER 28

7:45 - 9:00 AM
REGISTRATION
CONTINENTAL BREAKFAST:
Hosted by
Kemper Insurance Companies

9:00 AM
OPENING REMARKS

Alexandra Scott
International Business Forum

9:05 AM
KEYNOTE SPEAKER

THE CASE FOR INTEGRATION: SORTING OUT THE MYTHS AND REALITIES OF DISABILITY INTEGRATION MANAGEMENT

Dwight E. Davis
Wausau Insurance Companies

9:45 AM
ERGONOMICS: EFFECTIVE WORKPLACE PRACTICES AND PROGRAMS

Moderator:
Wayne S. Maynard
Liberty Mutual Group

Michael Lichtenberger
BOC Gases

Russell C. Opferkuch
Bankers Trust Company

Cynthia R. Parks
Turner Broadcasting System, Inc.

Michelle Robertson
Herman Miller, Inc.

Neal J. Taslitz
National Repetitive Strain Injury Foundation

10:45 AM
TABLE-TOP EXHIBITS REFRESHMENTS:
Hosted by Commonwealth Risk

11:15 AM
DEVELOPING A SUCCESSFUL ANTI-FRAUD PROGRAM

Moderator:
Peter C. Madeja
GENEX Services Inc.

Donald Elisburg, Esq.
Department of Labor Fraud Commission

William Kizorek
InPhoto Surveillance

Christopher E. Mandel
PepsiCo Restaurant Services Group

Philip J. Polazzo
Olsten Corporation

12:15
LUNCHEON:
Hosted by Intracorp

1:15
LUNCHEON SPEAKER
Adam W. Potter
Continental Airlines Inc.

SOARING TOWARD THE YEAR 2000

1:45 PM
BREAK

2:00 PM
INTEGRATING OCCUPATIONAL WORKERS COMP WITH NON-OCCUPATIONAL SHORT-TERM AND LONG-TERM DISABILITY PLANS

Moderator:
Kathryn J. McIntyre
Business Insurance

Elizabeth M. Lindner
Kemper Insurance Companies

Ruth D. Theule
Steelcase North America

Jenny Parker Emery
Towers Perrin

Charles A. Amis
Provident Companies Inc.

3:00 PM
TABLE-TOP EXHIBITS AND REFRESHMENTS

3:30 PM
CONCURRENT SESSIONS

Concurrent Session A:
RETURNING EMPLOYEES TO WORK

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The Walt Disney Company

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Moderator:
Rebecca S. Bruce
Aon Management Institute

Daniel L. King
Host Marriott Services Corporation

Larry Kurtz
The Achievement Institute

Rosemary Osman
University of Pennsylvania Health System

Concurrent Session B:
WORKERS COMPENSATION TRENDS IN CALIFORNIA TODAY: WHERE IS REFORM GOING?

Moderator:
John G. Pasqualetto
American Home Assurance Company

Rachel Kaganoff Stern
RAND

Edward C. Woodward
California Workers Compensation Institute

4:30 PM
CONCURRENT SESSIONS

Concurrent Session A:
IDENTIFYING FACTORS THAT DRIVE WORKERS COMPENSATION COSTS: CASE STUDY OF AN INNOVATIVE APPROACH

Introduction by:
Christopher Mandel
PepsiCo Restaurant Services Group

Christopher A. Duncan
Frito-Lay

I. Jeff Turshen
The MEDSTAT Group

Concurrent Session B:
CREATIVE INCENTIVES AND PAY-FOR-PERFORMANCE METHODOLOGIES

Michael Gibney
Rollins, Inc.

Lizbeth Mackenzie
Coors Ceramics Company

5:30 PM
COCKTAIL RECEPTION

WEDNESDAY, OCTOBER 29

7:45 - 9:00 AM
CONTINENTAL BREAKFAST:
Hosted by GENEX Services Inc.

9:00 AM
OPENING REMARKS FROM THE CHAIR

9:05 AM
OUTCOMES MEASUREMENT—MANAGED CARE VS. MANAGED COSTS

Moderator:
Maddy E. Bowling
Intracorp

Mary Furnanz
Levi Strauss & Company

Brenda Olsen
J & H Marsh & McLennan, Inc.

Richard A. Victor
Workers' Comp Research Institute

10:00 AM
TABLE-TOP EXHIBITS REFRESHMENTS:
Hosted by Wausau Insurance Companies

10:30 AM
ALTERNATIVE RISK FINANCING

John Kessock, Jr.
Commonwealth Risk

Art Engel
Southwest Marine, Inc.

Keith Terrano
Labor Ready, Inc.

11:30 AM
CONCURRENT SESSIONS

Concurrent Session A:
NEW MEDICAL APPROACHES TO OLD PROBLEMS

Moderator:
Mary Stoik Dymond
ACX Technologies Inc.

Peter G. Hanson, M.D.
Hanson Peak Performance Clinic

Robert S. Ivker, D.O.
American Holistic Medical Association

Concurrent Session B:
RISK MANAGEMENT INFORMATION SYSTEMS

Moderator:
David P. Duden
Deloitte & Touche LLP

Michelle DeLizio
CompReview

Tim East
The Walt Disney Company

Scott Lund
SAC3

12:30
LUNCHEON:
Hosted by
American International Group, Inc.

1:30
LUNCHEON ADDRESS
Sandra M. Jenson
CNA Insurance Companies
INNOVATIVE PRINCIPLES FOR REDUCING WORKERS COMPENSATION CLAIM COSTS

2:00 PM
BREAK

2:15 PM
CONCURRENT SESSIONS

Concurrent Session A:
SCREENING OUT YOUR PROBLEMS—HOW FAR CAN YOU GO?

Moderator:
Jeffrey W. Pettegrew
Western Staff Services

Chris Berka
Psychemedics Corporation

Brent A. Winans
Avert, Inc.

Concurrent Session B:
BUILDING A LABOR/MANAGEMENT TEAM TO WORK TOGETHER IN REDUCING WORKERS COMPENSATION COSTS

William C. Bruce, Esq.
Mayo, Gilligan & Zito

Catherine M. Hopkins
The New York Times

3:00 PM
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Jennifer A. Beukers • *Disability Coordinator* • The BOC Group, Inc.

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Recall

Continued from page 2

to a batch with a contaminant in the resin of the rocket's clear plastic shell, said Guy Thomas, Ohio Art's vp of sales.

At nearly $20 per water rocket, Ohio Art estimates it will lose $1.4 million in sales, not including the recall expense and the cost of storing the rockets in Ohio Art's warehouses while the company decides on the toy's future.

Despite lost sales and the cost of storing or destroying recalled goods, many manufacturers are hesitant to purchase product recall insurance, even though it could finance recall-related expenses. Although Ohio Art's insurance broker, Hylant-MacLean Group of Toledo, Ohio, presented product recall insurance in discussions last year, Ohio Art decided against buying the coverage.

Now, however, "We may look at it a little more closely," said Paul McCusty, vp-finance for Ohio Art, which had sales of $37.5 million last year. Ohio Art's decision to buy product recall insurance will depend on the cost, he said."You can be insurance poor," he said.

The toy manufacturer, which has general liability insurance underwritten by CNA Insurance Cos., has filed three claims with its insurer to cover compensation for the injured paries, said Mr. McCusty.

The CPSC, an independent agency of the federal government, last year issued 375 recalls involving more than 85 million "consumer product units," according to the commission.

The CPSC works with manufacturers to issue a product recall when the product "either violates mandatory safety standards or presents a substantial risk of safety to the public."

Separately, the Food and Drug Administration recalled more than 3,000 products last year.

The FDA ordered and coordinated 819 product recalls of food and cosmetic products last year, more than twice the number of products recalled by the CPSC.

Despite the number of recalls, recall insurance remains difficult to sell.

"In the last year or so, we haven't had a request for product recall or product tampering coverage," said Ken Fekete, senior vp-special accounts for Reliance National Insurance Co. in New York. That's in spite of the fact that Reliance insures against recall for "virtually any product," Mr. Fekete added.

One reason for the lack of interest, is that insurers may require potential policyholders to conduct product safety tests or add safeguards to minimize the risk of a defective product. Once manufacturers have done all that, they may think they've reduced the recall risk enough to eliminate the need for coverage, he explained.

"There's a lot of interest in product recall insurance, but in the past, a lot of clients felt it was inadequate or expensive," said Emily Freeman, vp and regional broking director for Sedgwick of Oregon Inc. in Portland. "It hasn't taken off as much as underwriters would like."

Product recall coverage is being sold as a monoline policy or as an endorsement to a general liability policy, Ms. Freeman said.

In addition to CNA Insurance Cos., Reliance National and Lloyd's of London, other insurers offer product recall policies.

Most of her sales are to food manufacturers, and the coverage is endorsed general liabilty policies, Ms. Freeman said. These endorsements which range from limits of $100,000 to $250,000, cover extortion, malicious tampering and product recalls, she said.

Endorsements have their limitations, Ms. Freeman pointed out: For example, some cover only voluntary recall and not malicious tampering, and the small limits usually just cover the expenses of issuing the product recall.

When it comes to product recall, there's "no such thing as a standard coverage," said Pete Conway, president of risk management for CNA in Chicago. CNA has designed product recall insurance specifically for bottling and food processing companies, Mr. Conway said. CNA policies cover one recall with a standard limit of $2 million per recall, Mr. Conway added.

Some brokers and insurers warn clients it is foolish not to buy a form of product recall or product tampering insurance. They also contend that the market for product recall insurance, along with a demand for product tampering coverage, is growing.

"There's around $100 million in premiums for malicious accident cover written in the United States today," said Jean McDermott-Lucey, vp of AIG's crisis management division in New York. Although she acknowledges it's a "niche product" and a "difficult sell," Ms. McDermott-Lucey said there is potential for the market to double or triple in the next few years, as buyers become more aware of the product and their need for the coverage.

AIG underwrites two monoline products, Ms. McDermott-Lucey said. They are policies for malicious tampering and accidental damage, which can also be combined.

"If someone calls the media and says, 'I poisoned the water,' malicious tampering coverage kicks in," Ms. McDermott-Lucey said.

She compared the potential of product recall insurance to another coverage that was once a "niche" product: kidnap and ransom insurance.

"No one wanted it a few years ago," she added, "and now it's become common."

Risk managers, brokers and insurers agree, however, that companies must act quickly and responsibly before and after a product recall. This will protect their future sales and a company's good name, they say, which is quite often a company's most valuable asset.

"What's important is to maintain a relationship with the public" and keep distribution channels open, said Greg Higgins, Deloitte & Touche L.L.P.'s associate national director for business insurance consulting in Chicago.

When facing a product recall, businesses must quantify and document their potential losses, try to maintain the product's market position and create a paper trail to document recall-related procedures expenses, Mr. Higgins said.

Structuring a product recall program can help companies prevent losses, various trade organizations say.

According to the National Soft Drink Assn., companies should set up product recall committees well before the threat of a recall. The committee should include the company's president as well as members of its legal, public relations and production staffs.

A recall coordinator appointed by the president of the company should oversee and administer the recall, the NSDA states in its Guidelines for Product Recalls. The group stresses the importance of documenting decisions made by the company during a recall as well as its accomplishments.

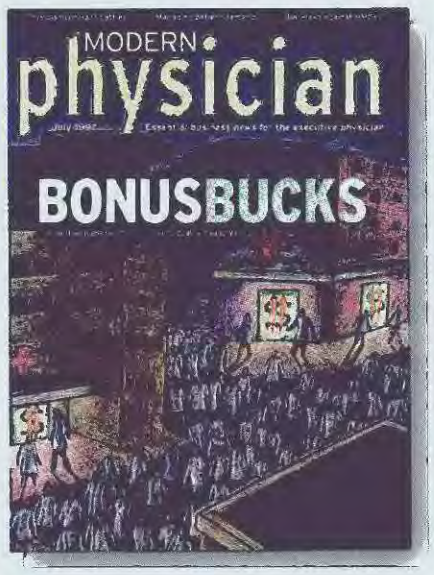
During the recall, the product recall coordinator can manage a quality assurance staff, which will: collect and analyze samples of the suspected prodect; identify the presence or absence of a real or potential problem or defect; review original laboratory records for indication of a problem or defect; document and submit all findings to the product recall coordinator. BI



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Sears outsources pension administration

By FRED WILLIAMS
Crain News Service

HOFFMAN ESTATES, Ill.—Sears Roebuck & Co. will outsource the administration of its $1.8 billion defined benefit plan and the investment management and administration of its $4.6 billion 401(k) plan.

Sears selected Wellspring Resources L.L.C., an Orlando, Fla.-based joint venture between State Street Global Advisors and Watson Wyatt Worldwide, to administer its defined benefit pension plan.

Boston-based State Street Global will serve as bundled service provider for the Sears 401 k) plan, which now is managed internally.

Sears officials in Hoffman Estates, Ill., declined to give details, but a spokesman acknowledged the selection of State Street Global and Wellspring effective sometime in 1998.

Sears made the decision to outsource its defined benefit and 401(k) plans to give employees 'access to more information around the clock and instantaneously.'

Jim Phalen, senior vp and managing director of retirement and investment services at State Street Global, declined to comment on details of the account.

He said through a spokeswoman that State Street is working with Sears to begin providing record keeping, administration, trust services and investment management for the 401(k) plan starting next year.

A Sears source said the company is considering expanding the plan's investment options to eight from five, including an international equity fund. One or more would be non-State Street funds, the source said.

Existing fund options are money market, fixed-income, balanced, Standard & Poor's 500 and Sears stock, all internally managed.

Wellspring executives said Sears decided to outsource the administration of the pension plan to increase the level of service to employees "by giving them access to more information around the clock and instantaneously" and because Sears, like many businesses, "wants to concentrate on its core competencies."

Tony Herron, principal at Wellspring, said Sears officials will continue to managed the defined benefit plan's investments.

Plan administration—including benefit calculations, compliance and reporting—will be phased into Wellspring over the next 18 months.

Other finalists for handling Sears' defined benefit plan administration were Hewitt Associates L.L.C. of Lincolnshire, Ill., and Buck Consultants of New York.

Mr. Herron said Sears will have nearly 1 million employees, retirees and former employees in the plan database.

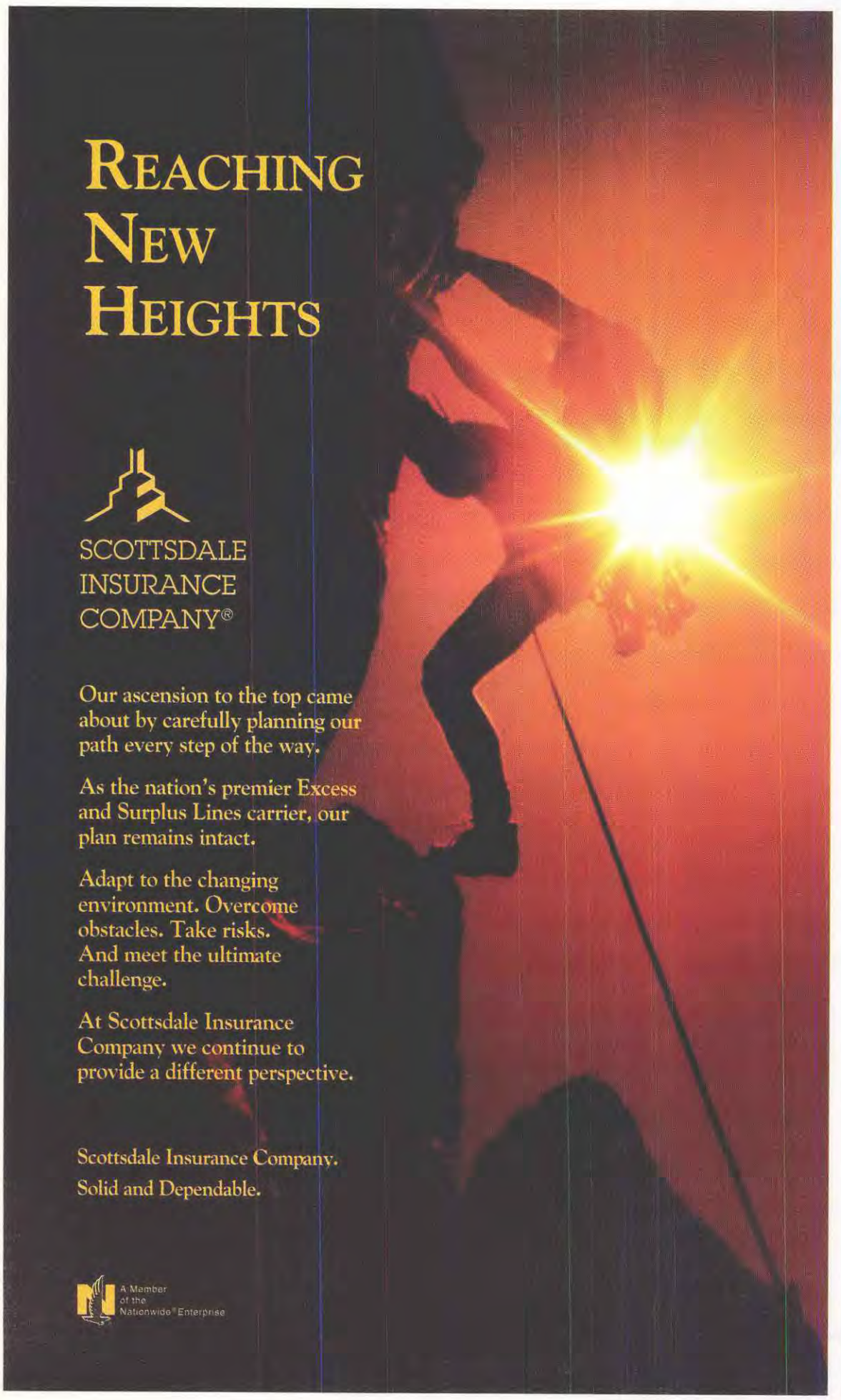
Employees and retirees will call a single toll-free telephone number at Wellspring to access benefit information, make changes or conduct transactions.

Sears will provide Wellspring regular payroll and employee information. The 401(k) data will be "stripped out" and forwarded to State Street; pension information will remain with Wellspring, said Mr. Herron.

"We will run a consolidated data feed for State Street, and Sears employees will have a single point of contact for information about both plans," he said. If the matter is 401(k)-related it is forwarded to State Street seamlessly, he said.

"The fact that we have a joint venture with State Street Global; Advisors helped Sears make its decision to go with Wellspring," according to Mr. Herron. "It will be the closest thing to having a single vendor for them."

Wellspring already provides outsourced pension administration to such companies as Allegheny Teledyne Inc., Federal Express Corp., Lucent Technologies Inc. and US WEST Inc. BI



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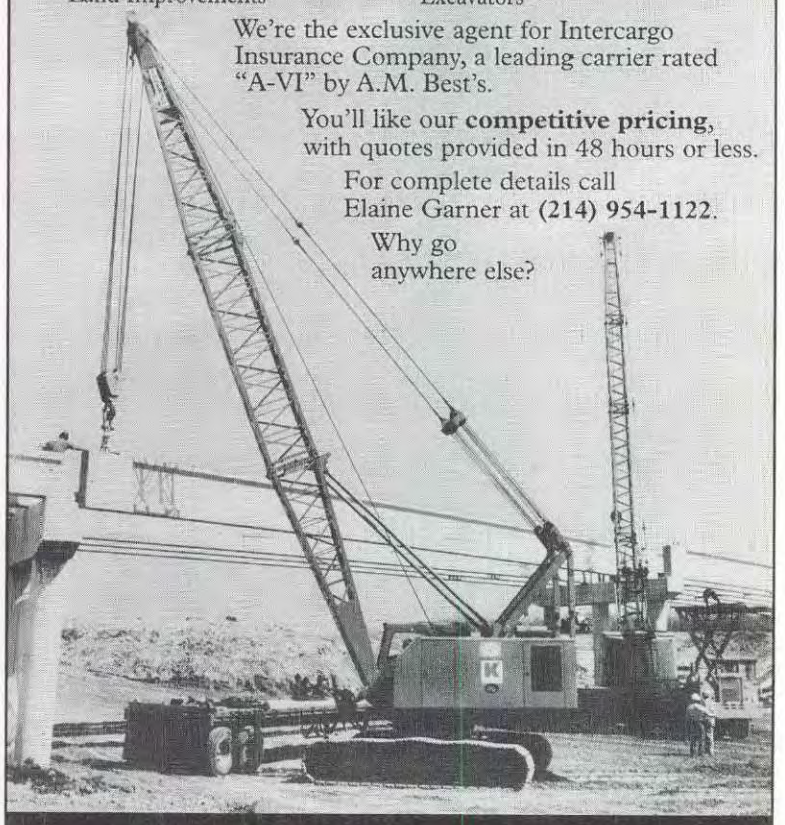
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INTERNATIONAL

Global Briefs

Members of **The London Steam-Ship Owners' Mutual Insurance Assn. Ltd.** have spent an estimated $300,000 removing 86 stowaways from their vessels during the first five months of this year, reports the London Club. Shipowners increasingly are being fined for allowing stowaways on board by countries that do not want stowaways seeking repatriation or political asylum. The London Club insures such fines as long as they are not incurred because of negligence. The $300,000 was spent on the operational costs of security and removing stowaways—by transporting them home, for example. The club has recommended a number of measures its members should take to reduce the risk. These include locking and guarding accommodation doors while vessels are in port, maintaining a gangway watch through loading and disembarkation, keeping adequate records of stevedore gangs, searching vessels before leaving port and inspecting containers before they are sealed. . . .Ian Finlayson has been appointed divisional director of **IRISC Claims Management**, an affiliate of claims adjuster IRISC Ltd. in London that specializes in liability claims management. . . .Rating agency **A.M. Best Co.** has assigned a "positive rating outlook" and a B++ rating to Colonia Baltica Insurance Ltd., following the company's first full year of trading. Colonia Baltica was formed by the merger of Colonia Insurance Co. (UK) Ltd. and Baltica Insurance Co. (UK) Ltd. and is jointly owned by Colonia Versicherung A.G. and Tryg-Baltica Forsikring A/S. . . .Creditors of **Andrew Weir Insurance Co. Ltd.** will receive increased payments under the insurer's scheme of arrangement, after a financial review by scheme administrator Paul Evans of Price Waterhouse. The creditors will receive a payment of 18% of what they are owed, up from 15% set a year ago. So far, almost £3 million has ($4.9 million) been paid to creditors of the scheme since it went into effect in 1994, and the increase will represent a further £600,000 ($978,000) in payments. At the end of last year, Andrew Weir, which ceased underwriting in 1991, had estimated total assets of £87 million ($141.8 million), against estimated total liabilities of £222 million ($361.9 million). . . .London-based broker **Swire Blanch Insurance (Holdings) Ltd.** has set up a new aviation department headed by Ben Pothecay, who formerly was with Bain Hogg Ltd. Swire Blanch is jointly owned by U.S. broker E.W. Blanch Holdings Inc. and Hong Kong-based Swire Group. . . .**Euclidian P.L.C.**, a Lloyd's of London corporate capital vehicle, has announced it will set up a new managing agency and composite syndicate, which will mainly underwrite non-marine business beginning next year. . . .The U.K. Department of Trade and Industry has authorized **ReliaStar Reinsurance Group (UK) Ltd.**, a reinsurance subsidiary of ReliaStar Life Insurance Co. of Minneapolis, to set up operations in London. ReliaStar Re, headed by Managing Director Jonathan Bowers, also has become a member of the London International Insurance & Reinsurance Market Assn. and specializes in accident and health reinsurance. The new operation has paid in capital of £7.5 million ($12.2 million), with a $60 million guarantee from ReliaStar Life. . . .**Workplace accidents** are on the rise in the United Kingdom, according to estimated figures released last week by the Health and Safety Executive, a government agency. For the 12 months to March 31, 1997, deaths rose 20% to 1.2 per 100,000 workers, mainly because of higher fatalities in the self-employed population. Fatalities in the manufacturing industry rose 36% to 57, from 42 for the same period the previous year. Fatal accidents to members of the public leapt to an estimated 394 from 86, though mostly this is due to new reporting requirements under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, which came into force in April 1996. These regulations have added railway trespasser fatalities and suicides into the figures, adding 251 deaths to the tally. Also, for the first time injuries due to workplace violence have been included: These figures indicate that two people were killed, 697 people received major injuries, such as fractures, and 3,980 suffered injuries that kept them away from work for more than three days.

Cat exchange set to open

By JUDY GREENWALD

HAMILTON, Bermuda—A new Bermuda Commodities Exchange, originally set to begin trading contracts based on catastrophe insurance risks in April, now is scheduled to begin next month, its president says.

Exchange President Thomas C. Heise said the delay is the result of a move to expand the scope of the exchange's membership (*BI*, March 17). The list of potential members "has expanded dramatically since last March" to "include a lot of companies in foreign jurisdictions" outside Bermuda that expressed interest in the exchange, said Mr. Heise. "Initially, we were going to keep it very local to start with," said Mr. Heise, who noted an offering soliciting members has just been sent out.

The exchange hopes to have up to 100 members when it begins trading next month, said Mr. Heise, who would not provide additional details about the offering.

Initial members of the exchange, which was authorized by a 1996 act of the Bermuda Parliament, are expected to include affiliates of American International Group Inc., reinsurance intermediary Guy Carpenter & Co. Inc. and Chase Manhattan Bank, all based in New York. Additional members are expected to be primarily insurers, reinsurers, commercial and investment banks and other financial institutions.

The Exchange initially will offer options covering six-month periods, January through June and July through December, for several regions: Florida, Northeast, Southeast, Gulf Area, Midwest and National. The contracts will cover damage from a single event or aggregate damage over the covered period.

Under Bermuda Commodities Exchange procedures, an option buyer, or "holder," will pay a premium to a seller, or "writer." The writer will be liable for payment of a specified amount if losses in the particular region and time period from catastrophes—including hurricanes, tornadoes and windstorms—exceed a specified loss-to-value ratio. There may be fluctuations in prices

See **Bermuda** *on next page*

U.K. libel case slows e-mail delivery

By CAROLYN ALDRED

LONDON—Risk managers must realize that even internal electronic mail messages can expose them to libel suits, U.K. attorneys warn.

A recent out-of-court settlement in England illustrates the point.

Norwich Union Healthcare Ltd., the medical insurance subsidiary of Norwich-based insurance conglomerate Norwich Union P.L.C., is paying rival health insurer Western Provident Assn. Ltd. £450,000 ($749,250) in damages and costs after NU employees spread damaging rumors about WPA via NU's internal e-mail system.

It is the first time a corporate libel lawsuit involving e-mail has been brought in the United Kingdom by a corporate plaintiff, lawyers point out.

This case won't be the only one of its kind, though, predicted Keith Mathieson, a lawyer who specializes in U.K. libel law.

Until now, "people haven't focused on the fact that e-mail is another form of written communication. The dangers are great, because people are inclined to think of e-mail as a telephone, where they can say what they like," said Mr. Mathieson, a partner with London law firm Davies Arnold Cooper.

"All companies need to take a careful look at their internal e-mail procedures," he said.

This case and the increasing use of e-mail and the Internet for business purposes have important risk management implications, agreed Chris Holden, director of professional standards for the Assn. of Insurance & Risk Managers.

In an open court statement July 17, lawyer David Engel, acting for WPA, noted that "rumors were disseminated by some of Norwich Union's staff via its internal e-mail system with the result that

See **Libel** *on page 54*

Eureko aims for growth; sets eyes on GAN

By MARIA KIELMAS

AMSTERDAM, Netherlands—Eureko B.V., an alliance of six European financial services firms, is looking to significantly expand its presence through acquisitions.

Amsterdam-based Eureko, the holding company for the alliance, has expressed an interest in acquiring French insurer Groupe des Assurances Nationales, which the French government is readying for sale.

In addition, Eureko recently signed a cooperation agreement with Pol'nobanka a.s., a Slovakian bank, to develop bancassurance business in Eastern Europe and also acquired a majority stake in a bond insurer Pol'nobanka previously controlled.

The privatization of GAN was cleared by the French government's July 18 announcement that it would continue with the privatization of the state-owned insurer, as initiated by the preceding government. In addition, the European Commission last week approved the French government's plan for a 23.76 billion franc ($3.82 billion) capital infusion for the company, with several stipulations.

Those include that the company be privatized no later than June 30, 1998; that GAN sell off its troubled banking and real estate units, as well as other assets to raise at least 2.4 billion francs ($386.2 million) in cash; and that GAN spin off at least 50% of its international operations.

The French government still has to approve the aid package.

Eureko Alliance Chief Executive Officer Jeff Medlock said the organization would "ensure that GAN retains its essential French identity whilst benefiting from participation in a dynamic European network."

Eureko, however, has not yet made a formal bid for the French insurer. Other potential bidders that have publicly expressed interest in GAN are: French insurer Assurances Generales de France; the French subsidiary of Allianz A.G. Holding; Dutch banking insurance group Fortis;

See **Eureko** *on next page*



AP/ WIDE WORLD PHOTOS

Germany is using military helicopters to deliver sandbags needed to shore up aging dikes.

Insured flood losses may hit $1 billion

By MARIA KIELMAS

Antigonus: "Thou art perfect then, our ship hath touch'd upon the deserts of Bohemia?"

Mariner: "Ay, my lord, and fear we have landed in ill time: the skies look grimly and threaten present blusters. In my conscience, the heavens with that we have in hand are angry, and frown upon 's."

—Shakespeare's "The Winter's Tale," Act III, scene III.

Residents of modern-day Bohemia have maintained a sense of humor in the midst of tragedy as they remind each other that Shakespeare wrote about their "coastal" region 500 years ago.

As flooding continues in Central Europe, estimates of insured losses are as high as $1 billion. Total economic losses will be much higher, perhaps topping $10 billion.

The good news for reinsurers is that "flooding in Poland, the Czech Republic and eastern Germany has not hit a major city, no insured industry is damaged and it's the kind of broad-based business primary insurers don't normally give to reinsurers," observed a Munich Reinsurance Co. spokesman.

Total losses may reach 13 billion deutsche marks ($7.05 billion), according to estimates by Munich Re. It sets its own losses at about 10 million deutsche marks ($5.4 million).

French reinsurer SCOR S.A. estimated insured losses in the region at up to $1 billion. Total economic losses, according to SCOR, may reach $10 billion. Last week,

See **Flood** *on page 53*

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INTERNATIONAL

Eureko

Continued from previous page
and a consortium led by Zurich Insurance Group and France's MAAF Assurances.

If Eureko were to acquire GAN, the alliance would become Europe's third-largest insurance group, with a combined premium volume of more than 40 billion Dutch guilders ($19.3 billion), said Mr. Medlock.

The consortium includes: Achmea Holding N.V. of Amsterdam; BCP Ocidental of Lisbon, Portugal; Friends Provident Life Office of Surrey, England; Gothaer Insurance Group of Cologne, Germany; Topdanmark Forsikring A/S of Copenhagen, Denmark; and WASA International Insurance Co. Ltd. of Stockholm, Sweden.

Members of the consortium have cross-shareholding agreements with each other.

Meanwhile, Eureko and Bratislava-based bank Pol'nobanka have agreed to jointly develop programs that blend insurance and banking products.

Eureko also has acquired an 80% stake in Bratislava-based Union Poistovacia, an insurance affiliate of Pol'nobanka, which retains a minority stake in Union.

Pol'nobanka was the first private bank to be created in the former Czechoslovakia after the fall of communism in 1989. Today, it is the fourth-largest bank in Slovakia.

Union Poistovacia a.s. became a private insurer in the first wave of privatizations in May 1992. Prior to 1989, it was part of state-owned Pol'nobanka, a Eureko spokeswoman said. After privatization of both companies, Pol'nobanka was Union's largest shareholder until the Eureko deal.

Union today has about 2% of the Slovak insurance market's premium volume and specializes in surety bonds. It does not write life or health insurance and has only a small share of the country's property and motor insurance markets. the spokeswoman said, however, that future plans are to develop products in those lines. BI

Bermuda

Continued from previous page
of particular options contracts as trading takes place during the risk period.

The options will be based on a loss-to-value index compiled and updated by IndexCo. L.L.C., a Guy Carpenter affiliate in Hartford, Conn. The index is designed to measure the amount of insured damage to homes in the United States from atmospheric perils.

The exchange has signed a letter of intent with the Chicago Board of Trade under which it also will offer CBOT members trading privileges and receive services from the CBOT, but no final contract between the exchanges has been signed. The CBOT already offers trading in catastrophe insurance options.

"We've been negotiating with them now for five or six months," said Mr. Heise. "I'm still hopeful that we will be able to reach an agreement."

Observers have questioned whether in light of the soft market this is an appropriate time to start the Bermuda exchange. However, Mr. Heise pointed to the tremendous investor interest generated by the $477 million catastrophe bond issue that will provide United Services Automobile Assn. with a high-level reinsurance layer for East Cost hurricane risks (*BI*, June 23).

That deal "clearly demonstrates the eagerness of investors to buy cat risk even at today's current soft market prices," said Mr. Heise. BI

Flood

Continued from page 51

SCOR estimates its own losses at $10 million to $12 million.

Munich Re estimates that economic losses in the Czech Republic and Poland could range between 3 billion and 5 billion deutsche marks ($1.63 billion to $2.71 billion) in each country. Munich Re estimates economic losses of 1 billion to 3 billion marks ($542.3 million and $1.63 billion) in the flooded areas of eastern Germany.

Cologne-based reinsurer Gerling-Konzern Globale Ruckversicherungs A.G. is estimating its reinsurance losses at 1 million marks ($542,300), according to a spokesman. He said it was too early to estimate losses of the company's direct insurance affiliate, Gerling-Konzern Allgemeine Versicherungs A.G.

Dikes on the German side of the river Oder were first breached on July 23, and waters threatened the Oderbruch, a rich agricultural area.

All of the larger German insurers have exposures in the flooded areas of eastern Germany, but Munich-based Allianz Versicherungs A.G. is the dominant insurer. Allianz holds between 60% and 70% of the former East German insurance market due to its 1990 purchase of the former state-owned monopoly insurer, Staatlische Versicherung der DDR. The company was renamed Deutsche Versicherungs A.G. after its purchase by Allianz. Deutsche Versicherungs inherited 4 million communist-era personal lines policies that cover flood damage. Insurance policies during the communist period automatically covered flood and catastrophe risks.

Due to those exposures, Allianz has estimated that its flood losses in eastern Germany alone may exceed 100 million deutsche marks ($54.2 million).

An Allianz spokesman confirmed the insurer will absorb most of these losses itself. "What reinsurance we have is mostly with Allianz A.G. It will remain in the family."

Under modern German practice, flood insurance can be—but rarely is—bought as a separate endorsement to property policies.

"After a flood, there is usually a wave of customers asking for flood cover, but it abates as quickly as the flood," the Munich Re spokesman said.

The German government has mobilized 9,000 troops and 5,000 other volunteers to strengthen dikes along the river Oder. The exercise is Germany's largest peacetime military mobilization since a similar rescue effort after the 1962 floods in Hamburg. A number of Tornado fighter aircraft belonging to the German air force, the Luftwaffe, have been deployed in the effort by fitting them with special cameras to help identify any dangerous locations on the dikes.

Thirty-four helicopters have delivered sandbags to threatened areas. So far, 5 million sandbags have been used, depleting Germany's entire stock. Government spokesmen said they were searching for 800,000 more sandbags from Holland. Water pressures on the dikes have been estimated by local experts as equivalent to almost 10 tons of water per square yard.

Nevertheless, by the middle of last week, there was renewed fear that the dike walls would not hold because of poor maintenance in the past.

"If you have dikes, you have to maintain them all of the time. Large water rats will burrow through them," says Herbert Tiedemann, former engineering consultant to the Swiss Reinsurance Co. in Zurich.

Elsewhere in Central Europe, loss estimates are rising.

In Poland and the Czech Republic, at least 105 people have died.

Poland's Interior Minister Leszek Miller initially estimated economic losses to be about $1 billion but has revised that figure to "a few billion dollars."

The Polish telecommunications utility, Telekominkacja Polska, has estimated it will cost 1.3 billion zlotys ($374.5 million) to repair damaged lines.

Initial estimates by the Culture Ministry to repair damaged works of art in Poland were 20 million zlotys ($5.76 million), but this does not include repairs to the structure of ancient buildings, many of which are still flooded.

In the Czech Republic, Environment Minister Jiri Skalicky said at a press conference that infrastructure repairs are proceeding smoothly on railway tracks and gas and electricity lines. Damaged telephone lines remain a significant problem. About 16,000 people in the Czech Republic are still in temporary accommodations.

As expected, the floods continue to threaten areas of the Oderbruch region, the area of reclaimed land to the north of Frankfurt-an-der-Oder. A 100-foot length of dike on the western bank of the Oder was breached in the middle of last week. Last week, about 4,500 of the 19,000 inhabitants in the area were evacuated.

Concern in Germany, Poland and the Czech Republic now has shifted to possible ecological and health effects of the flooding. Sewage systems, fuel tanks and pipelines were destroyed by the flood waters and their contents have seeped into the standing waters. German health authorities have begun a voluntary vaccination program against typhoid and hepatitis A in the flooded area.

Environmental groups have suggested that deforestation and river channel straightening in the upper reaches of the Oder river in Poland and the Czech Republic may have contributed to the flooding problems. Forests along the Czech-German-Polish border areas in Sudetenland have died from pollution due to the burning of brown coal for electricity generation.

"The trees look like matchsticks," said a spokesman for the Bonn-based Bund fur Umwelt und Naturschutz Deutschland.

He said the existence of a natural park and preserved natural flood plains in the lower reaches of the Oder river, known as the Unteres Odertal, will ease the flooding problem for cities in the region. "There are natural floods on that sector (of the river) every year. The (Polish) town of Szczecin has no problem today with flooding, and it is at the very end of the river."

Had such heavy rain fallen on the Rhine, Neckar and Mosel river valleys in western Germany, where flood plains are highly developed, the catastrophe would be have been even greater, he added.

The threatened Oderbruch area is known locally as the market garden for Berlin. Agriculture is the German industry most threatened by the floods, though the Allianz spokes-man could not estimate potential insured losses.

•

Don Lewis Kirk contributed to this report.



Libel

Continued from page 51

they could be used to the detriment of Western Provident Assn. in order to obtain new business."

The rumors, which were circulating among insurance brokers, clients and potential clients of WPA and the medical insurance industry generally in the middle of 1995, suggested WPA was insolvent and/or being investigated by the Department of Trade and Industry and/or in financial difficulties and therefore unable or unwilling to write any new insurance, said the statement.

WPA has provided health insurance services since 1901 and is one of the United Kingdom's largest 100 companies, according to the statement read in court.

Norwich Union now admits that "there was no truth in any of the allegations (about WPA) and that (WPA) was not under investigation by the DTI, its solvency margins were and are very healthy and it was and remains well able to write new insurance; and it was certainly not in financial difficulties," Mr. Engel, a lawyer with the media litigation group of London law firm Theodore Goddard, said in court.

As a result, NU agreed to pay WPA £450,000 "by way of damages and costs and to undertake to the Court never to repeat the allegations or any similar allegations," said Mr. Engel.

Company officials "deeply regret and sincerely apologize to (WPA) for dissemination of the rumors," David Sherborne, a lawyer with NU's law firm, Sheridans, said in court.

Mr. Sherborne also noted that "Norwich Union has made every effort to ensure that such unacceptable practices do not occur again."

Norwich Union and lawyers from Sheridans would not comment on measures that had been undertaken to prevent such practices from occurring again.

Mr. Engel, who specializes in libel issues and in Internet libel in particular, said the case is the largest e-mail libel case yet to be brought in the United Kingdom and the only case brought by corporate plaintiffs to his knowledge.

Although there have been several e-mail libel cases in Australia and the United States, these have involved information transmitted over the Internet and not through internal e-mail systems, pointed out Mr. Engel.

Companies using internal e-mail systems should learn several lessons, he said.

Employers "must provide employees with guidelines" on e-mail use, and employees must be careful about what they put on e-mails, he warned.

Under U.K. libel law, e-mail is just another form of publication, and an employer becomes responsible as a publisher for his employees' e-mail messages, said DAC's Mr. Mathieson.

If a message is defamatory, the sender of the message—and the company whose e-mail system has

Continued on next page

The Professional Marketplace

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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 17,043
Sub-total 30,511
Associations 290
Government, Unions and Educational Institutions 946

Commercial Consumers Sub-total 31,747
Insurance Agents and Brokers 8,583
Insurance Companies 7,327
Accountants, Actuaries, Attorneys & Consultants 2,834
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,624
Others Allied to the Field 963
Total Qualified 53,083
Non-qualified 3
Single Copy Sales 13

TOTAL CIRCULATION 53,103

★ *Source Business/Occupational breakdown of qualified circulation, November 25,1996 Issue, as submitted to BPA for December 1996 BPA Publisher's Statement*

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LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF NEW YORK

In re

LAWRENCE UNITED CORPORATION INSURANCE AGENCY OF SOUTHERN CALIFORNIA, INC.,
Debtor.

Chapter 11
Case No. 97-13204

NOTICE OF MOTION OF LAWRENCE UNITED CORPORATION INSURANCE AGENCY OF SOUTHERN CALIFORNIA, INC. PURSUANT TO 11 U.S.C.§ 363 FOR AUTHORIZATION TO SELL CERTAIN ASSETS OF DEBTOR'S ESTATE OUTSIDE THE ORDINARY COURSE OF DEBTOR'S BUSINESS AND FREE AND CLEAR OF LIENS AND OTHER INTERESTS

PLEASE TAKE NOTICE, that Lawrence United Corporation Insurance Agency of Southern California, Inc., the debtor in possession herein, (the "Debtor"), by and through its attorneys, Cooper, Erving, Savage, Nolan & Heller, LLP, will move this Court at the James T. Foley Courthouse, 445 Broadway, Suite 327, Albany, New York on the 14th day of August, 1997 at 10:30 in the forenoon of that day, or as soon thereafter as Counsel can be heard, for an Order pursuant to 11 U.S.C. §363(b) authorizing the sale of certain assets of the Debtor to Glocare, Inc. (hereinafter "Glocare") pursuant to the terms and conditions of a Letter Offer dated June 26, 1997, free and clear of all liens and other interests, together with such other and further relief as to this Court may seem just and proper.

PLEASE TAKE FURTHER NOTICE, that the assets to be sold are as follows:

1. Commercial lines (insurance policies) excluded from the sale to John Burnham & Company, with annual commissions estimated at approximately $60,000;
2. Used office cabinetry.

PLEASE TAKE FURTHER NOTICE, that the terms of sale are as follows:

Purchase Price: The purchase price for such sale shall be $20,000 cash at closing.

PLEASE TAKE FURTHER NOTICE, that at the Hearing the Bankruptcy Court will consider any higher and better offers for the assets to be sold.

Dated: Albany, New York
July 21, 1997

COOPER, ERVING, SAVAGE, NOLAN & HELLER, LLP
Attorneys for Debtor
39 North Pearl Street
Albany, New York 12207
(518) 449 - 3100

FOR MORE INFORMATION, CONTACT MR. JAMES FAUGHNAN AT (518) 381 - 9000.

REQUEST FOR PROPOSALS

NEW YORK CITY HOUSING AUTHORITY
RFP for Claim Investigator and Adjustment Firms

The New York City Housing Authority is soliciting proposals from investigations firms to investigate claims for personal injury and property damage asserted against the Housing Authority and to adjust certain Property Damage Claims and claims arising under the New York State No-Fault Law.

The Housing Authority seeks to establish a panel of firms capable of delivering high quality services in a cost-efficient manner. The Panel will work under the direction of the Tort Division in the Housing Authority's Law Department and will provide services for the Tort Division and outside legal counsel who have been retained by the Housing Authority to represent it in the defense of Personal Injury and Property Damage Claims.

Interested firms may obtain copies of the Request for Proposals from: **Evelyn Hernandez, 75 Park Place, 11th Floor, New York, NY 10007, Telephone: (212) 776-5088, on any business day between the hours of 10 a.m. and 4 p.m.** A proposer's conference will take place on August 11, 1997 at 3 p.m., 75 Park Place, 10th Floor. **The deadline for submitting proposals is 3 p.m., August 21 1997.**

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AP/ WIDE WORLD PHOTOS

Alaskan marine highway uninsured

PRINCE RUPERT, British Columbia—The Alaska Marine Highway System does not have insurance to cover the up to $3 million in costs it sustained after Canadian fishermen blockaded an Alaskan ferry.

"There is no insurance protection in place for a blockade or for civil disobedience," said a spokeswoman for Gov. Tony Knowles.

The costs that the state-run ferry incurred include alternative transportation for ferry riders on the blockaded ferry Malaspina and the chartering and purchase of other vessels to board the fishermen's boats to read an injunction against the blockade, she said.

The three-day blockade stemmed from a fishing dispute between Canadian and Alaskan salmon fishermen.

The Canadian fishermen charge that Alaskans are violating fishing agreements by overfishing salmon in the Pacific Northwest.

—By Gavin Souter

Libel

Continued from previous page

facilitated it—may be liable for defamation, even if the message has a very restricted circulation, according to Mr. Mathieson.

"A message which is sent merely by one employee to another within the same organization can be actionable if it contains defamatory statements about a third party," he noted.

Although the case was settled out of court and no court opinion issued, it set at least one precedent, in that WPA obtained a court order that NU should preserve the relevant e-mail messages and release them to WPA, said Mr. Engel.

Many people believe that e-mail messages are gone once the recipients discard them. This is certainly not the case, because all messages are recorded, noted Mr. Engel.

Some experts claim that even after the messages have been wiped from tapes, they still can be deciphered, he added.

"E-mail presents particular risks," Mr. Mathieson noted.

"In truth, e-mail is potentially one of the most lingering methods of communication. It may also be one of the least private and least easy to control since it can be copied, forwarded and accessed by large numbers of people within an organization and, via the Internet, sent outside the organization to computer users anywhere in the world."

The risk of e-mail libel still is not recognized by many companies that may also be uninsured, observers note.

Most standard property/casualty insurance policies do not cover libel, said Ken Bolland, assistant manager of the business development unit of Guardian Insurance Ltd., in Ipswich, England.

"A standard public and employers liability coverage would not cover libel, and most companies would not be covered for such a risk" unless they were in the publishing or communications sector, he said.

Mr. Mathieson agreed that e-mail issues create a business opportunity for the insurance industry as companies "would need a special libel extension to their property/casualty cover."

Meanwhile, law firm Davies Arnold Cooper is sending more copies of its e-mail guidelines to clients as a result of the case, said Mr. Mathieson.

The law firm produced a protocol on e-mail prior to the NU-WPA case that it gave to clients on request. "But we have received several phone calls in the last week and are now sending the protocol to all clients" for whom it is appropriate, said Mr. Mathieson.

Advice offered in DAC's protocol includes:

- Do not use e-mail if you would be uncomfortable sending the message by other permanent forms of communication.
- Take time to present important e-mail messages clearly. The informality of e-mail often leads to sloppy messages that can be misunderstood. Before sending an e-mail message, consider whether it could be misconstrued and how a judge might interpret it.
- E-mail messages can be transmitted to many people without restriction. If it is confidential, mark it accordingly.
- If a message is important, retain it. Do not rely on the recipient to retain a copy.
- Make sure all statements about persons and organizations are true. Do not use e-mail for gossip.

•

Copies of the full E-Mail Protocol can be obtained from Keith Mathieson in London at 44-171-936-2222; e-mail kmathies@dac.co.uk)

U.K. product recall raises awareness

By SARAH GODDARD

LONDON—Product recalls pose a huge threat to U.K. manufacturers' balance sheets, particularly for companies that rely on one or two product lines for the bulk of their sales.

Food and beverage manufacturers are particularly vulnerable to losses in the event of a recall, whether it is a result of accidental contamination, malicious acts or a threat.

In its last published figures for a twelve-month period ending in 1995, the U.K. Chartered Institute of Environmental Health recorded 15,785 incidents of "extraneous matter" in food and beverages as defined by the Food Safety Act 1990. Not all of those led to a recall of the products involved, but the numbers underline the very real danger manufacturers face, especially when set against a background of increasing public awareness.

There were several national recalls in the United Kingdom late last month, most of which involving removing store brand products from supermarket shelves.

One case involved The Co-Operative Wholesale Society, which recalled 6,500 boxes of its own private label hot oat cereal when a customer found a nut in it. Since the cereal does not normally contain nuts, the packaging did not carrying a warning for people suffering from nut allergies, and the retailer decided an immediate recall would considerably lower the risk to public health—and its potential liability exposure.

Another case involved grocer J. Sainsbury P.L.C., which withdrew its store brand milk for young children after consumption of the product was potentially linked with several cases of salmonella food poisoning.

In both cases, the products in question were packaged under the retailer's name, but supplied by a third-party food manufacturer. It is often this manufacturer that finds itself footing the bill for the costs of a recall, and of destruction of the faulty product and replacement costs.

A spokesman from the Co-Operative Wholesale Society confirmed that it expects the supplier responsible for the faulty cereal to cover all of the recall costs.

Increasingly, U.K. retailers are asking their suppliers to purchase insurance to cover recall exposures, according to David Page, director of the special risks division of London-based Nelson Hurst International Ltd. But he was unsure whether those requests are being met, despite the fact that a recall "could wreck their business."

From the retailers' point of view, the decision to recall a potentially contaminated product is "a question of image," said the Co-op spokesman, particularly when it comes to matters of public safety.

When these situations arise, the Co-op has procedures that ensure that the recall happens swiftly. At the first alert of a possible contamination, a technical group evaluates the problem by product line and batch code. As a result of the group's findings, a decision is made whether to halt supply, pull the product from shelves, or actually put out a public recall. In the recent case, Co-op decided to pull the cereal from the shelves and put out a recall notice to the general public because of the potential danger to people with nut allergies, said the spokesman. "Public recalls are extremely rare," he added.

Nevertheless, Giles Burrows, director of London-based broker Nicholson Leslie Special Risks Ltd., part of the Aon Group P.L.C., noted that all the recall incidents Nicholson Leslie has dealt with have included a full public recall.

"The single most difficult decision to make is whether to recall," said underwriter Tony Cassidy of Lloyd's of London agency Cassidy Davis Underwriting Ltd. "If you don't, what will be the downside to the company—the comeback against the company from the buying public?"

Jennie Seabrook, profit center manager of the crisis management division of AIG Europe (U.K.) Ltd., pointed out that not only are food manufacturers more aware of food safety issues than in the past, but so is the general public. "Because the consumers, or buyers, are more aware, they are almost becoming like judge and jury," she said. "People expect food that is of the highest standard and is 100% safe for use."

Recalls may follow a different pattern if an organization's products are the victim of malicious damage, said Peter Cheney, director of crisis consulting at Control Risks Group Ltd. in London. He warned that retailers and manufacturers should not try to apply the lessons they may have learned from accidental contaminations to cases of product tampering.

One of the problems of malicious contamination is that "there are tons of different motives," he said, "and there is probably no warning."

Perpetrators can range from disgruntled employees and ex-employees to individuals wishing to make a fraudulent compensation claim against the manufacturer or retailer, he explained.

One potential threat in the United Kingdom is from animal rights groups that have threatened to contaminate meat products, said Nicholson Leslie's Mr. Burrows.

These situations are "very, very difficult to deal with," said Mr. Cheney, and often require instant action by food companies or retailers to protect both customers and the organization's reputation.

"There is a very misconceived idea that a company would endanger consumers for financial return," said Mr. Cheney, but "no company really puts commercial safety against consumer safety because consumer safety is its commercial future."

At the same time, making fast but uninformed decisions can put the organization in further danger, he warned, because a recall alone does not prevent the perpetrator from tampering again—particularly in cases where extortion is involved.

By backing up a crisis management team with legal, public relations, recall and crisis control experts, an organization can "make good decisions," said Mr. Cheney.

Control Risks estimates that about 70% of all U.K. extortion cases in the food, drinks, cosmetics and over-the-counter pharmaceutical industries do not progress beyond an initial contact. Of the balance, a "fair few never quite get to the moment of receipt of payment," said Mr. Cheney.

Because of their very nature, extortion cases tend not to enter the media, said Mr. Burrows, though one particularly high profile case in 1989 resulted in a 17-year jail term for a former police officer who put shards of glass into jars of baby food.

As a result of this case, food manufacturers introduced tamper evident packaging in the United Kingdom.

Extortion is "a fairly unusual type of crime," said Bill Ilsley, director of crisis management at security consultant Kroll Associates in London, generally perpetrated by single men between the ages of 20 and 40 whose businesses are failing and who have no previous criminal record. Generally, "they need money urgently to get out of a particular problem," said Mr. Ilsley, and they "try and pit their wits against the company and authorities."

Mr. Burrows said he recently has noticed an increase in interest from food and beverage manufacturers of all sizes in purchasing coverage for contamination and extortion risks.

A new recall insurance product is available within the Lloyd's of London market, called the Total Recall Brand Protection Policy. It is provided separately by the Cassidy Davis Hiscox Consortium and syndicate 623, which is managed by Beazley Furlonge Ltd., to policyholders around the world.

The London market already offers two recall products. The first is products guarantee and recall insurance, underwritten on a lineslip by liability specialists in both Lloyd's syndicates and London market companies. Available through broker Nicholson Leslie, the lineslip was set up about 20 years ago and provides up to £10 million ($16.4 million) coverage, with further limits available in the excess market. It offers products guarantee, financial loss, accidental and malicious contamination and recall, and extortion coverage for component manufacturers, food and drink suppliers, construction materials manufacturers and domestic electrical products manufacturers.

AIG Europe in London also offers contaminated products insurance to organizations in the United Kingdom and Ireland. Aimed at food, beverage, tobacco, cosmetics and pharmaceuticals companies, limits up to £6 million ($9.8 million) for accidental contamination and £40 million ($65.6 million) for malicious tampering are available. Ms. Seabrook has noticed a recent move by the "middle market"—companies with revenues between £5 million and £150 million ($8.2 million and $246 million)—to buy contamination coverage.

Total Recall offers worldwide coverage for product contamination, whether malicious or accidental, and extortion, according to David Nicholson, underwriter for syndicate 623. The coverage has limits of around $20 million and additional capacity is available from other sources. "We are aiming the product at middle-market business that has not bought the product before," he said.

In addition to coverage for recall-related costs, the policy also provides up to 25% of policy limits to fund a public relations program, and also includes gross profits coverage.

The product is targeted at small- to medium-sized companies with gross revenues of less than $500 million, said Mr. Cassidy, particularly companies with a single brand name or that market their products through a small number of retail outlets. "It is not reimbursing for damage to the brand name or loss of goodwill—it is for the loss of sales that result from a contamination," he explained. BI

For the Record

Coverage denial approved by court

BOSTON—A workers compensation insurer has no duty to defend in cases where a policyholders brings a suit rather than files a workers comp claim, the Massachusetts Supreme Judicial Court has ruled.

The case arose when an employee sued Boston-based HDH Corp., claiming wrongful discharge. After HDH lost in arbitration and paid $145,000, the company sued its workers comp insurer, Atlantic Charter Insurance Co., to recover the amount paid and defense costs.

Reversing an appeals court ruling, Massachusetts' highest court found in favor of the insurer and dismissed HDH's suit.

"Requiring workers compensation insurers to defend civil actions outside the workers compensation system would represent an unwarranted expansion of coverage historically understood as provided under this mandatory form of insurance, a result which would increase insurance costs for employers and could gut the legislative scheme for workers compensation," the court stated in its July 14 opinion.

Insurer groups that filed briefs in support of Boston-based Atlantic Charter hailed the decision.

"With this decision, Massachusetts workers compensation law and practice remains in the mainstream and costs remain stable," Suzanne Bump, assistant vp and attorney with the American Insurance Assn. in Boston, said in a statement. "Had the appeals court been upheld, Massachusetts would have been the only state to recognize a legally wrong and absurd rule."

Auto renters to get insurance rebates

AUSTIN, Texas—Seven car rental companies and insurers that worked with them are refunding millions of dollars to renters in a settlement with Texas insurance regulators who charge the car companies illegally sold liability coverage in the state.

The Hertz Corp. and Philadelphia-based Reliance Insurance Co. are paying about $4.2 million to more than 312,000 customers, and Avis Inc. and Continental Casualty Co. are paying about $1.7 million to about 150,000 renters, according to figures provided by the Texas Department of Insurance.

Shortly after Hertz and Avis settled the complaints, five other rental car companies and insurers writing the coverage announced similar settlements. They are:

- Alamo Rent A Car Inc. and National Union Fire Insurance Co. of Pittsburgh, Pa. Refunds total $2.2 million to 130,000 customers.
- Thrifty Rent-A-Car System Inc. and Philadelphia Indemnity Insurance Co. Refunds total $325,000 to 25,000 customers.
- Dollar Rent A Car Systems Inc. and Empire Fire & Marine Insurance Co. Refunds total $500,000 for 48,000 customers.
- National Car Rental System Inc. and Philadelphia Indemnity. Refunds total $900,000 for 70,000 customers.
- Budget Rent A Car Corp. and Philadelphia Indemnity. Refunds total $1.4 million for 110,000 customers.

Regulators alleged in consent orders that the rental companies engaged in the unauthorized sale of insurance by offering renters third-party coverage for bodily injury and damage claims. The order said the rental companies illegally acted as both agent of the insurer and insurer, sharing commissions without authority and making misrepresentations regarding insurance.

In addition to refunds, the rental companies and insurers agreed to together pay $50,000 per consent order to the department for reimbursement of investigative costs and administrative fees.

In settling, the rental companies and insurers denied the allegations in the consent order and said they offered renters enrollment in an insurance plan commonly offered to customers by all rental companies.

A public hearing is scheduled Aug. 11 in Austin during which the department plans to present evidence it says will show Enterprise Rent-A-Car Co. sold third-party liability coverage without authority. The department says Enterprise paid losses related to the coverage and indemnified itself through an excess liability policy with an unnamed insurer.

A state law that becomes effective Sept. 1 sets up a method for rental car companies to become licensed and sell insurance related to rentals.

California utility fined for '94 mountain fire

NEVADA CITY, Calif.—Pacific Gas & Electric Co. was fined nearly $2 million by Superior Court Judge Carlos Baker after a jury last month found the utility guilty of causing a 1994 mountain fire by failing to trim trees and brush from its high-voltage lines.

Each of the 738 counts in the guilty verdict represents a separate tree limb, said a PG&E spokesman, who noted the utility has not yet decided whether to appeal the fine.

The fine levied July 18 by Judge Baker reflects a $1.6 million fine for causing the fire plus $359,500 in restitution fines, which could be increased depending upon the outcome of a hearing set for November.

The spokesman refused to say how PG&E would pay the fine.

American Eagle agrees to conservation

DALLAS—American Eagle Insurance Co. is operating in conservatorship after the proposed acquisition of its aviation book of business by American Financial Group Inc. fell through.

The insurer, a Dallas-based subsidiary of American Eagle Group Inc., agreed to a Texas Department of Insurance request that regulators appoint a conservator.

American Eagle announced earlier this year that it would sell its general aviation business to American Financial, the holding company parent of Cincinnati-based Great American Insurance Co. American Eagle was to receive 30% of about $30 million in unearned premiums transferred to the buyer, commissions on direct written premiums of renewal business, the value of furniture and equipment and other considerations.

The insurer said in April it had entered into an agreement under which Great American would reinsure all policies in force as of March 31 and any written or renewed by American Eagle after that date.

American Eagle said at the time that it would stop writing coverage when the transaction closed and the company would be placed in runoff.

The insurer was eager to find a buyer for the aviation business after A.M. Best Co. downgraded its rating to D from B based on the insurer's decision in 1996 to discontinue some property/casualty operations. The Texas Insurance Department said American Eagle ended the year with $141.8 million in assets, $3 million in capital and surplus of $22.6 million.

Great American would not comment on why the acquisition was canceled.

NCCI challenges new Aon business

NASHVILLE, Tenn.—The National Council on Compensation Insurance Inc. is protesting the selection of Aon Group Inc. to administer the Tennessee Workers Compensation Assigned Risk Plan.

The NCCI, which has had a long tenure as administrator of the plan, filed an appeal last month with the Tennessee Department of Commerce and Insurance, alleging Aon responded improperly to a request for proposal to administer the fund.

The protest claims, among other things, that Aon did not list all services and charges it would provide

It also alleges that the RFP would require a change in law, which under the RFP's own guidelines would result in rejection of the proposal. The protest says Aon's proposal does not "equitably distribute or apportion residual market risks among all voluntary market insurers" as required by law. It also gives the state's insurance commissioner powers not granted by law, the NCCI charged.

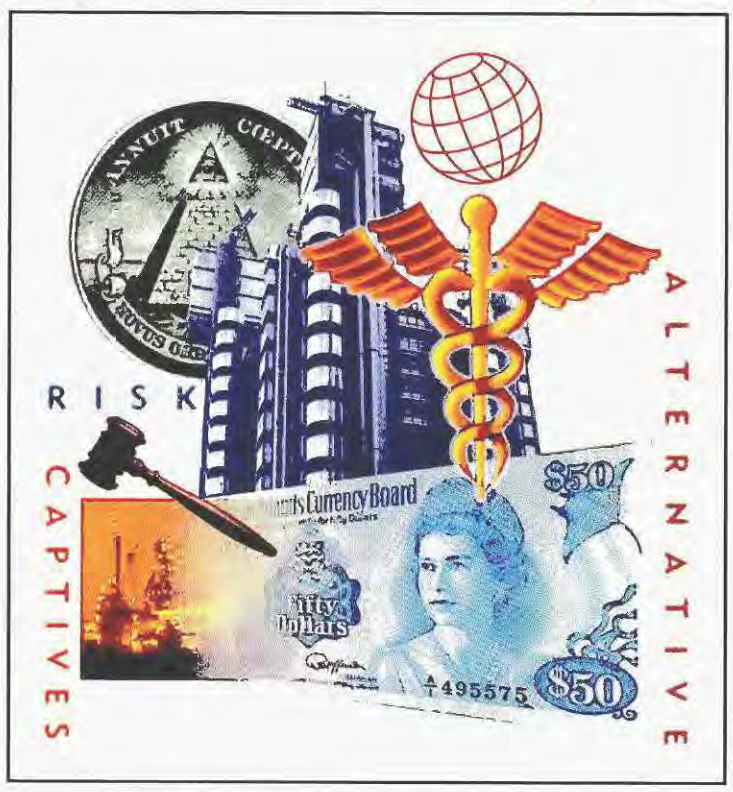
A spokeswoman for Aon declined to comment while the matter is under appeal but said Aon is confident its appointment to administer the fund will be upheld.

An Insurance Department spokes-woman said regulators are uncertain when a decision will be reached.

Information in brief

The **Pension Benefit Guaranty Corp.** is taking over and terminating two underfunded pension plans sponsored by financially troubled Edgewater Steel Co. of Oakmont, Pa., which is operating under Chapter 11. The two plans are underfunded by about $22 million and have about 1,000 participants . . . .The federal Equal Employment Opportunity Commission sued Fort Worth, Texas-based electronics retailing company **Tandy Corp.**, alleging racial discrimination in its now-defunct 17-store Incredible Universe chain. The suit was filed in federal district court in Dallas and accuses Tandy of not promoting two employees of the Arlington, Texas, Incredible Universe store because they are black. BI

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Tax bill

Continued from page 1

expand eligibility for tax-deductible individual retirement accounts; and create new non-deductible IRAs that would allow tax-free withdrawals in certain situations.

Employers have another reason to be jubilant: Their earlier lobbying efforts knocked out a provision that would have required written spousal consent on 401(k) plan withdrawals, which would have increased employers' administrative costs and reduced employee participation in the plans, critics of the provision maintained.

"The business community was active, made its voice heard, turned the situation around and got the 401(k) spousal provision removed," said James Klein, president of the Assn. of Private Pension & Welfare Plans in Washington.

"This success should underscore to benefit professionals the importance of getting involved," said Mr. Klein. The APPWP was one of several business groups that lobbied strongly on the 401(k) provision.

But there were a handful of setbacks for employers. Effective upon enactment of the legislation, employers would be the primary payer of medical bills for 30 months for employees who developed end-stage renal disease. Under current law, employers are the primary payers for those with ESRD for 18 months, and after that, the liability goes to Medicare. Medical bills for those with the kidney impairment often run about $50,000 a year.

This expansion of employer liability is "a straight cost shift to employers," said Frank McArdle, a consultant with Hewitt Associates L.L.C. in Washington.

Another Medicare-related provision also would increase costs for employers. That provision involves situations in which the federal government finds out that employer plans—not Medicare—should have paid an employee's medical bill. These situations typically have occurred when employees stay on the job after 65 and hospitals bill Medicare rather than group plans.

Under the legislation, which would end years of litigation on the issue, the government would have up to three years after a health care service was delivered to bring an action against employers or others for payments Medicare improperly made. This provision would in effect overturn a federal appeals court decision that gave the government in many cases only a year after a service was delivered to bring a legal action.

A related provision also would allow the government to bring action against third-party claims administrators for Medicare overpayments as long as the TPA was retained by the employer at the time the government filed for recovery and the TPA had means for recovering its cost from the employer.

While a handful of provisions would increase employer costs, "on balance, the outcome of this bill is pretty favorable," Mr. McArdle said.

Over the long term, the most significant benefit-related provision in the legislation is likely to involve the overhaul of the way the government pays HMOs for providing benefits to retirees eligible for Medicare.

Under a 1982 law, payment rates established for HMOs that agree to take over from Medicare the responsibility of providing health care benefits to retirees are based on Medicare's costs of providing benefits to participants on a county-by-county basis.

But benefit managers and others have complained that the current payment system is irrational and encourages waste. That is because the more money that Medicare spends in a county, the higher the payments to HMOs are. By contrast, the payment rates are lowest in those counties where buyers and providers have done the best job of controlling costs.

As a result, HMOs in areas of the country with high payment rates from the government provide rich benefits packages and typically charge either no or very low premiums, while payment rates in other areas are so low that it is not fiscally possible for HMOs to enter the Medicare retiree market.

The legislation would change the payment structure by basing payment rates on a blend of local and national Medicare costs. It also would set a minimum HMO payment rate of $367 a month per retiree.

The result of these changes would mean HMOs could vastly expand their presence in the risk HMO market.

"There will be more choices for people around the country," said Susan Foote, president of Durenberger/Foote, a Washington-based health care policy consulting firm.

If so, that will be good news for employers with retiree health care plans that supplement the traditional Medicare market. To the extent that retirees migrate into Medicare risk HMOs, they will have less need for health care coverage from their former employers (see story, page 3).

Another group winning big from the tax legislation is upper-middle and upper-income employees with pension plans who want to set up tax-deductible and non-deductible IRAs.

IRAs would be expanded by provisions that would:

- Allow individuals without pension coverage to qualify for a tax-deductible IRA even if a spouse were covered by a pension plan. A $2,000 tax-deductible contribution could be made to spousal IRA for joint filers with an adjusted gross income of $150,000. The $2,000 deduction would be phased out for joint filers with AGI of between $150,000 and $160,000.
- Increase the income that taxpayers with pension coverage could earn and still make a tax-deductible contribution to an IRA.

Under current law, the full $2,000 tax deduction for IRAs is allowed only for individuals with an AGI of less than $25,000 and joint filers with an AGI of less than $40,000. The $2,000 tax deduction under current law is reduced, based on a sliding scale, for individuals with an AGI of between $25,000 and $35,000 and joint filers with an AGI of $40,000 to $50,000.

Under the legislation, the income threshold for making the full tax-deductible contribution to an IRA would be lifted next year to $30,000 for individuals and $50,000 for joint filers. These income limits would be gradually increased. The income limit for an individual to make the full deduction would top out at $50,000 in 2005, while the limit for joint filers would be capped in 2007 at $80,000. Smaller tax deductions would be allowed for individuals earning between $50,000 and $60,000 and joint filers earning between $80,000 and $100,000.

- The current 10% excise tax on IRA withdrawals before age 59½ would be waived for distributions taken to pay for educational expenses and a down payment—up to $10,000—used toward the purchase of a first home.
- Establish new non-tax-deductible IRAs in which up to $2,000 in aftertax contributions could be made. Individuals with AGI of up to $95,000 could make the full contribution, while those with an AGI of between $95,000 and $110,000 could contribute smaller amounts. In addition, joint filers with an AGI of up to $150,000 could make the full contribution, while the $2,000 contribution would be phased out—based on a sliding scale for those with an AGI of between $150,000 and $160,000.

Funds could be withdrawn tax- and penalty-free for people at least 59½ and who held the contributions at least five years. Funds could be withdrawn without the normal 10% excise tax to pay for education expenses and the downpayment on a home.

While the IRA provisions would greatly increase the availability and appeal of IRAs, benefit experts doubt employees would divert contributions they normally would have made to a 401(k) plan—especially if there were an employer match.

"In general, employees in a matched savings plan still will be better off in a 401(k) plan than in an IRA," Mr. McArdle said.

The legislation, though, also is significant for what it does not include. Dropped from the bill, amid lobbying from senior citizen groups, was a provision that would have raised the Medicare eligibility age to 67 from the current 65, a provision that would have raised costs significantly for employers with retiree health care plans.

That issue, warned Stuart Brahs, vp-federal government relations with The Principal Financial Group in Washington, will be revisited.

The tax agreement also contains a provision that would make amend the Internal Revenue Code to make it more tax favorable for an employer to use structured settlements in workers compensation claims. The provision, a bill introduced in May by Rep. Clay Shaw, R-Fla., would allow employers to assign a structured settlement to a financial institution rather than maintaining ownership of it on behalf of the employee. The employer then would be able to immediately write off the entire value of the settlement rather than recognizing the expense as payments are made to the employee, and would pay the financial institution to administer it for the injured worker. BI

Tax legislation benefits

Employers and employees stand to gain from budget bill

- New payment system for Medicare risk HMOs
- Expanded employer liability for end-stage renal disease
- More time for government to recover Medicare overpayments
- Extension of educational assistance benefits
- Increase in pension benefit cash-out limit
- Repeal of 15% excise tax on big pension distributions
- Reduced pension reporting requirements
- Raised income limits for IRA eligibility for pension participants
- New non-deductible IRAs
- Removal of tax penalties for certain IRA withdrawals

GRAPHIC BY TONY BUCCINI

Child care credit to be sought again

WASHINGTON—Supporters of a proposal to give employers tax credits for establishing child care facilities hope the issue will be revived this fall now that negotiators have excluded it from the recent balanced budget package.

Sen. Herbert Kohl, D-Wis., likely will continue seeking support for S. 82, the "The Child Care Infrastructure Act" he re-introduced in January (*BI*, Feb. 24), his spokeswoman said last week.

He is expected to target members of the House, which failed to pass the measure during regular session. A large majority of U.S. senators have indicated their support for the bill, which they passed 72-28 in a June vote.

The bill as drafted would provide a federal tax credit to private businesses that acquire, expand or repair an onsite or near-site day care center, after-hours care facility or sick-child facility. The credit also would apply to employers that subsidize the operating costs of a child care facility, contract with a child care resource and referral center to help employees, reserve child care slots at a licensed facility or train workers.

Supporters' hopes are buoyed by indications that the White House will emphasize the importance of child care this fall, Sen. Kohl's spokeswoman said.

Specifically, the White House will host an Oct. 23 conference "to examine the strengths and weaknesses of child care in America and explore how our nation can better respond to the needs of working families for affordable, high-quality child care," according to a White House statement.

"Making high-quality child care more affordable and accessible is critical to the strength of our families and to healthy child development and learning. It is also good for the economy and central to a productive American workforce," according to a White House statement.

—By Meg Fletcher

Crash

Continued from page 2

does not, however, allow for recovery of non-pecuniary damages, such as loss of society and companionship, survivor's grief and sorrow and the pre-death pain and suffering of the victim.

Approximately one-third of the states allow damages for a survivor's grief and approximately 45 states allow damages for pre-death pain and suffering and loss of society, according to George N. Tompkins Jr., a partner with Tompkins, Harakas, Elsasser & Tompkins in White Plains, N.Y. Some states cap these damages and some states impose restrictions on who may recover them.

The House bill, H.R. 2005, was introduced by Rep. Joseph M. McDade, R-Pa., who represents the district where 21 high school students and chaperones lived before they were killed in the 1995 explosion of TWA flight 800.

The bill, which would be retroactive to Jan. 1, 1995, to apply to the TWA disaster, cleared the House and has been sent to the Senate.

"The gross injustice of the Death on the High Seas Act must be changed," stated Rep. McDade. "Where a plane crashed should not dictate your rights in a court of law."

Survivors of those killed in an airplane crash over international waters "should at least have the benefit of their state laws," said Lee Kreindler, a partner with Kreindler & Kreindler in New York and chairman of the plaintiff's committee representing the families of victims of the TWA flight 800 disaster.

The Death on the High Seas Act "is an antique" and never really was intended to apply to airplane disasters, Mr. Kreindler noted. The law originally was passed to provide some financial recovery for dependents of victims of the Titanic disaster or of sailors lost at sea because state laws did not have jurisdiction, according to experts.

However, Mr. Tompkins, a defense attorney, charged that the bill is "based on total misinformation" and "the House of Representatives has responded to the demands of family groups" in passing the bill.

Mr. Tompkins noted that courts consistently have upheld the application of the Death on the High Seas Act to airplane disasters over international waters.

"I doubt it will get through the Senate," he added. And if the bill does become law, it will mean "absolutely nothing except about 20 years of litigation over what the law means and whether it's valid or not."

Furthermore, there are three other federal death statutes in addition to the Death on the High Seas Act and none of them allows for recovery of damages for grief or loss of society, Mr. Tompkins pointed out.

These laws are the Federal Employers Liability Act, the Jones Act and the Longshore and Harbor Workers Compensation Act.

A spokesman for the Air Transport Assn. in Washington said that the Death on the High Seas Act "needs to be updated," but the group does not support the House bill. The ATA opposes the retroactive date included in the bill, he said.

A spokesman for St. Louis-based Trans World Airlines Inc. declined to comment on the bill, stating only: "We think that any law that is passed and is made to apply retroactively is extremely unfair." BI

Home makes interest payment

By GAVIN SOUTER

NEW YORK—Home Holdings Inc. was able to make its $11.6 million interest payment to bond holders last month after a last-minute decision by its troubled subsidiary, The Home Insurance Co., to pay a dividend to the holding company.

The dividend is covered by a special reinsurance provision and will not affect the statutory surplus of The Home.

The late payment is one of a series of problems that has affected The Home since it went in to runoff in 1995. The controversial runoff deal allowed Zurich Insurance Group to take on the profitable business of The Home without assuming the liabilities of its unprofitable business.

Home Holdings was due to make the interest payment in June. Shortly before the due date, The Home announced it would take advantage of a 30-day grace period to defer the decision on whether to make the necessary dividend payment to the holding company (*BI*, June 23).

Under the structure of the companies, most of the former Home group's assets are held by The Home, which was the principal operating company of the group of insurers under Home Holdings. Any interest payments to the bond holders of Home Holdings have to be financed through dividend payments by The Home.

The issue was complicated further earlier this year when the New Hampshire Insurance Department placed The Home under formal regulatory supervision after the company published worse-than-expected financial results. Under the terms of the supervision, The Home cannot make any single non-claims payment in excess of $500,000 without approval from regulators (*BI*, March 10).

The Home's directors decided to miss the first payment deadline "to obtain additional information on how the company was developing financially," said Mark Davidowitz, assistant controller and investment relations manager at New York-based Risk Enterprise Management Inc., the Zurich-owned company running off The Home.

The payment is covered by a reinsurance program provided by Zurich that kicks in if The Home eventually runs out of assets to pay policyholder claims. Under the reinsurance contract, Zurich provides $290 million in reinsurance to cover interest payments in addition to a $1.3 billion reinsurance agreement to cover policyholder claims.

Regulators approved the dividend payment plan largely due to the specific reinsurance related to the payment, said David Nichols, the examiner appointed by the New Hampshire department to oversee the runoff of The Home.

A similar interest payment to bond holders is due Dec. 15. BI

Heritage

Continued from page 2

Heritage.

- Lyle K. Pfeffer, a New York businessman who, with Mr. Blutrich, controlled several corporations used in the alleged fraud.
- Shalom Weiss, a New York businessman who controlled several other companies allegedly used to launder diverted funds.
- Richard B. Herman, a New York lawyer and one-time partner of Mr. Blutrich, who allegedly helped launder money used in a bogus National Heritage capital contribution.

The five men have been summoned to appear in court Aug. 21. None has yet entered a plea.

Mark Horwitz, an Orlando lawyer who has represented Mr. Smythe during the two-year federal investigation of National Heritage, described the indictment as "overkill" but declined to comment further. He said Mr. Smythe "no longer has the resources" to defend himself in criminal and civil cases stemming from the collapse and likely will seek court-appointed counsel in the criminal case.

A lawyer for Mr. Pfeffer declined to comment. The other defendants and their lawyers could not be reached.

The National Heritage investigation already has produced three convictions. Last December, a federal judge sentenced former National Heritage Treasurer David L. Davies to 84 months in prison and payment of $10.5 million in restitution after he pleaded guilty to wire fraud and tax evasion charges (*BI*, April 15, 1996; March 11, 1996).

Richard M. Plato, a Houston lawyer, pleaded guilty to fraud charges in August 1996 after prosecutors charged him with diverting $16 million in National Heritage funds and laundering $1 million of the money.

Jay I. Bartz, a former LifeCo director, earlier pleaded guilty to money laundering and was sentenced in December 1995 to five years' probation.

In the latest indictment, prosecutors charge that Messrs. Smythe, Blutrich, Pfeffer, Weiss and Herman helped engineer sham capital contributions to National Heritage while siphoning out $47 million of the insurer's assets.

In one example, a company controlled by Messrs. Pfeffer and Blutrich purported to acquire part of a block of problem mortgages from National Heritage for $12 million. The mortgages, which regulators had questioned, included loans the insurer had made to companies Mr. Davies and Mr. Blutrich secretly controlled and to other companies controlled by friends and associates of Mr. Blutrich, according to the indictment.

In return for relieving National Heritage of the loans, the buyer, LPDA Acquisitions Inc., insisted on taking over management of $15 million of the insurer's investments, the indictment says.

LPDA, which had no assets of its own, then pledged the National Heritage investments to secure a $15 million bank line of credit, which it later drew down, using some of the proceeds to pay the insurer for the mortgages and diverting part of the money to the defendants' own benefit, the indictment alleges.

In another instance, Messrs. Smythe, Blutrich and Pfeffer allegedly arranged for the purchase of $11 million of LifeCo stock by a non-existent investment group purportedly headed by Averell Harriman Fisk, a relative of U.S. diplomat Averell Harriman. Mr. Pfeffer gave National Heritage a letter of intent on the deal bearing the forged signature of Mr. Fisk, prosecutors charge.

In return for this investment, Mr. Blutrich and another company controlled by Mr. Pfeffer, Future Diversified Projects Inc., demanded the right to manage another $25 million in National Heritage assets.

The defendants then used these assets to secure a $20 million bank line of credit, which they used to pay for the LifeCo preferred stock, diverting the rest to their own benefit, the indictment charges.

New York-based Standard Chartered Bank, which provided both credit lines, eventually liquidated the National Heritage collateral to pay off the debts, the indictment says.

Messrs. Smythe, Blutrich and Pfeffer, however, concealed the bank loans, causing National Heritage to report receipt of $48.2 million in proceeds from the sale of its assets when in fact only $12.6 million remained after credit lines were paid off, the indictment says. BI

Colorado

Continued from page 1

cleared a disaster emergency, which released $5 million in state funds to aid the Fort Collins area. The governor requested federal disaster designation, which would provide additional funds.

In a letter to President Clinton requesting the designation, the governor acknowledged that while flood damage assessments were ongoing, conservative estimates put losses at $40 million to $50 million for Colorado State University and another $5 million to $6 million in "private property and infrastructure damage" in Fort Collins.

The governor's private property figure could well turn out to be low. One insurer alone last week estimated it would pay $2 million in auto claims.

Approximately 20 buildings at the university suffered damage. Flooding in the basement of the Morgan Library damaged about half of the facility's collection, which was being stored there during a renovation project.

University personnel acted quickly in an attempt to save around 500,000 books and periodicals, some a century old. The items were transported within hours of the flooding to a firm specializing in restoring printed material, a university spokeswoman noted.

"The reason they were in the basement was to accommodate the renovation," she said. "Normally, that's not where they would have been."

The spokeswoman said much of the damage likely is covered by a state self-insurance fund. Some operations that acted as businesses on the campus, such as the bookstore, are covered under policies written by private insurers, she added.

The state also has $25 million in flood coverage written by three insurers, according to John Cook, claims manager for the state.

National Union Fire Insurance Co. of Pittsburgh, Pa., writes the first $5 million in coverage. Excess layers totaling $20 million are written by Reliance Insurance Co. and Fireman's Fund Insurance Co.

Insurers were beginning to total homeowners and auto claims from the flooding late last week.

State Farm Insurance Cos. said it anticipates about 500 auto claims averaging $4,000 each.

The insurer doesn't expect a lot of homeowner claims, a spokeswoman noted, because most of the damaged residences were manufactured homes. "We didn't insure any of those."

Allstate Insurance Co. expects little claims activity from the area. "We've not declared it a catastrophe," said a spokeswoman. "It's being handled as routine."

Most buildings and homes in the area are not protected by flood insurance.

Latest figures recorded by the National Flood Insurance Program listed only 228 policies written for businesses and homes in the Fort Collins area, according to Norm Ashford, Denver-based regional sales manager for the program. The NFIP coverage is written up to limits of $500,000 for businesses and $250,000 for homes. BI

Updates

Court nixes Dow Corning plans

BAY CITY, Mich.—A federal bankruptcy judge hearing the Dow Corning Corp. case last week rejected competing reorganization plans submitted by the company and by a group of women plaintiffs with silicone breast implants.

Instead, Judge Arthur J. Spector suggested the two parties work together to develop a consensual plan.

The judge also rejected Dow Corning's request to convene a "science panel," a group of experts who would evaluate the plaintiffs' claims of immune system impairment. U.S. District Judge Sam C. Pointer Jr. already has appointed such a panel, which conducted hearings last month on the safety of silicone implants (*BI*, July 28). Judge Pointer was assigned by U.S. Supreme Court Chief Justice William Rehnquist to supervise the Michigan federal proceedings.

However, the bankruptcy court judge's opinion supported one element of Dow Corning's proposed reorganization plan: common issue causation trials, in which a single proceeding may be used to determine a causal link to claimants' injuries (*BI*, Dec. 9, 1996).

Judge Spector said he will recommend common issue causation trials if that issue is not resolved up front, either through a consensual plan or through rulings on other pending motions now before the court.

Tenet settles liability claims

SANTA MONICA, Calif.—Tenet Healthcare Corp. has agreed to pay about $80 million to settle 700 suits brought by former patients in the company's psychiatric hospitals.

The suits, pending in two Texas state courts, allege that the former patients were held in the hospitals against their will in order to obtain larger payments from their insurance policies. The hospitals were operated by National Medical Enterprises, which merged with American Medical International in March 1995 to form Santa Monica, Calif.-based Tenet.

Besides Tenet, the physicians involved have agreed to pay the former patients $20 million.

Coverage information was not made available.

Tenet has made other settlements related to NME's activities. Previously, NME paid $125 million to six insurers to settle charges it submitted fraudulent psychiatric claims and $379 million to settle a Justice Department investigation over its practices (*BI*, July 11, 1994; Oct. 4, 1993).

About 300 more suits by former patients are pending against Tenet.

CIGNA sells off life, annuities

FORT WAYNE, Ind.—Lincoln National Corp. said it will purchase CIGNA Corp.'s individual life insurance and annuity business for about $1.4 billion in cash in a transaction expected to close at year end.

The deal includes $37 billion of individual life insurance in force; CIGNA Financial Advisors, which has 600 agents; a life brokerage operation; and an annuity distribution system. Not included is CIGNA's corporate-owned life insurance; group life insurance; and life, health and accident reinsurance businesses.

CIGNA, which announced its acquisition of Healthsource Inc. earlier this year, now is focusing on commercial business, including employee benefits and risk management, said a CIGNA spokesman (*BI*, March 10).

He said proceeds of the deal will primarily be used to buy back its stock.

In June, Lincoln National said it would sell its 83.3% stake in property/casualty insurer American States Financial Corp. to Seattle-based SAFECO Corp., which, with repayment of intercompany debt, will yield aftertax proceeds of $2.15 billion (*BI*, June 16).

Briefly noted

Fugitive insurance executive **Martin Bramson** has been extradited to the United States to face charges of defrauding medical malpractice and liability policyholders with a string of bogus offshore insurance companies. Mr. Bramson, who fled house arrest while awaiting trial in 1991, was arrested in Liechtenstein in 1995 as he tried to cross the border from Austria carrying several million dollars of Swiss currency and gold (*BI*, Jan. 30, 1995). . . .Dominic Frederico has been named president of **ACE Insurance Co. Ltd.**, the Bermuda insurance operating unit of ACE Ltd., in a series of appointments aimed at delineating the insurance company and the holding company. Mr. Frederico was previously executive vp, underwriting for ACE's Bermuda operations . . . .The New York-based **Risk & Insurance Management Society Inc.** has named Amy Geffen director of professional development. Ms. Geffen, who holds a Ph.D., will assume the position today that has been vacant for a year. . . .The House of Representatives followed the lead of the Senate last week and overwhelmingly rejected a measure that would have cut the **Overseas Private Investment Corp.**'s administrative budget by one-third. OPIC, which writes political risk insurance for U.S. companies doing business in selected developing countries, has come under fire from both ends of the political spectrum as an example of "corporate welfare". . . .**Richard L. Huber** has been named president and chief executive officer of Aetna Inc. Mr. Huber, formerly the vice chairman of strategy and finance, takes over from Joseph Sebastianelli, who resigned the post in May. . . .Maine Insurance Superintendent **Brian K. Atchinson** will resign Aug. 29 to become second vp-government relations for UNUM Corp. in Portland, Maine, though a state law prevents him from representing the company before Maine regulators. Deputy Superintendent Alessandro Iuppathen will serve as acting superintendent until a successor is named. . . .A Massachusetts federal judge dismissed **a sexual harassment and retaliation lawsuit** brought against Astra USA, ruling the six former employees had reached previous settlement agreements with the Westborough, Mass.-based pharmaceutical company and therefore had no right to sue.

Tobacco

Continued from page 1

As it now reads, the proposal would require tobacco manufacturers to pay $368.5 billion over the next 25 years to settle the suits brought by 40 states and Puerto Rico. Sixty billion dollars would be considered punitive damages. In return, the states would drop all their suits against the tobacco companies, class-action suits against the cigarette makers would be banned, and punitive damages for past misdeeds would be prohibited. Individuals, though, could continue to sue for damages.

The proposed limits on litigation drew criticism from a somewhat unusual source.

Robert Falise is chairman and managing trustee of the Fairfax, Va.-based Manville Personal Injury Settlement Trust, which was created by Johns Manville Corp. to compensate individuals who suffered injury from exposure to asbestos. He criticized the settlement because it would not allow the trust or other asbestos litigants to obtain compensation from tobacco companies for lung ailments exacerbated by tobacco use.

Mr. Falise said that while the risk of lung cancer among asbestos workers in general was five times that of workers in other industries, the risk for workers who also smoked was about 53 times higher.

He said asbestos makers were paying in part for injuries for which the tobacco companies should be held liable. He suggested that a separate fund be carved out of the proposed settlement to compensate asbestos victims, though he would not specify how much of the settlement should go into the fund.

Mr. Falise's suggestion drew a scornful response from Mississippi Attorney General Mike Moore, who had spearheaded the negotiations.

During an impromptu press briefing during a break in the hearing, Mr. Moore noted that the asbestos makers had never sued the tobacco companies for any compensation. Now that there's a potential pot of hundreds of billions of dollars from the cigarette makers, though, "everybody wants a piece," he said.

Under questioning by Sen. Mike DeWine, R-Ohio, Mr. Falise agreed that to the best of his knowledge, no asbestos trust or manufacturer had ever sued tobacco companies.

That was confirmed after the hearing by Larry Fitzpatrick, president of the Princeton, N.J.-based Center for Dispute Resolution, an unrelated asbestos compensation facility.

Nevertheless, Mr. Falise said the asbestos trust remains concerned about the limits on cigarette makers' liability contained in the proposal.

Earlier, Sen. Frank Lautenberg, D-N.J., cited the tort limitations provided by the proposal and told the Judiciary Committee that "Congress should demand equally far-reaching public health concessions from the tobacco industry if we are to even consider such restrictions on the rights of people to sue for their injuries."

Sen. Lautenberg also noted that he had introduced legislation that would specifically "prevent the tobacco industry from getting backdoor relief" through comprehensive product liability reform legislation introduced earlier this year in the Senate.

"The American people still hold a wild card in their deck—the wild card of civil liability. We should not discard it unless we know we will win the game in favor of our citizens' health and the well-being of all future generations," he said.

A few minutes later, Dr. Lonnie R. Bristow, a San Pablo, Calif., physician who is immediate past president of the American Medical Assn., called on the senators to approve the proposal.

While saying Congress and the White House need to "carefully evaluate" some concerns raised about the agreement—particularly regarding the Food and Drug Administration's oversight power and penalties imposed on tobacco companies for not reducing youth smoking—Dr. Bristow said the settlement has "public health opportunities that potentially dwarf the impact of even the polio vaccine."

"Stay focused on the goals of prevention and treatment. Do not allow this opportunity to be consumed by those who may prefer vengeance to saving lives or who value process over outcome," Dr. Bristow said.

Fewer than 24 hours after his testimony, the AMA gave its conditional support to the proposed settlement, provided the FDA and youth smoking provisions are modified, giving the FDA more power and more severe penalties if the industry fails to meet youth smoking reduction goals.

Mississippi's Mr. Moore said last Thursday that he had reopened negotiations with the tobacco companies regarding those matters.

Dr. Bristow's position was not, however, shared by two other prominent medical authorities who testified before the Commerce Committee the same day.

Both former Surgeon General C. Everett Koop and former FDA Administrator David Kessler said the settlement should be rejected unless it first undergoes significant changes. Both doctors had served on the congressionally created Advisory Committee on Tobacco Policy and Public Health, which recently issued its own report.

Among the changes the doctors demanded were banning smoking in all public places, giving the FDA more money to regulate tobacco products and setting specific standards that would determine how much youth smoking should decline each year and penalize tobacco companies if the standards aren't met.

"You can accept this industry blueprint and tinker with it, improving it here and there but leaving its framework intact. That will make some difference, but it will keep the industry booming and profitable at the expense of the nation's health. If that is the best you can do, do it, but the American people want more, and history will not look kindly at your timidness," said Drs. Koop and Kessler.

The two doctors' testimony drew an angry response from Sen. Wendell Ford, D-Ky. The two want to "improve" the settlement in such a way as to make adoption of the terms impossible, he charged. The demands of Drs. Koop and Kessler amount to "nothing more than a backdoor prohibition," said Sen. Ford, adding that such "extreme views" would undo the "delicate balance" that led to the agreement.

Other possible areas of contention emerged during the Commerce Committee hearing.

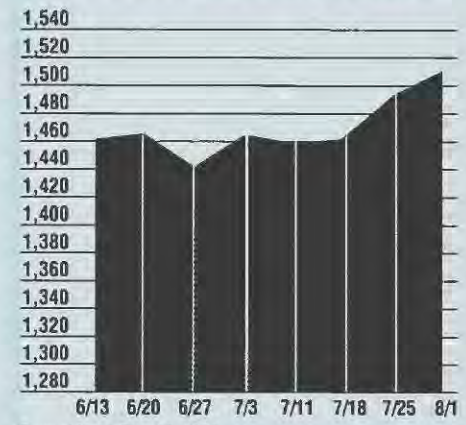
Both Sens. Ford and Bill Frist, R-Tenn., said tobacco farmers must be treated fairly. Sen. Frist, the only medical doctor in the Senate, emphasized that tobacco farmers had not been included in the negotiations and "should not be forgotten now."

"One other group, a group that appeared to be well-represented at that negotiating table, should not be forgotten, either," Sen. Frist said. "Let us not forget what this deal will mean for our friends at the bar. They are anticipating a harvest, too, and the numbers reach into the billions. No one knows just how much of that sum will end up in barristers' pockets, but I do hope my colleagues will look at this bottom line to exercise careful caution on the matter of legal fees," he said.

In other tobacco-related developments last week:

- A Palm Beach County, Fla., circuit court judge ruled that cigarette makers cannot use the fact that the public has known about the dangers of smoking for decades as a defense against the state of Florida's multibillion-dollar lawsuit seeking recovery of tobacco-related Medicaid expenses. The trial is expected to begin next month.
- Meanwhile, four more union health funds have sued tobacco manufacturers and a public relations agency that worked for them to recover money the funds paid to treat smokers' illnesses. The suit, filed in New York state court, alleges the tobacco companies, trade associations and public relations firm conspired to hide the hazards of smoking from the public. BI

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: Nordby International Inc.

PCS catastrophe options

As of Aug. 1

Call spread	Price bid/ask
Eastern September 1997	
40/60	3.0/3.9
60/80	2.1/3.5
80/100	1.5/2.5
National Annual 1997	
80/100	3.2/3.8
120/140	—/5.0
Southeastern September 1997	
40/60	2.5/3.6
60/80	2.2/2.5
80/100	.5/2.0
California Annual 1997	
40/60	.4/1.6
80/100	—/1.3
Western Annual 1997	
40/60	.6/1.8
70/90	—/1.6

Total volume: 339 Total open interest: 16,283

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
Comml Union	675	10.8	30.3	5.5	764—583
Genl Accident	915	6.6	34.3	4.7	978—629
Gdn Royal Exch	289	4.7	12.2	4.2	311—243
Independent	887	11.0	13.3	1.9	898—488
Royal & Sun	504	14.9	19.0	4.7	529—385
Brokers					
Bradstock	84	12.0	6.4	9.9	90—54
CE Heath	141	9.1	1.5	1.3	143—74
Lmbrt Fenchurch	130	12.2	8.4	8.4	133—101
Lloyd Thmpson	182	NA	NA	NA	206—163
Nelson Hurst	179	16.4	8.6	6.0	192—121
Sedgwick Grp	121	10.4	8.9	7.3	144—115
Steel Brl Jones	28	9.7	1.5	6.7	40—22
Willis Corroon	127	11.3	6.6	6.3	165—117

Note: Prices are Aug. 1 closings; other numbers from July 31.

Source: Nordby International Inc.

BI Industry Stock Report JULY 28, 1997, THROUGH AUG. 1, 1997

BROKERS		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
Aon Corp.	NYS	53.75	0.12	29.78	56.13	31.88	1109
E.W. Blanch Holdings Inc.	NYS	28.94	-1.49	43.79	30.63	18.00	77
Gallagher Arthur J. & Co.	NYS	35.94	-1.88	15.93	37.75	29.13	193
Hilb, Rogal & Hamilton	NYS	16.50	-1.86	24.53	17.25	12.13	128
Kaye Group Inc.	NDQ	7.13	32.56	35.71	7.75	4.38	32
Marsh & McLennan	NYS	76.69	3.63	47.48	77.75	44.75	1749
Poe & Brown	NDQ	36.88	-0.34	39.15	38.50	23.75	9
Sedgwick Group PLC	NYS	10.13	-2.41	-2.41	10.88	9.88	15
Willis Corroon Corp.	NYS	10.50	-9.68	-8.70	13.50	9.38	958
BROKERS	AVERAGE		2.32	24.44			
INSURERS/REINSURERS							
ACE Ltd.	NYS	84.25	4.58	40.12	84.25	43.63	365
Acceptance Insurance Cos.	NYS	22.88	-4.44	15.82	24.13	17.00	299
AEGON N.V.	NYS	74.06	-3.66	17.09	78.88	45.25	351
Aetna Life & Casualty	NYS	114.00	1.22	42.50	115.88	57.63	1878
AFLAC Inc.	NYS	54.56	-2.57	27.63	56.44	31.63	1025
Allied Group Inc.	NYS	47.06	6.36	44.25	47.06	23.63	135
Allstate Corp.	NYS	77.63	-0.08	34.13	79.94	43.50	3331
AMBAC Indemnity Corp.	NYS	82.31	-1.86	24.01	85.88	47.25	382
American Bankers Ins.	NDQ	66.88	2.39	30.81	69.13	39.75	97
American Financial Group	NYS	47.00	2.17	24.50	49.25	29.00	418
American General	NYS	51.75	0.73	26.61	54.75	34.25	3297
American Heritage Life Ins.	NYS	38.75	7.83	47.62	38.75	19.00	84
American Indemnity/Fin'l	NDQ	12.50	2.04	21.95	14.00	9.50	5
American International	NYS	103.38	0.61	43.24	106.88	62.13	4491
Argonaut Group	NDQ	33.00	2.33	7.32	33.00	26.75	64
Baldwin & Lyons Inc.	NDQ	19.38	-1.90	5.44	22.63	17.38	8
Berkley W.R. Corp.	NDQ	57.75	1.09	13.79	60.50	40.75	278
Berkshire Hathaway Inc.	NYS	47500.00	-0.42	39.30	48600.00	30000.00	1
Capital RE Corporation	NYS	52.88	-2.87	13.40	56.38	33.63	117
Capital Transamerica Corp.	NAS	26.63	-0.93	-13.41	27.50	13.13	34
CapMac Holdings Ltd.	NYS	27.13	-4.82	-18.11	36.88	22.50	307
Capsure Holdings Corp.	NYS	13.75	1.38	19.57	18.88	8.00	42
Centris Group Inc.	NYS	22.38	-4.28	14.01	23.56	14.88	65
Chartwell Re	NYS	33.13	4.33	23.83	33.50	21.50	70
Chubb Corp.	NYS	68.94	0.09	28.26	70.94	41.63	1705
CIGNA Corp.	NYS	196.75	3.01	44.01	200.75	106.13	901
CNA Financial Corp.	NYS	117.81	2.17	10.11	119.13	95.88	171
EMC Insurance Group Inc.	NDQ	13.13	-2.78	9.38	13.50	10.50	74
Enhance Financial Services	NYS	50.31	4.95	37.84	50.31	27.75	152
Everest Reinsurance	NYS	39.56	10.86	37.61	40.25	23.75	650
Executive Risk Inc.	NYS	54.63	8.98	47.64	56.38	33.38	146
EXEL Ltd.	NYS	54.44	1.40	43.73	56.38	31.75	798
Fremont General Corp.	NYS	42.56	4.13	37.30	42.75	23.88	258
Frontier Insurance Group	NYS	3[illegible].81	3.46	66.34	33.00	16.63	927
Gainsco Inc.	NYS	9.13	-2.01	-5.19	10.88	8.13	248
General RE Corp.	NYS	204.00	2.38	29.32	208.88	140.75	685
Gryphon Holdings	NDQ	17.13	0.00	21.24	17.75	12.00	62
Guaranty National Corp.	NYS	26.75	6.47	59.70	26.75	13.75	28
Harleysville Group	NDQ	38.56	2.66	26.43	38.56	24.50	171
Hartford Steam Boiler	NYS	55.75	2.76	20.22	56.00	42.75	178
HCC Insurance Holdings	NYS	30.69	-2.39	27.86	32.75	21.50	680
IPC Holdings Ltd.	NDQ	29.63	-2.07	32.40	30.50	19.50	343
ITT Hartford Group	NYS	85.63	-1.58	26.85	88.81	51.00	1246
LaSalle Re Ltd.	NDQ	33.75	-0.37	15.38	34.50	22.38	128
Lincoln National	NYS	7[illegible].88	6.58	36.90	71.88	42.13	3749
MAIC Holdings Inc.	NYS	47.31	6.02	39.67	50.00	28.25	165
Markel Corp.	NYS	145.00	1.40	61.11	147.50	83.00	14
MBIA Insurance Group	NYS	117.13	-1.78	15.68	122.00	75.00	438
Meadowbrook Insur. Group	NYS	25.38	-0.73	20.83	29.63	15.25	42
Mid Ocean Ltd.	NYS	60.00	0.10	14.29	61.00	39.25	284
MMI Cos. Inc.	NYS	27.69	1.61	-14.15	33.38	20.75	345
Mutual Risk Mgmt. Ltd.	NYS	48.56	-0.89	31.25	49.63	26.88	157
NAC Re Corp.	NYS	48.06	-1.03	41.88	49.50	32.63	149
Navigators Group	NDQ	18.50	0.00	1.37	20.63	15.75	16
Nobel Insurance Ltd.	NDQ	14.75	2.61	17.41	15.38	11.00	76
NYMagic Inc.	NYS	22.75	4.00	26.39	22.75	17.00	11
Ohio Casualty Corp.	NDQ	46.88	0.81	32.04	47.50	31.75	174
Old Republic Int'l	NYS	36.94	17.26	38.08	36.94	20.75	2381
Orion Capital Corp.	NYS	4[illegible].63	0.76	36.20	42.25	24.38	189
Partner Re Ltd.	NYS	4[illegible].44	0.15	21.88	42.50	26.75	328
Penn-America Group Inc.	NDQ	18.13	2.84	68.60	18.25	9.63	79
Philadelphia Cons. Holding	NDQ	38.50	-4.35	65.59	42.25	16.75	28
PXRE Corp.	NYS	30.81	0.20	24.49	31.88	22.25	36
Reliance Group Holdings	NYS	13.06	-4.13	43.15	13.88	7.50	1107
Reliastar Financial Corp.	NYS	77.88	1.05	34.85	78.38	41.50	816
RenaissanceRe Holdings Ltd.	NYS	43.25	-0.57	31.06	43.50	26.75	145
Risk Capital Holdings	NDQ	20.75	-4.60	7.10	22.13	15.88	96
RLI Corp.	NYS	36.88	-0.17	10.49	39.63	23.50	128
St. Paul Companies	NYS	77.75	-4.60	32.62	82.81	50.63	1303
SCOR	NYS	43.75	-1.69	27.27	44.50	34.00	3
SAFECO Corp.	NDQ	48.13	5.05	22.03	49.38	32.13	2560
Seibels Bruce Group	NDQ	8.38	-2.90	1.52	11.25	5.88	146
Selective Ins. Group	NDQ	53.25	0.71	40.13	54.00	32.00	3
Sphere Drake Holdings	NYS	8.81	0.71	-0.70	10.50	8.13	690
TIG Holdings	NYS	32.31	7.26	-4.61	38.00	26.38	1530
Titan Holdings, Inc.	NYS	23.63	3.56	43.18	25.00	12.75	256
Tokio Marine & Fire	NDQ	62.88	-1.95	34.85	66.00	42.00	60
Torchmark Corp.	NYS	78.06	-0.56	54.58	80.00	41.50	956
Transatlantic Holdings	NYS	73.25	1.74	36.49	75.00	43.38	166
Travelers Property	NYS	42.63	3.18	20.49	43.56	26.25	366
Travelers Corp.	NYS	70.94	1.79	56.34	73.63	30.38	6860
Trenwick Group Inc.	NDQ	38.25	0.00	24.05	39.63	30.75	57
Unico American Corp.	NDQ	11.13	1.14	2.30	11.50	7.13	4
Unionamerica Holdings	NYS	22.25	0.00	25.35	22.56	14.75	15
United Fire & Casualty	NDQ	38.50	-1.91	9.22	40.25	29.75	15
Unitrin	NDQ	61.75	0.00	10.76	64.75	45.00	116
UNUM Corp.	NYS	44.63	-3.12	23.53	48.44	30.00	2196
USF&G Corp.	NYS	24.13	-2.77	15.57	25.50	15.63	1657
Vesta Insurance Co.	NYS	52.81	0.48	56.33	54.00	24.50	215
Washington National	NYS	28.75	0.88	4.55	30.75	27.13	178
Zenith National Ins.	NYS	27.19	-0.46	-0.68	28.50	24.63	30
Zurich Reinsurance Centr.	NYS	39.31	0.00	25.80	39.50	28.38	118
INSURERS/REINSURERS	AVERAGE		0.94	26.04			
HEALTH MAINTENANCE ORGANIZATIONS							
Healthsource Inc.	NYS	21.69	0.00	65.24	21.88	10.50	26
Humana Inc.	NYS	23.94	1.59	25.99	24.75	16.00	2452
Oxford Health Plans	NDQ	83.25	-2.20	42.16	89.00	34.38	4947
Pacificare Health Sys.	NDQ	65.38	4.60	-19.54	86.25	55.50	1031
Safeguard Health Enter.	NDQ	13.13	-6.25	-25.00	22.50	9.63	140
Sierra Health Services	NYS	34.00	6.46	35.07	34.88	22.38	361
United Healthcare Corp.	NYS	56.50	1.57	25.56	57.19	33.25	3822
Wellpoint Health Networks	NYS	48.56	-1.65	41.27	51.25	24.38	710
HMOs	AVERAGE		0.52	24.22			
ALL COMPANIES	AVERAGE		1.26	24.90			

Top advancing issues: Kaye Group Inc., Old Republic Int'l, Everest Reinsurance. Leading decliners: Willis Corroon Corp., Safeguard Health Enter., CapMac Holdings Ltd. Most active issue: Travelers Corp. The *BI* index rose 1.1%; the Dow Jones 30 Industrials gained 1.0%; the S&P 500 increased 0.9% and the NYSE Composite gained 0.9%. Average P/E: Brokers, 17.5; Insurers/reinsurers, 43.4; HMOs, 33.6.

System design: Nordby International Inc.