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Updates

California health care coalitions won't see cuts in 1997 HMO rates

SAN FRANCISCO—Employer purchasing groups in California did not receive HMO rate reductions this year, contrasting with reductions won in recent years and possibly signaling a firming of rates.

Meanwhile, some HMOs say their prices will flatten or increase slightly in several states where they operate.

The San Francisco-based Pacific Business Group on Health said last week that rates for 1997 "will remain flat on average across the 15 HMOs that participate in PBGH's

See **Updates** *on next page*

Coverage exclusion reform clears Congress

Bill would remove a key obstacle to job mobility

By JERRY GEISEL

WASHINGTON—Employees and employers both will benefit under health care portability legislation passed by Congress last week.

The reform legislation, which President Clinton has promised to sign, will allow employees to move from job to job with little risk of losing health care coverage for pre-existing medical conditions. Gaining that freedom will eliminate "job lock," a situation in which employees can't afford to leave a job because a new employer won't provide coverage for medical problems they already have.

Reducing the problem of job lock also benefits employers. Job lock can hurt companies because it keeps employees stuck in jobs they don't want and also prevents applicants from accepting new positions. Under the legislation—the first comprehensive health care statute passed by Congress in a decade—employers can deny coverage for a new employee's pre-existing medical conditions for 12 months. But that 12-month exclusion will be offset by length of time the employee previously had health care coverage, as long as the employee's coverage did not lapse by more than 63 days from the time of leaving a prior job to the time the new position was taken.

"This is a breakthrough for all Americans who want to change jobs," said House Ways and Means Chairman Bill Archer, R-Texas.

"The biggest accomplishment of the legislation will be reducing the problem of job lock," said Mark Ugoretz, president of the ERISA Industry Committee in Washington.

Sen. Nancy Kassebaum, R-Kan., and Sen. Edward M. Kennedy, D-Mass., were the original co-sponsors of the health care portability legislation that Congress approved last week and that President Clinton has said he will sign.

"This is a very positive step. People should have the ability to join and leave employers without being concerned about the loss of coverage," added Jack Doerr, national practice leader for group benefits at Sedgwick Noble Lowndes in Chicago.

This change in law, which will go into effect next July 1, should have little cost impact on employers, even though it will affect the millions of employees who change jobs annually.

Employers will incur additional costs of providing coverage to new employees who now are excluded due to pre-existing conditions. However, in the long run, that expense will be offset by two key factors:

- More employees with medical conditions will leave to go on to a new job because they no longer can be denied coverage by their new employer.
- Employers will have lower overall COBRA costs. Under federal law, beneficiaries can hold onto COBRA coverage benefits—even after joining a new health care plan—if the new plan denies coverage for pre-existing conditions.

Because pre-existing condition exclusions will not be an issue, COBRA beneficiaries will have no need for dual coverage.

"If there is a cost impact, it will be very small," Mr. Doerr said.

While the cost impact of curbing pre-

See **Portability** *on page 45*

Fibreboard nears settlement on asbestos liability claims

Settlement may influence other class actions

By MICHAEL SCHACHNER

NEW ORLEANS—Fibreboard Corp.'s efforts to resolve all existing and future asbestos-related liabilities with proceeds from CNA Insurance Cos. Inc. and Chubb Corp. cleared a major hurdle last month when a federal appeals court approved a global personal injury settlement that could total $3.3 billion.

In approving *Ahearn vs. Fibreboard Corp.* as well as a backup "insurance" settlement, *Continental Casualty Co. vs. Rudd*, a three-judge panel of the 5th U.S. Circuit Court of Appeals on July 26 may have clarified or further confused the burgeoning issue of what types of class-action settlements will meet court approval, legal observers say.

The *Ahearn* decision, which potentially will be appealed to the U.S. Supreme Court, contradicts the 3rd Circuit's May ruling on the viability of a similar asbestos personal injury settlement offered to about 100,000 people by the Center for Claims Resolution, a group of 20 former asbestos producers (*BI*, May 20).

The 3rd Circuit vacated *Georgine vs. Amchem Products Inc.*, a $1.3 billion settlement offer, because the court found it failed several tests of civil procedure, primarily that the class was formed for settlement purposes only and would not have been viable had the case been litigated.

But the 5th Circuit ruled settlement class actions can be approved or rejected based on their terms' fairness even if the case does not go forward as litigation.

The 5th Circuit found the terms of Fibreboard's offer were fair to plaintiffs. Furthermore, the court noted the settlement is backed up by a free-standing insurance settlement that would require CNA and Chubb to honor all of Fibreboard's existing personal injury settlements and provide the Walnut Creek, Calif.-based wood products company with an additional $2 billion for unsettled and future claims. The panel unanimously approved this settlement.

"This is clearly a major hurdle for both the global settlement and *Rudd*," said William Irwin, an attorney with Brobeck, Phleger &

See **Asbestos** *on page 38*

Analysts recommend caution in choosing insurance stocks

By JUDY GREENWALD

Now is the time to be highly selective in picking commercial property/casualty insurance stocks, say stock analysts.

With the stocks already lagging the overall market, and competition among insurers continuing to intensify, buyers should pick stocks carefully, analysts say.

"It's a real stock picker's environment. . .and there are very few stocks that are very attractive," said Peter Wade, an analyst with Lehman Bros. in New York.

"I think going forward, it's going to be a company-by-company situation," said Michael A. Lewis, first vp at Dean Witter Reynolds in New York.

Some analysts pointed to the industry's fundamentals—its overall financial performance—as unattractive to investors.

"I think you're going to make more money on this group by trading them than (by making) long-term investments until the fundamentals change," Mr. Lewis said.

Ron Frank, an analyst with Smith Barney Shearson in New York, also pointed to the lack of change in industry financial performance as detracting from the property/casualty group's overall appeal.

"The principal dynamic in the insurance sector in the last few years has been stock prices, not fundamentals," Mr. Frank said. "Fundamentals have changed remarkably little."

See **Stocks** *on page 41*

Risk managers review security

TWA crash, Olympics bombing raise profile of terrorism risk

By DAVE LENCKUS and GAVIN SOUTER

Although many Americans' sense of invulnerability to terrorism is plummeting in the aftermath of the midair explosion of a Trans World Airlines jumbo jet and the fatal bombing at the Olympic Games in Atlanta, corporate risk managers are not making any knee-jerk reactions in response to either tragedy.

But, some security experts assert that airlines can take far better measures to ensure passenger safety than those President Clinton has suggested and the Federal Aviation Administration has ordered them to implement.

Some security experts and insurers also predict there will be tightened security at upcoming special events. Insurers and brokers do not, however, expect any immediate impact on coverage for property or special-events coverage.

Authorities late last week had not determined the cause of the July 17 explosion of the TWA jet en route to Paris from New York's John F. Kennedy International Airport (*BI*, July 29) or who planted the pipe bomb that exploded in an Atlanta park outside of the Olympic Village nine days later.

Regardless of what or who was behind those calamities, the incidents and other terrorist acts in recent years demonstrate the United States' vulnerability to violent acts by highly organized radical groups, security experts and others say.

"With the bombings at the World Trade Center and in Oklahoma City, we have lost our image of Fortress America. And, attacks in the U.S. bring much more publicity than attacks on U.S. companies overseas," said Frank Johns, managing director in Arlington, Va., of the risk assessment division of security company Pinkerton's Inc.

But, E.C. "Mike" Ackerman, managing director of The Ackerman Group Inc., a Miami Beach, Fla.-based security consultant, cautioned against lumping the bombing at the Olympics in the category of sophisticated terrorist acts by organized groups.

Mr. Ackerman, a former Central Intelligence Agency officer, said he is more concerned about what the TWA crash signifies. "If I were responsible for corporate travel, I'd

See **Security** *on page 46*

Updates

California HMOs halt rate cuts

Continued from previous page

Negotiating Alliance." In 1995, the coalition's Negotiating Alliance of member companies won a 4.3% reduction, following a 9% rate cut the previous year.

And the 6,000 small employers served by the state-sponsored administrative agency, Health Insurance Plan of California, are seeing flat rates effective July 1 this year. Last year, the HMOs contracted through HIPC cut premiums by 5%, after decreases of 6% in 1994 and 15% in 1993.

Cheryl Damberg, director of research for PBGH in Los Angeles, said her analysis of the situation is that decreasing insurer surpluses mean health plans have reached a trough in the underwriting cycle, with rates likely to remain flat or increase for now. Inflation and a dissipating threat of extensive health reform measures also are playing a role, Ms. Damberg said.

"There are a lot of things at work there, and it's not that all of a sudden we became less effective or the markets became smarter," she said. PBGH members stress that their negotiations have moved toward gaining assurances of quality rather than price-cutting and that gains have been made. But, there are still potential price reductions that in part depend on the creation of efficiencies in delivery systems, she said.

She declined to say which of the 15 HMOs that PBGH contracts with raised, reduced or did not change their premiums. Cypress, Calif.-based PacifiCare Health Systems Inc. and Fountain Valley, Calif.-based FHP International Corp. are among the HMOs that contract with PBGH members.

Quackenbush aides sued

SACRAMENTO, Calif.—Nine employees of the California Department of Insurance's fraud division claim that two aides to Commissioner Chuck Quackenbush retaliated against them for refusing to help thwart potential bad faith claims against insurers.

Among other allegations contained in a lawsuit filed last month in Sacramento County Superior Court, the employees claim that they were ordered to violate their oaths as sworn peace officers.

The plaintiffs seek $90 million from Deputy Commissioner of Insurance Barbara Dotta and William Palmer, the DOI's general counsel. Both are Quackenbush appointees.

Ms. Dotta was hired in November 1995 to improve the division's effectiveness and streamline a backlog of 2,500 fraud cases.

The department responded to the charges by saying the plaintiffs were a network of "good old boys" who dragged their feet under new standards aimed at getting fraud cases to prosecutors.

Additionally, department officials said $125,000 has been paid out to settle allegations of sexual harassment and retaliation against some of the plaintiffs. And, at least two of the plaintiffs have been placed on administrative leave while they are under investigation. Paul E. Lacy, a Sacramento attorney for the plaintiffs, said that the sexual harassment allegations were investigated two years ago and found to lack merit.

The investigators were ordered to limit their attention only to cases investigated by insurers and then forwarding those cases to prosecutors without scrutinizing the validity of the insurers' claims, Mr. Lacy said.

Briefly noted

Legislation signed last week lets Michigan become the fifth state to participate in the **Interstate Insurance Receivership Compact**, designed to streamline receivership activities among members. It joins California, Illinois, Nebraska and New Hampshire. . . .Small Florida employers will see an average 3% decrease in **workers comp insurance rates** while large companies will pay an average of 0.6% more if a proposal by the National Council on Compensation Insurance is approved by Florida regulators. The NCCI is seeking the 3% decrease and a modification of the premium discount program that would offset the savings for large companies. . . .Meanwhile, **Colorado** employers could see a 1.5% drop in the overall loss cost component of their workers comp rates beginning Dec. 1, if the Division of Insurance approves the NCCI request made last week. . . .**Sir Peter Green,** former chairman of Lloyd's of London from 1980-1982 while the Lloyd's Act 1982 was constructed and implemented by Parliament, died July 28 of cancer. . . .Standard & Poor's Corp. has **lowered the claims paying ability rating of Zurich Insurance Co.** to AA+ from AAA. Zurich is becoming increasingly focused on shareholder value and will do little to raise new capital it would need to maintain its previous rating, the rating agency said. . . .**John Darwood**, deputy inspector of insurance in the Cayman Islands since 1993, left that post last month to become senior adviser in the Insurance Division at the Guernsey Financial Services Commission. He has been replaced by Acting Superintendent John Mantz, formerly chief analyst with the Cayman Insurance Department.

Errors & omissions

• A July 29 Perspective article incorrectly referred to the author's employer. James E. McIntyre is manager of loss control for The Hanover Insurance Co. in Worcester, Mass.

• Gil y Carvajal S.A., a branch of Johnson & Higgins, was omitted from the geographical index in the July 22 directory of agents and brokers. Gil y Carvajal operates in Badajoz, Barcelona, Bilbao, La Coruna, Las Palmas, Madrid, Malaga, Murcio, Oviedo, Palma de Mallorca, Pamplona, San Sebastian, Santa Cruz de Tenerife, Seville, Tarragona, Valencia, Vallodolid, Vigo, Vitona and Zaragoza, Spain.

• Consent orders signed by Donald K. Anderson and Martin Levine with the U.S. Department of Labor allow them to act as insurance or reinsurance brokers for employee benefit plans governed by federal law as long as they place the coverage with licensed U.S. insurers. A July 22 article omitted this stipulation.

Tax bill simplifies pensions

By JERRY GEISEL

WASHINGTON—Seven years ago, business groups began a campaign to persuade legislators to simplify the nation's pension laws and regulations.

Last week, that effort finally bore fruit as Congress passed a small-business tax bill that includes many of the pension reforms first advocated by employers and many other beneficial changes, too.

Enactment of the legislation means employers will have a new and easier way to run non-discrimination tests on their 401(k) plans, while employers with generous matching features will qualify for new safe harbors and will not even have to run those tests.

Tax-exempt employers, such as trade associations, will once again be able to offer 401(k) plans to their employees. In addition, other provisions in the legislation, which President Clinton will sign, will allow many middle-income employees to boost contributions to 401(k) plans and encourage employers to open up their 401(k) plans to young and newly hired employees.

Other employee benefit provisions in the package—unrelated to pension simplification—will be a boon to employees.

Employers, for example, now will be able to reimburse employees for adoption-related and educational expenses without employees being taxed on those contributions. In addition, employees who receive lump-sum pension plan distributions of more than $750,000 will for the next three years escape a 15% excise tax now imposed on jumbo distributions.

At the same time, employees in the nation's 2,000 multiemployer pension plans will have a better chance of earning a benefit: The legislation requires multiemployer pension plans to adopt the same rapid pension vesting schedules that single-employer plans have used since 1989.

In addition, employees who

See **Tax bill** *on page 46*

EMLICO fight shifts to move

By DOUGLAS McLEOD

HAMILTON, Bermuda—After failing to halt the Bermuda liquidation of Electric Mutual Liability Insurance Co., reinsurers now are aiming to overturn regulatory orders that cleared the way for EMLICO's controversial 1995 move from Massachusetts.

Bermuda Supreme Court Judge Richard Ground granted EMLICO's winding-up petition July 26, finding that the liquidation proceedings are not the proper forum to hear charges that EMLICO conspired with its sole policyholder, General Electric Co., to dump huge GE pollution and asbestos losses on reinsurers under creditor-friendly Bermuda liquidation laws.

While finding Kemper Reinsurance Co. "has a serious issue to be tried on the fraud allegation," Judge Ground refused to delay the winding-up for hearings on the issue and rejected arguments that the winding-up petition itself was an abuse of process.

At the same time, though, he limited the liquidators' authority to accept contingent GE claims until Kemper Re's challenge to the redomestication is settled.

Kemper Re now will ask a Bermuda court to overturn a set of 1995 Bermuda government orders that allowed EMLICO into the country, arguing that EMLICO misled Bermuda regulators about its solvency. EMLICO is seeking to stop the judicial review on grounds that Kemper Re was granted an improper extension of time to file its petition.

Lawyers for several EMLICO reinsurers, meanwhile, are urging Massachusetts Insurance Commissioner Linda Ruthardt to reconsider her decision last month not to reopen hearings on the EMLICO redomestication.

In her ruling, Ms. Ruthardt said

See **EMLICO** *on page 34*

Texas firms settle comp dispute

By MICHAEL BRADFORD

DALLAS—Texas employers claiming they were illegally overcharged for workers compensation insurance over a five-year period have agreed to a proposed class-action settlement that calls for insurers to pay back $145 million.

The deal, given preliminary court approval, would bring to $190 million the total of settlements in the massive litigation dubbed the Weatherford Roofing case. The case pits Texas employers against some of the state's largest workers comp insurers and the National Council on Compensation Insurance (*BI*, June 15, 1995).

California coalition predicts rising workers comp costs ....Page 35

A hearing is set for Oct. 15 in the state's 116th Judicial District Court in Dallas, where the suit was originally filed in 1991, to determine whether the settlement should be given final approval. If it is approved, a handful of suits will remain against insurers that have not agreed to the terms.

The lawsuit claimed that about 170 insurers overcharged employers for workers comp coverage purchased between May 15, 1987, and April 1, 1992.

Employers say they were forced to buy coverage at rates not approved by regulators. The suit says insurers were able to do this by adding various charges in addition to premiums and got help from the NCCI, which misrepresented "the

See **Texas** *on page 37*

Broker results take some hits

By SALLY ROBERTS

Sold businesses and special charges took a bite out of net income for some of the largest U.S.-based publicly held brokers during the first half of 1996, as lower property catastrophe reinsurance rates continue to batter some brokers' top lines.

Nevertheless, six of the seven largest U.S.-based publicly held insurance brokers reported increases in gross revenues for the first half.

Gross revenues rise in spite of pressures

The revenue growth exemplifies the trend toward brokers finding other means to bolster their top lines in the soft market.

Alexander & Alexander Services Inc. was the lone exception among the pack with a slight 0.4% drop in gross revenues. However, excluding the effects of sold operations in 1995, A&A's first-half gross revenues were up 1.4%.

Net income results at several brokerages tell a similar story.

BROKER RESULTS 1st Half

A&A's 46.3% profit dive is partially attributable to its sold operations, namely its third-party administration unit

See **Brokers** *on page 45*

Inside

• In a rare show of bipartisanship, Congress finally achieved agreement on health care reform legislation, this week's editorial says. **PAGE 8**

• A new report is questioning the effectiveness of California's workers compensation reforms. **PAGE 35**

• Lloyd's R&R plan is winning support. **PAGE 39**

• Carpal tunnel syndrome could lead to a sharp rise in workers comp claims, a study says. **PAGE 44**

Departments

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Managed Care Market Report

Employers' choices harder as PBMs grow, add services

By ROBERT KAZEL

For employers, finding a prescription benefit manager is easy. Finding the right one, in a time of turbulent and intense competition within the industry, may be harder.

To be sure, more plan sponsors are becoming persuaded of the value of PBMs as prescription drug costs continue to rise.

Among employers with 500 or more employees, 42% offer a prescription card plan, and one-third offer a mail-order prescription service, according to a 1995 survey by Washington-based A. Foster Higgins & Co. Inc. The trend is even more pronounced among the largest companies, those with 20,000 or more employees. Six in 10 of these offer card or mail-order plans, or both.

Employers are the engine of PBM innovation, but they also may be perplexed by the options available and unsure of the goals they want their PBMs to achieve. The PBM industry, which in its infancy five years ago consisted of little more than some basic discount prescription card plans and mail-order programs, has become a strapping adolescent. Now a big business, it has big burdens: how to lure plan sponsors not only with everyday drug discounts but with advanced utilization management and promises of long-term, futuristic programs harnessing outcomes research, sophisticated economic analysis and disease state management.

The essential tools of PBMs still are similar everywhere: prescription discounts, employer rebates, drug formularies to rein in and guide doctors' prescription choices, generic drug substitution programs, mail-order prescription services and patient education programs.

But as PBMs add new services, the task of the employer has grown beyond merely checking off a list. Finding the right long-term relationship with a PBM can require in-depth study of a candidate's reputation, technical skills and potential for growth, and such a project often requires the help of consultants.

The job will be most complicated for plan sponsors that are not simply concerned about immediate drug savings but also are trying to weave PBM programs into an integrated corporate health strategy.

"In the last few years, the focus has gone from simple cost containment to drug cost management," said Wayne Gattinella, senior vp of marketing for Montvale, N.J.-based Merck/Medco Managed Care Inc. The distinction may seem slight, but the concept of management, for PBMs, implies a more aggressive manipulation and monitoring of how pharmacists dispense drugs and which drugs are given out.

Two-thirds of the savings plan sponsors can realize through a PBM now come from prescription management, not simply through unit price savings, said Steven J. Shulman, president of the pharmacy and disease management group of Minneapolis-based Value Health Inc., parent company of ValueRx, a leading PBM. Savings can be obtained by consulting with doctors on using the least expensive, yet still effective, type and brand of drug possible—decisions that PBMs maintain doctors won't make independently.

"Physicians are absolutely uneducated historically on the cost of medications," Mr. Shulman said. "They do not pay for it, and most of the members pay for it with some kind of insurance."

For those employers concerned chiefly with discount formulas when they look at a PBM proposal, the subject is arcane and often beyond benefit managers' training, experts say. Deciding which PBM company is offering the best value may be challenging for non-specialists.

"The pricing is extremely complicated," said Richard Trapp, vp of finance and administration of Tampa, Fla.-based Employer Purchasing Alliance, a league of employer health care coalitions with members in Florida, Vermont, Louisiana, Georgia and New York. PBMs may be paid by plan sponsors in several different ways, including fee-for-service, in which the PBM receives payments from the employer for each drug claim processed, or capitated payments, by which the PBM gets a fixed payment per member per month. The employer may or may not be responsible for actually paying the pharmacy, because under some capitated contracts the PBM itself will take on all or a portion of the financial risk.

The Tampa alliance last spring awarded its first PBM contracts to ValueRx and Salt Lake City-based RxAmerica. The alliance's 700 member employers, which comprise nearly 2 million workers and dependents, are now eligible to use the umbrella agreements negotiated by representatives of the alliance's 10 constituent coalitions.

See **PBMs** *on page 12*

Spotlight Editor: Joanne Wojcik

Employers seek help in evaluating health plan data

By JOANNE WOJCIK

Employers are finding it increasingly difficult to see the forest for the trees as more organizations develop health care plan "report cards."

Even before the National Committee for Quality Assurance released the first version of its measurement tool—the Health Plan Employer Data and Information Set—three years ago, employer coalitions and consultants already were "grading" plan performance on various criteria, focusing mostly on cost, access and user satisfaction.

As HEDIS moves into its next generation—HEDIS 3.0 will focus more on results, or "outcomes," than on events, or "processes"—many health plan experts are questioning the quality of data collection efforts.

In fact, most of these experts insist the quality of the data collection itself must be more consistent and accurate before any of the report cards can judge health plans effectively.

"As an employer, we really don't have the internal resources to take all this data and capsulize it to make something meaningful out of it," said Peter Veysey, manager of health and welfare plans for United Technologies Corp. in Hartford, Conn.

That's why UTC hired benefit consulting firm Towers Perrin to sort through all the information on its health plans.

UTC offers employees the choice of a point-of-service plan administered by CIGNA Corp., a self-insured indemnity plan and about 40 HMOs nationwide.

Towers Perrin has developed its own scorecard, which uses 72 indicators to rate plans in four categories: quality, employee satisfaction, cost and cost-efficiency, and access.

"We concluded that quality should be more broadly defined than just HEDIS alone," explained Emmett Seaborn, a principal in the consultant's Stamford, Conn., office.

The scorecard charts health plan performance according to an X axis representing price and a Y axis indicating quality. So far, all of the UTC health plan scores fall in the upper right-hand quadrant, which represents the highest quality and cost-effectiveness.

"It's been nice to have someone who can encapsulate the data," Mr. Veysey said. However, "there is a risk to us," he said. "We don't know how they determined their algorithm. We have to trust" their interpretation.

Virtually every other employee benefit consultant has also developed a system for synthesizing HEDIS and other report card data for employers. For example:

- Watson Wyatt Worldwide's customized Value Creation Process lets employers rank in importance between 30 and 40 criteria selected by the consultant from the various report cards. The consultant then compares the employer's preferences against the plans' HEDIS and other report card findings to find the best matches.
- Employers can use William M. Mercer Inc.'s Value Process database of 1,200 national, regional and local managed care plans to evaluate HMOs and other managed care plans based on cost and quality.
- Hewitt Associates L.L.C.'s Health Value Initiative includes an extensive national database of cost, quality and satisfaction information gleaned from an analysis of plans offered by 250 large employers as well as data from more than 2,000 health plans.
- A. Foster Higgins & Co. Inc. does both a quantitative and qualitative analysis for its clients using its extensive, private HMO database.

Consultant health plan evaluation models are proliferating primarily in response to employers' need to interpret HEDIS and other report card scores.

A survey published in May by the International Foundation of Employee Benefit Plans found that 63% of the benefit professionals already evaluate managed care plan quality. Those measures include satisfaction surveys, used by 72%; health plan accreditation, 57%; and report cards, 52%.

The most common uses of quality measures are to monitor plan performance—chosen by 80%—and select plans—40%.

"Many employers go after HMOs on cost," observed Towers Perrin's Mr. Seaborn. "But some more sophisticated employers use cost and quality data in negotiating with HMOs. This is having an effect on plan quality."

AT&T has "used report card information to negotiate improvements in plan performance," said Lee Saviola, district manager of health plan administration in Morristown, N.J., for the telecommunications giant.

"The ability to collect and provide data also is an integral part of any RFP" to provide or administer health care benefits, he said. "It raises the bar on vendor performance."

See **Scorecards** *on page 14*

Spotlight report

'Gates' opening wider in some HMOs

By JUDY GREENWALD

It's like walking a tightrope.

Most health maintenance organizations engage in a delicate balancing act between participant satisfaction and cost control when using primary care physicians to regulate access to specialists.

"Essentially, health plan members see the primary care physician not as a gatekeeper, but as a gate closer," said Paul Hofmann, senior consultant with Alexander Consulting Group Inc.'s strategic health care practice in San Francisco.

At the same time, HMOs are concerned about keeping a tight rein on expenses, including the money they spend on specialists.

It is "one of the stickiest issues in managed care," said Mary Case, a principal with Kwasha Lipton L.L.C. in Fort Lee, N.J.

How to reconcile the competing concerns with the referral process? One health plan—Blue Shield of California—thinks it may have an answer.

Under a program to be introduced in September, members of the San Francisco-based health insurer's Access Plus HMO will be allowed to go directly to a specialist without first obtaining the permission of either their primary care doctor or the plan.

There are restrictions, however: Members must go to a specialist who works for the same medical group or independent practice association as their primary care doctor, and there is a $30 copayment per specialist visit.

Blue Shield of California is not alone in tackling the HMO gatekeeper issue.

Edina, Minn.-based United HealthCare Corp. has had an open access program in place in a number of its markets since 1982 and is rolling it out to about 40 of its 43 large markets, a process that should be complete by January 1998, said Sid Stolz, senior vp-delivery system management.

The program permits patients to go directly to specialists for an initial visit, though under United HealthCare's "medical management process" they would need network approval for later visits.

In a related approach, Cypress, Calif.-based PacifiCare Health Systems has been involved with two pilot programs that expedite referrals by peer group committees, with the intent of redesigning the whole referral system, said Chris Wayne, vp and general manager.

Other HMOs are expected to follow. "We are now seeing other plans starting to acknowledge that the referral process is something that probably needs to be changed," said United HealthCare's Mr. Stolz.

"I would think that there's quite a few exploring this, and probably a number that have adopted them," said Jack Doerr, group benefits practice leader at Sedgwick Noble Lowndes Group in Chicago.

Assuming costs can be held in check, observers say this is a natural step in HMOs' development. For years, they point out, many HMOs have already been permitting women to go for their annual gynecologist exam without seeing a primary care physician first.

"From what I can tell, all the major players are exploring ways to essentially take managed care to the next level, to evolve this structure that has been in place for some time," commented Glenn Meister, a principal in A. Foster Higgins & Co. Inc.'s Los Angeles office.

There are a couple of forces driving the issue, said Mr. Meister. "The gatekeeper requirement and the referral process itself is the most significant negative feature from a standpoint of plan satisfaction. . .when consumers are asked what they think about HMOs," he said.

"Secondly, from a standpoint of just inconvenience and potential inefficiency, the rules that have been established in many cases are really just an impediment for people getting to the level of care they truly need.

"They're forced to go through this maze and incur additional visits to simply get to the specialist they knew they needed in the first place," said Mr. Meister.

HMOs approaching this issue see not only the opportunity to "provide a more appealing product to the consumer, but also make the network more efficient, and I would think higher quality," he said.

"There's no other issue with HMO members that is more of a concern to them than access to specialty care," said Paul Markovich, Blue Shield of California's director of product management. "Consumers are looking for this, and that's really why we made the change," he said. "It's the next generation of HMOs."

Mr. Markovich said there will be only "minimal incremental costs" associated with this program.

And cost control remains critical for HMOs and employers.

"I think most people would say the gatekeeper is really one of the very critical items or issues in the whole concept (of HMOs) and to go totally away from that without controls would seem to have some costly repercussions," said Sedgwick's Mr. Doerr.

The "worst case" scenario would be to move from an HMO-type structure to a loosely managed preferred provider organization cost structure, and if the relaxing of gatekeeper restrictions is done too quickly,"there could be some significant cost implications" in terms of more people visiting specialists, said Foster Higgins' Mr. Meister.

Some employers have a cautious attitude about this approach.

"I don't know that I like this idea," Robert L. Bonin, manager of benefits administration for Chicago-based First Chicago NBD Corp. said of Blue Shield of California's approach.

"I would much prefer a categoric definition of occasions when a person may see a specialist," he said.

If it costs too much more to see a specialist, "we might have a problem with access issues," said Mr. Bonin. But, he added, if it costs too little, "it's not going to offset the anti-selection problem."

"It remains to be seen whether the economic research in California applies across the country," he said.

Chris Queram, chief executive officer of the Employer Health

See **Gatekeeper** *on page 18*

First, the top hex nut is tightened.

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Competition driving staff model HMOs to evolve

By MICHAEL PRINCE

Amid the merger mania reshaping the health care industry, another trend has emerged: health maintenance organizations are getting out of the doctor business.

Some staff model HMOs—where health care services are delivered through physicians controlled by the HMO—are splitting into separate organizations: "doctor-free" HMOs and physician groups.

The doctor-free HMOs perform the traditional HMO functions of bringing patients into the system and acting as administrators and gatekeepers.

The physician groups can contract with multiple HMOs in addition to their former parent. Often these groups are purchased by physician management companies—which manage the business affairs of several physician groups.

"HMOs don't want to own hard assets," and doctors want to focus on treating patients, said Kenneth Abramowitz, a health care analyst with Sanford Bernstein & Co. in New York.

"Staff model HMOs are all restructuring from a staff model to a more flexible type of organization," said Dr. Richard Reece of Old Saybrook, Conn., chairman of the National Assn. of Integrated Health Organizations in Fredericksburg, Va. "The brick and mortar approach is over."

"(Staff model HMOs) are starting to let the people who manage doctors manage them," said Richard Sinni, national practice leader for health care at Buck Consultants Inc. in Secaucus, N.J. "HMOs are becoming like insurance companies."

This trend accelerated with the announcement last month by Fountain Valley, Calif.-based FHP International Corp. that it would spin off its newly created physician group, Talbert Medical Management Corp.

FHP formed the company last year and staffed it with FHP doctors. At the same time FHP sold its two hospitals in Orange County, Calif., and Salt Lake City.

With the spinoff's completion at year's end, FHP only will be an HMO and a health and life insurance company, and Talbert will be a physician group composed of 450 physicians at 54 centers covering 300,000 patients.

"The spinoff enables Talbert to compete for patients in addition to those served by FHP, and allows FHP to concentrate on its core HMO business," said Westcott W. Price III, FHP's president and chief executive officer.

The story of FHP mirrors that of many staff model HMOs. From its founding in 1961 until 1983, FHP was strictly a staff model HMO. In 1983 the company won Medicare contracts and needed more providers. Because it would have been too costly and taken too long to expand its buildings and add the doctors and equipment needed, FHP contracted with outside doctors. Also, to control the quality and costs for its members, FHP built hospitals.

Since the 1980s, however, business has changed. Hospitals, looking for patients for their empty beds, now court HMOs. Hospitals also are accepting lower rates from HMOs. In this environment, it no longer makes sense for an HMO to own the doctor and hospital networks when it can contract for the same service.

"There is no downside," said an FHP spokeswoman. "We can provide the same level of quality at lower costs."

FHP's handling of the Talbert spinoff typifies this type of transaction, said Peter Grant, head of the health care section with the law firm of Davis, Wright, Tremaine in San Francisco and Seattle.

First, the HMO places the physicians into a separate company. Later, this physician group is spun off as an independent company or sold to a PMC. Then this group makes capitation agreements from its former parent and accepts patients from other HMOs.

Many analysts say staff model HMOs no longer can compete in today's health care environment. At its core, the staff model HMO has a fixed number of providers serving a fixed number of plan enrollees. Problems arise when enrollment increases, requiring an increase in the number of physicians. This cannot always be done without adding to the building and equipment. Also, to lower health care costs, HMOs limit use of specialists and hospitals. Consequently, these two areas are underutilized, and because the doctors have high, fixed salaries, they become a drain on profits.

By contrast, an independent practice association, or IPA model HMO contracts with a loose organization of doctors in their own offices or group practices.

This system provides enrollees more choices. Unlike doctors in a staff model HMO, IPA physicians can treat patients who are not members of the HMO. Also, an IPA model HMO has the flexibility to grow or shrink in response to enrollment that a staff model HMO lacks. As a result, enrollment in IPA model HMOs are up while staff model enrollment is flat, Mr. Grant said.

Flat enrollment, combined with the high costs of maintaining the overhead of doctor salaries, building and equipment are eroding staff model HMOs profits. "People need to find ways to shift overhead to someone else," Mr. Sinni said.

Lack of flexibility has also hurt the staff model HMOs. Employers want to enroll their employees in medical plans that offer a wide array of choices. A staff model HMO has fixed locations that are not always convenient for enrollees spread over a large metropolitan area. "It was not worth their while to drive several minutes to our center," the FHP spokeswoman said.

Some other recent examples of HMOs getting out of the doctor business include:

- Miami-based Physician Corp. of America sold its 40-clinic, 125-physician group in Florida to FPA Medical Management Inc., a San Diego-based PMC, for $25 million.
- FPA Medical Management is also purchasing Foundation Health Corp.'s 30 health care centers serving almost 300,000 members in the Southwest.
- CIGNA HealthCare in Los Angeles sold its staff model delivery system, consisting of 29 clinics and 330 physicians, to Northbrook, Ill.-based Caremark International Inc., a PMC, which is merging with MedPartners/Mullikin in Birmingham, Ala., a growing giant in the PMC world. The centers will become part of the Friendly Hills HealthCare Network headquartered in Orange County, Calif.

See **HMO** *on page 18*

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Opinions

At last, health care reform

WHEN IT COMES to health care reform legislation, what a difference a few summers can make.

Remember the summer of 1993? That was when Clinton administration officials drafted the health care reform package—with its mandatory government-established purchasing pools and other loathsome features—that just about everyone came to hate.

And, one year later, when Congress took the lead in drafting a reform package, the results were just about as disastrous as the Clinton effort.

Seemingly learning nothing from the failed Clinton effort, congressional Democratic leaders put together a package without the slightest attempt to bring in Republicans to work out an agreement. Without bipartisan support, the Democratic bills died as they reached the House and Senate floors.

Fortunately, this summer was different. Republicans and Democrats showed that our political system, contrary to what many have been saying, does indeed still work.

Republicans and Democrats have labored mightily over the past few weeks to come to an agreement on an important and badly needed health care reform measure.

Those weeks of labor bore fruit as congressional negotiators reached agreement last week on a reform measure that will allow the millions of workers who change jobs each year to do so without fear that they will lose health care coverage for pre-existing medical conditions.

To be sure, there were many tense moments during this negotiating process. That is perfectly natural and indeed necessary. Agreements come out of negotiations and offers and counteroffers.

Even at the most tense moments, though, the negotiations kept going, culminating in last week's agreement.

And the agreement is as important for employees as it is for employers. For employees, the legislation means they no longer have to worry that they will lose coverage for when they may need it the most: treatment of ongoing medical conditions.

"GOSH, MAYBE WE SHOULD ALL RUN FOR RE-ELECTION EVERY TERM!"

And employers, we believe, also will benefit from the curbing of pre-existing medical condition exclusions in health care plans.

They will be more able to attract new employees who might otherwise have been reluctant to change jobs because of fears of losing health care coverage for pre-existing conditions.

This isn't to say that the legislation solves all the nation's health care problems. After all, 40 million people still lack group health insurance.

But, passage of legislation will be a significant accomplishment. This is one piece of employee benefits legislation that truly is in everyone's best interest.

Letters

Pulling teeth to get payouts

To the editor: The tooth fairy got a new lease on life when policyholders were advised in a June 24 letter to the editor that "there is no reason for policyholders to take an adversarial view toward their insurers and the adjusters and accountants who represented such insurers."

The plain facts of life are that policyholders with business interruption claims are treated as scam artists and thieves by insurance companies, the insurance company adjusters and the accountants who represent these insurance companies.

Business interruption claims are not paid without significant controversy and delay.

Business interruption insurance is a defective product because policyholders cannot collect without an inordinate expenditure of time and money.

I am certain that the letter's author, Chris Campos, an accountant who works for insurance companies, would much prefer to have pussycats as policyholders.

But pussycat policyholders are unlikely to get any milk.

Eugene R. Anderson
Partner
Anderson Kill & Olick P.C.
New York

Temporary lapse of judgment

To the editor: The June 3 issue of *Business Insurance* featured the article, "Temporary Workers Increase Unknown Risks." I anticipated reading an in-depth analysis of the use temporary workers and its implications on managing risk.

However, I am disappointed.

This article, filled with misinformation, demonstrates a lack of knowledge and understanding of the temporary industry and sound risk management principles. This does not justify bashing the temporary help industry.

How does Mr. Lev attribute workplace violence to temporary workers? Where are his facts and his statistics? Perhaps the most irresponsible statement is Mr. Lev's assertion that "as much as half of high-tech thefts may be directly related to temporary workers." An obviously discriminatory remark can only be drawn from ignorance, not fact.

Unfounded assertions must be left to tabloid journalism and not part of professional trade periodicals. I believed

See **Letters** *on page 44*

Business Insurance welcomes letters to the editor. The section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Please send your letters to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; fax: 312-280-3174; e-mail: pwinston@crain.com.

NAIB supports fees for brokers

To the editor: The members of the National Assn. of Insurance Brokers appreciate that your Opinion of July 22, 1996, "Move to Fee-based Services" draws attention to the fact that, in many states, there are statutory or regulatory bars to providing fee-based services.

As stated in our recent Critical Issues Paper, "Rethinking the Regulation of Commercial Insurance," the NAIB has consistently urged the states to revise these provisions. They are intended to protect smaller consumers but do not address the needs of larger commercial insurance buyers that are very capable of negotiating their own compensation arrangements.

We must, therefore, correct the misimpression that brokers are reluctant to enter into fee-based arrangements where permitted by law and desired by their clients. Independent market studies, such as the Risk & Insurance Management Society's 1995 Cost of Risk Survey, show that 75% of larger accounts are already on a negotiated compensation basis but that a substantial number prefer a commission arrangement.

Our members are rightfully proud of their reputations for professionalism and service to clients, which should in no way be diminished by the fact that they still operate, in part, under the historical system of commissions.

Carl A. Modecki
President and COO
National Assn. of Insurance Brokers
Washington

Business Insurance

Reporting weekly on corporate risk, employee benefit and managed health care news

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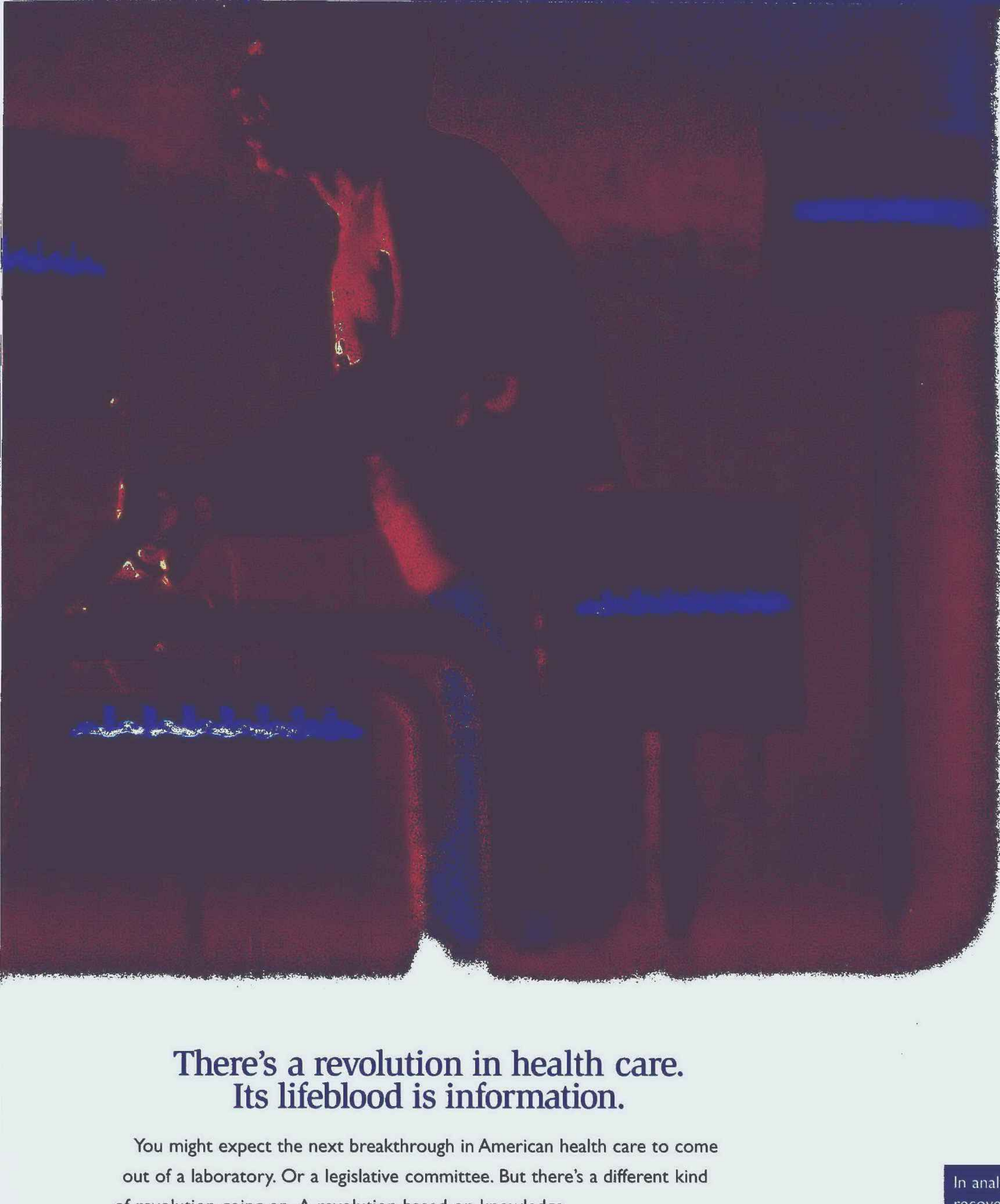

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Spotlight report

PBMs

Continued from page 3

Although alliance officials estimated companies using either PBM would save as much as 20% on prescription costs, it was difficult to choose among the 17 national PBMs that responded to the purchasing alliance's call for bids, Mr. Trapp said.

"There are so many ways to price these things," said Frank M. Brocato, president of the alliance (see story, page 13).

"There are a lot of different measures and criteria you need to apply to make a good decision. Be willing to spend a lot of time with consulting groups and others that can help you. You're not going to know if you got the best (deal) unless you're really willing to dig in," he said.

Plan sponsors frequently make the mistake of nickel-and-diming prospective PBMs on discounts and rebates, while more experienced benefit managers take a broader look at overall plan design, said Mary Sevon, who formerly worked for Scottsdale, Ariz.-based PCS Health Systems Inc. and now owns her own consulting firm in Levittown, Pa., which provides PBM advice to employers and HMOs.

Source: Emron Inc., CibaGeneva Pharmaceuticals

GRAPHIC BY ADAM COI

"The traditional employers are very bottom-line conscious," Ms. Sevon said. "We used to call them bean counters. A lot of employers think they need to cut. They don't see the bigger picture. Cut, cut, cut doesn't necessarily make sense."

According to a recent survey sponsored by Summit, N.J.-based Ciba-Geneva Pharmaceuticals, more than four out of five employers want their PBM to manage employees' use of generic and brand-name drugs—a traditional cost-cutting strategy. But nearly 80% of employers surveyed wanted newer drug utilization review and drug use evaluation programs. DUEs set standards for safe and effective drug use (see chart). Fewer companies, about 62%, said they expected disease state management programs, which detect and monitor patients with chronic illnesses such as diabetes and asthma to insure early and effective treatment. The survey was conducted by Warren, N.J.-based Emron Inc. and sampled benefit managers representing 1.4 million benefit recipients.

But in negotiation, plan sponsors suffer from a lack of knowledge about how prescription benefit managers operate when they look into hiring one, Ms. Sevon said. The exceptions are usually the largest companies. "Plan sponsors like the GTEs of the world have huge committees, trying to buy very smart," she said. "But that's not the norm. The norm is that the companies don't have an expert to look at it."

To make matters more confusing, PBMs as a rule offer additional services to try to make themselves look unique in a crowded field. Often it takes perseverance to get past the window dressing.

Despite the new services, price and customer service remain the two chief focal points for employers in today's market, said Debi Reissman, president of Prescription Solutions, a small PBM based in Cypress, Calif. But, pricing differences tend to be small, she said, and extra services—ranging from drug utilization management to over-the-counter drug substitution programs and mail-order services—can be effective in attracting plan sponsors.

"PBMs need other services in order to differentiate themselves in the market," she said. "What a PBM can do is to make itself more interesting and more of a partner with the client it is wooing, so to speak."

Buyers especially are looking for utilization review programs in search of cost savings, she said. Under these programs, prescriptions are screened to detect opportunities to substitute generic or lower-priced name brand drugs. In UR, the prescribing patterns of physicians also may be analyzed over time by computer in an attempt to ferret out costly or even fraudulent prescribing. "PBMs have to do everything they have always done, and now add to that UR," Ms. Reissman said.

Benefit managers also increasingly judge PBMs on how easy it is to coexist with them. The real difference today is the responsiveness of PBMs' claims adjusting processes and customer service, said Craig Stern, president of Northridge, Calif.-based Pro Pharma Pharmaceutical Consultants Inc., which advises employers and managed care organizations on pharmacy programs.

"The industry in general has a

See **PBMs** *on next page*

Tips on selecting PBMs

Let the buyer beware. More specifically, let the buyer do research. Consultants and those within the prescription benefit management field offer employers a variety of tips on being wise consumers of PBM services:

• **Get high-tech help.** For companies that plan to put a PBM contract out to bid, a kit containing planning documents, questionnaires for bidders, and a computer diskette with spreadsheet software to calculate the employer's needs is for sale by the Washington-based National Business Coalition on Health. The Managed Pharmaceutical Services Request for Information Kit costs $500 and can be ordered by calling the coalition's member services number, 202-775-9300.

• **Spend to save.** Employers should consider employee access to high-quality drugs to be a key and worthwhile benefit because they can help employees deter serious illness and costly hospitalization later on, said Todd Swim, health actuary and capitation practice leader of Buck Consultants Inc. in Chicago. Or, as Frank Brocato, president of the Tampa, Fla.-based Employers Purchasing Alliance, put it: "It doesn't do you any good to save $20 on medication. If the employee spends one day in the hospital, you've blown it."

• **Think about size.** Employers who are interested only in basic PBM services should consider medium-sized PBMs, said industry consultant Mary Sevon. "If I tell you (a smaller firm) to jump, you'll say how high, instead of laughing at me," she said, adding that medium-sized firms tend to be more entrepreneurial and less bureaucratic.

• **Ask about DSM.** For those employers that want more than the basics, they should find out how various disease state management alternatives can improve work-site wellness programs—now and a few years down the road.

• **Consider the ownership.** The matter of whether a drug company owns a PBM should give benefit managers pause as they consider bidders. Merck & Co. purchased Medco Containment Services Inc. in 1993. SmithKline Beecham Corp. bought Diversified Pharmaceutical Services Inc. the next year, followed in short order by Eli Lilly's purchase of PCS Health Systems. In addition, Pfizer Inc. in 1994 created a strategic relationship with Value Health Inc.

Some analysts caution employers that a drug maker might not be able to administer subsidiary PBMs' formularies fairly. "I think you'd have a hard time finding a client who wouldn't be concerned," said Bob Eicher, a principal at A. Foster Higgins & Co. in New York. "There's obviously a conflict of interest."

The PBMs are making no apologies. "Any major PBM that is competing today is aligned with several manufacturers," said Wayne Gattinella, Merck/Medco senior vp for marketing. "They have to be."

Plan sponsors also should probe how the drug companies view their relationship to their PBM subsidiaries. In some cases, the search for an income stream to offset the PBMs' high purchase prices could create balance sheet turbulence or even shifts in ownership. Of special interest is Lilly, which recently has been searching among other drug

See **PBM tips** *on next page*

PBMs

Continued from previous page

poor service level," said Mr. Stern. He said the following problems plague many PBM/employer relationships: poor responses from PBMs to consumer and employer questions, lack of regular information on what PBMs are doing for the client, and poor response to individual clients' problems.

"There are ways to do much better," acknowledged Jean-Pierre Millon, president and chief executive officer of Scottsdale, Ariz.-based PCS Health Systems Inc., the nation's largest PBM and a division of drug manufacturer Eli Lilly & Co. Customer service will improve once electronic reporting systems linked to plan sponsors are enhanced and when disease state management programs, now their early stages, bring employees and their health data in closer contact with the PBM, he said.

Mr. Millon blamed "a multiplicity of plans, a fragmentation of health care plans" for making information flow between employers and PBMs difficult, but said perceptions of customer service problems will be resolved within a year as more reports are converted to online data.

A way to prevent customer-service skirmishes is to build safeguards into every PBM contract. Performance standards with incentives and penalties can reduce frustration when a relationship with a PBM sours.

In the case of the Employer Purchasing Alliance, a list of performance guarantees was drawn up for its two PBMs, including phone response time, waiting time for new enrollees, accuracy of eligibility data, billing accuracy, and proportion of generic medications prescribed.

A contract also can include specific guidelines that outline how much money the PBM will save the plan sponsor on pharmaceutical costs, Mr. Stern said.

It would be misleading, though, to imply tension exists between all plan sponsors and PBMs. "To make the blanket statement that there aren't any of them giving good service is a stretch, because I have had PBMs that have good customer service," said Michael T. McGinn, Atlanta-based senior vp of The Segal Co., a benefit consulting company. BI

PBM tips

Continued from previous page

companies, clinical labs, insurance companies and information technology firms for someone to buy into ownership of PCS.

There has been industry speculation that Lilly may take a huge write-down on its balance sheet to reduce the value of PCS after paying the McKesson Corp. $4 billion in cash for it. PCS reportedly has had much slower than predicted movement of Lilly drugs onto the market through PCS formularies.

Although a spokesman for Lilly said there are no current plans for a write-down, a specialist at a health care money management firm said Lilly clearly is ruing the price it paid for PCS.

"It is definitely an account that hasn't worked out as planned," said Ronald Nordmann, a partner in Deerfield Management in New York. But he said Lilly has several options if it takes PCS off its balance sheet, including spinning it off to Lilly shareholders, selling it outright, or turning it into a joint venture.

—By Robert Kazel

Scorecards

Continued from page 3

'We also want to know how the plans are using the data to improve quality of care," he added.

But, while benefit managers can use HEDIS to question plan performance or to set goals for improvement, it wasn't designed for benefit managers to use to weed out poor-performing plans, observers say.

That's why few, if any, employers have used report card data to terminate plans, they say. Another reason employers rarely cancel plans is they don't want to disrupt the relationships employees have with doctors.

Employers may intend to use HEDIS measures to weed out HMOs, but first they put the plans on notice, setting deadlines for improvements in targeted areas, said Beth Costello, product manager for MedScore services and tools at MedStat in Ann Arbor, Mich. The Pacific Business Group on Health, a San Francisco-based employer coalition, used MedStat to collect and measure data for its own report card.

In some cases, employers might decide to continue working with plans they like or encourage employees to enroll in certain plans, she explained. "Or, in other cases, performance guarantees are negotiated."

But, in general, "cutting a plan is usually the last resort," Ms. Costello said.

"It's going to be tough for employers finally to say to some plan, 'You're not NCQA accredited, your HEDIS score isn't good,'" predicted UTC's Mr. Veysey.

"It's going to be some time before we actually pull the plug on a plan based on these quality measures," he said. "To me this is still relatively new."

But the next step in the quality improvement process may be to actually execute one of these threats, he suggested.

"When you take a few out and some big-name plans are dropped, you enter the next stage in the process," Mr. Veysey said.

Unfortunately, it will be quite a while before employers can get that aggressive because the data available so far are still in embryonic stages, observed AT&T's Mr. Saviola.

And while HMOs are becoming more cooperative with requests for data, "there's still inconsistency" in the way it is collected and reported, said Towers Perrin's Mr. Seaborn.

For example, when collecting data on childhood immunizations, some HMOs may not include all members in all locations because the rate may be low in one area and they don't want to skew the results unfavorably, he explained.

Capitation arrangements in which physicians receive a monthly stipend per patient rather than fees for services rendered also remove the incentive for individual data collection, according to Mr. Seaborn.

He suggested that may be one reason many plans, particularly in California, are moving away from capitation (see story, page 4).

The employee satisfaction survey data likewise must be taken with a grain of salt, Mr. Seaborn added.

"Some of the self-reported data we just throw out," he said. "Our research suggests that satisfaction survey results are more optimistic than our fact-based survey responses indicate. Our job is to continuously question those results."

But the quality of the data being collected is continuously improving, according to UTC's Mr. Veysey.

"We took baby steps before. The steps are getting bigger now," he said.

For example, UTC was one of the employers that worked with the NCQA to develop standardized member satisfaction surveys.

"I give the NCQA a lot of credit for trying to collect and compare all this data," Mr. Veysey said.

Unfortunately, building complex data collection systems is very expensive, and most plans can't afford to pay for them because they're already being pressured by employers to keep administrative costs down, Mr. Seaborn said.

Already, some plans are reporting higher administrative costs in response to HEDIS and other report card requirements, MedStat's Ms. Costello said.

"They're choking on it," observed Dr. David Friend, global director of health care consulting for Watson Wyatt in Wellesley Hills, Mass., referring to the proliferation of rating agencies and subsequent data requests.

"Eventually there are going to be so many different rating agencies, there's going to be a dilution of their value," he predicted. "I think

See **Scorecards** *on page 16*

Fishing Boat

Nantucket

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1315 hrs

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Scorecards

Continued from page 14

we're going credential overboard."

He compared the situation with the military specification system that has been criticized for inflating costs.

"The B-2 bomber may have passed all the tests, but it still couldn't fly," he said.

Similarly, in health care, "people think if you just credential enough, it'll fly."

Oakland, Calif.-based Kaiser Foundation Health Plan Inc. already has six employees in its corporate offices who are assigned solely to quality measurement activities, according to David Lawrence, chairman and chief executive officer of Kaiser Foundation Health Plan Inc. and Kaiser Foundation Hospitals.

"There are also many employees out in the regions and at the hospital levels" gathering data for the various report cards, Mr. Lawrence said.

"Every week there's another RFP from some client requesting some additional data or the same data in a different format," said Dr. Charles Cutler, vp of medical services for Prudential HealthCare, a unit of the Prudential Insurance Co. of America in Roseland, N.J.

That's why health plans, like their employer-customers, "would like to see some synthesis into one common data set," he said.

'Every week there's another RFP from some client requesting some additional data or the same data in a different format,' Dr. Charles Cutler says.

"What we would like to see is some agreement among the various interest groups regarding data requests.

"HEDIS has been a great start," Dr. Cutler said. "But just collecting HEDIS data by itself is very labor-intensive and expensive."

"The proliferation of different data sets from various groups just adds to the complexity of what we need to do," he added.

And the next step in the report card process—collecting outcomes data—will be even more difficult, Dr. Cutler predicted.

He pointed to the Foundation for Accountability's plan to collect performance measures on diabetes, breast cancer and major depression as especially difficult.

The year-old Portland, Ore.-based foundation, created by managed care pioneer Dr. Paul Ellwood, unveiled its first set of health care quality measures in June (*BI*, July 1).

"Data consistency is the single most substantial hurdle to cross," agreed Kaiser's Mr. Lawrence. "That's the problem with the FACCT model. It presumes data adequacy and consistency."

But while some physicians are compulsive and record symptoms, diagnoses and treatment for each patient seen, "some have no diagnosis—just a chronology of what they've done."

"You also get diagnosis creep" when physicians in HMOs are paid capitated rates based on diagnosis, Mr. Lawrence added.

Physicians' reports on many conditions also vary in severity, he said, citing hypertension. "Hypertension comes in many forms. We need the exact blood pressure and categories for what's considered high, low and mild."

The practice of medicine is inherently vague because "just as individuals are different, there's an infinite variety of ways disease presents itself," he said.

One proposal under discussion for ensuring consistency and accuracy of data is to require that only audited data be reported to the NCQA.

But requiring independent audits to ensure the accuracy and consistency of data collection "will be an immense expense," UTC's Mr. Veysey acknowledged. "Who's going to pay for it?"

"We also have found irregularity in audited data reporting," Prudential's Dr. Cutler noted.

Some skeptics suggest the report cards don't necessarily measure health plan quality but rather plans' ability to collect data.

"There has been some criticism of plans improving their results by improving their data collection," he suggested.

In other cases, plans that provided less data scored better than those that more accurately tracked procedures measured by HEDIS and other report cards.

Some organizations may have inherent conflicts of interest in gathering data for report cards or credentialing purposes, suggested Watson Wyatt's Dr. Friend.

For example, the Joint Commission on Accreditation of Health Care Organizations in Oakbrook Terrace, Ill., offers consultants to advise plans on what they need to pass the accreditation test.

"That's like paying teachers for answers," he quipped.

In many cases, HMOs are complying with data requests without involving plan physicians.

"You'd be surprised how many plans are trying to comply without involving doctors," Dr. Friend said. As a result, "if you talk to doctors, they probably wouldn't know what HEDIS is."

Despite the criticism of HEDIS, FACCT and other report cards, most benefit managers and managed care experts agree that any attempt at quality measurement is better than none.

"HEDIS has been really a great step forward over what previously were measures not too rigorously evaluated," said Dr. Cutler. "But I don't think it's the be-all and end-all."

"A true apples-to-apples comparison is beyond our reach," agreed Blaine Bos, director of the HMO database for Foster Higgins in New York.

"But we're getting close with NCQA." BI

Gatekeeper

Continued from page 4

Care Alliance Cooperative, a Madison, Wis.-based employer coalition, said, "One of the principles we're starting to encourage is more use of primary care and gatekeeper concepts rather than less, so it does seem to be moving into a direction different from what we're seeing."

"It seems counterintuitive from what we think are the important concepts of managed care," he added.

However, Susan Moriconi, manager, health benefits, for Palo Alto, Calif.-based Hewlett-Packard Co., said, "If they feel they can provide that broader access and still be competitively priced, I think on that basis it wouldn't matter much to us," though it remains important to maintain a "central repository" of information about each plan participant.

"Obviously, it's an improved customer service, so if they can still manage their cost and improve customer service by open access, I think it's great," said Fred Hamacher, vp of compensation and benefits for Minneapolis-based Dayton Hudson Corp.

And if it is done successfully, "I think we're going to see more and more open access," said Mr. Hamacher.

Others agree.

Referring to Blue Shield of California's plan, Joseph Martingale, a principal with Towers Perrin in Valhalla, N.Y., said: "I think if it's done well, it becomes a model. It could catch on."

"I think it's part of a trend that will probably emerge," agreed Chuck Hartwig, a principal with William M. Mercer Inc. and head of its western unit health and welfare practice in Los Angeles. "I think you'll see more HMOs pressured to make some changes in this area because of the fact the referral process in many cases has become very problematic."

Alexander Consulting's Mr. Hofmann agreed. "I think there's a reasonable likelihood that other health plans will carefully evaluate the response to this arrangement and obtain feedback from the health plan members regarding their reaction to this available option, which may not have been available in the past."

Other changes in HMO approaches can be expected in the future.

Blue Shield of California's approach is "a step where we ought to be headed," said Steve Richter, Los Angeles-based health care practices leader for Watson Wyatt Worldwide in Southern California.

"I think what we'd really like to see is where employees can go directly to the right provider initially, without having to screen that through an extra primary care physician visit or extra cost as a deterrent to access. I think ultimately where we want to be is a more protocol-driven approach to when it is appropriate to go directly to a specialist," said Mr. Richter.

Other innovations also are likely, said Alexander Consulting's Mr. Hofmann. "Given how competitive the marketplace is becoming it really behooves every managed care plan to explore creatively all of the possibilities for maintaining and expanding market share," he said.

As a result, "I think it would be premature to predict that there will not be other innovations or opportunities to demonstrate responsiveness to plan members." BI

HMO

Continued from page 6

• Harvard Pilgrim Health Care in Brookline, Mass., is restructuring its 14 Massachusetts health centers with 640 physicians and putting them into a non-profit doctor group. Half of this group's board of directors will be from the doctor group and half from Harvard Pilgrim.

Like the laws of physics, where energy is never destroyed but only converted, the doctors formerly with the HMOs do not disappear but are converted to a new form. Frequently, these newly formed physician groups are sold to PMCs, which band together doctors to improve bargaining position with HMOs and handle the management. "They run the business side of the doctor organization," Dr. Reece said.

PMCs contracting with HMOs constitute a second attack on staff model HMOs because they are better at lowering costs, industry analysts said.

One drawback for physicians is that because a PMC generally takes capitated patients—those where the doctors receive a fixed fee per patient for all their medical expenses—the doctors take on an added layer of risk, according to analysts.

At the moment doctors don't seem to mind, as they feel it gives them more flexibility to treat patients efficiently and keep the savings.

"That's the best way to make money, manage quality and it aligns incentives with cost and quality," said Steven Lash, executive vp and chief operating officer for FPA.

But to do this successfully they need to spread the risk. "To play you have to assume risk and to assume risk you have to have capital and expertise. You have to become big business," Dr. Reece said.

The advantages of a PMC or an individual physician group to the doctors are demonstrated by the Talbert spinoff. While owned by FHP, Talbert could only accept patients enrolled with FHP. This restriction put it at a disadvantage compared with competitors enrolled in numerous networks or part of their own physician group.

Now freed from FHP, Talbert can pursue more patients, while continuing to act as provider for FHP's enrollees. "It was absolutely necessary to attract patients outside of the system to Talbert," the FHP spokeswoman said.

Adding enrollees allows PMCs to spread the cost of the facilities over more patients and fully utilize their specialists. The biggest advantage a PMC has over the HMO, however, is it allows doctors to share in the revenue by giving them a stake in the profits, said Dr. Albert E. Barnett, chairman and CEO of Caremark's Friendly Hills HealthCare Network.

Both FPA and Friendly Hills provide salary and performance-based incentives to their physicians, something HMOs generally do not. It is because of these advantages that Dr. Barnett sees the staff model eventually disappearing.

Not everyone, however, agrees that the staff model HMO is an endangered species. One analyst, Barry Moore, managing director for North America with Hamilton/KSA in Atlanta, said the current trend is only temporary to give managed care companies more flexibility.

Ultimately, he predicted that the staff model will reign supreme as it is the best for containing costs while also providing a high quality of care. "It will be the predominant model," he said. "It is the logical model. Nobody knows what the right answer is, however. People are casting around, but nobody knows what the right model is." BI

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1995 revenues	
PBM gross revenue	$6,000 000

PBM Clients	
Total	100
Employer/group plans with direct service	95

Lives Covered	
Group Health:	
Total	56,000
Active enrollees*	14,000
through employers	45%
through third-party vendors	55%

Retail Network	
Pharmacy locations	38,000

Mail-order services	
Percent of prescription volume	74%

Generic usage	
Percent of prescription volume	38%

Staff	
Total	30

Includes: 2 registered pharmacists

PBM services since: 1994.

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, workers compensation, capitated programs.

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, standard, ad hoc, customized.

Service area: United States.

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

Contact: Tony Cerdan, director-marketing.

* *Estimate.* ** *Subcontracted.*
*** *Offers three types of networks: EPO, PPO and customized.*

Aetna Health Plans/Aetna Pharmacy Management

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1995 revenues	
Total gross revenue	$52,900,000
PBM gross revenue	$49,400,000

PBM Clients	
Total	1,082
Employer/group plans with direct service	1,082

Lives Covered	
Group Health:	
Total	5,060,186
Active enrollees	5,060,186
through employers	75%
through third-party vendors	25%

Retail Network	
Pharmacy locations	42,500

Mail-order services	
Percent of prescription volume	20%

Generic usage	
Percent of prescription volume	40.24%

Continued on page 24

How to use directory

The second annual *Business Insurance* directory of prescription benefit managers (PBMs) lists organizations that provide general prescription benefit management services.

Prescription benefit management services are defined as an integrated package of services designed to control the types and distribution methods of prescriptions used by plan participants.

The package of services must include several of these elements: pharmaceutical benefit design consulting, disease management of participants, prescription educational services for users or physicians, utilization review and claims processing.

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

Listings begin with the company name, address, phone and fax numbers.

1995 revenues include total gross revenues, gross revenues generated from PBM services and gross revenue from unbundled PBM services.

The **PBM clients** section specifies total clients for which prescription benefit management services were provided and the number of employer/group plans who contracted directly with the company in 1995.

Lives covered lists total **group health** plan lives (both eligible and active), active group health enrollees and active **workers compensation** enrollees in 1995.

Please note: Active enrollees includes only those participants who actually received prescriptions through the plan.

Along with the number of active group health enrollees is a breakout indicating the percent enrolled via direct contract with employers, through third-party vendors and through Medicare/Medicaid. The percent of active workers compensation lives enrolled through direct contract with employers is also given.

Retail network information includes the number of pharmacies who participate in the company's network.

The percent of prescriptions filled through **mail-order services** and the percent of prescriptions filled with **generic** equivalents is listed next.

Staff information is given in full-time equivalents for 1995 and 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. Services that are provided through a subcontracted organization are indicated with a footnote.

Network design specifies the type of formularies offered by the PBM.

Open formularies allow patients to receive prescriptions from a relatively unrestricted list of drugs, whereas a closed formulary specifies the brand names/generic drugs that must be dispensed to receive coverage through the plan.

Restricted/customized formularies fall in the middle and usually provide coverage for drugs not specified in the formulary—but at a reduced rate—and may allow the client to have some input in the design of the formulary.

The sections that follow indicate the types and names, if provided, of **pharmacies** participating in the network; the types of **reports** provided to the client; **service area**; and **billing methods** offered. If volume discounts are given to employer clients, those discounts are noted under the billing methods section.

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

Listings are responses to a *Business Insurance* questionnaire. The directory is published as an editorial service; there is no charge to be included.

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Business Insurance®

Benchmarks

Continued from page 25

That group was comprised of seven large firms—GTE Corp., Xerox Corp., PPG Industries Inc., Whirlpool Corp., Abbott Laboratories, Colgate-Palmolive Co., and Johnson & Johnson. Each participant had ample statistical information for internal benchmarking, but was unable to make meaningful external comparisons.

The group pooled its workers compensation loss and exposure information to measure and identify best practices for reducing total cost of risk.

With the group's combined information assembled, external benchmarks were developed using the top-down approach discussed above.

Some of the participants were surprised that their results were not as impressive as they thought; others now had the means to validate their success. The group prepared process maps of practices of members with the best results and compared them with their own.

By understanding practices that led to improved results and how the culture of the corporation affects the process, several members of the group were able to apply these practices to their own operations and achieve improved results.

Benchmarking is becoming an increasingly popular method for organizations to reduce their total cost of risk. While internal benchmarking is often the best place to begin, more sophisticated techniques now exist for external benchmarking.

Through proper comparison, an organization can identify target areas that may have a positive effect on its bottom line. BI

Paul Steinman is vp and client systems manager for Johnson & Higgins in New York.

Employee sponsored shuttle is not a 'ride-share' program

Legal Briefs

An employee injured on a shuttle bus provided by her employer to transport employees between the workplace and an off-premises parking area was not participating in a "ride-share" program within the meaning of the workers compensation law, according to the Supreme Judicial Court of Maine.

Doris L. Croteau-Robinson was employed by a bank which provided its employees off-premises parking located between one and two miles from the office. The employer also provided a shuttle bus to transport employees between the parking area and the workplace.

While returning to the office during a lunch break, Ms. Robinson caught her shoe on the edge of the bottom step of the shuttle bus and injured her back and neck.

Ms. Robinson filed for workers compensation benefits, which were denied.

On appeal, the employer argued that the shuttle bus service was a ride-share program and that injuries received while using the service did not arise out of or in the course of employment for workers compensation purposes. According to the court, the term "ride-share" ordinarily refers to the transportation of commuters between the work-place and home. The court concluded that the employer-sponsored here was not used for the purpose of commuting between the workplace and home and was, therefore, not a ride-share program. The court said the denial of benefits to Ms. Robinson was erroneous.

Croteau-Robinson vs. Merrill Trust/Fleet Bank, Supreme Judicial Court of Maine, Jan. 17, 1996 (*BI*/04/Au.-$10).

Property damage cause is crucial

The Oregon Court of Appeals ruled that a commercial liability insurance policy required that the property damage be *caused* by an accident, not that the property damage itself *be* an accident.

Oak Creek Construction Co., a general contractor, was hired to build a custom house.

It retained a subcontractor to paint the woodwork in the home. The subcontractor completed the painting; however, two to three weeks later, the paint failed to cure properly.

The contractor hired another subcontractor to repair the painting, expending more than $10,000. The contractor was covered under a commercial liability insurance policy issued by Austin Mutual Insurance, which covered property damage caused by an occurrence.

The policy defined "occurrence" as an accident. The contractor filed a claim with the insurer for the $10,000 expenditure.

The insurance company declined payment.

The contractor sued the insurer, but lost in the trial court.

The appellate court agreed with the insurance company that the property damage here was not caused by an "occurrence" because the property damage was not the result of an unexpected event.

According to the court, the property damage was itself the unexpected event. Thus, the court said that the property damage was not caused by an accident, but by the subcontractor's intentional act.

The court rejected the contractor's argument that the term "accident" should be broadly construed to include the unintended consequences of intended acts.

Oak Crest Construction Co. vs. Austin Mutual Insurance, Oregon Court of Appeals, Nov. 8, 1995 (*BI*/05/A.-$10).

Assist not linked to work

Is an employee injured while assisting an accident victim engaged in an act incidental to his employment because it advances the employer's interests? The Court of Appeals of Indiana decided that it was not.

Lynn VanDerWeele worked for Construction Management & Design Inc. as part of a four-man trimming crew at a house under construction. The crew were allowed two 10-minute breaks a day.

Their activities during breaks were not restricted so long as they did not exceed the 10-minute limit.

In February 1994, the crew members were working in the house when they heard tires spinning outside. They went out of the house and saw a van driven by a woman had slid off the driveway of the house next door. They decided to assist the woman.

While Mr. VanDerWeele was walking on the adjacent driveway, he slipped and hit his head, suffering an injury. He filed for and was awarded workers compensation benefits.

The employer appealed, contending, in part, that Mr. VanDerWeele's injury was not work-related.

Mr. VanDerWeele argued his act in helping the stranded woman was a charitable act promoting goodwill between his employer and the public.

Thus, Mr. VanDerWeele maintained his act was incidental to his employment.

The appellate court rejected the notion that "such an amorphous and speculative benefit can by itself supply the required nexus between the accident and the employment so as to confer coverage under the Act." The award was reversed.

Construction Management vs. VanDerWeele, Court of Appeals of Indiana, Jan. 23, 1996 (*BI*/01/S.-$10.)

Soliciting, advertising differ

Does a business owner's liability insurance policy provide coverage for a competitor's suit alleging that the competitor's former employee took proprietary information when he left the competitor to join the policyholder and used the information to lure away the competitor's customers? The Supreme Court of Vermont concluded that it did not.

Select Design Ltd., a custom screen-printing business, hired Glen Cousins, former sales manager of RMH Associates Inc., Select's competitor. At that time, Select was covered by a business owner's liability insurance policy issued by Union Mutual Fire Insurance Co. The policy provided coverage for bodily injury, property damage, personal injury and advertising injury.

RMH sued Select, alleging that, on leaving RMH, Mr. Cousins took with him proprietary information, including a customer list, and then tried to lure RMH customers to Select with the proprietary information he had taken.

Select notified its insurance company and requested that it defend and indemnify it in the suit. The insurer denied coverage. The trial court ruled for the insurance company.

On appeal, Select argued that the complaint against it alleged an advertising injury and was within the scope of the business owner's policy. According to Select's argument, the term "advertise" is broad enough to encompass solicitation. But the court said that the general definition of advertising is "widespread distribution of promotional material to the public at large."

According to the court, this is distinguishable from "advertising injury," which is injury to another that results from the *content* of statements about the products or services of the policyholder.

The court emphasized that there was virtually no causal connection here between the alleged injury and the alleged advertising.

The trial court decision was affirmed.

Select Design vs. Union Mutual Fire Insurance Co., Supreme Court of Vermont, March 22, 1996 (*BI*/02/S.-$10.)

No comp benefits for fall

Injuries from idiopathic falls on the job generally are not afforded coverage under the Workers' Compensation Act, according to the Court of Appeals of Georgia.

The claimant in this case was employed as a computer clerk with a bank. When her supervisor noted numerous errors in her work, the claimant explained that these errors were related to vision problems. Shortly thereafter, she had a fall at work, apparently from fainting, and hit her head on the baseboard.

She alleged suffering double vision, headaches, neck pain and carpal tunnel syndrome as a result of the fall. The claimant filed for but was denied workers compensation benefits on the ground that the fall did not arise out of her employment.

The appellate court said the claimant did not fall into an exception to the general rule excluding benefits for idiopathic falls in cases where the claimant strikes some object specifically related to the workplace, such as a work bench, machinery or equipment, because of the increased risk caused by the presence of the work-related object.

The court rejected her claim that her fall was not directly to the floor, but was interrupted by hitting her head on the baseboard.

The court said the baseboard—like a floor—is a structural hazard that the claimant was equally exposed to apart from her employment. The denial of benefits was affirmed.

Prudential Bank et al. vs. Moore, Court of Appeals of Georgia, Jan. 17, 1996 (*BI*/03/S.-$10.) BI

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a $10 check payable to Mayo H. Stiegler, to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

ASK A RISK MANAGER

Managing comp cases can reduce claim costs

Q **We are always looking for ways to improve the workers compensation claims management function but wonder if we are getting the optimum value from medical case management activities. Do you have any experience in this area which may be of help to us?**

A Yours is a very valid question, especially because medical case management services play an important role in workers compensation cost containment programs. As workers compensation costs continue to escalate, risk managers are faced with the challenge of putting all available resources together to keep claim expenses under control.

And, realizing there is a real opportunity to use medical case management in a workers compensation setting, service providers have been eager to offer a variety of programs. It is important, however, to make the marriage of medical case management services and claims administration services a productive and fruitful relationship.

To achieve the optimum results from these groups, you and your service providers must be willing to invest time in the development and planning stages of the program. It's your job to let your service provider know what your expectations are and then establish common goals to achieve them.

I don't believe anyone will argue that claims adjusters and medical case management personnel have very distinct roles when it comes to workers compensation.

For example, the claims adjuster verifies that medical bills are in keeping with fee schedules and that any medical treatment provided to the employee is relative to the diagnosis. They are responsible for maintaining adequate case reserves and see to it that all medical and indemnity payments are issued in a timely manner.

And, let's not forget about those cases that find their way into the legal system. The claims adjuster is responsible for coordinating defense activities with outside counsel.

Finally, it is that same claims adjuster who assures that the proper reporting forms are filed with state insurance regulators. Working in tandem with the adjuster, the medical case manager is focused on directing the treatment plan for the employee and coordinates this plan with the attending physician, claims adjuster, employee and employer.

If it appears that a variety of forces impact the process, you are absolutely correct.

The success of the entire coordination effort is found in a single word: communication. Without continuous dialogue among these parties, the claims management process loses some valuable efficiency.

A growing number of third-party administrators, recognizing how complex the claims adjusting process has become, are beginning to introduce a new concept, that of a nurse/adjuster. I must admit the notion was a bit strange to me initially, but as I began to contemplate the purpose of the role it made perfect sense.

Those of us who are entrenched in the claims management process recognize the importance of early intervention in the medical treatment process. My risk management group attempts to channel employees to "approved" care providers whenever possible and subscribers to a program that requires an initial telephone assessment by a nurse or physician on any workers compensation case involving three or more lost workdays. Under our current scenario, when the assessment has been completed, the information is routed to the claims adjuster, who determines if additional medical case management services, such as rehabilitation, are necessary.

It remains the role of the claims adjuster to orchestrate the case management activities, including those of the medical case manager. The nurse/adjuster, however, would assume a major role in the claims management process after the first telephone assessment by remaining actively involved in approving and reviewing the treatment path of the employee. Both the nurse/adjuster and claims adjuster would be in continuous communication until the claim was settled.

Our TPA enables us with to view adjuster notes online and plans to include the nurse/adjuster notes in the database. Under this approach, we could receive an immediate update on the complete adjusting file with just a few key strokes.

I believe the greatest hurdle for a TPA to overcome is to sell the nurse/adjuster program to the claims adjusting unit, because the adjusters have a tendency to quite literally take ownership of their files.

As a customer, the risk manager looks for the quality of service and must always consider the price. When it comes to pricing, we want to assure ourselves that we are paying a reasonable fee for this expanded claims adjusting service.

To evaluate whether medical case management activities are generating a beneficial financial return, these should be a tracking system in place to measure the results. What I refer to as "real" savings will not be evident immediately. Medical case management costs involve dollars spent up front but should generate measurable savings in six to 12 months depending on your workers compensation claim frequency and severity history. If you have a risk management information system, you can program various reports to compare claim costs with medical management costs.

In summary, as I see it there are three key objectives of a medical case management program:

- Reduce the cost of workers compensation claims.
- Decrease the administrative cost of the workers comp program.
- Provide appropriate, high-quality medical services to the injured employee.

When these have been accomplished you can consider the program a success. BI

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four quarterly features in the Perspective section of Business Insurance can give you some answers.

Ask A Risk Manager, Ask A Benefits Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

Ms. Werner

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Dennis J. Nirtaut, managing director of compensation and benefits for Andersen Worldwide in Chicago, answers questions on employee benefit plans. William J. Miner, an actuary with Watson Wyatt Worldwide in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore., answers actuarial questions in the casualty field.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Surfing

Continued from previous page

corporations. She shows why riding the crest of the latest management wave, then paddling out again just in time to ride the next one, may ultimately lead to corporate wipeout. Formerly with McKinsey & Co., Ms. Shapiro is president of the Hillcrest Group, and should know of what she speaks on the issue of management consulting and fads. Ironically, if clients take her advice, she may end up with less work!

Ms. Shapiro's anecdotes show how managers can learn from their predecessors' clever innovations or misguided assumptions. For example, using her steady but less-than-ideal relationship with her own dry cleaner, Ms. Shapiro shows how customer loyalty is not always the product of customer satisfaction.

"Fad Surfing" also contains a humorous glossary titled, "The Fad Surfer's Dictionary of Business Basics," giving risk managers jargon-free and tongue-in-cheek definitions to "bizbuzzwords" frequently bandied about in boardrooms and top management confabs.

One criticism often leveled at risk managers is that they don't speak the language of top management. "Fad Surfing" offers one antidote, as it gives risk managers broader insight on popular management trends. For this alone, the book is worth reading, even though admittedly its target market and audience is not limited to risk managers.

Cash-strapped companies are increasingly tempted either to eliminate the risk manager's position as a costly luxury or to outsource the function. A corollary of Ms. Shapiro's book, however, is that outsourcing cannot replace the hard work of thinking, a task that should be the responsibility of those inside the company. She thinks too many CEOs and leaders have essentially outsourced the job of strategic thinking, wanting highly credentialed gurus to validate plans. In other words, risk management as a function has to get done, whether you do it through an on-staff risk manager or outsource the function. If you think hiring a risk management consultant or leaving it to your broker is the answer to the risk management challenges of the '90, well. . .perhaps think again.

The point is not that re-engineering, benchmarking or TQM are worthless management theories or practices. The point is that these must be carefully thought out and customized to the unique needs of each organization's aims, culture and values. Quick fixes are illusory, in management and in risk management. Rather than chasing the latest management theory hula hoop, instead of aping the nostrums proffered in today's hottest business book best-seller, the hard choices of thinking confront us all. There will likely never be a "One-Minute Risk Manager," even in these nanosecond '90s.

Ultimately, Ms. Shapiro explains why most management solutions lay not with expensive consultants but with people already in the company. Arguing that managers should use their brains and not their penchant for quick fixes, she strips the hard-sell varnish off the fads and gives solid advice for the long haul.

Fun and irreverent, "Fad Surfing" belongs on any smart risk manager's bookshelf. BI

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

Benchmarks keep companies moving

External reference points key to significantly improving risk management results

By Paul Steinman

A GROWING NUMBER OF ORGANIZATIONS now use benchmarking to improve how they manage and control their total cost of risk.

By comparing operations against a standard, it's possible to identify good and poor performers relative to the benchmark, as well as the factors contributing to the performance differences.

Alternative practices then can be applied to improve results.

Figure A GRAPHIC BY LISA KRUSS

Until recently, internal benchmarking—such as comparing loss experience of one location against that of another—was the most popular benchmarking technique used in risk management.

In figure A, five locations of the hypothetical ABC Co. are compared with each other with regard to ultimate losses per some unit of exposure.

In addition, each location is compared against two standards—the company average at ABC Co. and the average for the top 10% of locations within the company.

Without the benchmarks, individual locations can compare themselves against one another. However, the significance of their performance becomes more apparent when compared against the benchmarks, which provide a point of reference and furnish each location with a new yardstick. In this way, each location can determine if its performance is above or below the company average, as well as the average of the top 10%.

Such comparisons help identify ideal performance standards, and companies can use them to set attainable incremental goals.

In this case, although Location E is the best in the group, it still has a long way to go to become a top performer. Benchmarks can help Location E adjust its goals accordingly.

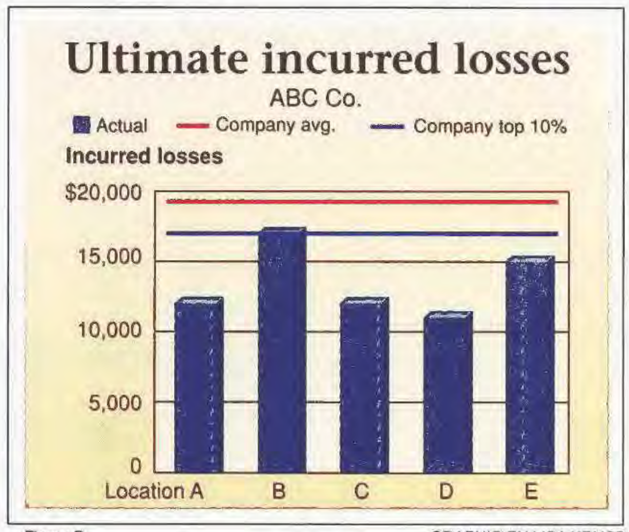

Figure B GRAPHIC BY LISA KRUSS

Similarly, Location D may set a more realistic goal of reaching the company average.

These comparisons are the first step to gaining insights about the underlying processes that contribute to superior results.

Identifying the practices and procedures that achieve the best results provides the operations in the comparison group with blueprints that can lead to improved results.

Even though internal benchmarking can be very useful, it doesn't always produce optimal reference points.

In figure B, five locations of the ABC Co. again are compared with one another, the company average, and the average for the top 10% of locations within the company.

However, this time all locations are performing better than the company average based on the benchmarks established earlier, and all but one rank among the top 10% of performers in the company.

Figure C GRAPHIC BY LISA KRUSS

Although Location D has achieved the best results in the comparison group, its performance hasn't created a new standard for the company.

Missing from this comparison are external points of reference. Without them, the ABC Co. can determine only how well it is performing against itself. Gauging whether its performance is in fact superior or inferior can only be accomplished by adding an external reference point.

In figure C, two external performance standards have been added—best in the industry and best in the world. With these references, it's clear that the ABC Co. has a long way to go before it can consider its results the best in its industry, and even longer before it makes it into the upper echelon of World Class.

Further, although Location D, ABC Co.'s top performer, can be classified among the best in the industry, the external benchmark implies that it still might identify practices that can improve its results further.

One reason internal benchmarking is more widely used over external benchmarking is the availability of information.

Typically, external benchmarks are either unavailable—because competitors rarely share this information—or unreliable. Nonetheless, external benchmarks yield a wider array of methods to improve results.

For external benchmarks, use a top-down approach. Start with broad comparisons before examining information with a greater level of detail.

For example, a benchmark based on a national average could be the first point of reference.

The next point of reference could be refined to a particular industry based on an industry average.

Subsequently, a more detailed view could be created for each state.

This approach is particularly important for workers compensation, where each jurisdiction is governed by a different set of rules.

Finally, information would be analyzed by various factors and processes, including length of disability for return-to-work programs.

In evaluating claims and exposure statistics, several items can be compared, including:

- Coverage, such as workers compensation, general liability.
- Financial information, including medical, indemnity, expenses.
- Medical costs and medical-only claims.
- Indemnity costs and claims.
- Expense costs and expense-only claims.
- Average incurred.
- Industry type.
- Cause of loss.
- Contributing hazards.
- State, province, or country.
- Time to report claims.
- Time to close claims.
- Body part (for workers compensation).
- Injury (for workers compensation).

These items can be used in any combination.

The benefits of external benchmarking can be illustrated by a group formed in 1993, the Johnson & Higgins Workers' Compensation Quality Council.

See **Benchmarks** *on page 27*

Irreverent book tries to re-engineer focus away from fads

"Fad Surfing in the Boardroom: Reclaiming the Courage to Manage in the Age of Instant Answers"
By Eileen C. Shapiro
Published by Addison-Wesley, Jacob Way, Reading, Mass., 01867, 617-944-3700
$22

By Kevin M. Quinley

Book & Ideas

A RE YOU FED UP with flavor-of-the-month management fads?

Re-engineering. Total quality management. Reinventing re-engineering. Best practices. Outsourcing. Market discipline. Fourth-generation risk management.

It seems as though risk managers—like other business professionals—can't turn around nowadays without being force-fed some new prescription for organizational nirvana.

An insurance chief executive officer attends a monthly Big Think with other industry executives.

Invariably returning with some new acronym-laden panacea (e.g., "PRIDE," "EXCEL," etc.), the CEO forgets performance review dates of key managers and rarely circulates advance agendas for staff meetings.

All the while he exhorts his troops on the need for advance planning.

Companies worried about managing risks and surviving into the 21st century have retained consultants, fired risk managers, empowered themselves with the latest computer technology and jumped on the information superhighway, yet many of them remain clueless.

In her new book, "Fad Surfing in the Boardroom," management consultant Eileen Shapiro explores the pitfalls companies face when they jump on the latest bandwagon.

Ms. Shapiro also gives intelligent advice for managers selecting programs that will work for their

See **Surfing** *on next page*

Insurance marketing on Internet won't eliminate need for agents

But strategies on luring Web browsers differ

By ROBERTO CENICEROS

As insurers and other industry-related organizations explore applications for the Internet, their approaches and goals remain a mixed bag, revealed a panel addressing the Insurance Marketing Communications Assn.'s annual meeting recently.

Just how to entice customers and distributors to cut through the Internet's clutter and search out their particular Web site is one area generating different ideas. But panelists don't foresee direct marketing through the Internet radically altering the current distribution system by entirely eliminating agents.

'By and large, people want to deal with people,' says Peter Van Aartrijk. 'They want to buy from people.'

"Part of the problem right now is that people are experimenting with the Internet," said Peter Van Aartrijk Jr., vp of communications for the Independent Insurance Agents of America in Alexandria, Va. "Everybody says, 'Well you have to be there.' "

You do have to be there to make sure your home page compares with the competition's, Mr. Van Aartrijk said.

But Mr. Van Aartrijk he said he is not certain the Internet will be absolutely vital for sales in the short run because it remains too cumbersome. Long term, it will become more conducive when it is as easy to use as changing channels on a television, he said.

But the IIAA and insurers are forging ahead, using the Internet to get their names and messages out.

For example, the IIAA uses the Internet to attract agents to its membership list and to send out action alerts when pending legislation stands to affect agents.

Novato, Calif.-based Fireman's Fund launched a Web site in April, said Richard Denney, director of creative services. Although the insurer spread word of the site through mailings, the Internet eventually could become the primary method of communicating with distributors and cementing relationships with them.

"Right now it's primarily (for) our own customers and our agents," he said. "We haven't really developed a strategy for trying to mass market through the Internet yet, and I'm not even certain that that is one of our goals."

Yet Fireman's Fund is currently examining several options, such as Internet shopping malls, for reaching potential customers, he said.

But malls are not an attractive channel for Universal Underwriters Insurance Co.'s Recreational Products Insurance Division, said Glenna Menard, marketing communications specialist in Overland Park, Kan. Her goal is to attract traffic to the company's Web site.

"Our strategy is to stay away from malls" she said. "Our idea was to create community for our customers so our Web site is a public relations project for our company. We provided something of value for our customers and potential customers; from bulletin boards to chat rooms and we will be adding more things as we go. But the idea is to be a fun place."

The more traffic, the more potential customers learn about the insurer and its products. But Ms. Menard urged caution in the rush to generate traffic. Too much, too rapidly can create a traffic jam of sorts because some customers seek answers to technical and legal questions. Those can take time to research, tying up staff and causing response delays if the company is not ready for it. The result could be poor service.

Universal chooses to stay away from malls because it does not want to be lumped alongside competitors, Ms. Menard said.

But a demand for comparison shopping virtually guarantees companies will have to line up side by side on the Internet, said Carolyn Grossman, director of marketing communications for San Mateo, Calif.-based Strategic Concepts Corp., the publisher of InsWeb, a Web site offering information on the insurance industry.

"That is the way people are going to have to go because that is what consumers want," she said. "We do a lot of focus group research and the one thing that people said they wanted more than anything else out of an industry marketplace for insurance is to be able to comparison shop."

InsWeb offers a variety of information on insurers and the insurance industry, including quotes on certain types of coverage. Users can access the site at http://www.insweb.com.

After the panel discussion, Ms. Grossman said that such thinking applies to personal lines insurance rather than commercial lines where mass customization is more difficult.

Yet even in the personal lines arena, the panelists do not see direct marketing eliminating the need for agents.

"By and large, people want to deal with people," Mr. Van Aartrijk said. "They want to buy from people. So I feel really good about the independent agent of tomorrow working on the Internet. It has global applications, but it also has applications for your customer right down the street."

Ms. Grossman added that selling direct through the Internet offers efficiency and great reductions in marketing and distribution costs.

But insurers are not about to abandon their agent distribution channels, she added.

"No, they are not because their infrastructures are such that they are heavily invested in the current distribution channel, which as my boss likes to say is 300 years old," she explained.

"They are not just going to jump to direct because they can do it now. So the agents have never had a better opportunity to establish a competitive advantage on a worldwide basis," Ms. Grossman said. BI

IMCA meeting tackles the Net

The Internet was a popular theme at the annual meeting of the Insurance Marketing Communications Assn., which attracted about 250 people earlier this summer to the Hotel Nikko in San Francisco.

Someone browsing through the Internet typically takes about two seconds to decide if he or she will click into your Web site, said Jim Sterne, author of "World Wide Web Marketing" and co-founder of Target Marketing of Santa Barbara, Calif., a company that specializes in Internet marketing strategies.

"So it's just good marketing practice to have (a Web site) that is more interesting than the next guy," he said at the conference.

"Because I have an infinite number of Web sites to look at. I mean, we thought, 'Oh boy, 500 channels on cable TV.' That's nothing. Every man, woman and child can have seven (Web sites). It's not expensive to have a really bad Web site," Mr. Sterne said.

Among his other advice:

- When planning a Web site make sure someone will be responsible for quickly answering all electronic mail generated by visitors to the site.

"If you can't answer an e-mail in 24 hours, 48 hours at the outside, don't bother," Mr. Sterne said. "People expect a 24-hour turn around return on e-mail, even if it's only to say: 'I don't know. I will look into it.' "

- Don't blanket the Internet landscape with unsolicited advertising messages.

Members of topic-specific groups that focus on subjects not related to your product or service will get angry. Besides boycotting your product, they can round up other Internet users who will help make your site crash.

Next year's IMCA annual meeting will be held June 22-25 at the Boca Raton Resort and Club in Boca Raton, Fla. For information, contact William T. Hadley, executive director, at 602-443-8860.

A/BT Briefs

Council relocates

WASHINGTON—The Council of Insurance Agents & Brokers has moved to new offices in Washington and has changed its telephone and fax numbers.

The Council's new address is: 701 Pennsylvania Ave. N.W., Suite 750, Washington, D.C. 20004-2608; 202-783-4400; fax: 202-783-4410.

"The expansion of our membership services and programs has made it necessary to move to bigger offices in order to accommodate the addition of new employees," said Ken Crerar, executive vp.

"The space provides us with the essential room necessary to broaden our activities, offers us more visibility and an enhanced presence among other trade groups and key officials and allows us to maintain our close proximity to the Capitol," he said.

The new phone and fax numbers also will apply to these association services: PPI, the Council's professional licensing service; CICE, the Council of Insurance Company Executives; CouncilPAC, the Council's political action committee; and FAME, the Foundation for Agency Management Excellence.

In other Council news, Mr. Crerar recently was reappointed to the Industry Sector Advisory Committee on Services for Trade Policy Matters by U.S. Commerce Secretary Mickey Kantor. Members of the committee representing various industries, including insurance, advise the government on trade policy and other issues.

PLAN president

SILVER SPRING, Md.—Robert S. Wilson has been elected president of the Professional Liability Agents Network.

PLAN is a Silver Spring, Md.-based association of more than 50 professional liability insurance agents and brokers in the United States and Canada. Members specialize in loss prevention and risk management services for architects, consulting engineers, environmental professionals, accountants and attorneys.

Mr. Wilson is chief executive officer of Pro-Form Insurance Services Inc., a professional liability brokerage he founded in 1991 in Toronto.

For more information, contact the Professional Liability Agents Network, 8811 Colesville Road, Suite G106, Silver Spring, Md. 20910; 301-589-5642.

Agencies honored

WASHINGTON—Two agencies have received Agency of the Year awards from the National Flood Insurance Program.

Aparicio, Walker & Seeling, of Metairie, La., and Comegys Insurance Corner, an agency in St. Petersburg, Fla., were honored this spring at the 1996 National Flood Insurance Conference in Nashville, Tenn.

Both agencies were recognized for improving sales through marketing flood insurance in their areas. Aparicio, Walker & Seeling and Comegys Insurance Corner are members of the National Assn. of Professional Insurance Agents.

Woman of the Year

JACKSONVILLE, Fla.—Kay Bishop, underwriting officer at American Surety & Casualty Co. in Jacksonville, Fla., has been named Insurance Woman of the Year by the Insurance Women of Jacksonville.

The IWOJ, a chapter of the National Assn. of Insurance Women, is a non-profit organization that promotes insurance education and advancement of insurance professionals.

Ms. Bishop, a member of the Insurance Women in Jacksonville since 1984, is the chapter's president for 1996-1997.

Top speaker

RALEIGH, N.C.—Sandy Kenley, a member of the Raleigh Assn. of Insurance Professionals in Raleigh, N.C., recently won the National Communicate with Confidence speaking competition.

The event, held at the national convention of the National Assn. of Insurance Women in San Francisco, is sponsored by the NAIW to help participants build self-esteem, feel at ease when addressing groups of people and think more quickly.

En route to the national award, Ms. Kenley won local, state and regional speaking competitions.

Ms. Kenley is a marketing representative at Great American Insurance Co. in Raleigh, N.C.

ARMI directors

AUSTIN, Texas—ARM International Inc., an insurance marketing organization with operations in the United States and Canada, has elected four new members to its board of directors.

The new directors include: Marty Rhodes, president of Rhodes & Associates in Little Rock, Ark.; Steve Warner, chairman-executive committee at UVW/Elizabeth Group in Somerset, N.J.; Parke Ellis, executive vp of Gillis, Ellis & Baker in New Orleans; and Richard Cliff, president of Bowersox Insurance Agency in St. Louis. Walter Roe, president of Roe Agency in Patchogue, N.Y., was elected chairman of the ARMI board.

Austin, Texas-based ARMI develops risk management and insurance programs for trade and professional associations and selected industries. BI

USI

Continued from page 24L

that want to expand their business, he explained.

For example, if a small broker that specializes in employee benefit coverages is looking to spread its business to other states or other areas of the country, USI can "provide a degree of sophistication that enables them to reach their goal," Mr. Mizel said. "USI provides capital to companies that want to grow and expand."

"Firms joining us share our vision," he said. "We want to be a major niche player. Why? It's very profitable."

In 1995, USI acquired 17 companies from all over the country. At the end of June this year, the broker had completed 12 more acquisitions and had seven letters of intent for additional purchases.

But USI doesn't plan to stop there. Its next goal is to reach $150 million in revenues by year end and exceed $200 million in 1997, he said.

"We're opportunistic. If an opportunity presents itself, we try to pursue it," Mr. Mizel said. "The market is very fluid. We've been blessed with a lot of opportunities to look at."

Unlike other companies that mold or rename acquisitions to create uniformity, USI believes in letting its subsidiaries maintain their identity. USI organizes the companies it acquires into what Mr. Mizel calls a "hub and spoke" approach.

"Hubs" are regional brokers, typically with gross revenues of $3 million to $10 million, while the "spokes" generally are smaller brokers. In property/casualty business, hubs tend to be geographic, covering specific regions of the country. Employee benefit brokers, however, may be organized by line of business, and specialty brokers tend to be national, he said.

While USI is becoming a bigger fish, it doesn't intend to compete with the other large brokers in the pond.

"We're not interested in butting heads with the alphabet houses," Mr. Mizel said. "I see us as a unique distributor of the products and services we offer."

Big names like Marsh & McLennan Cos. Inc., Aon Group and Alexander & Alexander Services Inc. often handle very large, international accounts, whereas USI caters to the U.S. middle market, companies with 100 to 1,000 employees.

Before forming USI, Mr. Mizel engineered dozens of acquisitions as chairman of American Business Insurance Inc. and Jardine Insurance Brokers Inc.

Still, an aggressive acquisition strategy isn't for every agent or broker, he said. "Don't try to grow through acquisition without a permanent source of capital and an infrastructure to do it," Mr. Mizel advised. "Consolidations and acquisitions are very complex. If you're not capable of doing that, it's a very, very risky process." BI

Big Apple wasn't big enough for acquisition-minded broker

Small brokers turning to M&A to survive

By ALICE LIPOWICZ
Crain News Service

Manhattan insurance broker Bill Kornreich is no stranger to mergers as a way of growing a business quickly.

His brokerage teamed up with a partner of similar size in New Jersey, acquired a small agency in White Plains, N.Y., and recently began talks to buy another.

"We could have just stayed as a New York City broker, but we wanted to be a regional player," he said.

Many of New York's small and midsize independent insurance brokers are expanding through acquisition and other forms of partnership to become more efficient and to satisfy insurance companies' requirements for greater volume.

Soft market demand and increased competition from insurers selling directly to the public have resulted in thinner profit margins for agents and brokers. And, with their expenses steady or rising, agencies must grow to survive.

Mergers may bring other challenges. Clashes of personalities and business cultures can derail many partnerships that appear promising on paper. Still, the buyout trend is expected to continue as long as current market pressures remain.

"It's very difficult for independent brokers with two or three people to survive," said James Reed, executive director of the Professional Insurance Agents of New York, New Jersey & Connecticut. The regional PIA's agency membership has shrunk by 10% since 1990, to about 2,000 agencies.

Insurers also are encouraging agency mergers to reduce their own costs. They are setting higher volume thresholds and dropping small brokers who don't make the quotas.

"The (insurance) companies would rather have a few select agencies than thousands of small brokerages," agrees Sandra Lee, executive vp and principal of Harold L. Lee & Sons Inc., an agency in New York's Chinatown with $5 million in gross revenues.

The Lee agency shares office space with other minority-owned brokers in its California office and is negotiating a merger with a Japanese-American agency on the West Coast. If successful, the merger would extend the Lee agency's distribution network to 28 states from eight and enhance its position with insurers.

But Ms. Lee also sees potential pitfalls.

"You have to be careful. Some agents are looser about accepting clients than we'd be comfortable with," she said.

Mr. Kornreich had similar concerns when he merged his family's agency two years ago with National Insurance Associates of Paramus, N.J. He and his family partners found not only compatible business lines but also a congenial mesh of personalities with NIA's principal, Paul Gross, and his two sons.

"We hit it off," said Mr. Kornreich, executive vp of the NIA/Kornreich Group of Cos. "We share the same entrepreneurial attitude."

Based on 1995 gross revenues of $32.4 million, NIA/Kornreich was the 27th largest broker in the *Business Insurance* rankings of the 100 largest brokers of U.S. business.

While both were full-service brokers, NIA brought in expertise in equine and title insurance while Kornreich contributed knowledge of real estate and non-profits. The new partnership also trimmed overhead. "Profit margins are up," said Mr. Kornreich.

Shelly Kozel's experience wasn't as rosy, however.

Revenues rose after the president of Lezok Ltd. in Manhattan merged his Long Island agency with several others a decade ago. But expenses rose, too, for more powerful computers. Partners feuded. Worst of all, Mr. Kozel didn't enjoy his new duties overseeing computer systems and personnel policy.

"It was taking me away from insurance," he said. "I won't do another merger." BI

EVENTS

RISK MANAGER OF THE YEAR AND RISK MANAGEMENT HONOR ROLL AWARDS

These awards recognize individual accomplishments in the field of risk management. For nominating forms and rules, write or call:

BUSINESS INSURANCE • Editorial Department • 740 N. Rush St. • Chicago, IL 60611-2590

phone: 312/649-5319 • fax: 312/280-3174

EMPLOYEE BENEFITS COMMUNICATION AWARDS

The EBC awards honor employers for excellence in communicating benefits programs to their employees. Insurance companies and consulting firms also are recognized for their participation in the preparation of award-winning communication programs. For entry forms and rules, write or call:

BUSINESS INSURANCE • Communication Services • 220 E. 42nd St. • New York, NY 10017-5806

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Business Insurance®

2000

Continued from previous page

security for several reasons. Upper-level managers who do not have computer backgrounds may see the problem as a routine systems maintenance task, not deserving of extraordinary attention or resources. They may also believe that because the company is experiencing limited date-related problems now, problems will remain minor. These managers probably don't realize, Mr. Stevens said, that the frequency of problems will multiply toward the turn of the century as tremendous incidences of dates in the new millennium come into play.

In other companies, budget constraints probably come into play.

Wavering on whether to invest in a brand-new computer, top managers resist updating the software of an old computer "that is being held together by bubble gum and barbed wire," said Dick Kearney, partner in charge of Boston-based KPMG Peat Marwick L.L.P.'s Global Year 2000 team. The firm has 50 programmers working full-time on the year 2000 issue.

"A lot of people think it's just computer industry hype," said Bruce Hall, a research director for Stamford, Conn.-based Gartner Group, an information systems consulting group.

Mr. Hall, whose company is consulting with many large companies on the year 2000 problem, estimates that 50% of computers needing modifications will accomplish needed tasks by the year 2000. Insurance companies are making strides in this direction faster than other industries, he said, though he added this "isn't so much, because everyone else is moving very, very slow."

Most insurers have a project team in place by now looking at their computer systems to study the extent of the problem, said Scott Joyner, assistant vp for advanced technology at the National Assn. of Independent Insurers in Des Plaines, Ill. But for those companies just beginning the effort to find consulting help, he said, "I think there's going to be a real mad scramble at this point."

The impact of the problem on the insurance industry, Mr. Joyner added, will vary. "It may be quite small or it may be so big it might cripple your company."

Industry systems experts warn that companies that drag their feet on remedying their year 2000 problems will find themselves without assistance before long. Many companies probably will need consultants' help to assess and correct their systems, deal with vendors selling diagnostic software, and test converted systems for bugs.

Consulting firms know the insurance industry is vulnerable to the millennium problem and will be courting insurers, agents and brokers in the next several months.

But insurers may soon find that good consultants are hard to find, Chubb's Mr. Jung said. Not only will the demand for outside assistance soar with each passing year, but the pool of trained specialists is limited. Most younger computer programmers have little knowledge of the software of the 1960s and 1970s. This is the same software that will have the most acute year 2000 ills.

Of course, not every insurer, agent or broker will want to hire a legion of consultants to cure its year 2000 problem, and depending on the size of the job an existing data processing department might be able to handle the job—if it starts quickly.

Seattle-based SAFECO Insurance Cos. began examining its situation in late 1994 and decided it wanted to do its own work with its own staff and software tools, said Lani Mobius, senior system analyst. The conversion will cost more than $4 million, she estimated.

For SAFECO, as for other companies in the insurance industry, the luxury of moving slowly until the year 2000 arrives does not exist. SAFECO is preparing to "hit the wall" with some computer files in 1997, meaning certain multi-year commercial and personal policies that extend beyond 1999 already are heading for trouble with dates. Other sources report that minor system emergencies already have occurred in similar circumstances at other companies.

Despite the warning signs, Mr. Kearney said, some in the industry aren't listening and probably won't.

"Right now there still is enough time to do it right, if it is done now," he said. "Some people are asleep at the switch, and some people will bet wrong." BI

USI's spectacular growth keeps it in the spotlight

Broker's results spurred by acquisitions

By REGIS COCCIA

Growth through acquisition has created some of the largest insurance brokers in the world, and that strategy soon could put USI Insurance Services Corp. in those ranks.

USI, a San Francisco-based broker created in 1994 by Bernard H. Mizel, recently surpassed the $100 million mark in annualized gross revenues, and it's still growing.

Since its formation only two years ago, USI has made quantum leaps in the annual *Business Insurance* rankings of the 100 largest brokers of U.S. business.

The broker jumped 66 places last year to No. 13, with 1995 revenues of $78.4 million (*BI*, July 22). Its revenues last year rose 680%, from slightly more than $10 million in 1994. And, in the next 60 days, Mr. Mizel expects USI's revenues to exceed $129 million.

"Nobody has been able to achieve what we've achieved in a little over 24½ months," said Mr. Mizel, USI's chairman and chief executive officer.

Even Mr. Mizel has been surprised at how quickly USI has grown, saying, "When we did our business plan, we did not anticipate this would happen" so soon.

Acquisitions also led to revenue growth among the world's 20 largest brokers last year, yet none of those brokers posted revenue increases greater than 29%, in U.S. dollars. Consolidation also is taking place among independent insurance brokers (see story, page 24N).

So what's the secret to USI's success?

"USI was created as an insurance-related financial services firm, not as a conventional broker," according to Mr. Mizel.

Its growth strategy is based on

"Nobody has been able to achieve what we've achieved in a little over 24½ months,' says Bernard Mizel.

acquiring well-managed brokers that want to expand their businesses. USI's mix of business is about 40% financial services, 35% specialty business and 25% general brokerage, he said.

Mr. Mizel attributes USI's phenomenal growth to three factors. "Our plan was well constructed, we have very strong investment bankers and the timing of the marketplace" helped, Mr. Mizel said.

But, "our interest is not in growing revenue for revenue's sake. We're interested in getting pieces that fit."

Those pieces typically are regional brokers—niche players

Year 2000 spells trouble for industry's computers

Agencies, insurers must correct programming quirk to avert system crashes

By ROBERT KAZEL

It is ironic that the insurance industry, which manages the risks of others by using modern information systems, in a few years may find itself awash in widespread errors generated by those same high-tech tools.

And while computers in all industries will be endangered, experts say, those used by insurance companies, brokers and agencies and will face unique perils.

Computer programmers call it the year 2000 problem. The culprit is time, and how computers typically keep track of it. In less than four years, when Dec. 31, 1999, turns to Jan. 1, 2000, thousands of computer systems worldwide—including some belonging to agents and brokers—are expected to make a colossal gaffe that perhaps only an unthinking super-brain could commit: to assume that the year 2000 is 1900 instead.

The explanation is sadly simple. When computer programmers 20 to 30 years ago were designing software for the rapidly automating corporate empires of America, they needed to compress lines of software as concisely as possible to conserve operating memory. References to months, dates, and years were abbreviated to two digits each. "1960," became "60," and "1971" became "71." And when the New Year's Eve ball drops to the ground in 2000, many computers will see two zeros and, finding nothing in their programming to the contrary, assume that William McKinley is president once more.

The result, for agencies, insurers and other companies that have not corrected the problem, could be terribly destructive. Erroneous calculations could cascade through pension accounts, benefits calculations, billing and accounting systems, to name just a few.

In the insurance industry, several companies already are preparing to prevent disaster; they warn that organizations large and small must begin assessing and correcting software weaknesses long before 1999—and that this year is definitely not too early to begin.

At Warren, N.J.-based Chubb & Son Inc., for example, a full-time team of 10 senior programmers forms the Year 2000 Team and is working in conjunction with two outside data processing consulting firms. Since last June, the team has analyzed thousands of lines of software to spot potential trouble. The effort to evaluate and repair the software, which Chubb intends to conclude by 1998, will costs tens of millions of dollars, said John Jung, ...-applications systems delivery.

The basic task at hand, checking ...ware for date locations, is sim... But making the change is akin ...mbing through millions of ... in billions of haystacks.

...ubb's case, Mr. Jung esti...e company's computers have more than 1.5 million date locations and, of these, 70% are of the troublesome two-digit variety. Unfortunately, there is no simple way to "tell" computers to convert all dates to four-digit years: What was written by hand long ago must now be undone the same way.

Although most of the insurance industry is aware of the problem, most companies are just starting to consider how to approach it, what tools are needed to evaluate the risk and how much time, staff and money a conversion will take.

"Most companies are just beginning to awaken to the fact that they have a problem," said Jeff Stevens, engagement manager for the Change of Century program at San Antonio-based USAA Group. USAA has between 40 and 50 people working on the year 2000 problem, including some outside vendors, and most are on the task full-time, Mr. Stevens said.

"We are considering this the largest software modification in the history of our company," he said, estimating it could cost the insurer between $50 million and $75 million.

Surprising as it may be, many insurers and agencies apparently are aware of the impending danger but are moving slowly.

Many insurers are just starting to write impact studies of the problem, Mr. Stevens said, a step USAA undertook in 1994.

Only about 100 or so weekends remain between now and when the situation needs to be covered. "That is not a lot of time to put in millions of lines of code."

According to the Agency-Company Organization for Research & Development, the year 2000 problem may prompt agents to upgrade their computer systems.

This may not happen immediately, however.

In its biannual Automation and Interface Survey Report, which polled 500 agencies nationwide, Pearl River, N.Y.-based ACORD said few agents are rushing to buy state-of-the-art software.

The ACORD survey found that a majority of agents with computer systems designed for agency management do not plan to buy new software systems within the next three years (*A/BT*, June 3).

Insurers may have a false sense of

See **2000** *on next page*

Streamline

Continued from previous page

computer company Sun Microsystems initiated the project late last year as part of a strategy to streamline certain functions within the company. It turned to its longtime broker, Sedgwick James of California Inc., for help.

"In its strategic thinking, Sun decided that they wanted to look real hard at two major projects," said Matt Davis, vp at Sedgwick James in San Francisco, who is responsible for the Sun account.

Those two areas involved alternative risk—redesigning Sun's approach to insurance and developing a corporatewide risk retention strategy—and making use of information technology, Mr. Davis said.

"We started talking with them about it and made it into a formal program," he said.

Sedgwick James then suggested expanding the partnership to include one of Sun's insurers. The broker and computer company chose Chubb & Son Inc., a unit of the Warren, N.J.-based Chubb Group of Insurance Cos., because Chubb is a prominent underwriter of high-technology risks and, as Sun's casualty insurer, writes the greatest volume of Sun business, Mr. Davis explained.

In looking at ways to streamline administrative functions, Carol Harrington, Sun director-risk management, found that she could set up templates for certificates of insurance for liability, workers compensation and other lines, "so salespeople who get requests for certificates can stop bugging the risk management department," explained Patrick Vice, proprietor of Toronto-based technology consulting firm Electric Coffee House.

Mr. Vice, who was consulting on multiorganizational projects at Sun Microsystems, was hired to help coordinate the initial phase of the Sun/Chubb/Sedgwick project.

Ms. Harrington, on leave from Sun, could not be reached.

On the Internet, Chubb set up a memorandum of insurance for Sun at a site administered by Sedgwick James. Sun contractors needing proof of insurance can obtain that information at http://insuranceusa.iconnet.net/netpartners/index.html.

The project's home page also contains an international directory of Sedgwick contacts involved in placing insurance for Sun Microsystems and links to the Internet sites of Sedgwick James North America and Chubb Corp.

Listed in the memorandum, among other things, are: the name, address and contact numbers of the producer, Sedgwick James of California, and the policyholder, Sun Microsystems; types of coverage; the insurance companies providing the coverage; policy numbers and their effective dates; and coverage limits.

For example, Sun has $2 million in aggregate limits under its commercial general liability policy, which expires March 15, 1997.

Having this basic information available over the Internet is a big timesaver for Sedgwick James, which processes requests for certificates of insurance, Mr. Vice said.

The online memorandum of insurance helps reduce the "administrative burden," Mr. Davis agreed. "That has significantly decreased the man-hours at Sun and Sedgwick" needed to produce certificates, which previously involved sending customers to the risk management department and the broker.

One of the project's goals is "to produce certificates electronically, without ever touching a piece of paper," he said.

In certain cases, however, when additional coverage information is required, Sedgwick James staff will produce certificates manually and mail them out, Mr. Davis said.

"We think it amounts to some pretty dramatic results in only a few months," Mr. Vice said.

Two of the most important results of the project, according to Mr. Vice, were the memorandum of insurance and management of the project primarily via the Internet during the first phase. Sun, Chubb and Sedgwick James communicated through e-mail, involving people on the East and West coasts and in Canada, he noted.

"By my reckoning, if we had to rely on phone and fax, this project would have taken 18 to 24 months," Mr. Vice said.

The project now is in Phase 2, which is "still being designed," Mr. Davis said. "Phase 1 was the proof of concept to see if the idea made sense. Now we're trying to identify what other functions can be automated—whether they're performed by an underwriter or a broker or a risk manager."

Chubb, Sedgwick and Sun meet at least monthly, either in person or by videoconference, to discuss the project, he said. The partners plan to meet this month to outline strategies for the next phase.

Although the three companies are the only members of the partnership, they plan to share what they learn with the industry.

In fact, at the 34th annual Risk & Insurance Management Society Inc. conference last April in Toronto, Chubb, Sedgwick and Sun reported their progress.

Many risk managers and brokers have expressed an interest in the project, Mr. Davis said.

The project also has had important benefits for Sedgwick, he said. It has helped solidify the broker's relationship with its client, learn a lot about electronic commerce and "spread it on a grander scale."

"What Sedgwick is trying to do is take what we've learned from this and apply it to other initiatives" in information technology, such as risk management home pages for other clients, he said.

"We see information technology not just from an internal standpoint—how it makes us more efficient—but what we can bring to a risk manager's table," Mr. Davis said. That's especially important for Sedgwick James of California, which places coverage for many high-tech companies based in Northern California, he noted.

"A lot of people are dabbling with (electronic commerce projects). What sets this one apart is we've formalized it and identified partners.

"We have a contract that further formalizes the process. The fact that Sun is such a big player on the Internet scene (means) we've been able to accomplish a lot," Mr. Davis said.

Where the project goes in its next phase will depend on what the partners decide to explore, Mr. Davis said. "Once we've identified the things we want to do, that will dictate what happens in the future." BI

Continued from page 245

interns typically choose to work six months to two years while taking classes and do everything full-time agents do, only part-time.

"This is not a gophership where they have to push papers or do everything nobody else wants to do," he said. "This is a very real-world business experience."

Mr. Van Grinsvan said their goal is to help an intern grow personally and professionally. "We see it as a challenge for us to communicate how insurance works," he said.

"Most people on campus don't know what life insurance is other than getting a check when someone dies, but when they go beyond that and understand it, they become much more interested in it."

Todd Ahrens, Northwestern Mutual's top college agent in life sales, has been an intern for almost four years while going to school. Five years ago, he says he did not even have a glimmer of an idea that he would sell insurance for a career. "I had the luxury of testing the waters before jumping in," he said. "People can test-drive a career in insurance sales without having to commit all the resources they would when they got done with school."

Mr. Ahrens, a junior at the University of Iowa, admits he had many of the misperceptions other students have about insurance, but he entered the field with an open mind. "The great thing is I've got all the support of Northwestern, so it's really up to me on where I want to take it," he said. "Here, I'm truly my own boss, so I get paid as much or as little as I want to work."

And work he does. Mr. Ahrens sold 59 life insurance policies in one year, which made him No. 1 among college agents.

Mr. Ahrens said interns should focus on the help they can provide to people in need. "The issues that we deal with in insurance, everyone wants them taken care of, but (they) just don't want to take the initiative to do that," he said.

George Flanigan, an insurance industry professor with the Katie Insurance School at Illinois State University in Normal, Ill., says internships benefit students and the insurance industry. The school runs a risk management and insurance degree program that has more than 40 students in summer internships.

"It gives companies the opportunity to take a potential employee as an intern with the possibility of making the intern a full-time employee," he said. "From the companies' point of view, they get excellent employees that way because they get to screen them beforehand."

Rob Hoyt, a professor of risk management and insurance at the University of Georgia in Athens, said the department has an active program in which students can receive college credit for their internships. "An internship is really an opportunity for them to show some experience to industries, and it gives them direction in where they would like to go in a job," he said. "The real advantage is that it provides then a real leg up in terms of recruiting activities."

The Georgia program has about 280 risk management and insurance majors and averages 60-70 students doing related internships each year, said Mr. Hoyt, adding that 95% of their alumni work in the insurance field.

Mr. Hoyt said it is sometimes hard to recruit new employers to hire interns, but finds "employers reap significant benefits" from jobs students can perform. "The internship is an opportunity for them to take a free look, so to speak," he said. BI

Venture makes Net gains

Project aims to tap Internet potential

By REGIS COCCIA

Doing business electronically is a goal of many agents, brokers and insurers, and one joint venture is helping pave the way.

A project undertaken earlier this year by Sedgwick James of California Inc., Chubb & Son Inc. and Sun Microsystems Inc. to create a seamless flow of information between insurer, broker and risk manager could become an insurance industry model.

The three companies have been working together to lay the groundwork for future electronic commerce in a number of areas, including distributing a "memorandum of insurance" containing basic coverage information to fulfill requests for certificates of insurance. Other areas involved in the project include online directories of offices and contacts, loss run and policy data, loss control information and e-mail.

Requests for certificates that show proof of coverage often are presented to companies like Sun Microsystems by customers before contracting with the company.

Satisfying numerous such requests can be a time-consuming, paper-intensive process for risk managers and brokers.

In fact, that's what led to the joint venture.

Mountain View, Calif.-based

See **Streamline** on next page

Agent/Broker Topics

Internship investment yields big dividends

Insurers, brokers are rewarded with their pick of top-notch prospective employees

By CRISTAL CODY

Ask college freshmen what they want to be when they graduate, and insurance and risk management professionals are not likely to be their first picks. But thanks to several internship programs across the country, more students are choosing insurance careers.

Rob Drennan, director of an internship program at Temple University in Philadelphia, placed about 75 of 300 undergraduates majoring in risk management and insurance and actuarial science in internships this summer. Nearly half of these students will continue the internships during the academic year, he said.

"It's amazing to see the transformation from when they leave in May until September," he said. "They have more experience in the insurance field and have a sense of professionalism."

Students know internships can be crucial to their success. Companies realize strong internship programs are low-cost recruiting tools that provide excellent young workers who may later join those companies after graduation.

"If they want a career in risk management and insurance and actuarial science, it is imperative for them to do an internship to get a full-time job," he said. "There is a very high correlation between having an internship and securing a good offer after graduation."

The late John P. Gallagher, who died in February, saw the need for new talent early on at broker Arthur J. Gallagher & Co. in Itasca, Ill. He founded the company's summer internship program in 1965. Since then, more than 300 interns have been recruited, and 30 students are employed in Gallagher offices this summer.

"It was true back then as it is now; a lot of college students don't grow up wanting to be insurance agents," said Terry Hennen, director of training and communications at Gallagher, which *Business Insurance* ranks as the world's eighth largest broker (*BI*, July 22). "We really want young, enthusiastic insurance people that we can start with from scratch."

Gallagher interviews many more students than it hires as interns in what Mr. Hennen called an "extremely competitive" process.

The Gallagher internship provides eight weeks of basic instruction in sales techniques. After the first week of learning business skills, students are then assigned to brokers to shadow while they make sales calls and negotiate with underwriters. "By the end of the summer, they have a good feel for what it would be like to be a producer at Gallagher," he said. "We want them to know what it really feels like to have this job, and they find they love meeting new people, the chase for new clients and the technical experience."

Mr. Hennen said on average, 50% of Gallagher's interns are hired to full-time positions upon graduating—and half of those have remained with Gallagher. "We're not just hiring people, but hiring (those) who progress to be the top people in the industry," he said. "We're trying to hire new producers. It's a recruiting device—that's the real benefit."

The main cost to Gallagher is not what the company pays interns—$300 a week—but the costs necessary to train and develop them, Mr. Hennen said. "We get paid back a hundred fold," he said. "What we get out of it is top-notch employees who stay for a long, long time."

Dennis Tamcsin, senior vp-agencies at Northwestern Mutual Life Insurance Co in Milwaukee, said its intern program began almost 30 years ago and has helped more than 3,000 students start careers in insurance. The project began as a way for students to gain experience selling life insurance and to earn some money, he said.

The program recently earned a listing in the Top Ten Internships in America, according to the 1997 edition of America's Top Internships, published by Random House/Princeton Review Books. As the only insurance and financial company featured, this is the second time Northwestern made the directory of 105 companies.

"I think part of the reason they felt we were worthy of recognition probably had to do with the fact that we embrace our interns almost like they are full-time employees," Mr. Tamcsin said. "It gives them a wonderful experience and at the same time, they have the opportunity to earn money."

Each year, the company selects 600 interns from 500 campuses to work nationwide in open-ended internships aimed at teaching about life insurance sales. Each week, the students learn more about life and disability income underwriting while earning commissions.

Michael Van Grinsvan, assistant director for Northwestern Mutual's campus recruitment, said Northwestern's interns are licensed and contracted to sell insurance. The

Continued on next page

Continued from previous page

Another agency, NIA Ltd. in Paramus, N.J., uses an extensive audit procedure to catch mistakes, said President Paul Gross. Outside auditors review the files each quarter while internal quality control people work full time looking for lapses in the agency's procedures.

But having a procedure in place is not enough—it must be followed. "Few organizations really recognize the importance of implementing the process," said DBH's Ms. Hicks.

"If senior principals don't recognize the value of it and importance of it and say, 'It will be done every time,' it won't happen," she said.

At Hamilton-Dorsey-Alston, implementation is emphasized. The agency charges a "substantial portion" of its deductible to any agent whose violation of its detailed E&O program leads to a loss, said Mr. Smith. "We are holding their feet to the fire on this thing," he said.

Another area of concern, said Hales & Associates' Mr. Cunningham, is the increased use of technology.

Many agencies, he said, run into problems when they rely partly on paper files and partly on computer files. "If agencies have a hybrid environment, they tend to do a poor job of both," he said.

It creates an uneven adherence to the rules where each person makes their own procedures rather than following the company's, he said.

"They are asking for trouble," with such a system, Mr. Cunningham said.

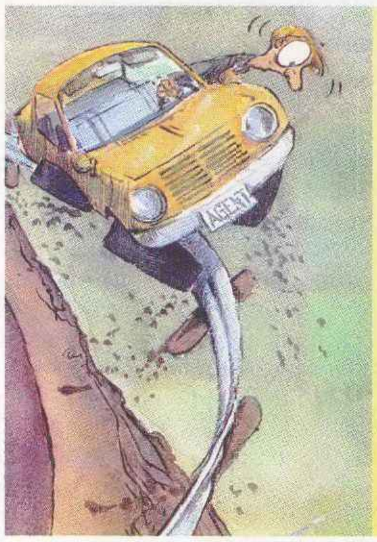
Agents exceeding their binding authority also could encounter suits. This happens if an agent binds the client for limits above those approved by the insurer or for unapproved types of coverage.

The NIA's Mr. Gross said that exceeding binding authority is grounds for dismissal at his agency.

As a result of their diligence, Mr. Gross said that E&O losses have decreased while business has gone up.

"We want consistency in our services," he said.

"Any client is happier to know we have a tight set of procedures in place. Otherwise, we would be seen as a sloppy shop," he observed. BI



Steering clear of trouble

Many E&O claims arise from mistakes in determining a customer's loss exposures and coverage needs. Steps agents and brokers can take to prevent claims include:

- Using a comprehensive survey each time an account changes or is reviewed
- Keeping a list of subjects discussed with client
- Documenting actions taken
- Comparing customer's prior coverage
- Examining client's need for limits

Source: Fireman's Fund Insurance Co.

GRAPHIC BY LISA KRUSS

Institutes name new chairman

MALVERN, Pa.—Norman A. Baglini has been named chairman and chief executive officer of the American Institute for Chartered Property Casualty Underwriters, Insurance Institute of America and Insurance Institute for Applied Ethics.

Mr. Baglini, who has been CEO of the institutes, has taken on the additional post of chairman. His responsibilities include overseeing the Malvern, Pa.-based institutes' ethics education and research, executive education, management development and use of technology in learning.

Also at the AICPCU, IIA and IIAE, Jerry S. Rosenbloom has been named chairman of the board of trustees. Mr. Rosenbloom, a professor of insurance and risk management at the University of Pennsylvania's Wharton School, is the first academic to be elected chairman.

Joseph W. Brown Jr., chairman, president and CEO of Talegen Holdings Inc., has been named vice chairman of the institutes' board of trustees. He will succeed Mr. Rosenbloom as chairman of the trustees in 1998. BI

Agent/Broker Topics

'Agent cover thyself' is wise advice to cut E&O risk

Loss-prevention steps should include survey of client's needs, training and documentation

By MICHAEL PRINCE

A good program to prevent errors and omissions losses is nothing more than good business. Not only will it prevent costly lawsuits against agents and brokers, experts say, but a loss program will make clients happy, leading to an increase in business.

The most common reason for an E&O loss for an agent or broker is poor risk assessment of the client, which then leads to a lack of proper coverage. A study conducted by E&O loss control program PAR Ltd. shows that 56% of all claims fall into this category, said Demmie Hicks, a principal with DBH Consulting, which oversees the PAR program.

To avoid this problem, agents and brokers must create a detailed E&O loss-prevention program.

Under such a program, the agent uses a survey to review with the client the exact risks faced.

It is up to the agent to discuss all risk areas and types of coverage available, and then provide the client with the opportunity to accept or reject such coverage.

The agent should also discuss any changes in locations, operations or additional machinery.

"Adhering to good systems and procedures will keep (agents and brokers) from getting burned," said Timothy Cunningham, senior vp of agency consulting firm Hales & Associates in Westchester, Ill.

Thorough documentation of all transactions should be made in case a dispute later arises. All oral communication should be confirmed in writing and if necessary, the client should sign or initial key documents.

"Documentation, documentation, documentation is the defense to E&O," said P. Bruce Higgins, assistant vp and director of marketing for commercial group

at Fireman's Fund Insurance Co.

Robert C. Smith, chief operating officer at Atlanta-based agency Hamilton-Dorsey-Alston, cited the following as an example of an E&O claim in the making.

A client asks for core business insurance—property damage, workers compensation and liability insurance.

That client, however, may not be aware of the need for other insurance to cover potential business interruption, environmental damage or employer practices claims.

If the broker does not discuss these types of coverage with the client and the client has a loss in one of those areas, the client may have grounds for a suit.

The difficulty facing agents is that their clients are not always insurance experts. As risk assessment has become more complex, the agent's role has changed.

"In the past, an Agent/Broker could concentrate his/her efforts on being a sales person," states a guidebook entitled "Your

E&O losses and increased revenues 'are the flip side of the same coin,' says Robert C. Smith.

Agency Risk Management and Loss Prevention Guide" produced by the Fireman's Fund. "Today, however, clients demand a broader service. The service includes managing the client's known potential loss, and providing advice on the management of risks."

As agents and brokers assume this expanded role, their E&O risk is reduced while also generating more business.

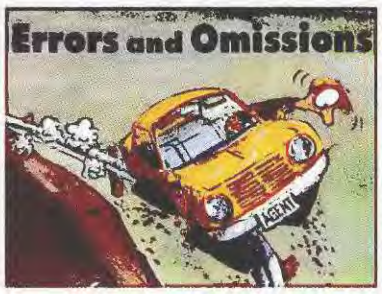
An insurance agent cannot separate E&O loss from increased revenues, said Mr. Smith. "They are the flip side of the same coin."

To hone his agents into insurance professionals, Hamilton-Dorsey-Alston invests heavily in their education.

Mr. Smith estimated that the agency spends more than $1,000 a year on each employee's educa tion.

"Five years ago the amount c money we spent on develo ment was relatively incidenta he said. "Today it is a spe line-item on our budget an resents over 1% of our nues."

Continued on



Continued from previous page

"Essentially what (the guidebook) says is document, document, document," Mr. Higgins explained.

Fireman's Fund also handles claims and underwriting for Asurex's captive. Loss control requirements are stringent for participants. Evaluations and consultations can take days, and the agency must agree to have a point person oversee an E&O loss prevention program.

Larger agencies with a person assigned to E&O oversight often do best in holding the line on losses, observers note. Holding the line on losses also is helping insurers compete without necessarily sacrificing earnings.

"We haven't lost as much business over the last several years as we thought we may have," Mr. Higgins said. "Now, we have not been able to get any kind of a price increase. Our premiums have been relatively flat. The good news with that is we also came out with loss control programs several years ago where we think it actually helped stem the tide of losses. So, with fewer losses and loss adjustment expenses, we can still break even or make a profit in this line of business."

Although prices continue to fall in many regions, several observers, including Mr. Higgins, report that the larger, more established insurers in the market are starting to hold the line on pricing, particularly in certain regions like California.

"I think the real players are firming them," Mr. Higgins said.

"The rates are pretty much like last year. There isn't any rate-cutting like last year going on with the real professional players," Mr. Higgins said.

Additionally, claims and the number of outstanding policies are down in California because of mergers and acquisitions among agents and brokers, Mr. Higgins said. The mergers mean fewer agencies, and those that emerge typically have the better loss control practices expected of bigger operations.

Mergers and acquisitions are reshaping the E&O market in other ways.

Shand Morahan's Ms. Rzepecki reports that her company—which specializes in insuring managing general agents, wholesalers and retail agencies that typically place difficult lines or do more than $2.5 million in premium volume—is seeing more business because newly merged companies are now large enough to seek coverage from companies like hers.

'We are seeing a lot of companies come in with bare-bones or minimum coverage forms, and agents really need to be aware of that,' Yvonne Wiley says.

The agency that has increased in size is no longer limited to coverage offered through agent associations or the insurers that compete with those association programs, she said.

Associations like the IIAA say they are losing some business to price-slashing competitors.

"I suppose the competition has picked up a few policies, but I don't think that we are losing a significant number to the competition," Mr. Magill said.

Association representatives warn that agents need to examine the insurance they purchase because some policies are cheaper but their coverage is stripped down. For example, prior acts may not be covered under some E&O policies, leaving a gap in coverage when an agency changes insurers.

Agents need to be cautious, agreed Yvonne Wiley, insurance program director for the IIAA in Alexandria, Va.

"It's not only a price war out there with the soft market," she said.

"We are seeing a lot of companies come in with bare-bones or minimum coverage forms, and agents really need to be aware of that. Even if they are in an economic situation where they need to save some money, they also need to compare coverage if they are going to move."

To compete, the associations are marketing the stability and claims-handling records of the E&O programs they endorse. The IIAA endorses Employers Reinsurance Corp. of Overland Park, Kan.

"There is always somebody in the property/casualty business that will come along and undercut somebody else's price on a given account," Mr. Magill pointed out. "But I would say, overall, the association's program is the most stable and price-competitive of any of them around," he said. BI

E&O market

Continued from previous page

Co. Inc., an underwriting manager for Evanston Insurance Co. in Evanston, Ill.

"They are coming in and they are going to take whatever the agency is at, whatever the lower price is to get that book," she said. "And until the market turns, it doesn't even matter what the niche is. Price often seems to be the key. (It's) who has the lowest price."

Not only is the pricing war affecting all niches within the producer E&O market, but it also is impacting all layers of coverage. Even the excess insurers and facultative reinsurers have had to come down in price, Ms. Rzepecki said.

"Everybody has been affected, and who knows when it is going to turn around," she said.

Currently, insurers and agent associations estimate that the E&O market for agents generates roughly $300 million in annual premiums nationwide.

On average, a typical small retail agency carries professional liability coverage with limits of $1 million per claim and a $1 million aggregate, Scottsdale's Ms. Reid said. Deductibles can range from about $2,500 to $5,000 per claim.

Others report that some small retailers carry $500,000 in limits and some even less, with amounts varying by region and specialties.

She stressed that the types of hazards for which an agency places coverage could have more impact on their limits than the premium volume it handles. But, in general, a larger retail agency placing approximately $30 million in premiums could carry limits of $5 million, with deductibles ranging as high as $50,000 per claim, she said.

'If (agents) want to write coverage, the insurer will say, "Let me see your E&O policy." If they don't have one, they don't get an appointment,' Allen Sterger says.

But many insurers require agencies that place their business to have at least a $1 million limit in E&O coverage, Ms. Reid said.

Placing higher-risk lines, such as aviation and marine, can require higher limits because the need for specialized knowledge can mean there are increased chances of agent error.

Wholesale operations and managing general agents can require more coverage because of the amount of premium volume they take in and the involvement of several other agents placing policies, observers said.

Some members of agency network Assurex International have E&O limits of up to $10 million per claim through Professional Agencies Reinsurance Ltd., a Bermuda-based captive insurer owned by Assurex, said Tom Harvey, chairman of the Columbus, Ohio-based network.

Deductibles start at about $50,000. Many Assurex members are large, independently owned U.S agencies averaging about 100 employees and $10 million in annual revenues, Mr. Harvey said.

Insurers also are more stringent today in their requirements that agents placing their policies carr professional liability coverage, sa Allen Sterger, president of Alle Sterger & Associates Insurance S vices in San Diego, a whole specializing in E&O coverag agents and brokers.

"It's kind of become a work mit," he said. "If they wan write coverage, the carrier wi' 'Let me see your E&O policy, if they don't have one they don't get an appointment."

E&O liability claims can vary, but typical claims by policyholders allege failure to provide adequate coverage or adequate limits, Ms. Reid said.

Another less common reason for claims is improper cancellation, which typically involves failing to notify a policyholder or insurer of a cancellation.

"About half of our claims involve failure to place coverage at inception or renewal, and most of those claims have to do with personal property," said Bruce Higgins, director of program development for the commercial group department at Novato, Calif.-based Fireman's Fund Insurance Co. "Another 29% have to do with commercial property.

"It's the peril (the agent) missed, or maybe a building they missed or some coverage they said, 'Don't worry about it.' That is the scariest agency out there, the 'don't worry' agency," Mr. Higgins said. "The ones who will say, 'I don't know, but I will find out' and then confirm it with a letter (to the client) are the ones we like."

Letters to the client documenting what the agent can and cannot do are some of the best risk man agement tools available, Mr. Higgins explained. Fireman's Fund, like other insurers, produces risk management guidebooks and conducts seminars for agent protection (see story, page 24F).

Continued on next page

"Everything that enlarges the sphere of human powers, that shows man he can do what he thought he could not do, is valuable."

-Samuel Johnson

At Fireman's Fund we believe that, with determination and encouragement, the human spirit is driven to overcome hardship. This is at the foundation of SmartCARE,^{SM} *our workers' comp managed care program which is designed to help our customers' employees get back to their productive and fulfilling lives. The inspiration of Paralympic athletes only reinforces our faith in what human beings can do.*

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Fireman's Fund

Exposure to E&O suits increasing

But rates staying low as insurers compete to write coverage for agents and brokers

By ROBERTO CENICEROS

It used to be that insurance agents could get a good night's rest without worrying too much about their errors and omissions coverage.

But no longer. A variety of forces is changing the climate for producers, making them bigger targets for E&O claims as well as insurers entering the professional liability market with policies that are cheaper but sometimes offer less coverage, observers say.

A key factor behind the increased E&O exposure is the increase in consumer sophistication and a willingness to file lawsuits.

"There is a little less hesitancy on the part of the customer to bring an action against their agent than there used to be," said Larry Magill, vp-member products for the Independent Insurance Agents of America in Alexandria, Va.

"There is no question about it: If someone has an uninsured loss today, they are going to look to somebody else to pay for it. That is just part of the litigious attitude in society today," he said.

So agents are encouraged to mention to buyers as many coverage options as possible. "That is one of the reasons we stress sales of flood insurance, for example, to our members," Mr. Magill said.

Combine the trend to litigate with a spate of catastrophic losses from hurricanes, floods, fires and earthquakes and you have more E&O claims, explained Pat Reid, insurance agent product line manager for Scottsdale Insurance Co. in Scottsdale, Ariz.

Natural disasters force consumers to seek coverage, and after a loss they often are asking why their agents did not recommend certain types of insurance, such as business interruption.

"Customers are more sophisticated now and they expect more out of their insurance agents," Ms. Reid said. "So there has been an increase in E&O claims."

But there is some good news for agents and brokers.

E&O coverage remains highly competitive, with many insurers entering the market for the first time—including admitted insurers providing new competition for surplus lines insurers over the past few years. The capacity the new companies bring has continued to force prices down.

Data on claims and pricing for E&O is plentiful and losses are predictable, observers say. Those factors make it a choice market for insurers looking for new areas to underwrite.

"The pricing is about as soft as I have ever seen it," said Marta Love, assistant vp-underwriting for E&O Professionals, a division of Media Professional Insurance Agency Inc. in Kansas City, Mo.

"Some of the new companies coming in have driven pricing down and we, like other carriers, have taken a rate deduction in many, many states to stay competitive," she said.

Agents and brokers say price quotes on E&O liability coverage can vary.

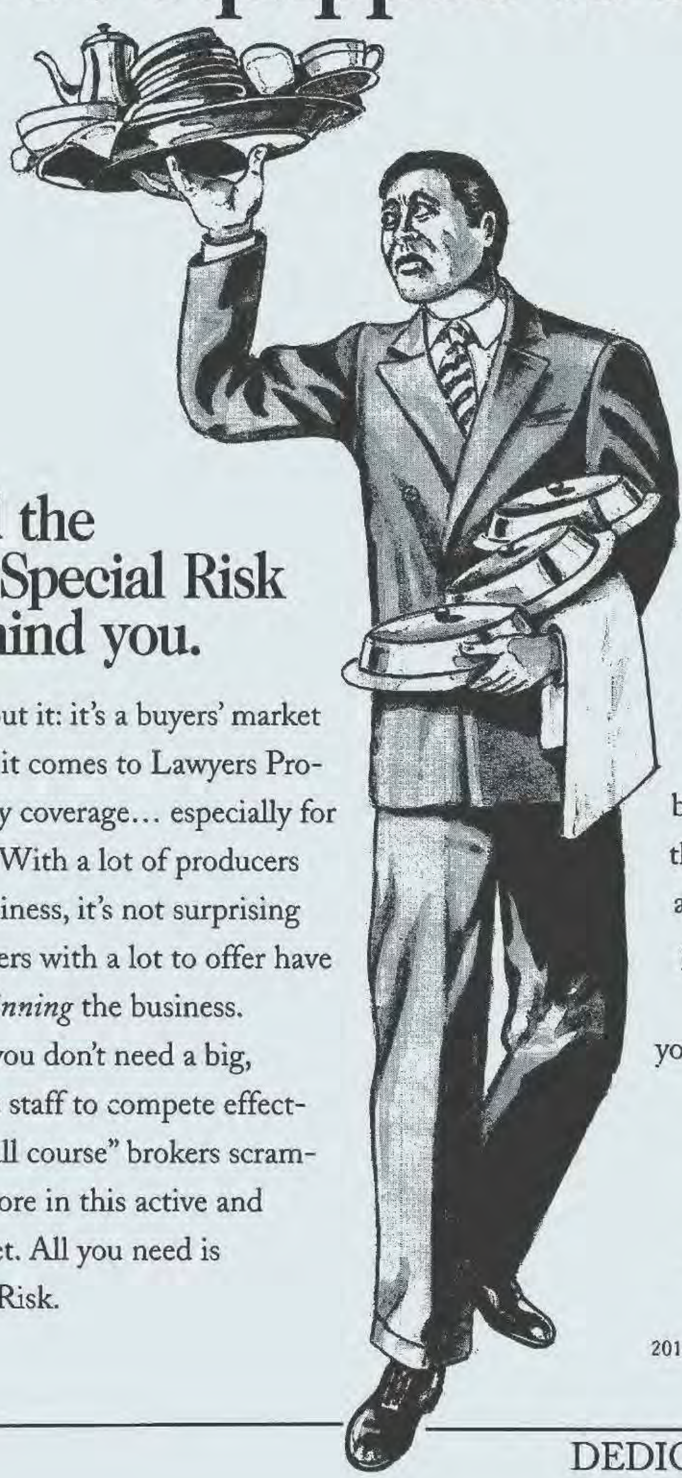
Nic Wiggishoff, senior vp and manager in Nashville, Tenn., for wholesaler Stewart Smith Group Inc., said Stewart Smith recently obtained six quotes for a two-person agency in Florida that writes some marine coverage. The quotes ranged from $12,000 in the London market to less than $7,000 from a U.S. insurer.

"The marketplace is so soft," Mr. Wiggishoff said. "It's very indicative of what the (entire) insurance industry is going through. Insurance agency E&O is not a line that is holding the ground at all."

Yet broker and insurer executives who have been in the market for years warn that extremely low pricing by newcomers could catch up with them if their rates don't adequately cover potential losses.

"The real recent players, they don't have the loss experience development that some of the players that have been around for quite some time have," said Stephanie Rzepecki, senior underwriter for agent and broker products for Shand Morahan &

See **E&O market** *on page 24D*

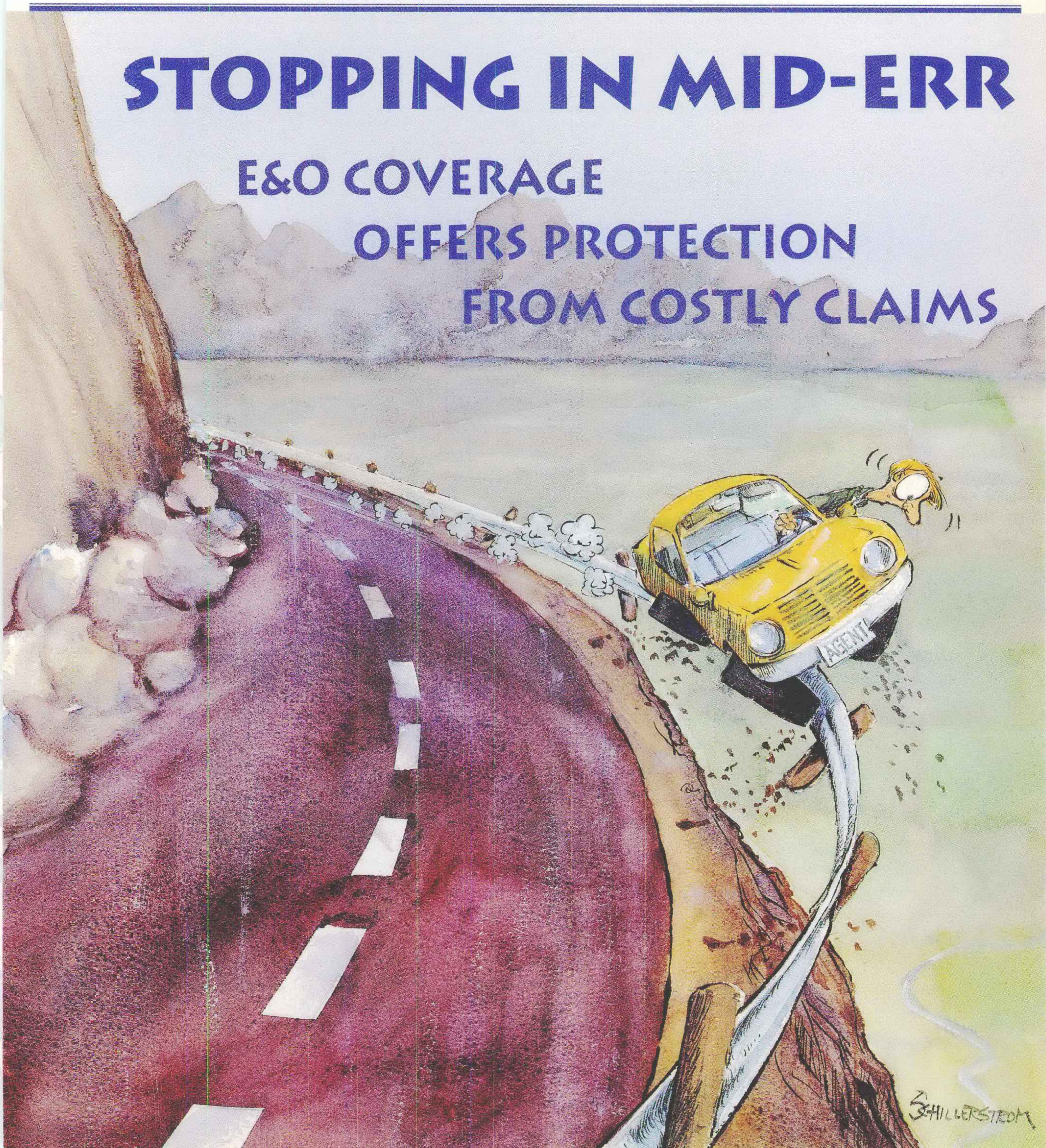


Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

STOPPING IN MID-ERR

E&O COVERAGE OFFERS PROTECTION FROM COSTLY CLAIMS



Continued from page 20

Staff	
Total	160

Includes: 20 registered pharmacists

PBM services since: 1990.

Parent: Aetna Life Insurance Co.; primary business: insurer.

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.

Pharmacies contracted: Independently owned, retail chains.

Reports provided: Generic vs. name brands dispensed analysis, employee utilization, cost savings benefit, financial utilization, top 200 drugs by claim cost/number of prescriptions, employer group summary.

Service area: United States, Puerto Rico.

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

Contact: Nancy T. Baba, director-sales/marketing, 860-636-7050.

* *Subcontracted.*

Albertson's Managed Care

250 ParkCenter Blvd., Boise, Idaho 83706; 208-385-5920; fax: 208-385-6103

1995 revenues	
Total gross revenue	$155,000
PBM gross revenue	$155,000
PBM unbundled revenue	$155,000
PBM Clients	
Total	5
Employer/group plans with direct service	5
Lives Covered	
Group Health:	
Total	48,000
through employers	100%
Retail Network	
Pharmacy locations	28,000
Mail-order services	
Percent of prescription volume	10%
Generic usage	
Percent of prescription volume	41%
Staff	
Total	23
Professionals	3

Includes: Three registered pharmacists

PBM services since: 1993.

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

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, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including Albertson's, Eckerds, Kmart, Osco, Sav-On, Revco and Walgreen.

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

Service area: Florida, Texas; Midwest, Northwest and Southwest regions.

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

Officers: Richard King, president; Mark C. Shadle, vp.

* *Subcontracted.*

C

CareCard Inc.

7 E. Lee St., Baltimore, Md. 21202; 410-385-4355; fax: 410-685-4135

1995 revenues	
PBM gross revenue*	$733,000
PBM Clients	
Total	4
Employer/group plans with direct service	2
Lives Covered	
Group Health:	
Total	55,000

Continued on page 29

Methodology differs for this directory

The methodology for the directory of prescription benefit management companies differs from that of previous directories.

For the first time, to be listed *Business Insurance* required companies to report gross revenues. In requiring gross revenues to be reported, *BI* is striving to give readers more complete information on the companies listed. By setting a threshold for inclusion in our listings, *BI* intends to provide readers with a listing of the companies that have developed a substantial presence in a given marketplace.

While big is not always better, exceeding a given threshold of business does suggest experience and the capability to meet our readers' needs.

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"I learned a lot of things at this conference; valuable information that can be implemented."
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"I appreciate being invited to participate in the conference – I felt it was an excellent program."
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"Without question the best conference. The topics presented gave me ideas I will be able to apply. I would rate this conference as 'excellent.'"
Augustine (Gus) Vigil
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"The 'Meet The Press' panel formats create a dynamic and informative conference which encourages participation of the attendees!"
Mary Stoik Dymond
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WEDNESDAY, NOVEMBER 6, 1996

- SPECIAL WORKSHOP: RISK FINANCING & THE CAPITAL MARKETS
  Presented by Marsh & McLennan, Incorporated and Centre Reinsurance
- EMPLOYER'S PRIVATE ROUNDTABLE
- EARLY REGISTRATION AND WELCOME RECEPTION

THURSDAY, NOVEMBER 7, 1996

- REGISTRATION AND CONTINENTAL BREAKFAST
  Hosted by Kemper National Insurance Companies
- OPENING REMARKS FROM THE CHAIR
- CONFRONTING WORKPLACE VIOLENCE AS A WORKERS COMPENSATION ISSUE
- REFRESHMENT BREAK AND TABLETOP EXHIBITS
  Hosted by Commonwealth Risk Services, Inc.
- POINT/COUNTERPOINT SESSION: INTEGRATING MANAGED CARE APPROACHES INTO WORKERS COMPENSATION
- ELECTRONIC DATA INTERCHANGE
- LUNCHEON: WHY SOME EMPLOYERS DO SO MUCH BETTER THAN OTHERS AT WORKERS COMPENSATION
  Hosted by Intracorp
- CASE STUDIES:
  - U.S. Air, Inc. Case Study: Alternative Collateral Raises $70 Million
  - Creative Safety Incentive Programs
  - Return to Work
  - Reducing & Managing Repetitive Stress Injuries
- RECEPTION

FRIDAY, NOVEMBER 8, 1996

- BREAKFAST
  Hosted by GENEX Services, Inc.
- OPENING REMARKS FROM THE CHAIR
- COST CONTAINMENT PERFORMANCE MEASUREMENT
- REFRESHMENT BREAK AND TABLETOP EXHIBITS
  Hosted by Wausau Insurance Companies
- HOW TO MAKE PERFORMANCE GUARANTEES WORK WITH RISK MANAGEMENT PARTNERS
- LUNCHEON
  Hosted by AIG Claim Services

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- **Wausau Insurance Companies**

Continued from page 24

Active enrollees	37,000
through employers	15%
through Medicare/Medicaid	85%
Retail Network	
Pharmacy locations	40
Generic usage	
Percent of prescription volume	70%
Staff	
Total	10
Professionals	10

Includes: seven registered pharmacists

PBM services since: 1995.

Parent: Genesis Health Ventures Inc.; primary business: provides health care and support services to health care employers.

Services: Retail pharmacy network, 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.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, therapeutic category utilization, outcomes-based drug utilization review.

Service area: Mid-Atlantic, Northeast.

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

Officers: Michael G. Bronfein, president; Stanton G. Ades, executive vp; Barry M. Bress, vp.

Contact: Kelly Tinelli, clinical coordinator.

* *July 1995 through March 1996.*
** *Subcontracted.*

CLAIMSPRO Health Claims Services Inc.

24370 Northwestern Highway, Suite 200, Southfield, Mich. 48075; 810-352-2852; fax: 810-352-3714

1995 revenues	
Total gross revenue	$4,399,344
PBM gross revenue	$4,064,993
PBM unbundled revenue	$2,845,495
PBM Clients	
Total	800
Employer/group plans with direct service	7,200
Lives Covered	
Group Health:	
Total	700,000
through employers	75%
through third-party vendors	25%
Retail Network	
Pharmacy locations	40,000
Mail-order services	
Percent of prescription volume	2%
Generic usage	
Percent of prescription volume	40.5%
Staff	
Total	31
Professionals	15

Includes: one registered pharmacist

PBM services since: 1987.

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/physician education*.

Formularies offered: Open.

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

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

Service area: United States.

Billing methods: Capitated rate, fee per claim.

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

Contact: Ron Klein.

* *Subcontracted.*

E

Eckerd Health Services

8333 Bryan Dairy Road, Largo, Fla. 33777; 813-399-6022; fax: 813-399-7390

PBM Clients	
Total*	49
Retail Network	
Pharmacy locations	40,000
Generic usage	
Percent of prescription volume**	42%
Staff	
Total	40
Professionals	16

Includes: seven registered pharmacists

PBM services since: 1995.

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

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned; all major retail chains.

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

Service area: United States, primarily in the Southeast.

Billing methods: Capitated rate, fee per claim.

Officers: Rick Powis, senior vp-pharmacy services; Roger Davis, vp-sales/marketing; Frederick Howe, senior vp.

* *As of July 1996.* ** *Average usage in 1996.*

If your organization provides prescription benefit management services and you would like to be listed in next year's directory, please contact Sandra Budde at 312-649-5279.

F

FFI Health Services

8536 Crow Drive, Suite 105, Macedonia, Ohio 44056; 216-467-9898; fax: 216-468-3847

1995 revenues	
Total gross revenue	$18,419,000
PBM gross revenue	$18,419,000
PBM unbundled revenue	$6,206,000
PBM Clients	
Total	600
Employer/group plans with direct service	580
Lives Covered	
Group Health:	
Total	353,000
Active enrollees	250,000
through employers	80%
through third-party vendors	20%
Retail Network	
Pharmacy locations	26,000
Mail-order services	
Percent of prescription volume	2%
Generic usage	
Percent of prescription volume	40%
Staff	
Total	20
Professionals	15

Includes: two 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.

Formularies offered: Restricted/customized.

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

Service area: United States.

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

Officers: Paul Wutz, president; James Mindala, executive vp.

* *Subcontracted.*

First Health

4300 Cox Road, Glen Allen, Va. 23060; 804-965-7464; fax: 804-965-7416

1995 revenues	
Total gross revenue	$4,100,000,000
PBM gross revenue	$40,000,000
PBM unbundled revenue	$15,000,000
PBM Clients	
Total	1,200
Employer/group plans with direct service	1,150
Lives Covered	
Group Health:	
Total	10,000,000
through employers	20%
through third-party vendors	55%
through Medicare/Medicaid	25%
Retail Network	
Pharmacy locations	40,000
Generic usage	
Percent of prescription volume	45%
Staff	
Total	310
Professionals	110

PBM services since: 1982.

Parent: First Data Corp.; primary business: information and transaction processing 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.

Formularies offered: Open, closed, restricted/customized.

Pharmacies contracted: Independently owned, retail chains.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, drug utilization review, pharmacy profiles, fraud and abuse.

Service area: United States.

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

Officers: Don Dahlin president; Teresa DiMarco, senior vp/general manager; John Gardynick, vp-specialty sales; Albert Wertheimer, vp-pharmacy managed care; A. Richard Hofheimer, senior account executive-marketing.

Contact: Dick Hofheimer.

* *Subcontracted.*

Continued on next page

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G

GenPlus Managed Care Inc.*

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

Retail Network	
Pharmacy locations	50,000

Mail-order services	
Percent of prescription volume	100%

PBM services since: 1996.
Parent: Genovese Drug Stores Inc.; primary business: retail pharmacy.
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.
Service area: Northeast.
Billing methods: Fee per claim. Volume discounts to employers.
Officers: Wayne Nash, president; Eileen Kett-Rainis, vp-administration; Jerry Stengal, vp-finance; Gene L. Wexler, vp/general counsel/secretary; Chris Noonan, treasurer.
Contact: Wayne Nash, 516-845-8459.
**Began operations in 1996.*

I

The INTEQ Group Inc.

5445 La Sierra Drive, Suite 400,
Dallas, Texas 75231; 214-739-9494;
fax: 214-739-7979

1995 revenues	
Total gross revenue	$2,700,000
PBM gross revenue	$2,700,000
PBM unbundled revenue	$950,000

PBM Clients	
Total	500
Employer/group plans with direct service	100

Lives Covered	
Group Health:	
Total	1,000,000
Active enrollees	300,000
through employers	35%
through third-party vendors	60%
through Medicare/Medicaid	5%
Workers Compensation:	
Active enrollees	50,000
through employers	100%

Retail Network	
Pharmacy locations	40,600

Mail-order services	
Percent of prescription volume	10%

Generic usage	
Percent of prescription volume	41%

Staff	
Total	32
Professionals	29

Includes: three registered pharmacists
PBM services since: 1992.
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 Albertson's, American Stores, CVS, Eckerd, Revco, Thrifty, Payless, Wal-Mart, Walgreens.
Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization.
Service area: United States.
Billing methods: Capitated rate, fee per claim. Volume discounts to employers.
Officers: Andrew P. Fisk, president; Jerry M. Hosler, vp-administration/finance; G. John Teichgraeber, vp-sales/marketing; Patti Carr, vp-pharmacy operations.
Contact: John Teichgraeber, 800-324-7799.
** Subcontracted.*

International Pharmacy Management Inc.

110 12th St. N., Birmingham,
Ala. 35203; 205-250-8035;
fax: 205-250-8037

1995 revenues	
PBM gross revenue	$15,000

PBM Clients	
Total	14
Employer/group plans with direct service	8

Lives Covered	
Group Health:	
Total	960,000
Active enrollees	210,000
through employers	35%
through third-party vendors	55%
through Medicare/Medicaid	10%
Workers Compensation:	
Active enrollees	36,000

Retail Network	
Pharmacy locations	46,152

Mail-order services	
Percent of prescription volume	85%

Generic usage	
Percent of prescription volume	32%

Staff	
Total	17
Professionals	4

Includes: four registered pharmacists
PBM services since: 1995.
Services: Retail pharmacy network, mail-order distribution, claims processing, online claims processing, concurrent utilization review, disease management, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient education.
Formularies offered: Open, restricted/customized.
Pharmacies contracted: Independently owned, retail chains.
Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, outcomes reporting based on protocol and result.
Service area: United States, Caribbean, Latin America.
Billing methods: Capitated rate, fee per claim. Volume discounts to employers.
Officers: David Bellin, president; Michael Newton, vp; Charles Hazlett, secretary/treasurer; Brian Black, vp-operations; David Beauchaine, vp-finance.

M

Managed Pharmacy Benefits Inc. (MPB)

1100 N. Lindbergh Blvd., St. Louis,
Mo. 63132; 800-585-5051;
fax: 314-872-5500

1995 revenues	
PBM gross revenue*	$4,000,000

PBM Clients	
Total	90
Employer/group plans with direct service	30

Continued on next page

Continued from previous page

Lives Covered	
Group Health:	
Total	500,000
Active enrollees	500,000
through employers	70%
through third-party vendors	30%
Retail Network	
Pharmacy locations	26,000
Mail-order services	
Percent of prescription volume	5%
Generic usage	
Percent of prescription volume	47%
Staff	
Total	11
Professionals	8

Includes: one registered pharmacist

PBM services since: 1994.

Parent: Medicine Shoppe International Inc.; primary business: retail pharmacy.

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, online access to management reports.

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: United States.

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

Officers: C. Thomas (Tom) Smith, vp/general manager.

Contact: Mark T. Obsorn, national sales director, 800-585-5051, ext. 5534.

* Estimate.

Merck-Medco Managed Care Inc.

100 Summit Ave., Montvale, N.J. 07645, 800-248-2268; fax: 201-782-7863

1995 revenues	
PBM gross revenue	$8,000,000,000
Lives Covered	
Group Health:	
Total	48,000,000
Active enrollees	48,000,000
Retail Network	
Pharmacy locations	55,158
Generic usage	
Percent of prescription volume	86%
Staff	
Total	9,000
Professionals	8,800

Includes: 1,200 registered pharmacists

PBM services since: 1982

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

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

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: United States, Puerto Rico.

Billing methods: Capitated rate, fee per claim, client request.

Officers: Per Lofberg, president; Dr. Larry Baker, chief medical officer; Joe Valesio, COO; Mike Atieh, senior vp-sales; Rick Schatzberg, executive vp-account management.

N

National Pharmaceutical Services Inc.

14748 W. Center Road, Suite 325, Omaha, Neb. 68144; 800-546-5677; fax: 800-458-1646

1995 revenues	
Total gross revenue	$3,870,000
PBM gross revenue	$1,500,000
PBM unbundled revenue	$1,500,000
PBM Clients	
Total	265
Employer/group plans with direct service	265
Lives Covered	
Group Health:	
Total	450,000
Active enrollees	265,000
through employers	100%
Retail Network	
Pharmacy locations	45,000
Mail-order services	
Percent of prescription volume	10%
Generic usage	
Percent of prescription volume	83%
Staff	
Total	18
Professionals	6

Includes: six 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, disease management, retrospective utilization review, benefit design consulting, formulary management/review, monitoring of physician prescribing practices, patient education, software.

Formularies offered: Closed, restricted/customized.

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

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, disease pattern, demographic, group specific.

Service area: Midwest, upper Northwest.

Billing methods: Capitated rate, fee per claim.

Officers: Douglas M. Pick, CEO; Daniel Cutler, CFO; Daniel G. Billerbeck, secretary/treasurer; Mick Rhoid, liaison-Creighton University faculty; Judy Petty, vp-network services; Melissa Schreiffels, vp-IHMO services.

Contact: 800-633-7328.

P

Pharmacy Services Group

1100 N.E. 51st St., Fort Lauderdale, Fla. 33334; 800-774-2002 or 954-938-9980; fax: 954-938-9784

1995 revenues	
Total gross revenue	$12,000,000
PBM gross revenue	$2,400,000
PBM Clients	
Total	130
Lives Covered	
Group Health:	
Total	400,000
Active enrollees	300,000
through employers	90%
through third-party vendors	10%
Workers Compensation:	
Active enrollees	10,000
Retail Network	
Pharmacy locations	35,000
Mail-order services	
Percent of prescription volume	50%
Generic usage	
Percent of prescription volume	43%
Staff	
Total	51
Professionals	47

Includes: six registered pharmacists

PBM services since: 1992.

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.

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: United States.

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

Officers: Ken Sack, CEO; Don Rombro, president; Raymond Matko, CFO;

Continued on next page

Continued from previous page

Larry Pizak, pharmacy director; Gina Hunt, director-client services.

* *Subcontracted.*

Pro-Mark Holdings Inc.

P.O. Box 3704, Peace Dale, R.I. 02883; 401-782-0702; fax: 401-782-0777

1995 revenues	
PBM gross revenue	$214,000,000
PBM Clients	
Total	65
Employer/group plans with direct service	2
Lives Covered	
Group Health:	
Total	1,165,000
Retail Network	
Pharmacy locations	22,000
Mail-order services	
Percent of prescription volume	1%
Generic usage	
Percent of prescription volume	68%
Staff	
Total	56
Professionals	48

Includes: 17 registered pharmacists

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.

Reports provided: Physician prescribing patterns, generic vs. name brands dispensed analysis, employee utilization, claims by therapeutic class, frequency distributions, physician/pharmacist report cards.

Service area: United States.

Billing methods: Capitated rate, fee per claim.

Officers: Richard H. Krupski, president; E. Paul Larrat, vp.

Contact: Terence Fleming.

* *Subcontracted.*

R

RESTAT

724 Elm St., West Bend, Wis. 53095-0758; 800-926-5858; fax: 414-338-5791

1995 revenues	
PBM gross revenue	$7,160,000
PBM Clients	
Total	2,000
Employer/group plans with direct service	95
Lives Covered	
Group Health:	
Total	3,000,000
Active enrollees	600,000
through employers	35%
through third-party vendors	55%
through Medicare/Medicaid	10%
Workers Compensation:	
Active enrollees	2,010
through employers	100%
Retail Network	
Pharmacy locations	47,000
Mail-order services	
Percent of prescription volume	15%
Generic usage	
Percent of prescription volume	47%
Staff	
Total	75
Professionals	26

Includes: 3 registered pharmacists

PBM services since: 1985.

Parent: The 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.

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: United States, Puerto Rico.

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

Officers: Robert J. Leinss Jr., president; Prati Agarwal, James Wisniewski, Sharon Murillo, Chris Downs, directors.

Contact: James Wisniewski.

* *Subcontracted.*

S

Super Pharmacy Network (SPN) dba United Scripts Administrators (USA)

K&B Plaza, Lee Circle, New Orleans, La. 70130-3999; 504-585-4458; fax: 504-585-4482

1995 revenues	
PBM gross revenue	$101,000,000
PBM Clients	
Total	35
Employer/group plans with direct service	33
Lives Covered	
Group Health:	
Total	30,000
Active enrollees	16,500
through employers	67%
through third-party vendors	33%
Retail Network	
Pharmacy locations	15,000
Mail-order services	
Percent of prescription volume	5%
Generic usage	
Percent of prescription volume	42%
Staff	
Total	4
Professionals	3

Includes: 3 registered pharmacists

PBM services since: 1994.

Parent: K&B Drugs Inc.; primary business: retail pharmacy.

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, refill/compliance program.

Formularies offered: Open, restricted/customized.

Pharmacies contracted: Independently owned; retail chains, including Albertsons, K&B Drugs, Kmart, Medicine Shoppe, Revco, Rite Aid and Wal-Mart.

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

Service area: Southeast.

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

Officers: Paul Drake, director; Burt Archer, manager.

Contact: Burt Archer, 504-585-4411, or Paul Drake, 504-585-4449.

* *Subcontracted.*

T

TDI Managed Care Services Inc.

620 Epsilon Drive, Pittsburgh, Pa. 15238; 412-967-2300; fax: 412-967-2334

1995 revenues	
Total gross revenue	$500,000,000
PBM gross revenue	$15,000,000
PBM unbundled revenue	$11,000,000
PBM Clients	
Total	150
Employer/group plans with direct service	120
Lives Covered	
Group Health:	
Total	1,200,000
Active enrollees	800,000
through employers	80%
through third-party vendors	20%
Retail Network	
Pharmacy locations	43,500
Mail-order services	
Percent of prescription volume	95%
Generic usage	
Percent of prescription volume	43%

Continued on page 34

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1995 DIRECTORIES

Issue Date	Directory
Feb 6	Third-Party Administrators
Feb 20	Utilization Review Providers & Case Managers
Mar 6	Benefit Information & Claims Systems
Mar 20	Risk Management Consultants
Apr 3	Prescription Benefit Managers
Apr 24	Captive Managers
May 29	Alternative Facilities
Jun 12	Property Loss Control Consultants
Jun 26	EAPs & Mental Health Networks
Jul 17	Agents & Brokers
Jul 31	Dependent Care Resource & Referral Services
Aug 14	401(k) Plan Administrators
Aug 28	Leading Reinsurers Worldwide
Sep 11	Surplus Lines Insurers & Wholesalers
Oct 2	Environmental Risk Management Consultants
Oct 9	Safety Consultants & Rehabilitation Services
Oct 23	Reinsurance Brokers
Nov 6	International Insurers & Benefit Networks
Nov 20	Benefit Communication Systems
Dec 4	Risk Management Information Systems
Dec 11	Employee Benefit Consultants
Dec '95	Managed Care Providers—HMOs & PPOs

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Issue Date	Directory
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Feb 19	Utilization Review Providers & Case Managers
Mar 4	Risk Management Consultants
Mar 18	Benefit Information & Claims Systems
Apr 22	Captive Managers
May 20	401(k) Plan Administrators
Jun 3	Alternative Risk Financing Facilities
Jun 24	EAPs & Dependent Care Resource and Referral Services
Jul 22	Agents & Brokers
Aug 5	Prescription Benefit Managers
Aug 19	Property Loss Control Consultants
Sep 2	Leading Reinsurers Worldwide
Sep 16	Surplus Lines Insurers & Wholesalers
Oct 14	Reinsurance Brokers
Oct 28	Benefit Communication Systems
Nov 4	Safety Consultants & Rehabilitation Services
Nov 11	Environmental Risk Management Consultants
Nov 18	International Insurers & Benefit Networks
Dec 2	Risk Management Information Systems
Dec 9	Employee Benefit Consultants
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Continued from page 32

Staff	
Total	94
Professionals	69
Includes: 10 registered pharmacists	

PBM services since: 1993.

Parent: Thrift Drug Inc./J.C. Penney Co. Inc.; primary business: retail pharmacy.

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, including American Drug, CVS, Eckerd, Kmart, Medicine Shoppe, Osco, PayLess, Revco, Thrift Drug, Thrifty, Wal-Mart, Walgreens.

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

Service area: United States.

Billing methods: Capitated rate, fee per claim, risk sharing, per employee per month. Volume discounts to employers.

Officers: Francis Marasco, president; David Halpern, vp-managed care; Lloyd McDonald, vp-sales/client service; Jim Smith, vp-EPS operations, Dennis Santo, vp-pharmacy services.

Contact: Bill Jardine, 412-967-2322.

V

ValueRx

4700 Nathan Lane N., Plymouth, Minn. 55442; 612-509-2500; fax: 612-509-2540

1995 revenues	
Total gross revenue	$1,479,097,000
PBM gross revenue	$1,479,097,000
PBM Clients	
Total	3,000
Lives Covered	
Group Health:	
Total	27,000,000
Workers Compensation:	
Active enrollees	12,687
through employers	21%
Retail Network	
Pharmacy locations	46,000
Generic usage	
Percent of prescription volume	35%
Staff	
Total	2,524
Professionals	558
Includes: 558 registered pharmacists	

PBM services since: 1987.

Parent: Value Health Inc.; primary business: specialty healthcare.

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, patient utilization, financial and clinical comprehensive.

Service area: United States, Puerto Rico.

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

Contact: Kirsten Stewart, 800-440-1486.

Y

York Enterprises Inc. dba York Prescription Benefits Management

50 York St., New Haven, Conn. 06511; 203-782-7783; fax: 203-776-7544

1995 revenues	
PBM gross revenue	$1,530,000
PBM Clients	
Total	27
Employer/group plans with direct service	26
Lives Covered	
Group Health:	
Total	50,000
Active enrollees	35,000
through employers	50%
through third-party vendors	50%
Workers Compensation:	
Active enrollees	200
through employers	100%
Retail Network	
Pharmacy locations	35,000
Mail-order services	
Percent of prescription volume	10%
Generic usage	
Percent of prescription volume	45%
Staff	
Total	50
Professionals	10
Includes: 3 registered pharmacists	

PBM services since: 1995.

Parent: Yale-New Haven Health Services Corp.; primary business: integrated health care, including HMO/PPO and hospital.

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, customized.

Pharmacies contracted: Independently owned, retail chains.

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

Service area: Northeast, East coast, West coast.

Billing methods: Capitated rate, fee per claim, per employee per month.

Contact: Tim Humphreys or Karen Bradbury. BI

Business Insurance will publish its ninth annual Managed Care Directory in December, listing health maintenance organizations, preferred provider organizations and point-of-service plans.

The directory is published as an editorial service. There is no charge to be included, but HMOs, PPOs and POS plans must complete and return a questionnaire by the Sept. 27 deadline.

If your organization was not in last year's directory and would like to receive a questionnaire, please contact assistant directory editor Rich Trout at 312-649-5483.

EMLICO

Continued from page 2

she found "sufficient grounds to warrant inquiry" into the fraud allegations but deferred to the Bermuda courts to handle the reinsurers' charges.

Judge Ground noted in his own ruling, however, that the Massachusetts commissioner is "best placed to determine whether or not her office was deceived" and suggested that the Bermuda judicial review would not consider charges that EMLICO also misled Massachusetts regulators about its financial condition.

"The ball was in one tennis court and now it's in the other," observed David I. Finnegan, a Boston lawyer representing Lloyd's of London underwriters.

He said the Massachusetts hearing should be reopened.

Kemper Re also said it will ask Ms. Ruthardt to reconsider.

The Insurance Division had not received any requests to reopen the hearings last week, said a spokeswoman, who would not comment on the expected requests.

Lloyd's underwriters, Kemper Re and other reinsurers are suing the Massachusetts insurance division to rescind its approval of EMLICO's reorganization. Two of the reinsurers, Allstate Insurance Co. and units of General Re Corp., have amended their suits to add EMLICO and a former unit, Electric Insurance Co.

The Massachusetts division, EMLICO and EIC want to have the complaints dismissed, arguing among other things that the reinsurers have no standing to sue.

EMLICO, a longtime GE general liability insurer, won regulatory approval last June to move to Bermuda after spinning off to EIC all of its business except dozens of loss-plagued GE liability policies dating back to at least 1952.

A few months after arriving in Bermuda, EMLICO filed for liquidation, declaring itself massively underreserved for GE pollution and asbestos claims and insolvent by $512 million.

Reinsurers, however, charged that EMLICO knew it was insolvent long before the move, concealed the fact from regulators and plotted with GE to move the company to Bermuda, where GE would have more control over the liquidation and where—unlike Massachusetts—liquidators could bill reinsurers for estimated long-tail claims.

Earlier this year, Judge Ground took the unusual step of allowing Kemper Re to intervene in the liquidation proceeding to present its fraud allegations, and granted the reinsurer an extension of time to seek judicial review of EMLICO's admission to Bermuda.

After more than two weeks of hearings on the charges last month, though, Judge Ground decided not to delay the liquidation. "At the end of the day, I am faced with a Bermuda company which is insolvent. As things presently stand, only this court can wind it up, although that may change in the future," he said.

While Kemper Re contended the liquidation petition represented an abuse of process, Judge Ground disagreed.

The fraud alleged by Kemper Re—deception of regulators to get their approval—does not make the petition itself abusive, the judge found, noting that the judicial review action is the proper forum for the charges.

Judge Ground also refused to delay the winding-up for a trial of the fraud charges, finding again that the charges should be dealt with in the judicial review, in separate proceedings in Massachusetts or—ultimately—in arbitration between the reinsurers and EMLICO's liquidator.

"The trial of the issue of fraud in these proceedings would serve no real function," he added, noting "there is no meaningful relief" he could grant Kemper Re even if fraud were proved.

"I cannot, in the winding-up, quash the redomestication in some way and enforce the removal of the company back to Massachusetts. I cannot give damages. I cannot give relief from the reinsurers' obligations. In reality, I could not even dismiss the petition, the company being wholly insolvent and there being no other practical means of dealing with it," he wrote.

Judge Ground also refused Kemper Re's request to delay the liquidation pending the outcome of the judicial review proceedings. To win the delay, Kemper Re would have to show it had a "serious issue to be tried" and that the "balance of convenience" weighs in favor of the delay.

Kemper Re met the first test, but not the second, he found.

"To succeed in their allegation of fraud, Kemper. . .(must) show both that the company was in fact insolvent before the redomestication and that management knew that. If that is shown, then it is plain that the regulators were in fact misled. . . .It would be no answer that the company had explained to the regulators, as it did, that there was a possibility of future insolvency if certain contingencies turned out badly," he wrote.

But, "I do not think that it is my function at this stage to attempt to resolve any of this, unless the evidence in support is so weak, or that against so clear, that I can summarily dismiss Kemper's allegations. I am not able to do that, but rather consider that Kemper has shown that it has a serious issue to be tried."

At the same time, a trial in the judicial review probably would take a year or more to begin, and Judge Ground rejected such a delay of the liquidation.

He also rejected the argument that a liquidation order would deny Kemper Re the remedy it is seeking in the judicial review.

"I do not in fact accept Kemper's implicit assertion that any steps taken by liquidators in Bermuda would be undoable if the company were eventually sent back to be liquidated in Massachusetts," he wrote.

"I am (also) not prepared to assume that the eventual liquidators will allow themselves to accept inflated claims from GE," the judge added.

In granting the liquidation petition, though, he added a condition—proposed by EMLICO—that bars liquidators from allowing any contingent claims from GE while the judicial review is still pending.

A hearing in the judicial review is expected in October, and the first battle will be over EMLICO's effort to halt the review on grounds that Kemper Re missed the deadline for filing its petition and that an extension Judge Ground issued was improper.

If the review goes forward, the next fight likely will be over the extent of discovery the sides will be allowed.

Judge Ground said that if he had allowed a trial in the liquidation proceedings, Kemper Re likely would have pursued a broad attack on EMLICO's actions in the redomestication and would have had wider discovery powers. The judicial review, though, may be limited to the question of whether Bermuda authorities were misled, and Kemper Re's access to EMLICO documents may be limited, he said. BI

California comp reforms questioned

By JOANNE WOJCIK

Hold on to your wallet: A new crisis may be brewing in the California workers compensation system that will cost employers plenty, a new report predicts.

Many of the worst abuses and underlying costs of the system still have not been brought under control, despite the state's far-reaching 1993 reforms, according to Charles Bader, executive director of Californians for Compensation Reform, an employer coalition based in Sacramento.

Recent premium reductions are more the result of reduced payroll caused by the state's three-year recession and elimination of the minimum rate law in 1995, which has spurred competition in the market, the report concluded.

"Seeds of a New Crisis: Are the 1993 Workers Compensation Cost-Containment Reforms Working in 1996?" was released by CCR last month.

The researchers used data from numerous sources, including the California Workers Compensation Rating Bureau and the California Workers Compensation Research Institute.

"In the first year following the reforms, the cost of providing benefits and services to injured workers did drop significantly. But that drop was less the result of the reforms than of the California recession from 1991 to 1994. With soaring unemployment, far fewer workers compensation claims were filed, and thus they cost far less to service," Mr. Bader said in the executive summary of the report.

But, "as the economy recovers, these cost reductions are likely to evaporate," Mr. Bader predicted. "Future workers compensation crises are, thus, all but certain."

In response to the report, California's workers compensation insurers say the employer group is overreacting because the effects of many of the 1993 reforms have not yet been felt.

"It's a political document," said Barry Carmody, president of the Assn. of California Insurance Cos., a 31-member insurer lobbying group based in Sacramento.

"In no way is it a profound, final word on the work comp reforms of 1993." For example, at least one of the reforms—a reduction in the fee schedule for medical-legal examinations—"was a super money saver," he said. "It reduced these costs by 51%. And by doing that, you also reduce the incentives to get more."

"We cannot say the rest of the reforms haven't manifested a cost savings, because it's really too early to tell," Mr. Carmody said. "It's now up to the vagaries of the open market system to see if the costs or savings are shared across the board."

According to another report recently released by Gov. Pete Wilson's office, workers compensation premiums have fallen 30% to $6 billion in 1995 from $9 billion in 1993.

Measured in terms of percentage of payroll, the average premium per $100 of payroll in California has dropped 36.4% to $3.18 in 1996 from $5 in 1993.

The governor's report, "Workers Compensation Reform, Third Anniversary Update," also found that the total cost of California's workers comp system has declined from more than $11 billion at its peak in 1993 to about $8 billion at the end of 1995.

While the CCR report acknowledged the Wilson report's cost reduction estimates, it said: "The bulk of this shrinkage cannot be credited to the workers compensation reforms of 1993 nor to any significant improvement in the underlying design of the system. Rather, the system shrank because employment itself dropped during the 1991-1994 recession and workers compensation claims dropped with it."

The CCR report also cited two other factors for the drop in costs: A statewide anti-fraud effort launched in 1991, and deregulation of the sale of workers comp insurance in California.

"The timing of these changes is critical," the report asserts. "In 1992 and 1993, the insurers' actual costs of providing benefits and services to injured workers were plummeting due to the recession and the anti-fraud efforts. But in this same period, premium prices were nonetheless climbing. Thus, by the time the actual costs of the system finally became known, the insurers had accumulated enough money to afford the premium cuts urged by the insurance commissioner in 1993 and early 1994 and even the steeper cuts the insurers put into play as deregulation went into effect in 1995."

"If insurers got the savings, I don't know where they are," said ACIC's Mr. Carmody. "We lost $4 billion in the premium base over the last year."

He also suggested employers may be getting anxious about upcoming scheduled increases in injured workers' benefits, which also were included in the 1993 reforms.

"The employers are not sure of the savings being long term. While we see savings in 1995—when open rating went into effect—we don't know if that's going to be long term," he said.

However, the benefit increase also included in the 1993 reforms will be long-term, he said.

"One of the things that they say is that benefit increases are forever, but these short-term savings may not be," according to Mr. Carmody. "Why would employers want to commit to a benefit increase that will be there forever when the savings may be short term?"

Indeed, the CCR report warns, "It is. . .possible that the savings achieved by the 1993 reforms, which were supposed to be split half-and-half between employers and injured workers, may end up being insufficient to pay for even the benefit increases already enacted."

And while employer premiums have fallen significantly, "premium prices are no longer an accurate signal of the system's health," because deregulation severed the relationship between premiums and system costs, the report suggests.

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Copies of the report are available for $10 from Californians for Compensation Reform, 925 L St., Suite 600, Sacramento, Calif. 95814; 916-441-4111. The Wilson report can be viewed at http://www.cal.gov.

Benefit products and services information resources

EMPLOYEE BENEFITS

■ The fairest, most cost-effective method of **compensating "expatriate" employees** is evaluated in a paper from Buck Consultants Inc. Request item **3501**.

■ The capabilities of a **group marketing system** are highlighted in an information packet presented by CSI Software Inc. Request item **3502**.

■ NILS Publishing Co. supplies a newsletter with statistical data and analysis of recent **insurance and health care regulation**. Request item **3503**.

■ A manual from Duncanson & Holt Group overviews **long-term disability**, underwriting and claims administration. Request item **3504**.

■ The Apex Management Group Inc. offers a demonstration disk profiling **health care benefits software**. Request item **3505**.

■ Buck Consultants Inc. offers a newsletter discussing the advantages of **outsourcing benefit administration**. Request item **3506**.

■ A brochure offered by The Mutual Group (U.S.), Employee Benefits outlines **fully insured group products and group services**. Request item **3507**.

■ The basic issues employers face when **extending benefits to an employee's domestic partner** are examined in a research brief provided by The Alexander Consulting Group. Request item **3508**.

■ **Reasons to adopt a Section 125** plan are listed in an outline supplied by VISTA Administrators Inc. Request item **3509**.

■ An overview of **dependent care benefits** for employers and EAPs is featured in a booklet supplied by Child & Elder Care Insights Inc. Request item **3510**.

■ Buck Consultants Inc. provides a paper explaining an **IRS private letter ruling** that allows the coupling of a non-qualified retirement plan with a qualified 401(k) plan. Request item **3511**.

■ Monumental Life Insurance Co. offers a brochure with an overview of **payroll deduction life insurance**. Request item **3512**.

■ The factors that influence **corporate absenteeism** are explored in a booklet from Martin-Dennison Press. Request item **3513**.

■ The Segal Co. offers a 1996 annual **reporting and disclosure calendar** for benefit plans. Request item **3514**.

■ A research brief supplied by The Alexander Consulting Group analyzes the **benefits of Medicare Risk Contract HMOs** for employers that sponsor retiree health plans. Request item **3515**.

■ **Hybrid pension plans** are described and compared against traditional defined benefit plans in a newsletter from Buck Consultants Inc. Request item **3516**.

■ Marsh & McLennan Cos. Inc. provides an article that discusses **changing employee demographics** and the reduction in federal entitlements for the elderly. Request item **3517**.

■ **Employee investment education** is the featured section of the second-quarter issue of a periodical offered by the International Society of Certified Employee Benefit Specialists. Request item **3518**.

■ An article from EDS explains **how to create a data warehouse** for health care organizations. Request item **3519**.

■ The Mutual Group (U.S.), Employee Benefits offers a brochure with an economical program designed to educate **expectant mothers**. Request item **3520**.

■ **Accelerated death benefits** are defined in a research brief prepared by The Alexander Consulting Group Inc. Request item **3521**.

■ Reducing the costs of **disability benefits** is discussed in a newsletter from Buck Consultants Inc. Request item **3522**.

■ An information packet from Monumental Life Insurance Co. contains sample enrollment materials and product illustrations for **worksite marketing of life insurance plans** and benefit communication services. Request item **3523**.

■ A guide by The Mutual Group (U.S.), Employee Benefits highlights tips on structuring a **flexible benefits program**. Request item **3524**.

■ Current **legislative and regulatory issues** affecting compensation and benefit plans are detailed in a booklet supplied by W.F. Corroon. Request item **3525**.

■ The review process of a **utilization management firm** is discussed in a paper from United Wisconsin Services Inc. Request item **3526**.

■ Meridian Resource Corp. supplies a set of fliers describing its **employee benefit services**, including consulting, claims auditing and utilization management. Request item **3527**.

■ Proservices offers a paper describing its integrated information **network for providers to communicate with insurers**. Request item **3528**.

■ The **products and services** of United Wisconsin Group are explained in a set of brochures. Request item **3529**.

■ ReliaStar Employee Benefits supplies a booklet examining the role of **hospital executives and managers** in communicating with key audiences. Request item **3530**.

■ An outline explaining **Social Security and Medicare** benefits is offered by BNA Books. Request item **3531**.

■ **Trends in technology use** by health care and life insurance administrators are covered in a newsletter from Genelco Inc. Request item **3532**.

■ ReliaStar Employee Benefits provides a booklet that examines the nature of **health care fraud** and how to combat it. Request item **3533**.

■ A newsletter presented by BNA Books explains employee rights and responsibilities in **sexual harassment**. Request item **3534**.

■ The way employers in midsize companies perceive the **financial security of their employees** is examined in a booklet from ReliaStar Employee Benefits. Request item **3535**. BI

Directions to using information resource on employee benefits

The Employee Benefit Information Resource section is an editorial compilation of current informational and educational materials on employee benefit-related topics other than health care.

For a listing of materials on health care topics, please see the information resource section in the July 1 issue of *Business Insurance*.

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 items you want 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.

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Survey sheds light on opt-outs

By MICHAEL BRADFORD

AUSTIN, Texas—Texas retailers with fewer than four workers probably are not buying workers comp insurance. But if you're in the mining industry and have 500 or more employees, you probably do.

Those are two conclusions drawn from a survey earlier this year by the Austin, Texas-based Research and Oversight Council on Workers' Compensation, which monitors the system. The council relied on 2,870 phone interviews of employers conducted this spring by the Public Policy Research Institute at Texas A&M University in College Station.

Texas is the only state where employers can opt out of the workers comp system. New Jersey law in theory allows opt-outs, but the procedure is so stringent that apparently no employer has chosen it. South Carolina, the only other state to allow non-subscription, recently made the coverage mandatory.

The council's survey found that 39% of Texas employers do not have coverage, down from 44% in 1995. The report showed 20% of workers in the state are employed at businesses that do not buy coverage.

In a state that allows employers to opt out of the system, many have chosen to beef up safety procedures and offer benefits that replace purchased coverage.

Of the employers responding, 29% of the non-subscribers said they pay benefits to employees injured on the job. Those companies' workers make up 71% of all employees working for employers that do not buy coverage.

Texas employers that choose to bear the cost of workplace injuries also give up protection afforded by the exclusive remedy doctrine and risk unlimited tort liability.

The risk of liability and the falling cost of workers comp insurance in Texas are why a number of employers are returning to the system or deciding to continue coverage.

The survey found only 3% of non-subscribers had been sued by employees over work-related injuries. But, 38% of larger non-subscribers had been sued, while only 2% of smaller non-subscribers had faced litigation.

Many employers are buying coverage because they think they have to, the study said. While 40% of those that bought coverage did it to protect themselves from suits, another 23% purchased the insurance because they thought it was required.

The data shows that businesses with one to four employees make up 44% of all non-subscribers, while those with 500 or more workers amounted to just 14% of the total. The percentages decline as the number of employees increases.

While the percentage of employers that opt out is falling, many non-subscribers are gone for good. Thirty-nine percent 39% said they would never buy coverage again, and 38% said the cost would have to be cut at least in half before they would buy workers comp insurance.

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Free copies of the survey are available by calling the Research and Oversight Council on Workers' Compensation at 512-469-7811.

Texas

Continued from page 2

propriety of the defendants' rates to the named plaintiffs."

The suit also alleged the NCCI helped insurers avoid detection by forwarding rates to regulators that the organization knew were not the actual rates charged to the plaintiffs.

Among the schemes plaintiffs say the insurers used were residual market charges in addition to premiums, altering retrospective premiums in an "unapproved side agreement" and writing and using arbitration clauses to destroy the "protection offered to the insured by the policy form approved" by regulators, court papers state.

A notice detailing the proposed settlement indicates the insurers and the NCCI, while agreeing to the settlement terms, deny any wrongdoing and claim their "conduct was or has become authorized by statute and that some or all of the claims are barred by the statutes of limitations."

Other large defendants in the case include Liberty Mutual Insurance Co., Argonaut Insurance Co., CIGNA Property & Casualty Insurance Co. and Travelers Insurance Co. The proposed deal says the NCCI, 14 insurance groups and a number of their subsidiaries have agreed to participate in the settlement.

"I think it's a fair settlement," said Scott M. Clearman, an employer attorney with McClanahan & Clearman L.L.P. in Houston. He said a final payout of $190 million would be close to the amount of the overcharges.

The settlement would:

• Require immediate distribution of 95% of the proceeds to policyholders, with the remainder placed in a fund with other settlement amounts to be paid upon final resolution of the litigation.

• Require that insurers calculate a "premium differential" for each class member to determine the amount of any overcharges. The calculations would be subject to review by a third-party actuary.

• Allow insurers to offset a distribution to policyholders by the amount of any bills or debts owed to the insurer.

• Pay $10,000 to each plaintiff that was subjected to discovery and $5,000 to each that was not. The payments will be made from the combined fund.

• Pay attorney fees and expenses of about $48.3 million plus one-third of any accrued interest.

Insurers that already have settled, attorneys say, include ITT Hartford Insurance Group, The St. Paul Cos., Reliance Insurance Group, Nationwide Group and Employers Mutual Casualty Co. BI

Asbestos

Continued from page 1

Harrison in San Francisco, which represents Fibreboard.

Mr. Irwin said he was not surprised by the court's decision even though several legal experts had doubted the 5th Circuit would approve *Ahearn* in light of the 3rd Circuit's *Georgine* ruling.

"This was a different court deciding a case with extremely different facts," he said. "An overriding factual difference. . .is that the CCR was trying to settle mass torts, and ours was largely a settlement of insurance coverage issues."

According to the Fibreboard settlement, CNA and Chubb will provide $1.54 billion to an independent trust to pay claims filed after Aug. 27, 1993, as well as any future claims. CNA will pay about $1 billion of this amount. The insurers also will provide up to $1.8 billion to respond to claims filed before Fibreboard and the two companies settled their insurance disputes in August 1993 (*BI*, Sept. 6, 1993). Chubb's responsibility for this portion of the settlement is capped at $635 million.

If ultimately approved, the global settlement will supersede the insurance settlement and let Fibreboard avoid bankruptcy.

Supporters of the CCR settlement, meanwhile, are hopeful that the conflicting rulings on a pair of unprecedented asbestos personal injury settlements will prompt the Supreme Court to review *Georgine*, and maybe both cases, to resolve once and for all the issues surrounding acceptable class actions.

"The Fibreboard decision further underscores the head-on conflict among circuit courts on an issue of monumental importance to hundreds of thousands of people and dozens of companies. Fortunately, we have a U.S. Supreme Court with the power to resolve such conflicts," said Lawrence Fitzpatrick, president and chief executive officer of the Princeton, N.J.-based CCR.

The Judicial Conference of the United States, which establishes rules of procedure for state and federal courts, is interested in overhauling Rule 23 of the Federal Rules of Civil Procedure, which governs class actions. In June, the Judicial Conference instructed its Advisory Committee on Civil Rules to publish for public comment a draft paper that recommends permitting judges to certify class-action settlements even if the same class would not be certified for trial purposes (*BI*, June 24).

Fred Baron of Baron & Budd in Dallas, a plaintiffs attorney representing the lead appellant in both class actions, said the 5th Circuit's approval of Fibreboard should not positively impact *Georgine*, nor does it offer significant precedent for future asbestos-related class actions.

"Fibreboard presented such a unique fact pattern that I do not believe it will ever arise again. Although a casual observer might say (Fibreboard) is precedent for national class actions for asbestos cases, it's only precedent for a class action in the event there's a dispute between an insurance company and an insured where the insured would go insolvent otherwise. That won't occur very often," Mr. Baron said.

Lawyers for Fibreboard also insist the facts and terms of the Fibreboard and CCR settlements are different in nature and that it was appropriate for the 5th Circuit not to rely on the same reasoning used by the 3rd Circuit.

"*Georgine* is there to resolve cases purely by disease categories and it ignores relevant differences between claimants. The 5th Circuit said that, faced with similar conditions, it would have done the same thing" as the 3rd Circuit, said Brobeck Phleger's Kelly Wooster.

Mr. Wooster, like the court, also pointed out that the two settlements seek to pay claims in entirely different ways. "Fibreboard's settlement takes a fixed amount ($1.54 billion) and gives that to a trust not run by Fibreboard. Conversely, *Georgine* would be run by the CCR, which could walk away in 10 years. It's not irrevocable."

The Fibreboard settlement, though, does not base damages on disease type and pays much less to attorneys involved, he added.

"This is just another step in an amazing game of chess," according to Mr. Baron. "It's certainly not over." BI

Pay or play saga ends

Massachusetts health care law dead after repeal

BOSTON—Massachusetts' "pay or play" health care law is no more.

Massachusetts legislators last month successfully overrode Gov. William Weld's veto of a measure that repeals the never-implemented 1988 law that once was a model for states looking for new ways to expand health care coverage to the uninsured.

Gov. Weld favored repeal of pay or play, but he vetoed the bill because another provision will raise the state cigarette tax by 25 cents a pack. That money will be used to provide health insurance to children from lower-income families.

The repeal of the statute ends an 8-year-old saga that began in 1988 when Massachusetts enacted health care legislation incorporating pay or play. The statute was so named because employers were to be automatically hit with an annual tax of $1,680 per employee.

However, that tax was offset by each dollar an employer spent on its health care program. Employers that spent more than $1,680 per employee on their health care programs were exempt from the tax.

The law was supposed to take effect in 1992. But soon after enactment, opposition—mainly from small-business groups—began to swell. The small-business lobby argued that a health care mandate would force employers to lay off workers. Employer lobbyists also argued that some employers would flee the state, costing Massachusetts more jobs.

In response to those arguments, legislators delayed implementation of the law several times. Opposition to the law, though, continued to grow and by earlier this year it became clear that pay or play would be repealed. Prior to the repeal vote, the law was to go into effect Aug. 1.

Last year, Washington state repealed a similar law that would have required employers to pay at least half the cost of employees' health insurance premiums.

—*By Jerry Geisel*

INTERNATIONAL

House of Lords ruling a win for reinsurers

By SARAH GODDARD

LONDON—Reinsurers have won the right to mount legal challenges to the "follow-settlement" clauses that currently bind them to their cedants' decisions on claims settlements.

Handing down the opinion in the House of Lords on the *Hill and Others vs. Mercantile & General Reinsurance Co. P.L.C.* case last month, Lord Mustill granted M&G Re, which filed a suit over reinsurance claims relating to the sequestration of aircraft during the Gulf War, the right to bring the suit to the Commercial Court.

Although the Court of Appeal in 1994 upheld a lower-court ruling that follow-settlement clauses must be adhered to, the five-member House of Lords panel unanimously said that reinsurers need not be bound to the clauses.

Though the sums involved in the M&G Re case are not that high—they are estimated at approximately $10 million—the decision could have implications for a number of claims within the London market excess-of-loss spiral. Reinsurers further up the chain may now challenge claims agreements reinsurers made on lower layers of coverage.

The underlying case for the decision relates to the seizure of 15 Kuwaiti Airlines and one British Airways aircraft at Kuwait airport by Iraqi invading forces on Aug. 2, 1990 (*BI*, Sept. 3, 1990). Under the follow-settlement clauses, reinsurers higher up the spiral were bound to accept the decision by the primary insurers that the invasion constituted one occurrence, hitting the policy limit of $300 million.

However, M&G Re had disputed that the loss of the aircraft was just one event, and the House of Lords' decision means the reinsurer can now test its argument in the commercial court. If M&G Re successfully argues that multiple events caused the losses, it may ultimately have little or no liability, because the individual claims would not be sufficient to reach the M&G Re layer of coverage.

"It will materially affect whether M&G Re is liable at all," confirmed Charles Gordon, a partner at London law firm Manches & Co, who acted for several Lloyd's of London syndicates who were challenging M&G Re's dispute.

However, he said he is confident that if M&G Re pursues the matter, the commercial court would uphold a December 1995 court decision by Justice Rix that the Iraqi invasion constituted one event with respect to the loss of the aircraft (*BI*, Jan. 1).

There will probably be a preliminary hearing in September to clarify the issues before the full hearing, Mr. Gordon said. The full case would not be heard until next year at the earliest, he said.

The follow-settlement clause traditionally has been accepted as binding on reinsurers, as long as the coverage is within the terms of the original insurance and applicable reinsurance policies, and the claims settlement was within the realm of good faith and normal business practices.

The implications of this decision are limited. It will only affect clauses that are worded in the same way as the one under dispute, according to Mr. Gordon.However, he admitted that it "muddies the water."

According to Mr. Gordon, the decision should not affect the Lloyd's of London settlement offer, which is partly funded from policies that went up through the spiral.

However, along with recent reinsurance cases such as the *Charter Reinsurance Co. Ltd. vs. Patrick Feltrim Fagan* dispute (*BI*, May 27), known as the "pay as to be paid" issue, the M&G Re case does indicate a growing trend in the London market for reinsurers to take certain issues to the courts.

"Most reinsurance problems relate to how they aggregate losses," pointed out Mr. Gordon. "There are always tensions between reinsurers looking to avoid aggregation and reinsureds who will be looking to aggregate."

These tensions will increasingly be legally tested, which could "cause chaos" in the market, he said. One implication may be slower claims payment as disputes relating to high reinsurance layers are settled through the court system.

In a statement, Mr. Gordon and another Manches partner, Chris Jones, said, "The reinsurer is now free to impose his own definition of the terms of the direct insurance policy and his reinsurance policy without being bound by any decision reached by his reinsured."

Members and U.K. courts give 'momentum' to Lloyd's R&R plan

One action group plans to seek judicial review

By SARAH GODDARD

LONDON—Now in its final month, the Lloyd's of London reconstruction and renewal plan is gathering support from members and assistance from the U.K. courts.

Last week, the Court of Appeal ruled that damages awarded to litigating members cannot be paid direct to the litigants, but must go to the trustees of the members' premiums trust funds. The decision affects about £300 million ($466.8 million) in litigation recoveries, now in escrow accounts, giving Lloyd's first call on the cash.

The ruling overturns the judgment in the original case, heard in 1992 in the High Court. After the first case had been brought, Lloyd's amended the premiums trust deeds governing members' premiums trust funds to combat any ambiguity about litigation recoveries.

The PTD amendment was only authorized to go ahead by the president of the Board of Trade, Michael Heseltine, on the understanding that its legality would be tested through the courts. So far, the High Court has found against Lloyd's in that case, and although the issue was appealed in the same case as the seizure by Lloyd's of litigation recoveries, the Court of Appeal did not make a ruling and "will take time to consider (the issue)" said Lord Justice Nourse.

Meanwhile, Lloyd's started sending finality statements to all members, emphasizing that the settlement offer is now in its final form. In a letter accompanying the 320-page Settlement Offer Document—itself an accompaniment to the comparatively insubstantial one-page finality statement—Lloyd's Chief Executive Ron Sandler wrote, "The settlement offer is now final. Negotiations with the various contributors regarding the size of the settlement fund have been concluded."

Nevertheless, the Paying Names Action Group—numbering now around 3,000 paid up and extremely unhappy Lloyd's members who think they have been financially sacrificed to appease the more vociferous action groups—continued to press for a better deal for its members and is following through on its threat to request a judicial review into Lloyd's. This could be completed before the end of August, according to PNAG chairman Tony Welford, in time for Lloyd's annual solvency test, carried out by the U.K. Department of Trade and Industry every Aug. 31.

But Barry O'Brien, a senior partner with London law firm Freshfields and Lloyd's legal adviser, said he was confident there are no grounds for a judicial review.

Except for the PNAG, the R&R plan is receiving endorsements from an increasing number of members' groups, including the Assn. of Lloyd's Members, the Gooda Walker Action Group and the MacKinnon Hayter Action Group. Others are expected to recommend their members accept the offer over the next few days. "It has built up a momentum which appears to be going in the right direction," a Lloyd's spokesman said.

In the last poll of members, carried out by independent pollster MORI, 82% of members said they were likely to accept the offer.

> **'Negotiations with the various contributors regarding the size of the settlement fund have been concluded,' says Ron Sandler.**

Members have until Aug. 28 to accept or reject the offer. They will be sent more detailed information on the calculations behind their finality statements later in the month, though Lloyd's refuses to release information on the level of acceptance it requires to make the plan work. A number of factors will be taken into account when assessing the relative worth of each member's acceptance, said Mr. O'Brien, such as action group membership, whether they have been successful in litigation, the level of their losses and the type of syndicates, such as spiral or long-term liability, on which they underwrote.

About 1,000 members who have applied for debt credits designed to help the names who still cannot afford finality bills, known as tranche four debt credits, have been informed of their allocation, and another 500 should hear by the middle of the month. However, several hundred members who have applied for additional assistance aimed at those who have been financially devastated by their Lloyd's memberships will only receive guidelines in August. They will not receive any details on their applications by the acceptance date.

Most members will not see any change between their second interim statements and the full finality statements. Before taking members' funds at Lloyd's into account, 12,500 members will receive a release; 7,200 have a bill up to £25,000 ($38,900); 4,100 will have a bill between £25,000 and £50,000 ($77,800); 3,500 will have a bill between £50,000 and £75,000 ($116,700); 3,500 will have a bill between £75,000 and £100,000 ($155,600); and 4,400 will have a bill more than £100,000 ($155,600).

These figures include tranche four debt credits and the U.S. state credits, which now amount to £31.3 million ($48.7 million). Lloyd's members in Tennessee will not have the opportunity to join in the settlement offer because of pending litigation there. About 29 members are affected by the situation.

U.S. members in states that did not sign on to the recent North American Securities Administrators Assn. agreement still may accept the settlement offer, though they will not be given the additional state credits.

Also, Lloyd's has appointed seven trustees to the trust that will own Lloyd's run-off reinsurer Equitas Ltd. Originally, the trustees were to be elected by the Lloyd's members reinsured into Equitas, but this could lead to arguments that Equitas is a security.

The trustees are Michael Deeny, chairman of the Gooda Walker Action Group and a member of Lloyd's ruling Council; former Lloyd's Deputy Chairman Colin Murray; John Mays, chairman of the Merrett 418 (1985) Names' Assn. and Merrett No. 2 Assn.; Viscount Bledisloe, a lawyer and former member of Lloyd's; Desmond Heyward, a member of the Names' Committee; Sir Adam Ridley, chairman of the Names' Committee and an executive director of Hambros Bank P.L.C.; and Richard Spooner, chairman of the Gresham 321 Action Group. BI

Pemex self-insured for plant explosion

MEXICO CITY—Petroleos Mexicanos, Mexico's state-owned petroleum company commonly known as Pemex, will have to meet a large self-insured retention before insurance policies are triggered to cover damages from an explosion that knocked out its biggest natural gas processing plant in the Southern state of Chiapas.

A propane leak ignited by an unknown source is blamed for the July 26 blast, according to Pemex. The explosion killed six workers and injured 39, some seriously. No damages estimates were available.

Pemex buys property and liability insurance from Aseguradora Mexicana, a unit of insurer Comercial-America, but has a significant self-insured retention, said J.D. Dawson, owner of broker Dawson y Correa, with offices in Mexico City and Irving, Texas. Mr. Dawson said Pemex is a minority owner of Aseguradora Mexicana.

A Pemex spokesman confirmed Pemex is insured by Aseguradora Mexicana, but could not provide details about its retention, property or liability limits or excess coverage. The company's liability to the deceased and injured workers is limited. They will receive benefits provided through the Mexican Institute for Social Security, which acts somewhat similar to workers compensation insurance in the United States.

The disabled plant processed about one-quarter of Mexico's gas used for cooking. Pemex said that throughout August it will import 300 cubic feet of natural gas per day from Texas and increase production at other sites to make up for the loss.

The company has been plagued by catastrophes, including an April 22, 1992, sewer-line explosion that killed 205 people and leveled 20 city blocks in Guadalajara (*BI*, May 4, 1992), and the November 1994 gas plant explosion near Mexico City that killed 300 people.

—*By Roberto Ceniceros*

GRAPHIC BY TONY BUCCINI

INTERNATIONAL

U.S. non-life insurers' growth to come from abroad: Study

By EDWIN UNSWORTH

U.S. insurers as a group will greatly increase their overseas non-life business over the next decade, but fewer companies will share in it, according to a report published last week.

The report, "Strategies for Success in U.S. Insurance," published by management consultant Datamonitor, forecasts that U.S. overseas non-life premiums will almost triple to $55.9 billion in 2005 from an estimated $20.9 billion in 1995.

Main growth areas will be in Mexico and other parts of Latin America, followed by Asia. Entry into Latin American markets will be assisted particularly by the North American Free Trade Agreement, which allows U.S. insurers to be majority owners of insurance companies there.

In all these countries, demand for non-life insurance will be spurred by sustained political and economic liberalization as they continue their "impressive" growth rates of recent years, by rapidly increasing middle classes, and by the inability of domestic insurance operations to meet the resulting growth in demand, according to Datamonitor.

Faced in their home market with relatively stagnant growth and increasing competition, U.S. insurers will experience their largest growth rates overseas. The proportion of overseas non-life premiums U.S. insurers earn in relation to their total non-life premiums will double to 12.5% in 2005 from about 6.2% in 1995.

This represents an estimated compound annual growth rate for overseas operations of 8.8% between 1995 and 2005, compared with the growth rate of just under 3% for domestic operations over the same period.

Datamonitor also predicts a sharp fall in the number of U.S. property and casualty insurers. Whereas now there are 371 property/casualty insurance groups in the United States, the report forecasts that by 1999 the number will fall by 20% to under 300. The study says mergers and acquisitions will fuel this consolidation and that the vast majority of companies acquired will be small. About 90% will have annual premium volume of under $1 billion, and, of these, over two-thirds will have premium volume of less than $100 million.

Datamonitor says it is more difficult to predict consolidation in the life insurance sector, but that a 15% reduction in the number of U.S.companies "would not be unrealistic."

The main reason for this consolidation will be the need for economies of scale. This would bring essential expense cuts but also provide the critical mass necessary for investment in new technologies and practices, such as direct-mail marketing programs.

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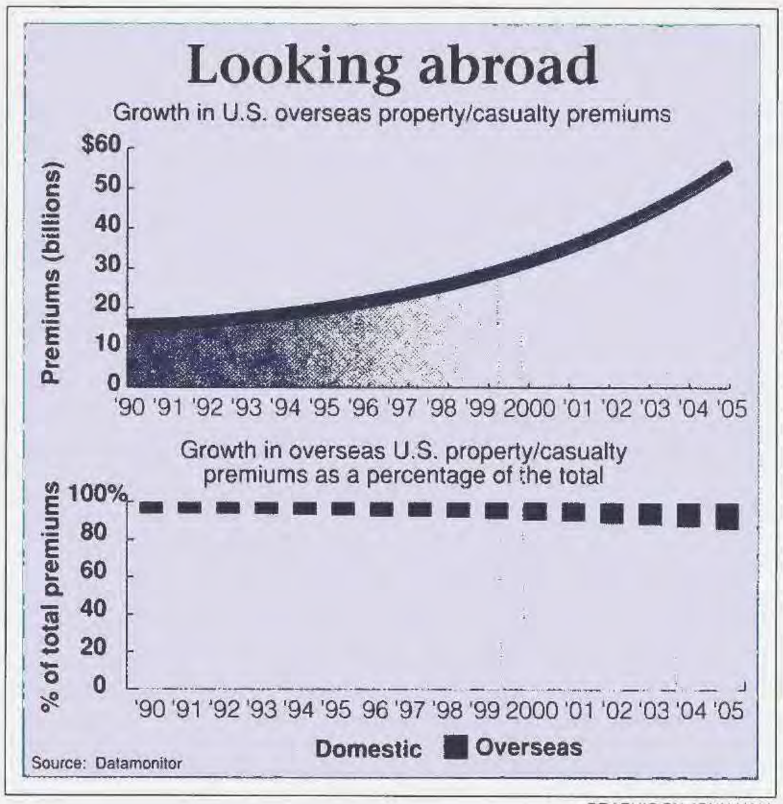
Copies of Strategies for Success in US Insurance are available from Datamonitor for $3,995. Datamonitor USA, 41 Madison Ave., 5th Floor, New York, N.Y. 10010; 212-661-2525, fax: 212-661-5551. Datamonitor Europe, 106 Baker St., London W1M 1LA; 171-625-8548, fax: 171-625-5080.



GRAPHIC BY JOHN HALL

Allianz, Munich Re reshuffle decks

Swaps strengthen each in new areas

By DON LEWIS KIRK

In a bid to settle antitrust questions by the German cartel office, a government antitrust authority, Allianz A.G. Holding has sold one of its prized subsidiaries to Munich Reinsurance Co.

Reducing its market dominance in health insurance, Allianz signed over Deutsche Krankenversicherung A.G., Europe's largest private health insurer, while opting to keep a smaller health insurance group, Vereinte Versicherungs A.G.

The move surprised analysts, who had expected Allianz to sell off Vereinte—the smaller, domestic portion of its health business—which it acquired from Swiss Re Group in 1994.

Recent speculation over potential buyers focused on talks between Allianz's French, German and Italian insurers, including Assurances Generales de France, Aachen-Muenchener Beteiligungsgesellschaft und Assicurazioni Generali S.p.A.

Industry sources suggest most of these companies balked at the 4 billion DM ($2.71 billion) price.

In return for 100% of DKV, Munich Re has agreed to give Allianz its 25% share in Vereinte, which now gives Allianz 100% control of the health insurance group.

Allianz also will get Munich Re's 50.3% stake in Hermes Kreditversicherungs A.G., the leading German credit and loan insurer and the reinsurer's holdings in Allianz's Austrian companies.

Neither Munich Re nor Allianz expect problems with the German cartel office. In a statement released after a July 26 supervisory board meeting, Allianz said it was confident the transaction would go ahead after informal talks with cartel authorities.

The acquisition by Munich Re will give both companies an advantage, a Munich Re spokesman said. "Besides solving Allianz's cartel problem, it will help us diversify at a time when reinsurance is becoming very volatile. By its very nature, reinsurance is a higher-risk business, and primary insurance offers more stability."

As a result, the spokesman said, the acquisition is a welcome balance. "At a time when reinsurers are doing less general business and are left with only very large risks, like airports or natural catastrophes, it is good to have other stable profit centers."

Prior to the acquisition, Munich Re had only life insurance companies in its group. The addition of Europe's largest health insurer will not help improve earnings but will allow a focus on private customers. The move also will raise Munich Re's group premium volume to over 33 billion DM ($22.34 billion) from 29.3 billion DM ($19.84 billion).

Munich Re and Allianz have long been cemented by a 25% crossholding. Together they now represent a 30% share of the German health insurance market.

Both companies see great profitability in health insurance as Germany's aging population and overtaxed state welfare system raises demand.

"It's a phenomenon prevalent throughout Europe," the spokesman said. "We see great synergies between reinsurance and primary insurance in this area. We also hope to gain valuable know-how from our primary health insurer that we can use in reinsurance."

At a July 29 presentation of Allianz A.G. Holding's annual business report, board Chairman Henning Schulte-Noelle echoed a similar statement, underlining the great potential for health and life insurance products. BI

Airline group moves to lift international liability limits

U.S., E.C. approval still needed

By EDWIN UNSWORTH

LONDON—Removal of fixed passenger liability limits on international flights came a step closer when the International Air Transport Assn. filed its Intercarrier Agreement on Passenger Liability last week with the U.S. Department of Transportation.

IATA Director General Pierre Jeanniot said he hoped the U.S. authorities would approve the agreement in time for it to become effective by the target date of Nov. 1, 1996.

The Department of Transportation normally allows a 21- to 30-day period for interested parties to comment. In this case, interested parties could include groups such as bar associations, aircraft manufacturers and survivors' groups.

Geneva-based IATA, which counts about 240 international airlines among its members, had been expected to file for approval of the agreement with the European Commission at the same time it made its U.S. submission, but it is waiting for a few major European airlines to sign up before approaching the E.C. IATA said it expects a number of these airlines to sign on to the agreement this week, enabling it to make a submission to the E.C. before mid-August. Once it has acceptance from the United States and the European Commission, other countries are expected to readily endorse the agreement.

The agreement would bring to an end specified limits on passenger liability on international flights as originally set up in the 1929 Warsaw Convention and subsequently modified in 1966 by the Montreal Protocol. These limits range from $75,000 in the United States to $150,000 in most of Europe and $350,000 in Australia.

In their place, if the agreement comes into force, airlines would have to pay full "compensatory damages," which will be regulated by the norms existing in the country of the a passenger's passport or place of residence. The agreement would also end the need for a claimant to prove an airline was at fault in order to receive full compensation for death or serious injury.

Mr. Jeanniot said, "The new system being introduced by the airlines will significantly benefit the traveling public and modernize an archaic regime which has long created unnecessary tensions between airlines and claimants, to the detriment of both."

The airline and insurance industries have mixed opinions as to whether the removal of liability limits will result in higher premiums for airlines.

Since the basic Intercarrier Agreement on Passenger Liability was presented at an IATA meeting last October in Kuala Lumpur, it has been signed by 50 international airlines representing more than 50% of scheduled international air transport operators.

IATA's agreement on passenger liability was motivated by "expenses and delayed litigation best exemplified by the Korean Airlines disaster and the Lockerbie incident, where willful misconduct was alleged and proven, delaying payment to families of passengers. In addition, there are the anachronistically low limits under Warsaw," said Desmond T. Barry Jr., a partner specializing in aviation with Condon & Forsyth in New York.

Trans World Airlines has become one of the latest signatories to the agreement, although the airline signed after Paris-bound Flight 800 crashed July 17 into the Atlantic Ocean shortly after departing New York's Kennedy International Airport. The disaster killed all 230 aboard (*BI*, July 22).

Other U.S. airlines to sign on to the agreement are Delta Air Lines Inc., American Airlines Inc., Hawaiian Airlines Inc., United Air Lines Inc., United Parcel Service of America Inc. and USAir Inc. UPS is signing on to the agreement because it plans to begin offering some passenger charter flights later this year, according to a UPS spokesman.

Many other major airlines have signed, although noted exceptions include Air France, Lufthansa, Alitalia and Iberia. However, IATA has indicated it expects these airlines to sign to avoid being at a considerable competitive disadvantage to other carriers.

Aviation hull and liability insurance rates have weakened considerably this year, and underwriters are uncertain if even the TWA crash will reverse the slide. Underwriters do not yet know whether insurers will be able to use the higher liability payments expected under the Intercarrier Agreement as a reason for raising premiums.

IATA has argued that the agreement should not necessarily lead to an automatic increase in insurance rates, because it should reduce legal costs and time needed to reach a settlement.

David O'Conner, a legal representative for IATA in Washington, said endorsement of the agreement should make very little difference to the overall liability premiums paid by U.S. airlines. They will only be affected on their international business, and most U.S. airlines are primarily domestic operators. In addition, any effect on rates should be only temporary, largely because the agreement should reduce time and costs involved in the claims procedure, he said. Longer term, liability insurance ratings will depend largely on an airline's claims record, he added.

However, Heni Burgi, head of aviation at Swiss Reinsurance Co., said prudent underwriters should not assume the change would have minimal impact.

"On the contrary, the market's leading underwriters should assume the responsibility of re-rating each risk individually and charging as appropriate an additional premium," Mr. Burgi said.

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Michael Schachner contributed to this story.

Stocks

Continued from page 1

"I think it's been really hard in this industry to make a 'group call' for a while," said Mr. Frank. "I think you're much better served to keep an eye on a handful of names you like and attempt to pick them off when they're undervalued."

"We look for selected winners in an otherwise difficult market," said Steven A. Gavios, managing director at Bear, Stearns & Co. Inc. in New York. These are companies that "should continue to show strong earnings gains in the face of weaker earnings for the industry as a whole."

According to the *Business Insurance* Index, the insurance industry stocks have declined by 15.4% year to date, compared with a 2.7% rise in the Standard & Poor's 500.

Some segments of the insurance market have done better than others, however, according to an index compiled by Hartford, Conn.-based Langen McAlenney, a division of Janney Montgomery Scott Inc.

Through July 26, primary property/casualty stocks were down 1%, multiline stocks were down 3.9%, and insurance broker stocks were down 1.2%.

However, reinsurer stocks were up by 0.8%, while Bermuda stocks were up by 7.5%, and life insurer stocks were up 0.9%. Overall, the stocks were up 0.6%, compared with 3.2% in 1995.

"They've been underperformers through the first seven months of the year, I think primarily due to their strong performance in 1995 with a particular surge in December of 1995," said David Seifer, an analyst with Donaldson, Lufkin Jenrette Securities Corp. in New York.

However, the stocks are "holding up better than technology" and still are reasonably priced, said Gloria Vogel, senior vp with Advest Inc. in New York.

"But clearly most of them took a little bit of pressure in the down draft, although some of them held up," she added, referring to the recent sell-off of high-technology stocks.

Stock analysts generally are not optimistic about the stocks' likely overall performance this year, however. "I'm definitely very bearish on the commercial insurance industry," said Lehman Bros.' Mr. Wade.

"I think the stocks as a whole are likely to be market performers at best, and fundamentally I think what you're going to see is even further declining growth and earnings disappointments" overall, said Mr. Wade.

"I think it's going to be a tough market for most property/casualty stocks, and we do expect the property/casualty group to underperform the market for the balance of the year unless interest rates show a strong rally, which we do not expect," Mr. Gavios of Bear, Stearns said.

Meanwhile, there could be a return to the traditional underwriting cycle, said Harry Fong, director at C.J. Lawrence/Deutsche Securities Corp. in New York. "After a decade of increasing price competition, cracks are beginning to surface in the underwriting results of the commercial lines carriers.

"While we have advocated a view of legal reform benefiting the industry's underwriting results, the notion that prices have been coming down faster than the benefits of this reform are now beginning to surface. . .hence the return to a traditional underwriting cycle is a distinct possibility," Mr. Fong said.

However, the worst may be over insofar as the stock market is concerned, said Smith Barney's Mr. Frank. "Among the large commercial carriers, the combination of a rocky bond market and increasing concerns over competition in the marketplace have probably done a good amount of the damage that you're likely to see.

"We were a little concerned about valuation toward the end of last year, and stepped back from a couple of names, but frankly year-to-date in '96, as the valuations have come down, we've found ourselves building up representation again."

It is hard to generalize on the outlook, said Mr. Frank. "I would say it depends on the (stock) market. If we continue to have a difficult overall stock market but bonds are stable, the group could shape up fairly defensively" and do relatively well.

However in a "runaway" market where the stocks overall jump up, "they might very well get left behind again," said Mr. Frank.

Larger commercial property/casualty insurers recommended by analysts include American International Group Inc., General Re Corp., Chubb Corp., USF&G Corp., American Re-Insurance Co., ITT/Hartford Group Inc. and RenaissanceRe Holdings Ltd.

AIG, General Re and Chubb are all on DLJ's recommended list. "We think all of those will do better in the second half," said Mr. Seifer.

Chubb also is recommended by Mr. Gavios. "At Chubb, we see a superior property/casualty company that should have good growth and stellar underwriting profitability, selling at a price/earnings multiple that is only average to the group."

Mr. Gavios also recommends AIG, which "we believe is one of the best-positioned insurers in the U.S. commercial insurance market environment, with an ability to buck the industry trend on growth by creating specialized products and by finding new markets to sell their insurance products to. That should allow them to grow faster than the industry as a whole while maintaining underwriting profitability."

Gen Re is also recommended by Mr. Frank. The reinsurer remains a leader in the market and a "fine beneficiary of consolidation" as demonstrated by its National Reinsurance Corp. transaction, said Mr. Frank, who noted the reinsurer may also make further inroads in Europe (*BI*, July 8, 1996).

Mr. Gavios recommends USF&G Corp. "At USF&G we see a company in the midst of what could be one of the most dramatic turnaround stories ever to have been achieved in this industry.

"We expect a continuing growth of specialty business, margin improvement in their commodity business, and we also see some further share repurchases at current price levels as bolstering earnings per share as well as the stock."

American Re is on Mr. Frank's recommended list. He noted that in light of National Re's acquisition, American Re has been the focus of market speculation that it might eventually be acquired as well (see story, page 45). For the week ended July 26, it closed at $50.88 a share, up $12.12 from the week before. The stock closed at $57.75 on Aug. 1.

"We really liked it at the outset for purely fundamental reasons, and now there's obviously been a

See **Stocks** *on page 43*

'It's going to be a tough market for most property/casualty stocks, and we expect them to underperform the market for the balance of the year,' says Steven Gavios.

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UNITED STATES BANKRUPTCY COURT
Southern District of New York
IN THE PETITION OF GARETH HUGHES AND ANTHONY JOAQUIN, AS JOINT PROVISIONAL LIQUIDATORS OF THE BERMUDA FIRE & MARINE INSURANCE COMPANY LIMITED (THE "COMPANY")
CASE NO. 93-B-46013 (PBA)

NOTICE IS HEREBY GIVEN that on July 23, 1996, an Order was entered by the United States Bankruptcy Court for the Southern District of New York continuing the Preliminary Injunction Order originally issued on December 14, 1993 (the "Order") which (a) enjoins and restrains the commencement or continuation of any judicial action, arbitration proceeding, administrative or regulatory action or proceeding against the Company or any of its property in the United States; (b) enjoins and restrains the enforcement of any judicial proceeding, arbitration award, administrative or regulatory proceeding to create, perfect or enforce any lien or other claim against the Company or any of its property in the United States; and (c) requires all persons to turn over and account to the Petitioners for all funds resulting from the drawdown of letters of credit in excess of what is expressly authorized by the terms of the contracts and any related trust or other agreements pursuant to which such letters of credit have been posted, in their possession, custody of control after written demand for turnover and accounting is made by the Petitioners against such entity. The Order shall remain in effect pending a hearing scheduled to be held in Room 617 of the Alexander Hamilton U.S. Custom House, One Bowling Green, New York, New York on December 5, 1996 at 2:30 p.m. Any party in interest who has not received a copy of the Order should contact counsel for the Joint Provisional Liquidators in writing at the following address:

Chadbourne & Parke LLP
30 Rockefeller Plaza
New York, New York 10112
Attention: Kenneth P. Coleman, Esq.

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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK
IN THE PETITION OF DAVID LLEWELLYN MORGAN AND MARK W.R. SMITH, AS JOINT PROVISIONAL LIQUIDATORS OF STOCKHOLM RE (BERMUDA) LTD. (THE "COMPANY")
CASE NO. 95-B-40543 (PBA)

NOTICE IS HEREBY GIVEN that on July 23, 1996, an order was entered by the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") in connection with the case filed with respect to the Company pursuant section 304 of the Bankruptcy Code (the "Order"):

1. Enjoining and restraining all persons and entities from (a) transferring, relinquishing or disposing of any property of the Company in the United States, or the proceeds of such property, to third parties; (b) commencing or continuing any action or other legal proceeding against the Company or any of its property in the United States, or any proceeds thereof; (c) enforcing any judicial, quasi-judicial, administrative or regulatory judgment, assessment or order or any arbitration award, and commencing or continuing any act or any action or other legal proceeding to create, perfect or enforce any lien, set-off or other claim against the Company or any of its property in the United States or any proceeds thereof, including, without limitation, rights under reinsurance or retrocession contracts; and (d) drawing down any letter of credit established by, on behalf or at the request of, the Company, or withdrawing from, setting off against, or otherwise applying property that is the subject of any escrow agreement or similar arrangement in which the Company has an interest, in excess of what is expressly authorized by the terms of which such letter of credit, escrow, or similar arrangement has been established, except, however, no drawing against any letter of credit shall be made in connection with any commutation unless the amount has been agreed in writing with the Petitioners or permitted by further order of the Bankruptcy Court;

2. Requiring all persons and entities that are beneficiaries of letters of credit established by, on behalf or at the request of, the Company, or parties to any escrow or similar arrangement in which the Company has an interest, to (a) provide notice to Petitioners' United States counsel of any drawdown on any letter of credit established by, on behalf or at the request of, the Company, or any withdrawal from, setoff against, or other application of property that is the subject of any escrow agreement or similar arrangement in which the Company has an interest, together with information sufficient to permit the Petitioners to assess the propriety of such drawdown, withdrawal, setoff, or other application, including, without limitation, the date and amount of such drawdown, withdrawal, setoff or other application and a copy of the agreement pursuant to which any such drawdown, withdrawal, setoff or other application was made and provide such notice and other information contemporaneously therewith; (b) turn over and account to the Petitioners for all funds resulting from such drawdown, withdrawal, setoff, or other application, in excess of what is expressly authorized by the terms of the contract, any related trust or other agreement pursuant to which such letter of credit, escrow, or similar arrangement has been established;

3. Requiring every person and entity that has a claim arising under a contract of insurance, reinsurance, retrocession or otherwise, written or entered into by the Company and who is a party to any action or other legal proceeding in which the Company is or was named as a party, or as a result of which a liability of the Company may be established to place the Petitioners' United States counsel on the master service list of any such action or other legal proceeding and to take such other steps as may be necessary to ensure that such counsel receives (a) copies of any and all documents served by the parties to such action or other legal proceeding or issued by the court, arbitrator, administrator, regulator or similar official having jurisdiction over such action or legal proceeding and (b) any and all correspondence, or other documents circulated to parties named in the master service list.

The Order shall remain in effect pending the hearing scheduled to be held in Room 617 of the Alexander Hamilton U.S. Custom House, One Bowling Green, New York, New York on December 5, 1996 at 2:30 p.m. Any party in interest who has not received a copy of the Order should contact counsel for the Joint Provisional Liquidators in writing at the address listed below.

Chadbourne & Parke LLP
30 Rockefeller Plaza
New York, New York 10112
Attention: Kenneth P. Coleman, Esq.

BUSINESS INSURANCE CLASSIFIEDS ASSURE TOP QUALITY RESULTS

Stocks

Continued from page 41

speculative element introduced," he said.

Even if the company is not acquired, it has a "limited downside" of a price in the mid-40s while, if it should become an acquisition target, it could be priced in the 60s or even higher.

"The beauty of American Re's speculative appeal is that even if nothing happens, you still own a first-rate market leader in the industry," Mr. Frank said.

Lehman Bros.' Mr. Wade recommends ITT/Hartford and Bermuda-based Renaissance Re. ITT/Hartford "is creating a distribution-based cost advantage, which I think very few companies, especially in the commercial industry, are able to replicate," Mr. Wade said.

He explained that the insurer is taking the technology used in the personal lines industry and introducing it to the commercial industry "and I think they'll have some success there."

Secondly, Mr Wade said, ITT/Hartford is planning to take some reserve charges in connection with losses from its asbestos and environmental as well as its guaranteed investment contract business that should remove a drag on its earnings.

Small cap companies recommended by analysts include Penn-America Group Inc., Capsure Holdings Corp., Navigators Group Inc., Philadelphia Consolidated Holding Corp. and Walshire Assurance Corp.

Penn-America, which writes commercial property and multiperil business, is "very well-managed," said John Keefe, Richmond, Va.-based vp and analyst with Ferris Baker Watts.

"Management has cultivated excellent relationships" with the 55 general agents that distribute its products in the wholesale market. "They have established a franchise value," according to Mr. Keefe.

'The beauty of American Re's speculative appeal is that even if nothing happens, you still own a first-rate market leader in the industry,' says Ron Frank.

The company also is very profitable, with combined ratios that have been consistently in the 90% to 95% range. It has enjoyed a 25% premium growth rate in the past five years, although this is expected to moderate to 15% to 20% over the next five years, Mr. Keefe said.

Penn-America also is recommended by Blair E. Sanford, an analyst with San Francisco-based Hoefer & Arnett, who said the company has "devised some fairly interesting ways of compensating producers."

Mr. Sanford's other recommendations include Capsure, which he said is likely to be either merged or sold. "I think any one of those two events equates to more value to shareholders than the price of the stock currently reflects," Mr. Sanford said.

Hew also recommends Navigators, which, he noted, recently became a corporate name with Lloyd's. The company is "a little bit misunderstood today in the market," he said. "There is softness in their core marine business, but I'm somewhat excited about their upcoming activities with Lloyd's as a corporate name."

Philadelphia Consolidated, he said, has "very decent second-quarter results. . .and given my confidence in management, I think there's some good upside here in the stock and at the current price level."

Mr. Keefe also recommends York, Pa.-based Walshire Assurance, a company that he said specializes in insuring small, long-haul trucking firms. The market is "pretty competitive," with large insurers coming in and out of the business.

Walshire Assurance, however, has been extraordinarily profitable, with combined ratios in the high 80s to low 90s "for as long as I'm aware."

"Their reserve practices have borne out the company's conservative management. They've had redundancies in nine of the past 10 years," said Mr. Keefe.

The company also has a conservative investment portfolio as well as "plenty of room for growth. We think they're going to grow 20% top line and bottom line going forward." Walshire had a 1.48-to-1 premium-to-surplus ratio as of the end of 1995, said Mr. Keefe. BI

Services Guide

Business Insurance

Circulation Breakdown
Commercial Consumers

Administrative:	
CEO's, Presidents, and Owners	1,790
Vice Presidents, General Managers and Other Administrative Personnel	4,961
Financial:	
Chief Financial Officers and Vice Presidents of Finance	3,172
Secretaries, Treasurers, controllers and other Financial Personnel	3,028
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	17,213
Sub-total	**30,164**
Associations	311
Government, Unions and Educational Institutions	881
Commercial Consumers Sub-total	**31,356**
Insurance Agents and Brokers	8,013
Insurance Companies	7,685
Accountants, Actuaries, Attorneys & Consultants	3,586
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,858
Others Allied to the Field	1,091
Total Qualified	**53,589**
Non-qualified	7
TOTAL CIRCULATION	**53,596**

★ *Source Business/Occupational breakdown of qualified circulation, Novermber 27,1995 Issue, as submitted to BPA for December 1995 BPA Publisher's Statement*

Carpal tunnel claims may soar, study says

By MEG FLETCHER

BOCA RATON, Fla.—Carpal tunnel syndrome injuries are rapidly increasing as an expensive cause of workers compensation claims, though a new study finds that the average total cost of the claims is decreasing.

"In the last few years, there has been a striking increase in the number of CTS injuries reported in the workplace," according to a study conducted by the National Council on Compensation Insurance Inc. in Boca Raton, Fla. The non-profit organization collects data, files advisory rates and operates residual markets in dozens of states.

Carpal tunnel claims were filed 55.2% more often between 1991 and 1994, compared with all other lost-time claims, which portends a "potentially dramatic" increase in the next decade, the study says.

The study analyzed data from 126,404 claims, including 3,279 carpal tunnel ones, which were drawn from NCCI's detailed claims information covering 40 states and the District of Columbia.

However, the overall frequency of carpal tunnel cases reported in 1994 was only 1.97%, up from 1.27% in 1991.

"CTS is caused by constant, repetitive flexing of the tendons located in the wrists between the carpal bones. The constant flexing builds up the protective sheath surrounding the tendons, which in turn increases pressure in the joint," the 11-page study explains. The onset of carpal tunnel syndrome occurs when the median nerve, which runs through the wrist, becomes compressed.

Carpal tunnel syndrome symptoms begin with stiffness, tingling and pain in the injured worker's wrists, fingers and forearms. As it progresses, the worker also may feel soreness in the arm, shoulders and neck. Eventually, the worker may lose the ability to grasp objects.

Routine treatment may include use of splints and anti-inflammatory drugs, as well as surgery. From 1991 to 1993, a typical worker needed 142.8 days to return to work and 243.9 days to reach maximum medical improvement, the NCCI study found.

Average lost wages and medical costs were $12,730 per claim, the third-highest amount spent in 10 injury categories. Carpal tunnel syndrome costs were exceeded only by $19,036 spent for amputations and $15,639 for a category that combined fractures, dislocations and crushing injuries.

However, an analysis of accident year data from 1991-1993 found that "the difference between CTS claims and all other claims is getting smaller," said Jennifer Kish, an NCCI researcher who co-authored the report. That amount dropped to 4.7% in 1993 from 9.8% in 1992 and 34.2% in 1991.

The relative drop in costs may have been spurred by new medical procedures and increased employer awareness, she said. Both factors reduce recovery time and speed returns to work.

"Treatment procedures are getting better because doctors are coming up with less invasive surgery techniques," she said.

"New treatments and surgery are beginning to see better results," though they are only in their early stages, the study said. They include an endoscopic surgical procedure and a non-traditional "carpal tunnel release operation," a 15-minute procedure requiring only a small incision and an average two-week recovery period.

In addition, "employers are probably more aware of CTS, and they may be doing more loss prevention and are more aware of the necessity of modifying work for an employee with CTS," Ms. Kish said.

Workers most at risk for carpal tunnel syndrome during 1991-1994 were employed by manufacturers, 49.7% of cases; office/clerical, 21.4%; goods/services, 20.5%; construction, 4.8%; and other, 3.7%.

The study also found "strikingly different" characteristics of carpal tunnel syndrome claims compared with all other workers comp claims:

- Women filed 68.1% of all carpal tunnel claims, but only 31.1% of all other workers comp claims.

This is at least partially explained by the preponderance of women working in high-risk occupations such as clothing manufacturing and office/clerical posts where they perform assembly work and use keyboards frequently, the study said.

- Surgery is performed in 42% of all carpal tunnel cases, compared with 14.8% of all others.
- Employers or insurers successfully challenged 8.3% of all carpal tunnel syndrome cases, compared with 6.3% of all others.
- Attorneys were involved in 18.8% of carpal tunnel syndrome cases, compared with 13.6% of all others.

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Single copies of the study, "Carpal Tunnel Syndrome in Workers Compensation: Frequency, Costs and Claim Charqcteristics," are available for $35 through InsNet, the NCCI's online service. To access InsNet, call NCCI customer service at 800-622-4123.

Letters

Continued from page 8

Business Insurance's reputation and integrity would have left a one-sided and misinformed article to the opinion page, if printed at all.

It is important that *Business Insurance* readers see that temporary workers are not, as Mr. Lev alludes, widely perceived as second-class employees but instead are productive and reliable workers.

I urge *Business Insurance* to professionally and thoroughly analyze the temporary help industry.

Show your readers its tremendous growth, how large and small business are benefiting from temporary services and the code of ethics established by the National Assn. of Temporary Services, among other positive developments.

Tom Bokosky
Director, Risk Management
Remedy Intelligent Staffing
San Juan Capistrano, Calif.

Business Insurance welcomes letters to the editor. The Letters section is intended to be a forum for readers' opinions and comments. Business Insurance reserves the right to edit letters for clarity or space. We will not publish unsigned letters. Please send your letters to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590; fax: 312-280-3174; e-mail: pwinston@crain.com.

Brokers

Continued from page 2

Alexsis Inc., which A&A sold at the beginning of 1995, explained Alan Kershaw, vp and treasurer of the New York-based brokerage.

Robert H. Hilb, chairman and chief executive officer of Glen Allen, Va.-based Hilb, Rogal & Hamilton, said the broker's nearly 5% drop in profits so far in 1996 would be an increase if results included the sale of its Green Bay, Wis., office in 1995.

And Aon Group's 5.6% drop in pretax net income for the first six months includes a $22.4 million special charge related to an early retirement program in the second quarter. Without the special charge, pretax income increased 12%.

While primary property/casualty prices remain flat, the downswing in catastrophe reinsurance premiums also is stunting revenue growth at brokerages with significant reinsurance brokerage operations.

Reinsurers report nationwide property catastrophe reinsurance rates are down about 10% during midyear renewals (*BI*, July 1).

"The reinsurance market is off," said Michael J. Cloherty, executive vp at Arthur J. Gallagher & Co. in Itasca, Ill. "We're lucky it doesn't affect us too much."

That is not the case for other brokers.

First-half broker results

(In millions of dollars)

Broker	Gross revenues	% change from 1995	Net income (loss)	% change from 1995
Marsh & McLennan	$2,114.5	11.4%	$258.3	14.0%
Aon Group	947.3	10.1	120.0[1]	(5.6)
Alexander & Alexander	649.5	(0.4)	34.6	(46.3)
Acordia	327.6	23.1	14.1	6.5
Arthur J. Gallagher[2]	203.3	5.7	15.3	24.0
Hilb, Rogal & Hamilton	81.0	6.6	7.8	(4.9)
Poe & Brown	59.3	12.0	7.8	10.1

1 Pretax 2 Restated 1995 figures
Source: Company reports.

GRAPHIC BY LISA KRUSS

When adjusted for foreign currency fluctuation, Marsh & McLennan Cos. Inc.'s reinsurance brokerage revenues were down 10% for the first six months of 1996.

"When we looked at January renewals, we knew, unfortunately, this is the way it's going to be for the rest of the year," said J. Michael Bischoff, vp-corporate development.

Despite the drop in reinsurance brokerage revenues, M&M's total revenues grew 11.4% in the first six months, fueled mostly by The Putnam Cos., its investment management subsidiary, and the sale of its U.K. insurance program management group.

A&A's results were a little below expectations in part due to lower results from its London-based reinsurance and wholesale brokerage business, Mr. Kershaw explained.

Revenues from Alexander Howden Group Ltd. are down 3.3% in the first six months to $151 million from $156.1 million in 1995. While the broker no longer breaks out revenues from its reinsurance and wholesale brokerage businesses, Mr. Kershaw said the decline "is principally due to the reinsurance market."

In the meantime, brokers continue to conduct business in a very competitive marketplace.

"It's kind of a wild and willy time," said J. Hyatt Brown, chairman and CEO of Poe & Brown Inc. in Tampa, Fla. "Every account is like a jump ball. You almost don't know which (insurer) will come out of the woodwork with a quote on an aggressive account."

"It's a constant battle," Mr. Hilb said of the market. "There is still a softness out there...a nagging type that won't go away. If it cooled off a little bit, it would be wonderful."

Individual results of the largest publicly held U.S. brokers follow:

Marsh & McLennan

Revenues for the first six months of 1996 increased 11.4% at the world's largest broker to $2.1 billion from $1.9 billion in 1995. Profits also were up, increasing 14% to $258.3 million from $226.6 million.

Second-quarter results include an extra $33.2 million M&M gained on the sale of its U.K. insurance program management firm, The Frizzell Group Ltd.

Excluding the Frizzell sale, foreign exchange rates and some small sales, U.S. insurance brokerage revenues increased 5% in the first six months and international brokerage revenues rose 8%, Mr. Bischoff said.

While reinsurance brokerage revenues are down, aviation, marine and energy and international specialty practices have produced double-digit growth so far in 1996, he said.

Rounding out the New York-based broker's six-month results: The Putnam Cos. reported a 45.9% growth in revenue, to $503.7 million from $345.2 million during the same period in 1995; and M&M's consulting unit, which includes revenues from William M. Mercer Inc., rose 10.6% so far in 1996 to $570.2 million from $515.5 million in 1995.

Aon Group

First-half revenues increased 10.1% to $947.3 million from $860.7 million. Pretax net income was down, however, to $120 million, a 5.6% slide from $127.1 million in 1995.

During the second quarter, Aon Corp. took a $30.2 million pretax charge relating to an early retirement program introduced internationally and domestically.

Of the charge to earnings, $22.4 million relates to Aon Group, said Patrick G. Ryan, chairman and CEO of the brokerage unit and its Chicago-based parent.

In addition to improving efficiency and productivity, "we've had very good luck in our consolidation strategy using early retirement as a way to reduce payroll," he said. "It helps make consolidation work while giving people a very good package."

The approximately 450 people who opted for the package will save Aon about $70 million in payroll expenses, Mr. Ryan said.

Excluding the special charge, Aon Group's pretax profits are up 12% for the first half of the year.

"We're quite pleased with that," Mr. Ryan said.

Alexander & Alexander

Revenues for the first half of 1996 decreased a modest 0.4% to $649.5 million from $652.3 million in the first half of 1995. Profits declined 46.3%, to $34.6 million from $64.4 million last year.

Excluding foreign exchange rates and sold operations in 1995, revenues were up 2.3% for the first half, Mr. Kershaw said.

He attributes the first-half profit decline to sold operations in 1995 and the soft market.

While first-quarter revenues were down 3%, second-quarter revenues rose 2.2% to $335.2 million, compared with $328.1 million in 1995.

"The quarter is marked by good performances in our U.K. retail unit, Alexander Consulting and our Asia Pacific business," Mr. Kershaw said. However, "two of our largest businesses (North American retail and specialty and reinsurance) are under pressure because pricing is weak."

The brokerage held expenses in check in the first half, posting only a 2% increase to $582.9 million from $571.4 million in 1995.

Acordia

Revenues at the Indianapolis-based broker increased 23.1% during the first half to $327.6 million from $266.2 million in 1995.

Profits were up 6.5% in the first half of this year to $14.1 million from $13.3 million the year before. First-half 1995 profits had dropped 18.1% from the same period in 1994.

"This is the second indication that we are right on track," said Patrick M. Sheridan, executive vp and chief financial officer. The first indication came in the first quarter, when profits increased 1.3%.

While results are "slightly ahead of expectation," he said he expects the second half to be even better.

Of the 23% revenue growth so far in 1996, the largest increase among the top U.S.-based publicly held brokers, 9% was derived internally. The remainder is acquisition-fueled.

While Acordia executives have said they are not going to make any large acquisitions in 1996, they did purchase two smaller agencies during the second quarter: Flat Top Insurance Agency, a property/casualty agency in Bluefield, W.Va., will become a part of Acordia West Virginia; and Rothschild, Bell & Walseth Agency Inc., a St. Paul, Minn.-based property/casualty agency, will become a part of Acordia of Minnesota. Terms were not disclosed.

Arthur J. Gallagher

Revenues increased 5.7% during first-half 1996, to $203.3 million from $192.3 million in the same period last year. Profits soared 24% to $15.3 million from $12.3 million in 1995.

"We're extremely pleased with our results," Mr. Cloherty said. "We're hanging in there."

He attributes the results to the broker's ability to deliver products efficiently and at the same time have revenues outpace expenses.

While revenues increased 5.7% over the first six months, expenses increased a modest 4%. That 2% margin gave way to a 24% increase in profits, Mr. Cloherty said. "It shows the power of watching costs."

During the second quarter, Gallagher announced its third-party administration subsidiary, Gallagher Bassett Services Inc., formed a joint venture with A.C.I Adjusters Canada Inc. called Gallagher Bassett Adjusters Canada Inc.

The Toronto-based venture provides claims management, information management, loss control and appraisal services for the Canadian workers compensation market.

In June, Gallagher acquired Phoenix-based Alliance Insurance Group Inc., and in July bought San Francisco-based Lamberson Koster & Co. Terms were not disclosed.

Hilb, Rogal & Hamilton

First-half 1996 revenues increased 6.6%, to $81 million from $76 million in the same period in 1995. Profits, however, slipped 4.9%, to $7.8 million from $8.2 million in 1995.

The California workers comp market "really hurt us," Mr. Hilb said. However, "we're comfortably ahead of last year because of acquisitions rather than an increase in premium rates, which doesn't exist," he said of the broker's top-line growth.

As for profits, Mr. Hilb said if the roughly $1.5 million gain on the sale of its Green Bay, Wis., office is excluded from 1995 results, "profits are up significantly."

In May, HRH acquired Clover Insurance Agency and substantially all of the operating assets of Clover Insurance Benefits & Service Inc. The new unit, located in Ontario, Calif., specializes in the dairy industry. In June, HRH completed three acquisitions: Agency One Weaver Financial Group Inc. in Mesa, Ariz.; Don C. Tardy Insurance Agency Inc. in Hereford, Texas; and Assurance Inc. in Washington. Terms of all the acquisitions were not disclosed.

Poe & Brown

Revenues increased 12% to $59.3 million in the first six months of 1996, compared with $53 million during the same period last year. Profits rose 10.1%, to $7.8 million from $7.1 million in 1995.

Of the top-line growth, 5% comes from internal growth; the rest is due to acquisition, Mr. Brown said.

During the second quarter, Poe & Brown acquired Atlanta-based B&R International Inc., doing business as Boger, Reid & Flournoy. Terms of the deal, which was effective April 1, were not disclosed. BI

Possible sale of Am Re has industry talking

PRINCETON, N.J.—The possible sale of American Reinsurance Co. to another direct reinsurer would likely realign the rankings of the top domestic reinsurers but is not expected to have a direct impact on rates.

Rumors are circulating on Wall Street that leveraged buyout firm Kohlberg Kravis Roberts is holding talks on the sale of its majority stake in American Re. KKR bought the reinsurer from Aetna Life & Casualty Co. in 1992 for $1.4 billion in a leveraged buyout and subsequently took American Re public (*BI*, Feb. 1, 1993; April 20, 1992). American Re's sale price could range from about $2 billion to $3.5 billion, market analysts say.

Attention has primarily focused on other direct reinsurers as potential buyers of American Re, including Employers Reinsurance Co.

Based on 1995 net premiums written, a combination of Employers Re and American Re would create the largest domestic reinsurer, moving ahead of General Reinsurance Corp., even after Gen Re's planned acquisition of National Reinsurance Corp. is taken into account (*BI*, July 8). A combined Employers Re/American Re would have $4 billion in 1995 premiums vs. Gen Re/National Re's $3.3 billion.

Employers Re declined to comment.

Other potential suitors are two direct reinsurers, Swiss Reinsurance Co. and Munich Reinsurance Co., both of which would significantly strengthen their U.S. operations with an American Re acquisition.

However, a spokesman for Munich Re said, "We were not approached and are not in a bidding process, if there is any." Swiss Re could not be reached for comment.

Officials of American Re and KKR declined to comment.

—By Judy Greenwald

Portability

Continued from page 1

existing medical condition exclusions will be small, employers do face the task of overhauling their health care plans.

Seventy percent of traditional indemnity plans and preferred provider organizations have preexisting medical condition exclusions, according to A. Foster Higgins & Co. Inc.

However, not all health care plans exclude coverage for preexisting medical conditions. Under federal law, federally qualified health maintenance organizations are barred from denying coverage for pre-existing conditions. Non-federally qualified HMOs for competitive reasons also typically provide coverage for pre-existing conditions.

In addition, some large self-insured employers with relatively low employee turnover rates do not deny coverage for pre-existing conditions.

Passage of the health care portability legislation, which contains several other employee benefits-related provisions, comes almost two years after the collapse of President Clinton's effort to win passage of a sweeping reform measure.

After that failure, the administration acknowledged that it overreached and would next time seek more limited reforms.

This reform effort, though, started in Congress and was bipartisan from the very beginning. One year ago, a health care portability bill sponsored by Sens. Nancy Kassebaum, R-Kan., and Edward Kennedy, D-Mass., unanimously cleared the Senate Labor and Human Resources Committee. The full House passed a portability bill earlier this year and the Senate followed a few months later.

But there were plenty of sparks along the way. Action on the legislation stalled while Republicans and Democrats squared off on whether tax-favored medical savings accounts should be included in the measure. A compromise was finally reached that allows a pilot test of MSAs (see story, page 46).

Sparks also flew over a provision in the Senate bill to require health care plans to provide the same coverage for mental disorders as for physical ailments. The provision was dropped after heated debate.

Despite their differences, Republicans and Democrats kept the negotiations going to try to reach an agreement on a portability bill.

"In the final analysis, Democrats and Republicans believed that some type of health care reform was in their best interests" and that of the country, said James Klein, president of the Assn. of Private Pension & Welfare Plans in Washington.

Republicans, Mr. Klein said, were anxious to prove their leadership abilities and get legislation passed, while Democrats wanted to shed their association with the "Big Government" health care package that President Clinton advanced. BI

Security

Continued from page 1

be concerned because of the threat to the civil aviation system."

But, even as evidence last week increasingly pointed to a bomb as the cause of the TWA crash, risk managers generally were not reevaluating their companies' travel safety efforts. Their stance was that they already had done as much as they could.

"It's not realistic to expect employees to do anything different to avoid the risk," said Scott K. Lange, director of risk management for Redmond, Wash.-based Microsoft Corp. "We have to rely on the FAA and airports for security," he said.

One additional measure that Microsoft has taken recently, though, is subscribing to an online intelligence service that provides warnings about potential trouble spots worldwide and about which airlines may be terrorist targets.

Microsoft loads the service onto its intranet system so company employees worldwide have access to it 24 hours a day.

Various security and risk management consultants offer such information for a fee either online or via fax.

For example, Kroll Associates Inc. of New York, the security consultant for American International Group Inc., continually updates travel bulletins on the safety, security and convenience of traveling to more than 250 cities worldwide, according to Chris Marquet, managing director of Kroll Information Services. It also includes information on a locale's food, health services, monetary exchange rate and time zone.

Kroll offers more detailed security reports for risk managers.

Ackerman's Executive Digest, which is part of the company's Risknet electronic information service, twice daily updates travelers on major events worldwide, analyzes the events and advises travelers on precautions they should take.

Also available are six- to seven-page forecasts on 81 countries that analyze terrorist activities, street crime and political and economic stability. They are updated once or twice annually. One- or two-paragraph summaries of the countries are updated frequently, said Joe Kiehl, director of special projects for Ackerman, Chubb Corp.'s security consultant.

Brian D. Casey, director of risk management and loss prevention for Corning Inc. of Corning, N.Y., advised resurrecting some travel precautions that were common during the Persian Gulf conflict: Use foreign airlines when flying overseas, and do not affix any eye-catching tags or labels to luggage that would easily identify the owner as a U.S. citizen.

Shortly after the TWA incident, the FAA imposed several additional security measures on airlines. Those include more intense screening of passengers on international flights, increased screening of carry-on baggage on all flights and greater controls on cargo.

Both TWA and Atlanta-based Delta Air Lines Inc. had already implemented many of those measures before the TWA crash, spokesmen said.

Federal law prohibits airlines and airports from commenting on their security measures. But, travel and security experts assert that even with the new security measures, U.S. airline security still is not as tough as it can be. The benchmark for airline security is generally regarded as El Al Israel Airlines.

El Al's security checks take an hour longer than other airlines', said Ira J. Furman, a former deputy director of the National Transportation Safety Board and currently an independent attorney. He also heads Esquire Private Investigations in Long Island, which provides security for shippers and cargo air carriers at Kennedy Airport.

El Al's security remains at such a consistent high level because it is run independently from the airline by the Israeli government, he explained.

"It's probably the only airline in the world that has X-rayed cargo and air freight," said John Clayton, a travel consultant who hosts a travel segment for several West Coast radio stations.

The lack of such a security measure at other airlines "scares me to death," said the former public relations executive for several airlines worldwide, who nonetheless heralds the safety record of the world's major airlines.

El Al security also uses a device that checks freight for pressure-sensitive bombs, he said.

El Al security likewise puts passengers through a rigorous screening. "They pound the hell out of you on the security of your bags," Mr. Furman said.

Another "cost-effective" security measure that many other countries impose but was missing from the FAA's new list would be to require everyone who checks baggage to board the airplane, he said.

Reinstating the 10% airline ticket excise tax that Congress let expire last year and boosting it to 12% also would generate $1 billion annually that could be used to bolster airport security, Mr. Furman said.

That additional money in the national trust fund for financing airport equipment like air traffic control equipment could be earmarked to cover the cost of devices that are designed to scan luggage for materials with the density of known explosives, he said. Only the airports in Atlanta and San Francisco are testing those devices now, according to Mr. Furman.

A provision that would reinstate the 10% excise tax was included in the minimum wage bill, H.R. 3448, which was reported out of a conference committee late last week.

The pipe bomb that exploded July 26 in Atlanta's Centennial Park killed a visitor, led to the fatal heart attack of a foreign journalist and injured more than 100 others gathered to hear a concert.

The Atlanta Committee for the Olympic Games, the state of Georgia and AT&T Corp., the presenting sponsor for Centennial Park, have guaranteed payment of any uninsured medical bills for victims of the blast, an ACOG spokeswoman said.

ACOG's primary property and casualty coverage for the Games is written by Fireman's Fund Insurance Co. in Novato, Calif. It was placed by Johnson & Higgins in Atlanta.

Like other security consultants, Mr. Ackerman described the Atlanta pipe bomb as a "primitive" device that looked like the work of one or two "deranged" individuals or a right-wing militia. It was not an extraordinary event from which authorities can glean any useful information about terrorist activity, he said. "So, there's no impact on corporate America."

According to FBI statistics, a total of 4,504 explosive devices either were planted or were recovered in law-enforcement searches nationwide in 1994, the last year for which figures are available. Of those, 1,752, or 39%, were pipe bombs. Thirty-one people were killed and 308 were injured that year when explosive devices detonated.

The TWA crash, the Atlanta bombing and other bombings on U.S. soil in recent years will not likely prompt insurers to add a sabotage and terrorism exclusion in property policies similar to those used in the United Kingdom, said Daniel O'Donovan, a managing director at Marsh & McLennan Cos. Inc. in New York. "We are a long way away from imposing an exclusion for terrorism or sabotage in the U.S."

The U.K. exclusion was added because of the massive property losses caused by terrorist bombs planted by the Irish Republican Army, he noted. The Atlanta bomb caused little property damage. Even the World Trade Center bombing did not cause the same amount of damage as IRA bombings have in London, he said.

Several brokers and insurers said the Atlanta bombing also should not have any impact on the special events insurance market, because of the overall softness of the property/casualty market.

"The industry can sense this was an unfortunate occurrence," said Bryan S. Reid, senior vp in the specialties division at Zurich Insurance Co. of New York.

But, security at special events likely will change.

Some of those changes may not be discernible to the public. For example, there likely will be more emphasis on matching the training of security personnel to the type of threat an event may face, said Larry Jorgenson, vp of banking, entertainment and special events for Encino, Calif.-based Pinkerton's, which provided security support for about 25 companies that either sponsored events during the Games or are located

See **Security** *on next page*

Other benefits of reform bill

Long-term care, MSAs addressed

WASHINGTON—While the heart of the health care portability bill will curb pre-existing medical condition exclusions, the measure contains several other employee benefits-related provisions. Those provisions include:

• Giving tax-favored status to long-term care benefits, a provision long sought by insurers and one that will give a boost to employer-provided programs.

Under this provision, employers could pay—up to certain limits—employees' long-term care premiums without employees being taxed on those contributions.

For example, for employees up to age 40, up to $200 in employer-paid premiums per year would be tax-free to employees.

This tax-free limit would increase with every 10 years of age until the limit hit $2,500 for employees more than age 70. The policies could provide benefits of up to $175 a day, a limit that would be increased annually to match changes in the medical care component of the Consumer Price Index.

• Expanding COBRA benefits. This provision would clarify current law to make clear that COBRA beneficiaries who become disabled during the first two months of collecting COBRA benefits would be eligible to purchase an additional 11 months. Employers, though, would be able to charge these individuals a premium equal to 150% of the group rate. Employers can charge all COBRA beneficiaries a premium equal to 102% of the group rate.

This provision affecting disabled employees slightly changes current law. Under current law, employees must be disabled at the time they first become eligible for COBRA benefits to be able to purchase the additional 11 months of coverage.

• Medical savings accounts. Under this hotly contested provision, employers with 50 or fewer employees would be able to establish tax-favored medical savings accounts linked to high-deductible medical plans. Self-employed individuals also would be able to establish MSAs.

Employers could make tax-deductible contributions to MSAs of up to $2,000 a year for individual coverage and $4,000 for family coverage. Employer contributions would not be added to employees' taxable incomes nor would investment income earned on those accumulated contributions.

Employees could withdraw money tax-free from their MSAs to pay for uncovered health care expenses.

This pilot program would be limited to four years, and during that time there could be no more than 750,000 MSAs established. At the end of that four-year period, Congress would have to decide to continue the program or expand it to larger employers.

However, if Congress decided to end the MSA experiment, current MSA participants would be grandfathered and could keep and continue to contribute to their accounts.

In addition, the measure would eliminate the tax advantages associated with most leveraged corporate-owned life insurance policies as well as gradually increase to 80% from 30% the current tax deduction the self-employed can take on their health insurance premium costs.

—By Jerry Geisel

Tax bill

Continued from page 2

work for public entities, such as state and local governments, and are covered by so-called Section 457 deferred compensation plans, will have greater protection for their pension benefits: The legislation requires that plan assets be held in trust and protected from the claims of creditors.

But some provisions will increase, though modestly, costs for employers and employees. One provision, for example, increases to 10% from 5% the excise tax penalty for employers who engage in transactions prohibited under the Employee Retirement Income Security Act.

In addition, employees will lose a tax break—known as five-year forward averaging on lump-sum distributions—a change that will slightly increase the tax bite on lump-sum distributions.

But taken as a whole, employer groups welcome the enactment of the legislation as a welcome first step in simplifying pension law and encouraging more companies to offer benefit plans.

"After years of making the system more complex, legislators are beginning to undo the web of complexity," said James Klein, president of the Assn. of Private Pension & Welfare Plans, a Washington-based benefits lobbying group.

"We think this package will improve the environment for many pension plans. . .there is significant relief for major employers as well as highly compensated employees," added Mark Ugoretz, president of the ERISA Industry Committee in Washington, which represents large employers on benefit issues.

Many of the benefit provisions were included in three earlier tax and budget bills that were vetoed by Presidents Bush and Clinton. Those vetoes were unrelated to the employee benefit provisions.

But this time, President Clinton will sign the tax measure. "I guess the fourth time around is the charm," said Mr. Klein.

Benefit provisions in the package—the Small Business Job Protection Act—include changes for:

• 401(k) plans.

Employers will have a new, optional way of running non-discrimination tests on their 401(k) plans. Under this procedure, employers will be able to compare deferrals made by lower-paid employees during the previous year with contributions made by highly paid employees during the current year.

Internal Revenue Service rules require comparisons of current-year contributions for both groups, so employers must monitor those contributions constantly. If lower-paid employees put in less than expected, employers in mid-year may have to reduce contributions by highly paid employees or return excess contributions to those employees, a messy administrative task.

By using prior-year contributions of lower-paid employers as a testing base, employers will know at the start of the year how much highly paid employees can contribute without causing the plan to violate non-discrimination tests.

This new testing procedure will reduce employers' administrative costs by eliminating the need to run non-discrimination tests throughout the year, said Pam Scott, a principal with Kwasha Lipton L.L.C. in Fort Lee, N.J.

Employers with rich matching features in their 401(k) plans won't even have to run those non-discrimination tests under a safe harbor provision.

Employers that match 100% of employees' contributions on the first 3% of compensation as well as match 50% of between 3% and 5% of employees' compensation will not have to conduct the non-discrimination tests.

Few matches, though, now are actually that generous. Companies typically match 50% of employees' deferrals, up to 6% of compensation.

Other 401(k) plan-related provisions include allowing tax-exempt organizations to offer 401(k) plans, an ability Congress took away a decade ago under a 1986 tax law.

The measure also allows employers to exclude certain employees when running the 401(k) plan non-discrimination tests. Under this provision, employers would not have to count 401(k) plan deferrals made by employees with less than one year of service or those under age 21.

Under current law, employers are not required to extend their 401(k) plans to employees under 21 or those

See **Tax bill** *on next page*

Tax bill

Continued from previous page

with less than a year of service. If employers voluntarily do so, they have to count deferrals by the two groups when running non-discrimination tests.

Because new or young employees tend to be lower-paid, they are likely to make only small contributions to 401(k) plans. And that in turn, under IRS non-discrimination testing rules, reduces the deferrals highly compensated employees can make to the plans.

By excluding new or young employees' deferrals from the non-discrimination tests, employers no longer will have to worry that broadening their plans to cover the two groups will have the effect of dragging down permitted contributions by highly compensated employees.

• Highly compensated employees.

The legislation simplifies the general definition of "highly compensated" employees for non-discrimination testing purposes to those earning more than $80,000 a year or owning at least 5% of a company. That threshold would be adjusted annually for inflation. By contrast, current law contains numerous definitions of highly compensated employees, including one that covers employees earning more than $66,000.

The effect of this change would be to enable more employees—those earning $66,000 to $80,000—to make the maximum contribution to a 401(k) plan because they would be considered non-highly compensated for testing purposes.

• Multiemployer pension plans.

Multiemployer pension plans will have to use the same vesting schedules—typically five-year cliff vesting for defined benefit plans and seven-year graded schedules for defined contribution plans—that single-employer pension plans now use. Currently, multiemployer plans can use 10-year vesting.

• Adoption benefits.

The legislation gives favorable tax status to employer-provided adoption assistance benefits.

Under this provision, employers could reimburse employees for up to $5,000 in adoption-related expenses per child without that reimbursement being added to employees' taxable income.

In the case of an adoption of a child with special needs, the maximum tax-free reimbursement would be $6,000.

This tax break would be fully available to employees earning up to $75,000 a year while the tax break will be phased out for those earning between $75,000 and $115,000.

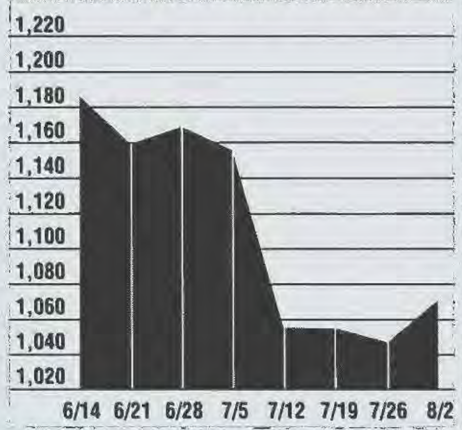
The favorable tax break for normal adoptions would expire on Dec. 31, 2001, but continue indefinitely for special needs adoptions.

• Educational assistance benefits.

The legislation retroactively extends Section 127, the now-expired section of the Internal Revenue Code that had allowed employers to reimburse employees—on a tax-free basis—up to $5,250 each year for their educational expenses. Section 127 expired Dec. 31, 1994.

The legislation will retroactively extend Section 127 from Jan. 1, 1995, through May 31, 1997, for undergraduate educational expenses. For graduate-level expenses, the tax break will apply only from Jan. 1, 1995, through June 30, 1996. BI

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: Nordby International Inc.

PCS catastrophe options

As of Aug. 2

Call spread	Price bid/ask	Call spread	Price bid/ask
Eastern September 1996		**California Annual**	
40/60	3/4	40/60	.8/1.6
50/70	1/—	80/100	.5/1.4
80/100	1.8/3.1		
Southeast Sept. 1996		**Western Annual**	
40/60	2.5/4.1	40/60	1/2
80/100	1.6/3.0	80/100	.6/1.6
Texas Sept. 1996		**Northeast Sept. 1996**	
40/60	1.2/2.2	40/60	1/1.6
80/100	.5/2	80/100	.6/2

Total volume: 0 Total open interest: 3,487

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

Security

Continued from previous page

near where the Olympic events were held.

"One of the things we'll definitely do is go through the bomb-threat procedures" with policyholders, said Patrick Hoffman, senior vp in charge of loss control for K&K Insurance Group Inc. of Fort Wayne, Ind., a managing general agency subsidiary of Aon Corp. Policyholders "really don't take the time to practice" evacuations or searches, he said.

Some of the more visible changes will be seen in admission controls, said Alexander Berlonghi at Event Risk Management, a risk management consultant in Dana Point, Calif. People were permitted into Centennial Park to a free concert without having to pass through metal detectors, which were used at admission points at other Olympic sites.

Corporate security officers should concentrate not only on making their facilities secure, but also they should ensure that they appear to be more secure than surrounding facilities, Pinkerton's Mr. Johns said.

"If they had had tighter security at Centennial Park it would only have driven the bomber to the next softest target."

Determined terrorists may not have been deterred by increased security at Centennial Park, said Rick Moscicki, a principal at Tillinghast-Towers Perrin in Dallas.

"There was so much equipment going in there, all they would have to do is, say, place a device in one of the speakers being taken in and then set it off at a distance. How can you defend against that? Are you really going to start examining every instrument?" he said.

The added cost of securing special events may scare away some potential sponsors and discourage others from promoting them extensively, Pinkerton's Mr. Jorgenson said. But, he does not expect it to impact major events.

Maintaining tight security is easier at private, less publicized events than it is at public venues, said John T. Horn, senior managing director for Kroll. "Obviously, the bigger the event, the more likely it is to attract the attention of disaffected or disturbed people."

Security procedures for the Republican Convention in San Diego likely will tighten in light of the TWA crash and the Atlanta bombing. "Certainly, already tight security will get tighter," said Paul Manafort, convention manager for the presidential campaign of Robert J. Dole, the former U.S. Senator from Kansas.

More security measures for the Democratic National Convention in Chicago were announced last week, but the plans had been formulated over the past year, said Mayor Richard M. Daley. Those plans include closing streets around the United Center and re-routing traffic. BI

Law raises issues for captive entities

WASHINGTON—The new tax law will create new burdens for certain tax-exempt shareholders of offshore captive insurers.

The legislation, which President Clinton will sign, would require certain tax-exempt shareholders of captives that are controlled foreign corporations to treat their captive's earnings as taxable unrelated business.

Such tax-exempt entities currently pay no unrelated business tax, which can range up to 35% on captive earnings. This provision had been part of the House-passed tax bill but was not in the Senate's version.

As part of the compromise agreed to by congressional conferees, though, negotiators agreed to exempt hospitals and universities that are shareholders in group offshore captives from the new tax bite.

This special treatment for certain types of captive owners, but not others, concerns some captive experts. "What is the rational policy argument for distinguishing (for tax purposes) some tax-exempt entities from others?" asked Jon Harkavy, vp and general counsel with captive manager USA Risk Group in Washington.

—By Jerry Geisel

British Issues

Aug. 1	Price	P/E	Div.	Yield	1 week
Companies	pence		pence	%	high—low
Comml Union	598	11.5	35.3	5.9	598—580
Genl Accident	628	9.4	38.8	6.2	628—620
Gdn Royal Exch	248	9.2	11.3	4.6	248—234
Independent	488	9.1	14.1	2.9	488—458
Royal & Sun	386	9.2	21.6	5.6	386—367
Brokers					
Bradstock	71	11.8	7.1	10.0	71—71
Fenchurch	94	6.3	10.6	11.3	94—94
CE Heath	93	10.9	6.3	6.8	95—93
JIB Group	106	10.5	9.4	8.9	108—106
Lloyd Thmpson	182	11.2	11.3	6.2	182—181
Lowndes Lmbrt	130	8.5	10.5	8.1	130—130
Nelson Hurst	185	11.3	9.8	5.3	186—185
Sedgwick Grp	125	9.8	8.1	6.5	127—123
Steel Brl Jones	39	5.1	5.6	14.3	39—39
Willis Corroon	139	12.5	8.3	6.0	143—139

Source: Philip Olsen, London

BI Industry Stock Report JULY 29, 1996, THROUGH AUG. 2, 1996

		Price	Weekly % change	Year to date % change	Year to date High	Low	Vol.(000)
BROKERS							
Acordia Inc.	NYS	31	0.00	4.20	33.75	23.50	18
Alexander & Alexander	NYS	17.125	0.74	-9.87	25.50	16.00	566
E.W. Blanch Holdings Inc.	NYS	19.25	3.36	-17.65	25.50	16.50	57
Gallagher Arthur J. & Co.	NYS	31.625	-0.39	-15.10	39.50	30.00	85
Hilb, Rogal & Hamilton	NYS	13.125	0.96	-1.87	14.38	11.38	58
Kaye Group Inc.	NDQ	4.75	1.33	-40.63	8.75	4.63	132
Marsh & McLennan	NYS	92.25	3.07	3.94	101.63	77.75	620
Poe & Brown	NDQ	23.75	1.06	-4.52	25.50	22.75	8
BROKERS	AVERAGE		1.3	-10.2			
INSURERS/REINSURERS							
ACE Ltd.	NYS	44.375	0.85	11.64	50.38	29.00	966
Acceptance Insurance Cos.	NYS	18.125	2.11	21.85	18.63	13.13	33
AEGON N.V.	NYS	48.375	8.10	9.94	50.38	33.25	47
Aetna Life & Casualty	NYS	59.125	-1.46	-14.62	78.75	55.38	6504
AFLAC Inc.	NYS	34.5	9.09	18.97	34.50	24.38	1458
Allied Group Inc.	NDQ	35.5	-0.35	-1.39	44.25	28.50	419
Allmerica Prop. & Casualty	NYS	26.5	1.44	-1.85	27.25	21.88	50
Allstate Corp.	NYS	46	3.08	11.85	46.75	29.88	3618
AMBAC Indemnity Corp.	NYS	49.25	2.34	5.07	55.25	39.88	383
American Bankers Ins.	NDQ	42	3.70	7.69	44.25	31.38	275
American Financial Group	NYS	31.125	5.96	1.63	34.50	25.25	280
American General	NYS	35.375	2.54	1.43	39.13	31.00	1033
American Heritage Life Ins.	NYS	19.125	-3.16	-16.39	24.25	18.88	168
American Indemnity/Fin'l	NDQ	10.25	-2.38	2.50	13.38	9.00	1
American International	NYS	98.875	7.04	6.89	103.38	72.13	3728
American Re Corp.	NYS	58.25	14.50	42.51	58.25	34.00	2601
Aon Corp.	NYS	49.5	1.54	-0.75	56.00	36.25	336
Argonaut Group	NDQ	29.5	0.85	-9.23	35.00	28.88	191
AVEMCO Corp.	NYS	15.625	4.17	-2.34	17.50	11.75	19
Baldwin & Lyons Inc.	NDQ	18.25	-5.19	12.31	20.75	14.25	11
Berkley W.R. Corp.	NDQ	41	1.23	-23.72	55.50	37.50	259
Berkshire Hathaway Inc.	NYS	31400	0.00	-2.18	38000.00	24200.00	1
Capital RE Corporation	NYS	34.875	4.89	13.41	38.25	26.50	63
Capsure Holdings Corp.	NYS	17.75	-0.70	0.71	18.75	13.00	139
Chartwell Re	NDQ	21.5	-1.15	NA	24.75	10.00	39
Chubb Corp.	NYS	45.75	8.28	-5.43	52.25	40.88	3685
CIGNA Corp.	NYS	109.875	2.69	6.42	125.50	80.50	990
CNA Financial Corp.	NYS	102.625	3.14	-9.58	123.25	88.75	89
EMC Insurance Group Inc.	NDQ	12	-11.11	-12.73	15.25	10.13	50
Everest Reinsurance	NYS	25.125	5.24	7.49	26.50	18.50	848
Executive Risk Inc.	NYS	35.25	2.92	21.55	38.25	18.75	30
EXEL Ltd.	NYS	34	2.26	11.70	36.88	25.88	993
Fremont General Corp.	NYS	25.75	9.57	5.10	26.25	17.75	374
Frontier Insurance Group	NYS	34.625	6.13	8.20	38.00	27.00	65
Gainsco Inc.	ASE	10.125	8.00	-10.99	12.38	8.31	181
GCE Holding Ltd.	NDQ	23.125	0.54	NA	27.25	19.75	268
General RE Corp.	NYS	152.375	2.35	-1.69	158.25	130.00	1199
Gryphon Holdings	NDQ	14.25	2.70	-25.97	20.25	13.75	15
Guaranty National Corp.	NYS	14.625	4.46	-4.88	18.13	13.38	127
Harleysville Group	NDQ	25.125	0.00	-22.39	33.00	25.00	75
Hartford Steam Boiler	NYS	44.25	0.85	-11.50	52.50	43.25	191
HCC Insurance Holdings	NYS	27.875	13.20	50.68	27.88	10.25	359
IPC Holdings Ltd.	NDQ	19.875	0.00	NA	22.25	19.00	110
ITT Hartford Group	NYS	54.125	6.39	11.89	54.75	44.50	833
LaSalle Re Ltd.	NDQ	23.25	9.09	NA	23.63	19.50	143
Lincoln National	NYS	44.5	5.01	-17.21	57.00	39.88	951
Markel Corp.	NDQ	86	1.18	13.91	94.50	59.50	28
MBIA Insurance Group	NYS	78.375	4.67	4.50	80.88	65.25	466
Meadowbrook Insur. Group	NYS	26.125	-2.34	-22.01	34.13	24.00	13
Mid Ocean Ltd.	NYS	41.625	3.74	12.12	43.00	30.88	123
MMI Cos. Inc.	NYS	32.125	3.63	33.85	32.13	19.75	29
Mutual Risk Mgmt. Ltd.	NYS	28	2.28	-18.40	34.88	25.63	136
NAC Re Corp.	NYS	35.375	3.28	-1.74	39.00	28.50	425
National Re Corp.	NYS	51.75	0.73	36.18	51.75	30.00	178
Navigators Group	NDQ	18	9.09	2.13	20.25	13.50	53
Nobel Insurance Ltd	NDQ	11.0625	0.57	-2.75	12.75	10.13	21
Ohio Casualty Corp.	NDQ	33	-3.65	-14.84	40.00	30.00	350
Old Republic Int'l	NYS	21	1.20	-11.27	24.38	17.38	521
Orion Capital Corp.	NYS	49.5	1.80	14.12	51.00	39.88	249
Partner Re Ltd.	NDQ	29.5	6.31	7.27	31.88	23.75	779
Penn-America Group Inc.	NDQ	14.5	-1.69	1.75	16.75	10.00	39
Philadelphia Cons. Holding	NDQ	17.375	2.21	6.92	22.50	15.25	192
PXRE Corp.	NDQ	22.75	0.55	-14.15	29.75	22.25	32
Reliance Group Holdings	NYS	7.875	1.61	-8.70	9.25	6.25	1449
Reliastar Financial Corp.	NYS	43	1.78	-3.10	51.63	36.25	257
RenaissanceRe Holdings Ltd.	NDQ	29.25	0.00	-3.70	33.13	20.72	0
Risk Capital Holdings	NDQ	17.75	2.16	-24.06	23.38	16.75	67
RLI Corp.	NYS	23.875	1.06	-4.50	25.88	21.75	95
St. Paul Companies	NYS	51.75	-3.27	-6.97	60.50	48.50	1359
SAFECO Corp.	NDQ	34	6.25	-1.45	39.75	28.88	2952
Seibels Bruce Group	NDQ	2	-11.11	33.33	4.25	0.44	102
Selective Ins. Group	NDQ	32	2.40	-9.86	38.75	30.75	89
Sphere Drake Holdings	NYS	8.375	-6.94	-40.18	19.13	8.38	465
TIG Holdings	NYS	28.25	0.89	-0.88	34.25	23.88	1047
Titan Holdings, Inc.	NYS	15	7.14	4.35	16.63	11.75	111
Tokio Marine & Fire	NDQ	62.625	3.09	-5.11	69.25	50.88	22
Torchmark Corp.	NYS	43.125	4.23	-4.70	49.88	38.25	1306
Transatlantic Holdings	NYS	67.75	1.69	-7.67	75.25	62.38	74
Transnational Re Corp.	NDQ	22.5	-2.17	-8.16	27.25	20.63	73
Travelers Aetna Property	NYS	26.75	2.88	NA	28.50	23.13	634
Travelers Corp.	NYS	44.875	10.12	7.49	47.25	30.88	6150
Trenwick Group Inc.	NDQ	48.75	-2.50	-13.33	57.50	45.75	156
Unico American Corp.	NDQ	7.25	1.75	16.00	7.75	5.50	63
Unionamerica Holdings	NYS	16.75	7.20	NA	18.13	14.75	40
United Fire & Casualty	NDQ	33	0.76	17.86	40.00	19.38	4
Unitrin	NDQ	46.75	2.19	-2.60	51.75	44.25	190
UNUM Corp.	NYS	61.5	0.61	11.82	63.25	45.38	662
US Facilities Corp.	NDQ	16.6875	3.49	-21.93	23.38	14.88	298
USF&G Corp.	NYS	16	3.23	-5.19	19.50	14.25	775
USLIFE Corp.	NYS	30	-1.64	0.42	33.25	26.88	368
Washington National	NYS	27.875	3.72	0.90	30.50	20.50	189
Zenith National Ins.	NYS	28	3.23	30.99	28.88	20.00	30
Zurich Reinsurance Centr.	NYS	29.75	2.59	-2.06	32.63	27.88	97
INSURERS/REINSURERS	AVERAGE		2.4	0.7			
HEALTH MAINTENANCE ORGANIZATIONS							
FHP International	NDQ	27.875	12.63	-2.19	34.25	21.75	3449
Healthsource Inc.	NYS	11.375	-15.74	-68.40	40.88	9.75	9946
Humana Inc.	NYS	16.25	-2.99	-40.64	28.88	15.00	3693
Oxford Health Plans	NDQ	37.625	0.67	1.86	55.25	23.00	9026
Pacificare Health Sys.	NDQ	68.75	1.48	-20.98	98.75	52.00	349
Safeguard Health Enter.	NDQ	20.125	10.27	73.12	20.63	10.50	31
Sierra Health Services	NYS	27.25	3.81	-14.17	36.00	24.13	304
United Healthcare Corp.	NYS	35.125	4.85	-46.27	69.00	30.00	7549
U.S. Healthcare	NDQ	52.75	0.00	13.44	55.88	30.50	0
Wellpoint Health Networks	NYS	26.25	5.00	-18.29	39.13	23.38	313
HMOs	AVERAGE		2.0	-12.3			
ALL COMPANIES	AVERAGE		1.9	-7.2			

Top advancing issues: American Re Corp., HCC Insurance Holdings, FHP International. Leading decliners: Healthsource Inc., EMC Insurance Group Inc., Seibels Bruce Group. Most active issue: Healthsource Inc. The BI Index rose 2.3%; the Dow Jones 30 Industrials rose 3.8%; the S&P 500 increased 4.2% and the NYSE Composite gained 3.8%. Average P/E: Brokers, 14.7; Insurers/reinsurers, 16.0; HMOs, 29.5.

System design: Nordby International Inc.

Cargo Vessel

Bangladesh

30 March
0800 hrs

SOME SEE A STRANDED SHIP.
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