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UPDATES

Employers winning most ADA cases, survey finds

Employers are winning more than 90% of the lawsuits that go to trial alleging violation of the Americans with Disabilities Act, a new survey shows.

Employers prevailed in 291 ADA cases decided in the federal courts in 1999, while employees won just 13, according to a survey conducted by the Chicago-based American Bar Assn.'s Commission on Mental and Physical Disability Law.

The survey was the third the commission

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House support may bode well for pension bill

By JERRY GEISEL

WASHINGTON—House passage last month of a sweeping pension reform bill significantly increases its chances, but by no means assures, Senate passage of the legislation.

Business groups were caught off guard—pleasantly so—by the overwhelming 401-25 House vote in favor of the measure, which would greatly increase the benefits that can be offered through pension plans, while also eliminating much of the red tape associated with plan administration.

"I don't think anyone expected the bill would pass by the margin that it did," said James Klein, president of the Assn. of Private Pension & Welfare Plans in Washington.

The margin of the House vote "caught everyone's attention. The Senate had been almost completely unaware of the bill," said Kyle Brown, an attorney with Watson Wyatt Worldwide in Bethesda, Md.

While the Senate may now be more aware of the bill and the support it commanded in the House, the bill's enactment is by no means a sure thing.

"This is a very popular measure, but it is not a shoo-in by any means," observed Henry Saveth, an attorney with William M. Mercer Inc. in New York.

The legislation, Mr. Saveth and others note, now faces several potentially derailing obstacles, including:

- Political maneuvering. Sen-

See **Pension** *on page 36*

Blanch defections spark court battle

By DOUGLAS McLEOD

DALLAS—E.W. Blanch Holdings Inc. calls March 20 "the worst day" in its corporate existence: the day the world's fourth-largest reinsurance broker disclosed that it would miss its first-quarter earnings target, triggering a stock price collapse that slashed $500 million from its market capitalization.

Three months later, despite stronger second-quarter results, Blanch is still feeling the repercussions.

The company is locked in a bitter legal fight with former top officers Rodman Fox and Paul Karon, who resigned to join rival broker Benfield Greig Group P.L.C. on March 20 and whom Blanch blames, in part, for the first-quarter debacle.

Some of Blanch's business has followed the two men to London-based Benfield, including Blanch's largest single account, Florida-based managing general agency Tower Hill Insurance Group Inc. Tower Hill generated $10 million to $12 million of Blanch's $244.5 million in 1999 revenues, according to a source familiar with the account.

Since then, Blanch has seen at least a dozen more officers leave, including several key officials of its New York-based E.W. Blanch Capital Markets Inc. unit.

Some of the departing executives have joined rival brokers Willis Re and Guy Carpenter & Co. Inc., while others have moved to banks, a venture capital firm and Blanch client companies.

These executives offer a variety of reasons for leaving, but one explanation recurs: Blanch's decision to bolster 1999 earnings by eliminating management cash bonuses, coupled with the share price crash that sharply cut the value of its stock incentive plan.

"People had outstanding years, worked very hard, and, at the end of the day, they didn't get paid," one executive said. "You don't wait around for that to happen again."

Another former Blanch official said he has lost money because of the fall of Blanch's stock. "It's one thing not paying (brokers), but taking money out of their pockets? That's not kosher."

The ultimate impact of the defections on Blanch remains to be seen. Officials who have quit include top producers, according to former Blanch employees, one of

See **Blanch** *on page 37*

Sax to succeed Max at helm of Lloyd's

By SARAH VEYSEY

LONDON—Max Taylor will step down as chairman of Lloyd's of London in December and will be succeeded by Sax Riley, who will serve in a part-time role.

The news follows Lloyd's announcement that the role of the chairman will change to a part-time from a full-time post. Lloyd's said Mr. Taylor played an active role in discussions about the change and, though he was invited by Lloyd's to stand for a second term of office, chose to step down as chairman when his current term ends in December.

Mr. Riley, who is now deputy chairman of Lloyd's and a director of Marsh & McLennan Cos. Inc., will succeed Mr. Taylor for one year, during which time a candidate for the new form of chairmanship will be selected.

Mr. Taylor, former group executive director of Willis, said he would return to his brokerage career in a full-time,

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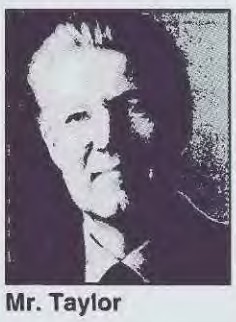

Mr. Taylor

Mr. Riley

High liability claims expected

Concorde's first disaster

By EDWIN UNSWORTH

LONDON—The crash last week of an Air France supersonic Concorde jet, which killed all passengers and crew in addition to several people on the ground, is an airline's and insurers' worst nightmare

The tragedy is not expected to result in a sharp increase in insurance rates for the aviation industry, though it may strengthen underwriters' resolve to firm up rates in general.

Estimates of hull-and-liability insurance payments for the Concorde disaster range from approximately $150 million to $350 million. While large, that amount is still far below the largest payouts on record; recompense for the 1998 crash of Swissair Flight 111, for example, may reach $1 billion.

PHOTO: AFP

The crash of an Air France Concorde into a hotel shortly after takeoff from Paris last week claimed the lives of all 109 people aboard and five others on the ground.

The crash of Flight AF4590 occurred on July 25. The supersonic Concorde crashed into a hotel near the French town of Gonesse soon after taking off from Paris' Charles de Gaulle Airport. Killed were all 100 passengers on board, nine crew members and five people on the ground.

Investigations into the crash are likely to focus on an engine problem. Flames were seen coming from one of the plane's four engines just before the crash, and a faulty reverse thruster in an engine had been replaced by mechanics shortly before the flight took off. Last Thursday, the French Accident Investigation Bureau said that initial analysis of the plane's two black-box flight recorders also revealed a problem with a second engine and with landing gear at the time of takeoff.

Although Anglo-French-built Concorde jets have been flying for almost 30 years, the only blemish on their safety record until now was a 1979 incident in which a tire burst during a landing.

The supersonic planes are used only by Air France and British Airways P.L.C., but they are the pride of their fleets and are profitable. The plane that crashed had been delivered to Air France in 1980.

The French Interior Ministry has grounded Air France's remaining five Concordes, at least until the cause of the crash has been determined.

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UPDATES

Employers winning ADA cases

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has conducted since the Americans with Disabilities Act took effect in 1992.

The first survey, covering 1992 through 1997, found that employers prevailed in 91.6% of the cases that went to trial. The second survey, which covered only 1998, found that employers prevailed in 94.4% of the cases. In 1999, the survey found, employers won 95.7% of the time.

"Most people are getting blown out of the water at the summary judgment stage," said Amy Allbright, managing editor of the ABA's Mental and Physical Disability Law Reporter, which published the survey in its May-June issue.

The survey, however, did not include cases that are settled after being filed, and those settlements typically favor employees, pointed out Susan Oxford, an attorney adviser in the general counsel's office of the Equal Employment Opportunity Commission.

Ms. Allbright said her publication had no way to track settled cases, because only a handful ever appear on the case reporting system used to identify matters related to the ADA.

The survey results can be found on the ABA's Web site at *www.abanet.org/disability/reporter/highlights.html*.

OSHA boosts self-audit policy

WASHINGTON—Employers that conduct voluntary self-audits of worksites will not be subject to citations if the hazards found are corrected and adequate steps are taken to prevent those hazards from recurring, according to the Occupational Safety and Health Administration's final self-audit policy, which appeared in last Friday's Federal Register.

The final policy will expand the definition of self-audits to include audits conducted by a third party hired by the employer, broaden the types of people who may conduct self-audits, and allow employers to provide self-audit reports as evidence of good-faith attempts to correct hazards. The policy also calls for OSHA personnel to be fully trained in the new policy to ensure that it will be applied consistently.

"We're formalizing this policy because we want employers to find and fix hazards and not fear that we'll use this information against them," OSHA Administrator Charles N. Jeffress said in a written statement announcing the policy last week. He said that self-audits would be used at the basis for citations only in rare cases, such as when an employer has ignored hazards that could result in serious injury or death.

The new policy takes effect immediately.

Few U.S. cyber risks insured

A new survey of some of the largest employers in the United States indicates that few companies have coverage to help mitigate the risks associated with e-commerce.

Of the 70 respondents—65 of which are Fortune 500 companies—only 31% have computer software and services errors and omissions coverage; 23.6% have business interruption coverage; 27.3% have patent infringement coverage; 21.8% have media liability coverage; 18.2% have crime loss coverage for e-commerce risks; 12.7% have unauthorized access and unauthorized use coverage; 5.5% have crisis communications coverage; and 1.8%have extortion reward coverage to cover costs associated with cyberterrorism.

A greater percentage—52.7%—carry traditional directors and officers insurance coverage, while 41.8% have product liability coverage, according to the survey.

The survey was conducted by the Human Resource Institute of Eckerd College, a non-profit research firm based in St. Petersburg, Fla., and sponsored by Assurex International, a Columbus, Ohio-based insurance brokerage network.

In addition to companies, the survey also polled three government agencies and two industry associations.

Of the 70 respondents, 21% said that their systems have been compromised by outside hackers; and 15% of those reported attacks that resulted in business interruptions lasting between two hours and two days. Nearly 54% said that their systems have not been hacked, while 25% said that they did not know whether they had been affected by hacking.

Another 27.1% of the respondents said that they had defended a claim of sexual harassment resulting from employee e-mail and/or Internet use. The remaining respondents said they had not.

Although insurance coverage remains limited, surveyed employers are guarding against cyber risks in other ways, the survey revealed. Nearly all the respondents, for example, have installed anti-virus software, developed firewalls and have employed full-time network administrators, the survey found.

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Errors & omissions

• A listing for Work & Family Benefits Inc. in the June 26 directory of dependent care resources and referral service providers contained incorrect compensation information. For child care and elder care services only, the rate is capitated at $3.50 to $10 per employee per year. The capitated rate for those combined services is $7 to $20 per employee per year.

PHOTO: AFP

A computer-generated picture of the Airbus A3XX.

'Superjumbo' liabilities

New jets need larger limits

By RODD ZOLKOS

The addition of so-called "superjumbo" passenger jets to the fleets of air carriers should prompt the airlines flying them and the airports they serve to review the adequacy of their insurance programs.

In both cases, the introduction of these airborne behemoths will likely mean an increase in limits. And, for the airlines, the increased hull and liability exposure the massive jetliners represent could require bringing additional players onto their insurance programs.

Airbus Industrie S.A., a European aircraft manufacturing consortium, recently announced that it would move forward with plans to build the A3XX, a plane with a minimum of 555 seats on multiple decks—compared to slightly more than 400 in a typical Boeing 747-400—with the potential to be configured to carry 800 or more passengers.

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Brown calls for dismissal of charges

By MICHAEL BRADFORD

BATON ROUGE, La.—Louisiana Insurance Commissioner Jim Brown is hoping federal prosecutors will close the Cascade Insurance Co. case now that another defendant has reached a plea agreement.

David Disiere, owner of the failed Shreveport, La.-based insurer, earlier this month became the third person indicted in the case to strike a deal with prosecutors. He will testify against Mr. Brown and co-defendants former Gov. Edwin Edwards and Cascade attorney Ron Weems.

In return for Mr. Disiere's promise to testify and a guilty plea on one felony count of concealing mail fraud by other defendants, prosecutors agreed to drop 45 criminal counts and promised that Mr. Disiere

See **Cascade** *on page 38*

AP/ WIDE WORLD PHOTOS

Louisiana Insurance Commissioner Jim Brown is under indictment in the Cascade Insurance case.

State raises bar on bias claims

Finding of pretext doesn't compel finding of discrimination

By MICHAEL PRINCE

BOSTON—A recent ruling by Massachusetts' highest court should make it easier for employers to defend themselves against job discrimination suits brought under the state's anti-discrimination statute.

The July 14 ruling by the Massachusetts Supreme Judicial Court held that a plaintiff does not automatically win a discrimination verdict if a jury or court rejects the employer's stated pretext for firing as untrue.

The decision overturned a trial verdict that awarded the plaintiff, Viatcheslav Abramian. $522,136 in compensatory damages and $750,000 in punitive damages.

The case, *Abramian vs. President and Fellows of Harvard College*, stemmed from Mr. Abramian's 1993 termination from his position as a security guard at Harvard College. Mr. Abramian sued Harvard, charging that he was terminated because he came from the former Soviet state of Uzbekistan. Mr. Abramian claimed that he was subjected to insults about his national origin and his accent from fellow employees and supervisors.

At the trial, Harvard denied Mr. Abramian's allegations and said that he had been fired because of a fight he had had with another security guard.

The jury, however, found for Mr. Abramian.

Harvard appealed the trial court verdict, claiming that the trial judge erred when he answered a question by the jury during deliberations. In giving his answer, the judge told the jury that, should it find that the pretext given by Harvard for the termination was untrue, it was compelled to render a verdict in favor of Mr. Abramian.

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INSIDE

• The Pension Benefit Guaranty Corp.'s plan to provide guidance on what can trigger a PBGC investigation of a plan is one of several efforts to improve its relationship with employers, this week's editorial says. **PAGE 8**

• William J. Miner of Watson Wyatt Worldwide of Chicago writes in Ask A Benefit Actuary that Medicare HMOs can still save employers money. **PAGE 27**

• The last fiscal year was a good one for Equitas Ltd., says Chief Executive Officer Michael Crall. **PAGE 31**

• Although many U.K. companies maintain specialty information technology departments, corporate risk managers must be involved in the management of these risks, many executives contend. **PAGE 31**

• The California Earthquake Authority may need to adjust its rates to reflect the risk of an unprecedented earthquake striking the state, a new report suggests. **PAGE 38**

Departments

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SPOTLIGHT REPORT

Managed Care Trends & Issues

Drug cost increases hard to swallow

Higher utilization among reasons prescriptions are lifting employers' expenses

By MICHAEL PRINCE

With drug expenditures growing at record rates, employers need to put on their thinking caps to devise new strategies to keep these exploding costs under control.

Overall, prescription drugs, which used to be an afterthought in the entire spectrum of health care costs, have recently moved to the forefront of employer cost control efforts. They now represent about 15% of an employer's health care costs—a figure that many experts feel will continue to grow.

One of the problems in devising a simple and effective cost-control strategy is that studies show multiple—and often conflicting—reasons why employers are paying more for drug coverage.

Although they generate a lot of publicity, the so-called lifestyle drugs, such as Viagra, are responsible for only a small part of overall drug cost increases, according to a study conducted by Protocare Sciences Inc., a health care research group based in Santa Monica, Calif. A much bigger factor is the sheer volume of drugs being prescribed, according to Dr. Bobby Dubois, chief executive officer of Protocare.

"More people are getting more drugs," he said.

The Protocare study also found that drug inflation—how much the same drug increased in cost from one year to the next—was not a major factor in driving up overall costs. In fact, volume is five times more important than drug inflation in driving up expenditures, Dr. Dubois said.

Another study, however, reached a different conclusion about the impact of inflation.

Express Scripts Inc., a prescription benefit manager, said in its 1999 Drug Trend Report that the average wholesale cost of prescription drugs jumped 17.4% compared with 1998, the highest increase ever recorded by the PBM in the seven years the study has been conducted.

The study showed that inflation is the second-largest factor in driving up expenditures, accounting for 31.2% of the increase, said Fred Teitelbaum, vp of outcome research and cost management for St. Louis-based Express Scripts.

"This is the largest we've seen, by far,"

See **Drugs** *on next page*

Disease management generating savings

By LEE FLETCHER

Employers are reaping savings—some substantial—from programs that seek to aggressively monitor and treat certain chronic conditions, consultants say.

Such disease management programs, some of which are using Web-based technology, aim to reduce employers' health care costs by helping individuals with certain costly diseases to better treat and self-manage those conditions.

"There's growing evidence that are showing some significant savings of benefit dollars from programs, but I think they're from the better-designed programs," which combine compliance with treatment plans and lifestyle-modification approaches, said Bruce Kelley, a Minneapolis-based senior consultant with Watson Wyatt Worldwide.

Mr. Kelley said that although the savings differ by disease type, the best disease management programs can achieve annual savings of 11% to 30% of treatment costs for some conditions.

Camille Haltom, a health care benefit consultant with Lincolnshire, Ill.-based Hewitt Associates L.L.C., agreed that the programs can produce some savings, estimating that a fairly aggressive program can bring annual savings of about 20% for certain diseases. But, she cautioned, those savings are difficult to quantify in the first year.

"You might see it after a year or two, because it's claim avoidance. There's where you have probably even greater returns," Ms. Haltom said.

Joan Cantwell, manager of the "Live Well, Be Well" program at Chicago-based Quaker Oats Co., said: "Quaker's priority is for the health of our employees, which is why our Live Well, Be Well program includes a Health Risk Appraisal process, focusing on identifying health risks so that precautionary measures can be taken. We want to help employees stay healthy by identifying risks before they become health problems." Quaker offers disease management programs for diabetes, asthma and coronary artery disease, Ms. Cantwell said.

Accordant Health Services Inc. in Greensboro, N.C., provides for clients a disease management program that covers several conditions not typically addressed by such programs, including multiple sclerosis, cystic fibrosis, hemophilia and Parkinson's disease. Accordant's specialized program, however, does not address many of the conditions typically covered by other disease management programs, including diabetes, certain cardiovascular conditions and asthma.

"Although diabetes and congestive heart failure may have a higher prevalence individually, when you look at all 15 of our covered diseases combined, the total population and the dollar figures involved probably surpass those other major ones," said Dr. Ed Dasso, medical director of clinical operations and informatics at Accordant.

"Our business plan is kind of a niche business, so the diseases that we focus on are less prevalent and are very complex, chronic diseases," he said.

Dr. Dasso emphasized the importance of providing a patient as much information as possible to help him or her self-manage the condition.

"A lot of this is about self-empowerment and how patients can manage their

See **Treatment** *on page 10*

Mental health parity not as costly as feared

By JUDY GREENWALD

Mental health parity has not been the financial nightmare many employers feared it would be.

The enactment of mental health parity laws, which at a minimum generally bar health plans from offering lower annual and lifetime coverage limits for mental disorders than for other medical and surgical benefits, had prompted fears about the creation of an enormous financial burden for employers.

Despite those concerns, mental health parity requirements—on both the federal and state levels—have increased employers' total health care costs by no more than about 1% to 5%, with the low end being closer to the norm, benefits experts say.

Lower-than-expected costs are at least partly attributable to plan modifications by employers that restrict the use of mental health benefits, such as limits on the number of outpatient visits.

But two other factors have played a significant role as well—managed care, particularly through the use of carve-out programs; and changing methods of treatment, which have been shaped, at least in part, by managed care. For instance, the days of standard 30-day psychiatric hospital stays are long gone.

As a result, even the more stringent laws enacted by many states have not proved to be a major problem for employers. In addition to the federal law that went into effect in 1998, 31 states have enacted their own mental health parity laws, including 16 that require full parity with other medical benefits and several that also call for parity for substance abuse, which is not included under the federal measure.

And on the horizon is the prospect of more stringent federal legislation that could replace the current federal law when it expires in September 2001.

Still, the effects of parity laws have varied among employers.

Those that had already introduced some type of mental health benefit—as have most major corporations—have been less likely to feel a financial pinch from parity.

At the same time, consultants say, there is a growing recognition that offering generous mental health benefits may ultimately be in employers' own best interests, because the benefits lead to greater productivity.

Under the federal Mental Health Parity Act, which was signed into law on Sept. 26, 1996, annual or lifetime limits for mental health benefits cannot be lower than the dollar limits for the other medical and surgical benefits offered by group plans of more than 50 employees.

But employers still have some discretion regarding the extent of the mental health benefits they offer. They can impose cost-sharing, limit the number of visits or the number of days that are covered, and institute medical-necessity requirements.

In light of rising health care costs, increases of even small percentages can add up. "We're seeing an accelerating rate of increase in health care premiums, so that when mandates are put on top of that, everything just kind of goes up faster," said Elizabeth Vollmar, St. Louis-based senior employee benefits attorney for the national benefits resource department of Willis North America Inc.

But most observers say the cost of mental health parity in isolation—on either the state or federal levels—has not been a major problem for employers. "I think, in general, most people think of parity as a pretty cost-neutral experience, particularly where there is a managed care approach," said Katherine Sternbach, principal with William M. Mercer Inc. in San Francisco.

That varies, of course, based on the par-

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Drugs

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Mr. Teitelbaum said.

The study found that the average wholesale price for all prescription drugs sold, per member/per year, stood at $387.09 in 1999, up $57.26, or 17.4%, from 1998's average. Of this $57.26 increase, 38.8% stemmed from a general increase in the use of drugs, according to Express Scripts.

Mr. Teitelbaum said that the Express Scripts study was more accurate in measuring the impact of inflation than the Protocare study because Protocare used data from the early to mid-1990s, when drug inflation was low. Since then, drug makers have pushed through price increases not reflected in the Protocare study, Mr. Teitelbaum said.

New drugs, generally those touted in drug-maker advertising, accounted for 10.7% of the price increases in the Express Scripts survey. But this figure is deceptively small as the impact of new drugs grows year after year. In fact, fully 40% of all drug costs for 1999 were spent on drugs introduced since 1992, Mr. Teitelbaum said.

"You're seeing a gradual replacement of the whole drug stock," Mr. Teitelbaum said.

Further contributing to high utilization has been the plan designs themselves, "which made drugs readily accessible," said Nick Vasilopoulos, leader of managed pharmacy consulting for William M. Mercer Inc. in New York.

The standard type of drug plan with a fixed copayment for participants does not impress upon the employee the actual cost of the drugs and a new strategy needs to be developed, he said. Also, since

It's important to educate doctors on the most cost-effective drugs to prescribe, says Nick Vasilopoulos.

doctors are the ones actually writing the prescriptions, it's important to educate them on the most cost-effective drugs to prescribe. A big change in drug expenditures will come when payers help doctors become smarter prescribers and help employees be smarter consumers, Mr. Vasilopoulos said.

One response to rising drug costs has been the creation of a group known as RxHealthValue. Launched this year, it includes employers, health plans, unions and other groups interested in the health care system. Its goal is to increase research in the field of cost-efficient uses of prescription drugs, said Daniel Wolfson, president and CEO of New Brunswick, N.J.-based Alliance of Community Health Plans and a co-founder of RxHealthValue.

The group's first project was a study conducted by the PCS Health Systems Inc., a large PBM, in conjunction with Brandeis University that looked at 1.5 million people enrolled in PCS for three consecutive years. The results showed that drug costs grew by an average of 28.8% each year from 1996 through 1999.

"This is staggering to us," Mr. Wolfson said.

The single biggest factor was the increased use of drugs. "People are getting more drugs," Mr. Wolfson said.

Adding confusion to the array of studies, Mr. Wolfson said the RxHealthValue study showed that drug inflation played a small role, with only about 1% of the increase attributed to it.

Like the Express Scripts study, this one showed that new drugs were a major contributor to higher spending. Specifically, drugs introduced after 1996 account for about one-third of increases in drug expenditures from 1996 to 1999.

One question that employers must grapple with is whether the increase in spending is good or bad. If it lowers health care costs in other areas, clearly it would be good. But what if it doesn't?

In theory, increased drug spending should lower other aspects of health-care spending, said Renee Brownstein, director, total compensation, at Eastman Kodak Co. in Rochester, N.Y. But she has never seen any specific studies proving this.

"Employers have been asking for this information but not getting it from health plans," she said.

But in general, medicines "don't cure diseases," Dr. Dubois of Protocare said. They make people feel better and lead longer lives. It's unrealistic to expect that more drug spending will lower other health care expenditures, he said. Instead, employers can benefit from a happier, more productive workforce.

That happiness, however, can be expensive, and employers "have to really take a good hard look at what they are willing to spend on health care," Ms. Brownstein said.

In the same vein, Mr. Vasilopoulos said the direct to consumer advertising by pharmaceutical companies has some positive impact. For instance, more people know a treatment exists for the condition they have.

"It's initiating discussions with their doctors," Mr. Vasilopoulos said.

The new, expensive drugs are excellent at what they do, but Mr. Vasilopoulos questions if they are always the most cost-effective choice.

Often these drugs are inappropriately prescribed to people who don't really need them, said Sean Maguire, director of client development for Watson Wyatt Worldwide in Atlanta. This is especially true with those drugs advertised directly to consumers. Part of the problem is the doctor has no incentive to prescribe a more cost-effective drug, such as a generic equivalent, and often is not even aware of the patient's health plan's formulary, which can save the employer and patient money.

The most common solution to this problem has been the implementation of a three-tiered copayment that gives patients an incentive to ask for generic drugs. With the three-tiered system, patients pay a small copayment for a generic drug, more for a name brand drug on a plan's formulary of approved drugs and even more for name-brand drugs not on the formulary.

But employers must be careful when creating a formulary, cautions Mr. Vasilopoulos. A concern

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Drugs

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is to not blindly accept a formulary offered by a PBM, he said. Often these are based on the discount the PBM receives from the drug maker, and not on the drug's effectiveness.

Instead, Mr. Vasilopoulos recommends that employers base a formulary on a drug's efficacy. If there is no difference between drugs, then look at their costs, he said.

Another more drastic response is to limit the number of drugstores in a plan's network, thereby getting a larger discount from the remaining ones.

"People are seriously considering it now," Watson Wyatt's Mr. Maguire said.

Besides adopting a three-tiered copayment, employers can change their drug plans so employees pay a percentage of the prescription cost, not a fixed dollar amount. This gives the patient a greater incentive to seek out a better price for the drugs.

But it's already common knowledge where the best prices generally are—mail order. So a good strategy is for employers to push employees to fill their long-term prescriptions via a mail-order house, consultants say.

One promising idea being pursued by some PBMs is using a personal digital assistant, such as a Palm organizer, that contains the formularies of dozens of plans, Mr. Vasilopoulos said. Doctors can then instantly know what is and isn't on an individual patient's formulary when writing the prescription so the most cost-effective drug can be prescribed.

For example, Express Scripts has teamed with PocketScript Inc. to distribute to 15,000 physicians a system for putting the drug formulary of health plans onto a PDA. Using the system, doctors in their offices can check the formulary of a patient's health plan and send a prescription electronically to a pharmacy. With the formulary information at doctors' fingertips, it's hoped they would write more cost-efficient prescriptions.

An interesting idea is to focus on just the top-selling drugs, said Douglas Ley, vp, compensation and benefits for Willis North America Inc. in Milwaukee. The 25 top-selling drugs represent between 30% and 40% of drug expenditures, he said, which is a ripe cost-saving opportunity. One method is to create "a network of one," and have all the top drugs filled by one pharmacy, at a substantially discounted price. The drugs can then be delivered to the workplace, where the employee can pick them up.

Since overall prescription drug use is up, controlling utilization, especially of expensive drugs, will help control costs. But increased utilization is not always bad, as it means more people are getting treatment. What needs to be cut is inappropriate use of drugs or using an expensive drug when a less costly one would do just as well, Mr. Vasilopoulos said. He said studies have shown that 7% to 12% of new drugs are improperly prescribed.

To accomplish this, employers can implement guidelines for when certain drugs, generally new and costly ones, can be prescribed over older, less expensive ones. These guidelines can be based on Food and Drug Administration or American Medical Assn. guidelines, he said. An extreme way to do this would be to have the PBM deny the prescription if it was improperly given. A better approach, he said, is to have the PBM call the doctor and review alternative drugs along with their costs and have the doctor change the prescription.

It's already common knowledge where the best drug prices generally are—mail order, consultants say.

But whatever strategy is devised, it must be put in place to have any impact, Mr. Ley said.

"Stop talking about it and start doing it," he said.

Views differ on how future costs shape up. Dr. Dubois said that with the population aging and more drugs becoming available, it's inevitable that drug prices will continue to rise. This view is shared by many others.

But Mr. Teitelbaum of Express Scripts said that this year will be the high-water mark for price increases and the increases will level off in coming years. Although the survey suggests that prices will continue to rise in 2000, projected to be a record 17.6% increase, the increases will moderate thereafter, he said. But looking ahead to 2005, price increases will once again grow as new and expensive genetically-based drugs begin to hit the market. BI

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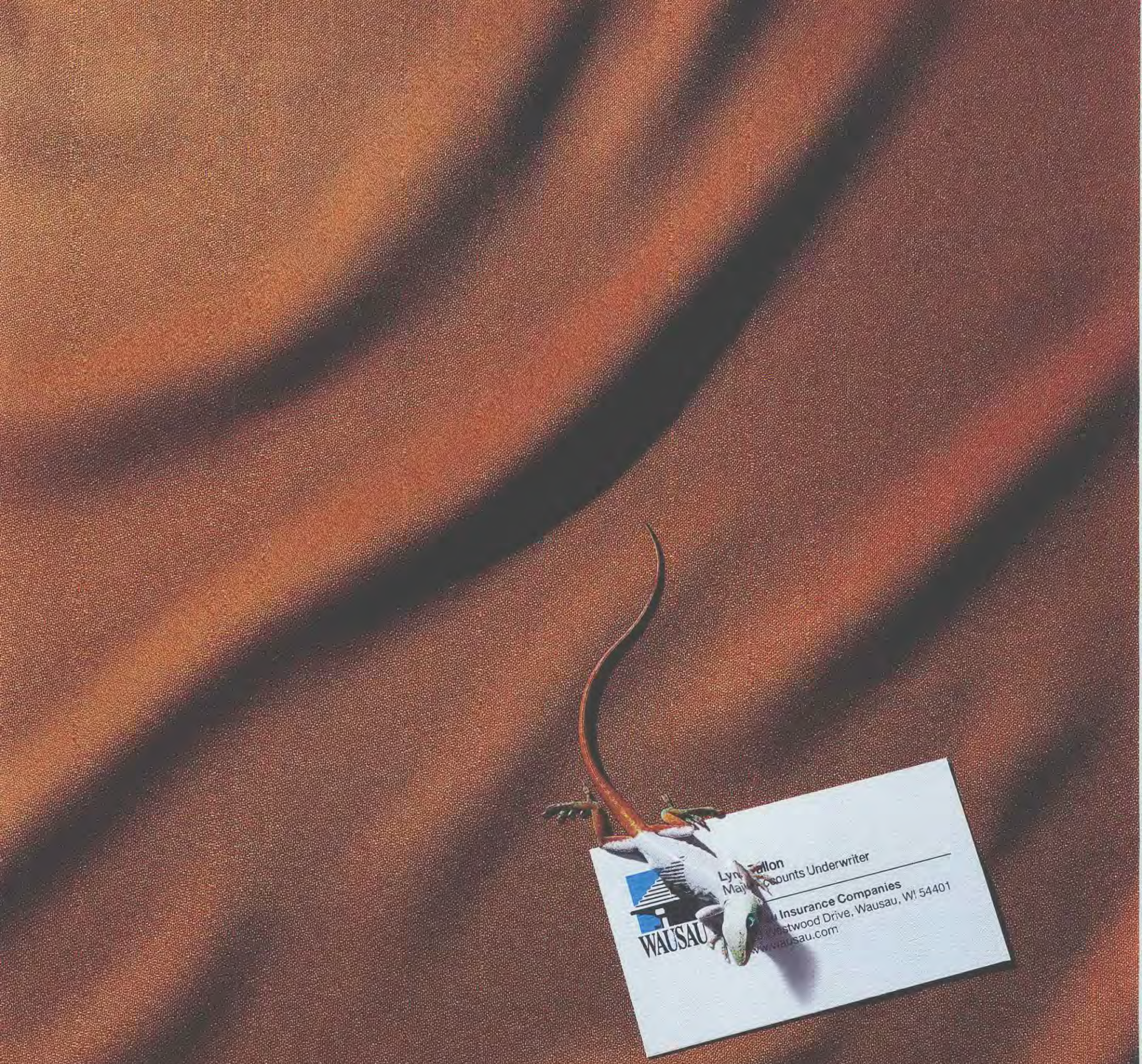

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OPINIONS

Early warning a good fit

IF EVER THERE EXISTED a perfect example of an ounce of prevention being worth a pound of cure, it would be the Pension Benefit Guaranty Corp.'s early-warning program.

The guiding principle of that program is that early intervention can prevent big losses down the road. For example, the PBGC can require a company to put more money in its pension plan before the company could sell a unit with a severely underfunded plan, preventing the pension plan from failing should the purchaser go under.

Employers, who support the PBGC through the insurance premiums they pay the agency, have no quarrel with the basic premise of the early-warning program.

But employers did object—with good reason—to the way the early-warning program was administered.

The PBGC never published written standards, leaving employers in the dark in regard to the kinds of transactions that could trigger PBGC intervention.

Fortunately, the PBGC has remedied that situation through the publication of a 10-page technical update.

That update makes clear that before the PBGC even would make an inquiry, a transaction would need to involve either a financially weak organization or companies with fairly large pension plans that were underfunded.

Translation: Financially solid companies with fully funded pension plans need not worry that the PBGC will interfere in business transactions.

Just as important, the PBGC only would get involved when there is a significant threat of a major loss to the agency's insurance program. In short, as PBGC Executive Director David Strauss puts it, involvement is a "tool we intend to use most judiciously."

That is how it should be. Defined benefit plans are voluntary programs, and undue and unneeded government interference is a reason why employers have been abandoning the programs, often to the detriment of employees.

There is, to be sure, a role for government regulation of pension plans, but unneeded interference in business transactions is not one of them. We're glad to see that federal

pension officials concur.

Indeed, the PBGC's action on its early-warning program is only the latest move that the agency has made over the last few years to improve its relationships and dealings with its customers—employers.

Other advances include the coordination of the filing of PBGC premium forms with other federal pension financial reports, a step that cuts administrative work for employers. The agency also reduced the amount of records that audited employers must supply to the PBGC, to three-years worth from six. Only if auditors found problems would they ask employers for records going back further.

Three years ago, when Mr. Strauss was appointed PBGC executive director, he promised to make the agency more customer-oriented. We are glad to see that promise is being kept.

Beware employment pitfalls

TWO RECENT COURT DECISIONS illustrate the effort courts are making to clarify the standards for proving employment discrimination, which will influence employers' liability exposure.

In Massachusetts, the Supreme Court this month provided much-needed clarification and tightening of its own standard for proving employment discrimination that should make it easier for employers there to protect themselves from such suits.

That case comes on the heels of a June ruling by the U.S. Supreme Court that also clarified employment discrimination law, but resulted in a lower standard of proof that may result in more such cases being heard by federal court juries and surviving appeals.

The case in Massachusetts, *Abramian vs. President and Fellows of Harvard College*, revolved around the issue of whether a jury or court should automatically find an employer guilty of discrimination if it does not believe its stated reason for an employment action, such as a job termination.

Until this ruling, Massachusetts law relied on the "pretext only" standard, which holds that an employee has to produce no more than prima facie proof of discrimination and evidence that casts doubt on the employer's stated reason for an action.

In this case, a security guard at Harvard College argued that he was terminated because of ethnic discrimination. Although the employer countered that he was fired for fighting with co-workers, the jury did not believe this argument and returned a verdict of discrimination.

The case suggests that the jury might not have believed the guard's argument, either, but within the confines of Massachusetts law was compelled to find the employer guilty of bias.

According to court papers, during deliberations the jury was instructed that if they found that a pretext existed for the firing, they were obligated to rule for the plaintiff. In other words, if they don't believe the employer's reason for an action, the plaintiff wins even if the jury hasn't considered whether—or doesn't believe—discrimination exists.

Harvard appealed the trial court verdict, asserting that "a finding of pretext *permits* but does not *compel* a finding of discrimination." The Massachusetts high court agreed.

This ruling is welcome news to employers and gives them a better and fairer chance of defending employment-related discrimination actions.

Unfortunately, other courts continue to rely on the "pretext only" standard and the federal courts recently took a step in that direction.

The U.S. Supreme Court in June relaxed the "pretext plus" standard that had governed federal discrimination cases. The justices unanimously held in *Reeves vs. Sanderson Plumbing Products Inc.* that plaintiffs do not have to show additional proof of discrimination after demonstrating that the employer's reason was a pretext for discrimination (*BI*, June 19).

As a result, employers can expect more employment discrimination cases reaching juries and fewer pro-plaintiff verdicts being overturned on appeal at the federal level.

The key in both cases for employers is to be sure the reason for an employment-related action, such as termination, was valid. If a person was fired for a legitimate reason, then the employer should state that reason and provide evidence to support it. If the evidence is not there, then the jury is less likely to believe the employer and is more likely to conclude the real reason was discrimination.

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Treatment

Continued from page 3

disease better, too. Particularly for these complex diseases, they have to feel empowered, because these are lifetime diseases," Dr. Dasso said.

Like some other disease management providers, Accordant uses a computer system to sort the health data of its 10 000 enrollees, which allows the company to categorize individuals by disease type and to identify at-risk individuals. The frequency of contact between an Accordant nurse and a patient is determined by the particular condition and its status.

A health assessment is completed between the patient and a nurse, and, based on the needs of the patient, a schedule is arranged. If an illness is severe, a patient could be put in touch with a case manager to plan for example, pre-hospital or post-hospital care. If a patient's condition is less severe, he or she may only need to speak with a nurse every few months.

"Follow-up can be several times a day to every other day or weekly or whatever. As long as they're in a high level of severity, they'll have frequent contact with a nurse," Dr. Dasso said.

Patients are asked questions, and certain responses trigger a call to a physician, Dr. Dasso explained.

For example, some patients suffer from myasthenia gravis, a neurological ailment treated by Accordant. A test is done involving the length of time a patient can hold one breath.

"If he or she can't hold it for at least 20, seconds then it would cause us to have an intervention. If it's pretty bad, the nurse will give instructions about what to do and then try to get that information to the physician," Dr. Dasso said.

One service Accordant provides is online interaction with patients.

'We need to make sure that we can demonstrate that overall costs are going down' says Dr. Ed Dasso of Accordant.

"We have the Web interactive capability. Patients can go through the same health evaluation that they would go through with a nurse. The patient's response triggers the same reference resources," Dr. Dasso said.

Although the Web is a popular tool with Accordant's clients, a patient also can manage his or her condition with a nurse by telephone or through a combination of online and telephone resources.

Dr. Dasso emphasized the importance of outcomes reporting that Accordant provides to its clients. Such reports provide quantifiable data on the program's results, which benefit managers can use in establishing the value of such programs when dealing with company executives, he said.

"We need to make sure that we can demonstrate that overall costs are going down. We want the plans to understand that there's a clinical outcome here," Dr. Dasso said.

Birdie D'Andrea, product manager of disease management services for Philadelphia-based Intracorp, said the company has provided disease management services since 1998 and has six active clients and about 600 active participants.

Intracorp, however, deals only with "the three most prevalent diseases that can be impacted with appropriate intervention—diabetes, cardiovascular disease and asthma," Ms. D'Andrea said.

She predicts that the number of diseases addressed in disease management programs will increase in the future, but that "you need to choose a disease where intervention will impact the outcome."

Dr. Joseph Aita, chief medical officer at San Jose, Calif.-based managed care company Lifeguard Inc., said Lifeguard sees its disease management program as a way to connect health plans with providers.

"We look at it as partnerships between health care plans and the physicians. We'll let the doctors know if their patient isn't getting their prescriptions filled on time," Dr. Aita said.

Lifeguard also processes patient information through a system that helps identify "high-risk" members. Nurse case managers will then call patients and their doctors to help expedite the referral process.

"If they (patients) know they're going to hear from that nurse, it gets them motivated," Dr. Aita said.

Dr. Aita said that Lifeguard also encourages patients to take an aggressive role in the disease management process.

"Lifeguard had giveaways of both Peak-Flo meters and glucose meters for asthmatics and diabetics, respectively, in order to encourage its patients to take control of their illnesses," Dr. Aita said.

Wausau Benefits, a unit of Wausau Insurance Co., has a disease management program called CareLink2Health.

For example, through Wausau's system, a diabetic patient who is not getting the tests or taking the prescriptions recommended to manage his or her disease is flagged, explained Medical Director Dr. Elaine Mischler in Wausau, Wis.

"We'll then call his doctor and let him know of the alert, and if the issue is more complex, we'll offer a recommendation or a reference of best practice," Dr. Mischler said.

She said disease management is about giving good care to patients.

"I had one doctor actually chuckle. He said, 'You're telling me to spend more money.' It's very different than the traditional call thought to be made by the medical director of TPA or other plan. I'm not calling and saying it's medically necessary; I'm calling and saying, 'Consider this, it might be very good for your patient,' " Dr. Mischler said.

Hewitt's Ms. Halstom said that she is seeing a lot of large employers exploring disease management, estimating that about one-third of employers will have some type of disease management program in place by the end of this year.

"Based on market response, I think we'll see a huge uptake by especially large employers who have a significant percent of their population in managed care plans," she said. "This is an industry that's still developing—there's still a lot of change, a lot of evolution. There's a growing body of evidence that says you can generate savings." BI

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SPOTLIGHT REPORT

Adapting benefit plans to fit new detox programs

By JOANNE WOJCIK

In the recent film "28 Days," actress Sandra Bullock plays a hip New York socialite whose habitual partying lands her in a 28-day inpatient detoxification program.

Although this modern look at life in rehab may have looked good on the big screen, such residential alcohol treatment programs are fast disappearing.

Today, rehab providers are finding that the old-fashioned 28-day inpatient program, which was once the standard treatment for drug and alcohol abuse, doesn't work for everyone, and, in fact, often leads to relapse.

Instead, they now mold treatment to the individual, usually combining shorter, three- to five-day, inpatient detoxification programs with intensive outpatient therapy.

But not all benefit plans are keeping pace with this evolution in chemical dependency treatment, behavioral health experts point out. In fact, many employers are cutting back on the availability of treatment alternatives, either by limiting benefits to inpatient detox programs or by capping the number of times an employee can use the benefit during his or her lifetime.

The origin of the 28-day treatment program is a mystery to many in the field, even though it was the standard of treatment for years.

While some say it developed according to the level of coverage that was provided under the benefit plans of most insured employees, it actually was based on the clinical treatment of chronic male alcoholics in the late 1950s at a state hospital in Minnesota, according to Ron Hunsicker, president and chief executive officer of the National Assn. of Addiction Treatment Providers in Lititz, Pa.

"For whatever reason, the Blue Cross/Blue Shield plans picked up on that, and it became the standard benefit in health plans," he explained.

"It made sense at the time," Mr. Hunsicker said. But, since then, "most of us have long since decided that's not the standard. The one-size-fits-all approach doesn't work."

Furthermore, any program that treats alcohol or drug addiction as an event, rather than as a chronic condition, will be unsuccessful, he aid.

"An alcoholic or someone addicted to other drugs is never cured," he said. "It's a lifelong, chronic disease. Therefore, they need ongoing treatment, just as if they had diabetes, hypertension or asthma."

Managed care companies were perhaps among the first to recognize this, instituting chemical dependency programs that focus more on ongoing outpatient treatment than on acute inpatient care, said Pamela Greenberg, executive director of the American Managed Behavioral Healthcare Assn. in Washington.

"This is one of the things managed care has brought to the table. Other settings are considered, and treatment decisions are made on an individual basis, rather than having insurance benefits dictate the treatment level," Ms. Greenberg said.

Unfortunately, "there are situations where tailored treatment may not be covered, which is why we support mental health parity," she said.

When Congress passed the Mental Health Parity Act, it did not apply to chemical dependency treatment benefits. This is because inpatient detox treatment is covered under the medical portion of most benefit plans.

But since parity was enacted, many employers have cut benefits for chemical dependency treatment while modifying mental health benefit packages.

Chicago-based Hartmarx Corp., for example, now limits the number of times its plan will cover detoxification to twice per lifetime, according to Mike Pikelny, benefits actuary.

This is a pretty common limit, according to Dr. David Whitehouse, corporate medical director at CIGNA Behavioral Health in Minneapolis.

"Most benefits for substance abuse are employer-specific, with large employers offering better benefits. Small employers have a much more punitive attitude. They say they can't afford to employ substance abusers, so we see a lot of two (per) lifetime detox benefits," he said.

"But this is completely inappropriate, because substance abuse is a relapsing illness," he said. Dr. Whitehouse also regards addiction as a chronic illness that requires regular attention. "It also drives people underground," so that they don't seek treatment when they need it, he said.

In fact, Dr. Whitehouse said that, based on CIGNA's experience, 50% of people who seek treatment for depression also have substance abuse problems, and these problems often go untreated. That's because, he said, today there is a greater stigma associated with substance abuse than with mental illness.

A new study of mental health and substance abuse treatment expenditures released by the Substance Abuse and Mental Health Services Administration seems to bear this out.

Although it covered a period prior to implementation of the federal parity law, the study found that spending on substance abuse treatment grew more slowly than did spending for other types of mental health care between 1987 and 1997.

Adjusted for inflation, private-sector spending on substance abuse declined 0.2% during the 10-year period. In that same time, spending on other mental health care services grew 3.6%, though that figure also lagged behind the growth of private spending on overall health care, which increased at an inflation-adjusted rate of 4.1%. Furthermore, the study showed that only 36% of substance abuse treatment costs were covered privately, that is, by insurers, philanthropy or out of the pockets of patients or their families.

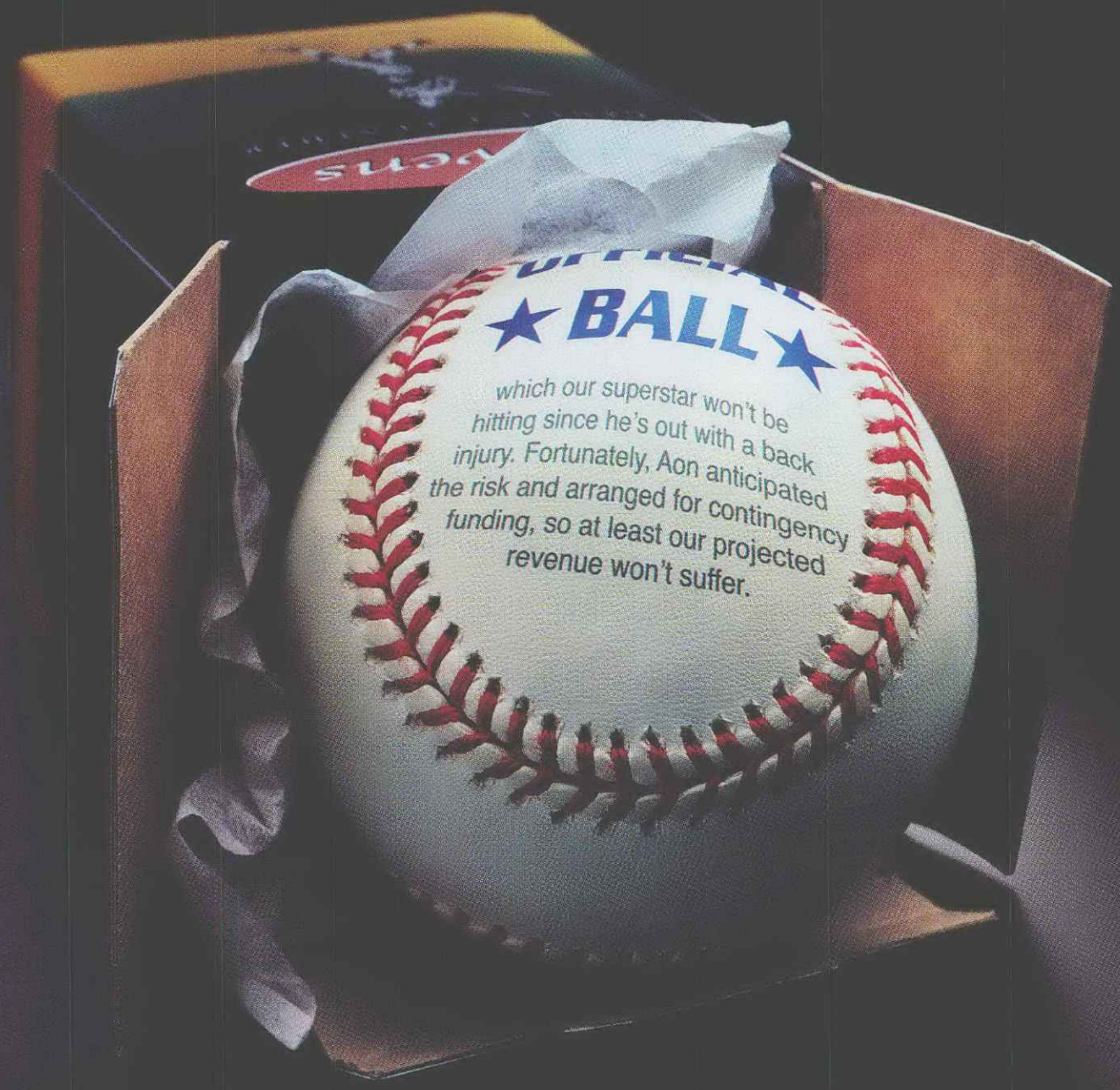
The study also questioned why independent specialists in mental health care and substance abuse treatment, such as psychiatrists, psychologists, counselors and social workers, receive a lower proportion of substance abuse dollars than do general physicians.

"Are these MH/SA specialists less likely to accept addiction clients than mental health clients?" the study asked. "Or are their services less likely to be covered by third-party payments?"

"Bingo!" said Joy Riley, a consultant at Watson Wyatt Worldwide in Atlanta.

"Definitely, the state of the art is more outpatient-oriented," she said,

See **Detox** *on page 16*



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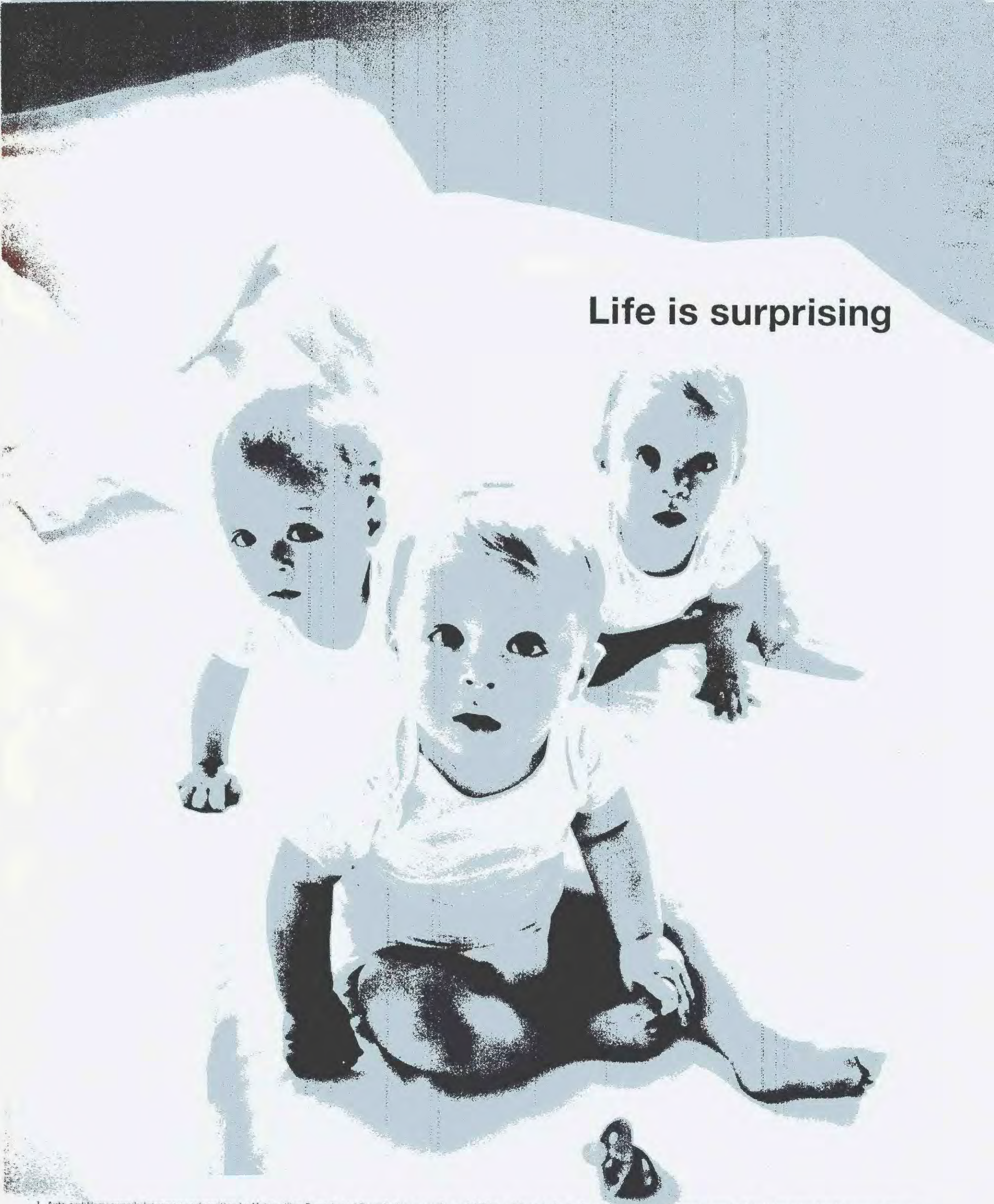

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Detox

Continued from page 12
yet "most employers significantly limit the benefit to inpatient treatment."

Outpatient treatment benefits for chemical dependency usually are subject to the same limits as for other mental health care services, with sizable co-payments or limits on the number of visits, Ms. Riley said.

While most chemical dependency treatment programs start with intensive inpatient therapy, that usually lasts just three to five days. Then a patient is usually referred to an intensive outpatient therapy program that meets two to three hours a day, three or four days a week, for two weeks or more, said Joe Vollmer, supervisor of Employee & Family Counseling Services, an internal employee assistance program at Golden, Colo.-based Coors Brewing Co.

"Then there's aftercare," where the number of outpatient therapy visits gradually declines to, perhaps, one visit per week or once every two weeks, he explained.

Substance abusers "don't live in a hospital," Mr. Vollmer said. "They have to learn to deal with the triggers and the problems in the environment that they live in."

Most of Coors' insurers have adopted this philosophy, he said. Coors offers its 5,800 employees a choice from among CIGNA, Kaiser Permanente and PacifiCare HMOs and PPOs and a self-insured point-of-service plan.

Outpatient treatment also is more cost-effective, said Dr. Jerry Vaccaro, vp and corporate medical director at PacifiCare Behavioral Health in Van Nuys, Calif.

"If you take the same amount of money and spread it out over time, it's a much wiser use of resources," he said. BI

Parity

Continued from page 3
ticular situation, Ms. Sternbach noted. But if it is a "reasonable benefit, then the cost is not significant. It usually could be between 1% and 5% of the overall health plan," she said.

States that have parity laws that are more strict than the federal law include California. California's law, which went into effect July 1, goes beyond federal law, by requiring insurers and HMOs to provide co-payments and deductibles that are equal to those provided for other medical care, as well as equal maximum lifetime benefits for the medically necessary treatment of severe mental illnesses and serious emotional disturbances of children. The law covers both outpatient and hospital services.

The Sacramento-based California Public Employees' Retirement System estimates the total cost of state mandates—of which mental health parity makes up the biggest piece—will add 1.5% to premiums for its 10 HMOs next year.

Dr. Robin Dea, chairwoman and chief of psychiatry for Kaiser Permanente in Northern California, said that, for the employer, the real cost of the parity bill is related to the level of mental health care the employer provided before the bill was passed.

For the many large employers that were already providing high-quality mental health benefits, "it's not going to impact them very much at all," said Dr. Dea, who is based in Redwood City, Calif.

A study of the mental health and substance abuse benefit programs of eight major employers, conducted by the Washington Business Group on Health for the federal Office of Personnel Management, found that "cost was not the issue," said WBGH Vp Veronica Goff.

Of greater concern, Ms. Goff said, was that while many employers offer very generous mental health care benefits, not enough employees are making use of them, because of the stigma that is still attached to mental illness.

One reason that compliance with mental health parity requirements has not proved onerous—at least in regard to the federal law—is that employers are taking advantage of the so-called loopholes in the law.

The General Accounting Office concluded in a study issued in May that 65% of the employers that had eliminated discriminatory annual and lifetime dollar caps changed at least one other mental health care design feature to make coverage more restrictive when compared with other medical and surgical benefits (*BI*, May 22).

"Most of the employers that I've worked with made cost-neutral adjustments to comply with parity" by implementing other design changes, such as visit limits, to offset the elimination of dollar limits, said Rich Stover, a principal with Buck Consultants Inc. in Secaucus, N.J.

Managed care, particularly when it is dispensed through carve-out programs offered by mental health specialists, and changing approaches to treatment also have been instrumental in holding down the cost of mental health parity.

Mental health benefits in an unmanaged environment would be too costly, "but that's not a realistic situation anyway," because it no longer exists in an unmanaged environment, said Roland Sturm, senior economist with the Santa Monica, Calif.-based Rand Institute, an independent think tank. "Under the carve-outs, you can provide unlimited benefits for mental health with very low copayments and deductibles," he said.

Joseph Marlowe, senior vp in Aon Consulting's Philadelphia office, said managed care programs "have forced a substantial change in the way mental health services are being delivered, with more focus on short-term, intensive outpatient treatment and less long-term, acute inpatient services."

When patients are hospitalized, "it's for substantially shorter lengths of stay," and treatment is supplemented with post-discharge, outpatient services, Mr. Marlowe said.

Although the federal mental health parity act has forced employers to adjust their plan designs for mental illness, "I think it's really coincident with a larger awareness within the marketplace of the issue of mental illness and productivity," he said.

"We believe that if you keep people healthy, you end up spending less money," said Tara Wooldridge, manager of the employee assistance program at Atlanta-based Delta Air Lines, which has no visit or dollar limits for its self-insured mental health benefits plan.

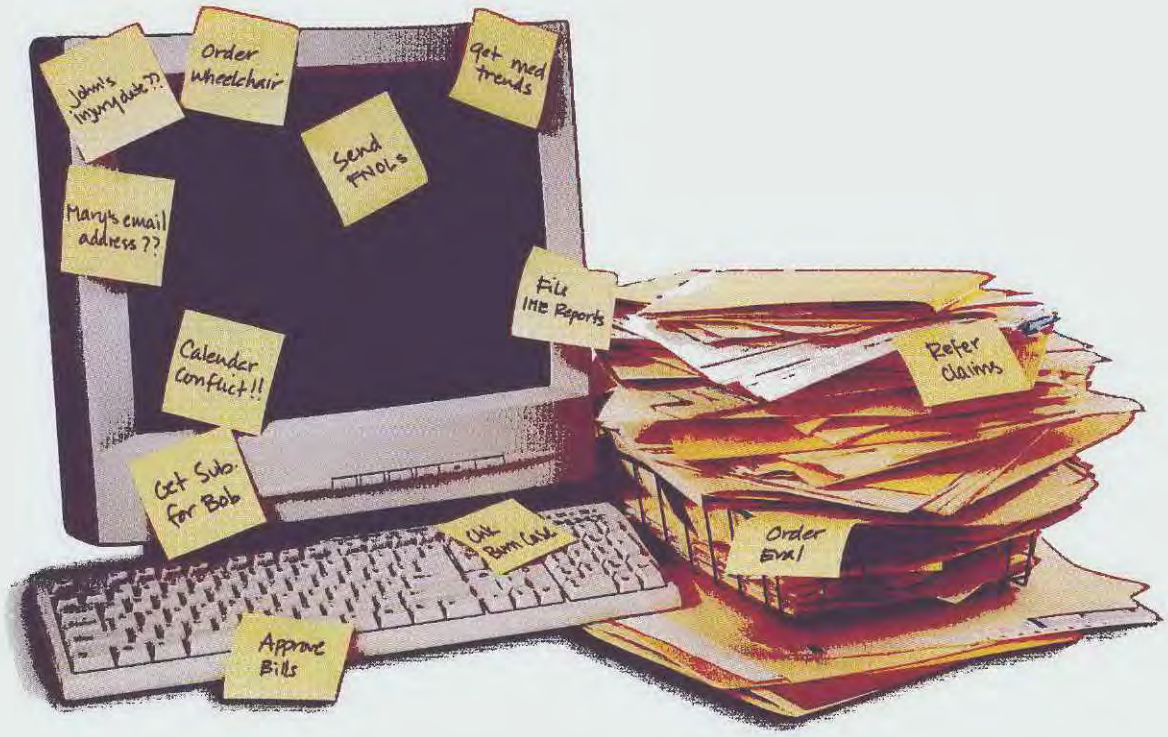
Meanwhile, more requirements may be on the horizon for employers, with new legislation expected to replace the current federal law upon its expiration next year.

Attention is focused in particular on S.B. 796—whose primary sponsors are Sen. Pete Domenici, R-N.M., and Sen. Paul Wellstone, D-Minn.—and H.B. 1515, which was introduced by Rep. Marge Roukema, R-N.J. Both would bring mental health benefits closer to true parity with other medical and surgical benefits.

The House bill includes substance and chemical dependency benefits within its parity provisions, while the Senate bill does not, noted Dan Schwallie, legal consultant in Hewitt Associates L.L.C.'s Cleveland office.

The pending bills are "not really on a lot of employers' radar screens right now," said Mr. Schwallie. BI

Everyone works hard.



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BI's annual directory of prescription benefit managers

A

Ameriscript Inc.

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

1999 revenues
Total gross revenues $920,853
PBM services $920,853
Unbundled PBM services $920,853
PBM clients
Total 1,158
Employee/group plans with direct service 1,158
Lives covered
Total 256,250
Active group health plan 1,200
Active workers compensation 205,000
Retail network
Pharmacy locations 40,000
Mail-order services
Percentage of prescription volume 75%
Generic usage
Percentage of prescription volume 41%
Staff
Total 40
Professionals 38
Registered pharmacists 2

PBM services since: 1986.
Parent: The Chandler Group of Managed Care Cos.; primary business: HMO/PPO.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Subcontracted services: concurrent Rx utilization review; disease management; mail-order drug distribution; online Rx claims adjudication; pharmaceutical claims processing; physician prescribing practices monitoring and management; retrospective Rx utilization review; Rx Formulary management/review.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: Arthur W. Chandler, chairman/CEO; Michelle Swigonski, president; Cynthia Craig, senior vp-operations.
Contact: Michelle Swigonski; miches@chandler-group.com.

C

Caremark Rx

2211 Sanders Road,
Northbrook, Ill. 60062;
847-559-4700; fax: 847-559-4981
www.caremark.com

1999 revenues
Total gross revenues $3,300,000,000
PBM services $2,800,000,000
Unbundled PBM services $2,500,000,000
PBM clients
Total 1,200
Employee/group plans with direct service 1,092
Lives covered
Total 20,000,000
Retail network
Pharmacy locations 50,000
Mail-order services
Percentage of prescription volume 23%
Generic usage
Percentage of prescription volume 93%
Staff
Total 2,263
Professionals 1,836
Registered pharmacists 354

PBM services since: 1985.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: Mac Crawford, chairman/CEO; James H. Dickerson Jr., president/COO; Howard A. McClure, executive vp/CFO.

CLAIMSPRO Management Services Inc.

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

1999 revenues
Total gross revenues $12,663,311
PBM services $12,200,000
Unbundled PBM services $10,370,000
PBM clients
Total 1,500*
Employee/group plans with direct service 1,350
Lives covered
Total 1,490,000
Active group health plan 1,490,000
Retail network
Pharmacy locations 51,000*
Mail-order services
Percentage of prescription volume 6%
Generic usage
Percentage of prescription volume 41%
Staff
Total 70
Professionals 36
Registered pharmacists 1

PBM services since: 1989.
Parent: PharmaCare/CVS; primary business: retail pharmacy.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim.
Officers: Bruce Liebowitz, president; Ron Klein, executive vp.
Contact: support@claimspro.com.
**Estimated.*

E

Express Scripts Inc.

13900 Riverport Drive,
Maryland Heights, Mo. 63043;
800-281-0712; fax: 314-702-7059
www.express-scripts.com

1999 revenues
Total gross revenues $4,300,000,000
PBM services $4,300,000,000
PBM clients
Total 1,379
Employee/group plans with direct service 1,211
Lives covered
Total 38,500,000
Retail network
Pharmacy locations 53,000*
Generic usage
Percentage of prescription volume 39.3%
Staff
Total 4,000*
Registered pharmacists 440

PBM services since: 1986.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff, independent panel.
Service area: nationwide, U.S. territories, Canada.
Billing method: fee per claim.
Officers: Barrett A. Toan, president/CEO; Stuart Bascomb, executive vp; David Lowenberg, COO.
Contact: Larry Zarin; lzarin@express-scripts.com.
**Estimated*

Continued on next page

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First Health Services Corp.

4300 Cox Road,
Glen Allen, Va. 23060;
804-965-7400; fax: 804-527-6849
www.fhsc.com

1999 revenues
Total gross revenues $120,000,000
PBM services $39,000,000
Unbundled PBM services $39,000,000
PBM clients
Total 21
Employee/group plans with direct service 21
Lives covered
Total 9,000,000
Active group health plan 9,000,000
Active workers compensation 600,000
Retail network
Pharmacy locations 51,332
Mail-order services
Percentage of prescription volume 3%
Generic usage
Percentage of prescription volume 47%
Staff
Total 989
Professionals 762
Registered pharmacists 45

PBM services since: 1968.

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

Subcontracted services: mail-order drug distribution.

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

Dispute resolution: PBM staff.

Service area: nationwide.

Billing method: fee per claim.

Officers: Teresa Dimarco, president; Peter Quinn, vp-marketing and account management; Steve Duvall, vp-sales.

Contact: info@fhsc.com.

The INTEQ Group Inc.

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

1999 revenues
PBM services $7,000,000
PBM clients
Total 2,500
Employee/group plans with direct service 750
Lives covered
Total 1,700,000
Active group health plan 1,400,000
Active workers compensation 300,000
Retail network
Pharmacy locations 47,000
Mail-order services
Percentage of prescription volume 5%
Generic usage
Percentage of prescription volume 44%
Staff
Total 65
Professionals 50
Registered pharmacists 2

PBM services since: 1992.

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

Subcontracted services: formulary management/review.

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

Dispute resolution: PBM staff.

Service area: nationwide.

Billing method: capitated rate, fee per claim.

Officers: Andrew Fisk, president; John Teichgraeber, executive vp-sales and marketing; Jerry Hosler, executive vp-finance and administration.

Contact: John Teichgraeber; info@inteqrx.com.

International Pharmacy Management Inc.

300 Corporate Parkway, Suite 1,
Birmingham, Ala. 35242;
800-476-3784; fax: 205-795-7298
www.ipmdrug.com

1999 revenues
Total gross revenues $31,839,084
PBM services $31,839,084
Unbundled PBM services $31,839,084
PBM clients
Total 164
Employee/group plans with direct service 164
Lives covered
Total 265,252
Active group health plan 158,321
Active workers compensation 52,000
Retail network
Pharmacy locations 47,000
Mail-order services
Percentage of prescription volume 32%
Generic usage
Percentage of prescription volume 42%
Staff
Total 35
Professionals 28
Registered pharmacists 3

PBM services since: 1995.

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

Subcontracted services: disease management.

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

Dispute resolution: PBM staff.

Service area: nationwide.

Billing method: capitated rate, fee per claim.

Officers: Arthur Jones, chairman/president/CEO; Greg Stein, vp-sales and marketing; David Beauchaine, vp-finance.

Contact: Greg Stein; 800-476-3784; gstein@ipmdrug.com.

Merck-Medco Managed Care L.L.C.

100 Parsons Pond Drive,
Franklin Lakes, N.J. 07417;
800-444-8338
www.merckmedco.com

1999 revenues
Total gross revenues $18,500,000,000

Continued on page 22

Directory terms explained

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

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

Each listing begins with the company name, address, phone number, fax number and Web site address. **1999 revenues** includes total gross revenues, gross revenues generated from all PBM services and gross revenues from unbundled PBM services. The **PBM clients** section specifies the total number of clients, as well as the number of employer/group plans that contracted directly with the PBM in 1999.

Lives covered includes total group health plan lives, both eligible and active. Active enrollees are those participants who actually received prescriptions through the plan in 1999.

Figures for active group health enrollees and active workers compensation enrollees in 1999 are also provided.

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

Staff information, given in full-time equivalents for 1999, indicates the total number of staff members assigned to prescription benefit management services. The total number of professional staff members also is provided, including the number of registered pharmacists on staff.

PBM **services** and **subcontracted services** offered by the company are listed next. The **reports** provided to the client along with the PBM's **service area** are also provided, followed by the PBM's **billing methods** and the **dispute resolution** approaches it offers.

Principal **officers** and a **contact** person for readers seeking more information complete each listing.

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

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Continued from page 19

PBM services $18,500,000,000
PBM clients
Total 1,051
Employee/group plans with direct service 491
Lives covered
Total 52,000,000
Retail network
Pharmacy locations 56,300
Generic usage
Percentage of prescription volume 68%
Staff
Total 13,554
Professionals 2,383
Registered pharmacists 1,777

PBM services since: 1964.
Parent: Merck & Co. Inc.; primary business: drug manufacturer.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Subcontracted services: pharmaceutical claims processing.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim, risk sharing.
Officers: Per G. H. Lofberg, chairman; Richard T. Clark, president; Isaac Shulman, executive vp-manufacturing contracting.

N

National Medical Health Card Systems Inc.

26 Harbor Park Drive,
Port Washington, N.Y. 11050;
516-626-0007; fax: 516-621-4793
www.nmhc.com

1999 revenues
Total gross revenues $134,031,026
PBM services $134,031,026
Unbundled PBM services $54,964,313
PBM clients
Total 295
Employee/group plans with direct service 5
Lives covered
Total 375,000
Retail network
Pharmacy locations 47,000
Mail-order services
Percentage of prescription volume 10%
Generic usage
Percentage of prescription volume 40%
Staff
Total 100
Professionals 85
Registered pharmacists 15

PBM services since: 1981.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: Bert Brodsky, CEO.
Contact: Kathleen Tilden, vp-marketing; ktilden@nmhc.com.

National Pharmaceutical Services Inc.

14303 First National Bank Parkway,
Omaha, Neb. 68154;
402-965-8800; fax: 402-964-9004
www.pti-nps.com

1999 revenues
Total gross revenues $110,000,000
PBM services $12,000,000
Unbundled PBM services $12,000,000
PBM clients
Total 1,200
Employee/group plans with direct service 1,200
Lives covered
Total 900,000
Active group health plan 210,000
Active workers compensation 17,000
Retail network
Pharmacy locations 50,000
Mail-order services
Percentage of prescription volume 10%
Generic usage
Percentage of prescription volume 50%
Staff
Total 25
Professionals 12
Registered pharmacists 8

PBM services since: 1994.
Parent: Pharmaceutical Technologies Inc.; primary business: health care reporting software.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim, percentage of savings.
Officers: Douglas M. Pick, president/CEO; Angela Pieper, CFO; Kevin Ridgeway, vp-clinical services.
Contact: Douglas M. Pick, pti-dpick@ccccorp.com.

P

PSG-PBM Inc. dba Pharmacy Services Group

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

1999 revenues
Total gross revenues $50,000,000
PBM services $50,000,000
Unbundled PBM services $20,000,000
PBM clients
Total 310
Employee/group plans with direct service 25
Lives covered
Total 300,000
Active group health plan 210,000
Active workers compensation 50,000
Retail network
Pharmacy locations 53,000
Mail-order services
Percentage of prescription volume 20%
Generic usage
Percentage of prescription volume 30%
Staff
Total 40
Professionals 39
Registered pharmacists 3

PBM services since: 1995.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Contact: Kenneth Sack, CEO; ks@rxmail.com.

Pharmacy Advantage System

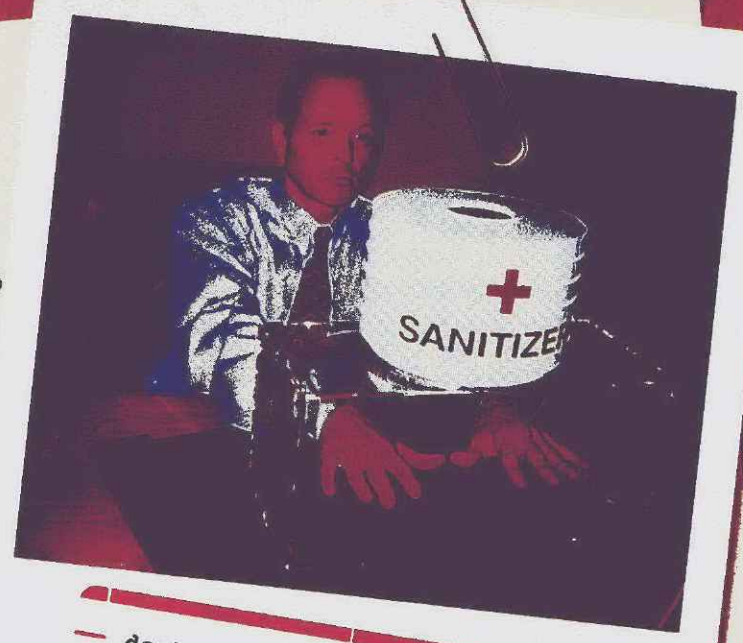
50 Lenox Pointe,
Atlanta, Ga. 30324;
404-262-6681; fax: 404-262-6689
www.pasrx.com

1999 revenues
Total gross revenues $163,372,283
PBM services $163,048,870
Unbundled PBM services $323,414
PBM clients
Total 842
Employee/group plans with direct service 655
Lives covered
Total 515,371
Active group health plan 139,478
Active workers compensation 477
Retail network
Pharmacy locations 45,683
Mail-order services
Percentage of prescription volume 8%
Generic usage
Percentage of prescription volume 42%
Staff
Total 29
Professionals 13
Registered pharmacists 9

PBM services since: 1986.
Parent: Georgia Pharmaceutical Assn.; primary business: state pharmacy association.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim, per employee per month.
Officers: Charles P. Callihan, COO; Dondi W. Ballard, vp-information systems; Richard G. Simon, vp-sales and marketing.
Contact: Richard G. Simon; rsimon@pasrx.com.

Continued on page 24

steelco
worldwi



desktop sanitizing station

MEMO

TO: All Employees
FR: Jack Graves, CEO
RE: Health Care Costs

This year the company's cost for providing health care has risen 12%. In order to keep these costs from cutting into our bottom line we are going to adopt a few new company policies:

1) Desktop sanitizing stations will be installed, and sneezing outside the anti-bacterial spray zone is now prohibited.

2) Coughing and/or wheezing will only be permitted in the yellow zone located outside of shipping and receiving.

3) Handshaking, "high fives," and other forms of physical greeting will be replaced with an audible greeting such as "hey," "hi," or "what's up?"

Jack

Continued from page 22

R

RxAmerica

369 Billy Mitchell Road,
Salt Lake City, Utah 84116;
801-961-6000; fax: 801-961-6008
www.rxamerica.com

1999 revenues
Total gross revenues $450,497,524
PBM services $293,264,110
PBM clients
Total 208
Employee/group plans with direct service 128
Lives covered
Total 6,400,000
Active group health plan 1,940,000
Active workers compensation 39,273
Retail network
Pharmacy locations 46,000
Mail-order services
Percentage of prescription volume 15%
Generic usage
Percentage of prescription volume 52%
Staff
Total 383
Professionals 96
Registered pharmacists 57

PBM services since: 1994.
Parent: Albertson's Inc. and Longs Drug Stores; Primary business: retail food and drug stores, respectively.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim, disease state management programs charged on a per member enrolled basis.
Officers: John Gardynik, general manager; Dan Salemi, vp-operations; Alan Kellogg, vp-sales and marketing.
Contact: Alan Kellogg; 801-961-6051.

Rx Direct Inc.

1445 Clarksville St.,
Paris, Texas 75460;
800-785-4197; fax: 903-784-4376
www.rxdirect.com

1999 revenues
Total gross revenues $30,000,000
PBM services $30,000,000
Unbundled PBM services $30,000,000
PBM clients
Total 4,500
Employee/group plans with direct service 4,482
Mail-order services
Percentage of prescription volume 100%
Generic usage
Percentage of prescription volume 30%
Staff
Total 6E
Professionals 6E
Registered pharmacists ..... E

PBM services since: 1994.
Services: mail-order drug distribution, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: fee per claim.
Officers: Gerry Teague, Bob Coopman, directors; Jim Slaton, vp-marketing.
Contact: Jim Slaton, jslaton@1starnet.com.

S

Scrip Pharmacy Solutions

100 Clearbrook Road,
Elmsford, N.Y. 10523;
888-818-3939; fax: 914-460-1660
www.mimhp.com

1999 revenues
Total gross revenues $370,000,000
PBM services $342,000,000
Unbundled PBM services $101,000,000
PBM clients
Total 120
Employee/group plans with direct service 98
Lives covered
Total 3,700,000
Active group health plan 423,000
Active workers compensation 60,000
Retail network
Pharmacy locations 48,000
Mail-order services
Percentage of prescription volume 2%
Generic usage
Percentage of prescription volume 60%
Staff
Total 100
Professionals 84
Registered pharmacists 29

PBM services since: 1993.
Parent: MIM Corp.; primary business: holding company for PBM and mail order pharmacy.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide.
Billing method: capitated rate, fee per claim
Contact: Mark Leeper; 888-818-3939, ext. 1522, mleeper@mimhp.com.

U

USI Prescription Benefits dba York HealthNet*

665-675 Foxon Road, Suite 204,
East Haven, Conn. 06513;
203-468-8367; fax: 203-468-8416
www.yorkpbm.com

1999 revenues
PBM services $23,500,000
PBM clients
Total 330
Employee/group plans with direct service 250
Lives covered
Total 165,000
Active group health plan 70,000
Active workers compensation 1,000
Retail network
Pharmacy locations 47,500
Mail-order services
Percentage of prescription volume 6%
Generic usage
Percentage of prescription volume 42%
Staff
Total 21
Professionals 9
Registered pharmacists 3

PBM services since: 1995.
Parent: USI Insurance Services Corp.; primary business: brokerage/TPA.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Subcontracted services: disease management.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff, independent panel.
Service area: nationwide.
Billing method: capitated rate, fee per claim, per member per month; flat fee.
Officers: James Pennington, chairman; Lily Khodadoost-Kamvar, COO.
Contact: Lauren Cornelio; 203-468-8367, ext. 2130; lcornelio@usi-rx.com.
**formerly York Prescription Benefits*

United Drugs

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

1999 revenues
Total gross revenues $6,400,000
PBM services $900,000
Unbundled PBM services $100,000
PBM clients
Total 16
Employee/group plans with direct service 2
Lives covered
Total 160,000
Active group health plan 47,000
Active workers compensation 200
Retail network
Pharmacy locations 30,000
Mail-order services
Percentage of prescription volume 2%
Generic usage
Percentage of prescription volume 65%
Staff
Total 35
Professionals 9
Registered pharmacists 2

PBM services since: 1990.
Parent: American Associated Druggist Inc.; primary business: independent pharmacy cooperative.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Subcontracted services: mail-order drug distribution.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: Arizona, Arkansas, California, Colorado, Florida, Georgia, Idaho, Louisiana, Montana, Nebraska, Nevada, New Mexico, North Carolina, Oregon, South Carolina, Texas, Utah, Washington, Wyoming.
Billing method: fee per claim.
Officers: Mike Huston, CEO; Elizabeth Schrader, vp-operations and finance; Bruce Semingson, vp-managed care sales.
Contact: Elizabeth Schrader; eschrader@uniteddrugs.com.

W

Walgreens Health Initiatives

520 Lake Cook Road, Suite 400,
Deerfield, Ill. 60015-5217;
847-374-2640; fax: 847-374-2645
www.whphi.com

1999 revenues
Total gross revenues $682,987,199
PBM services $6,415,761
PBM clients
Total 673
Employee/group plans with direct service 602
Lives covered
Total 2,100,000
Retail network
Pharmacy locations 46,786
Generic usage
Percentage of prescription volume 43%
Staff
Total 222
Professionals 31
Registered pharmacists 11,300

PBM services since: 1995.
Parent: Walgreen Co.; primary business: retail pharmacy.
Services: retail pharmacy network, mail-order drug distribution, claims processing, online claims adjudication, concurrent utilization review, disease management, retrospective Rx utilization review, benefit design consulting, formulary management/review, physician prescribing practices monitoring/management, patient education.
Subcontracted services: formulary management/review.
Reports provided: physician prescribing patterns, employee utilization, percentage of generic vs. name-brand prescriptions dispensed analysis, cost analysis, member utilization.
Dispute resolution: PBM staff.
Service area: nationwide; Puerto Rico; United States Virgin Islands.
Billing method: fee per claim, fee for service.
Officers: Robert H. Halaska, president; David W. Bernauer, Edward H. King, vps. BI

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ASK A BENEFIT ACTUARY

Medicare HMOs still a viable alternative

By William J. Miner

Q **I read a lot about Medicare HMOs pulling out of markets around the country. What does this development mean for our strategy of giving our retired workers financial incentives to leave the corporate retiree health care plan and join Medicare HMOs?**

A This question comes from a senior executive at a major publishing company. Like many employers, the company's retiree population is dispersed throughout the country. Also, like many employers, this company has implemented various strategies in an effort to better manage its significant retiree health care costs and liabilities under Financial Accounting Standard 106. One strategy has been to offer retirees a Medicare health maintenance organization plan.

The cost savings to the employer from a Medicare HMO relative to the employer-sponsored plan can be significant. Twenty percent savings or more are currently possible, though this varies significantly by geographical area.

A Medicare HMO is an HMO that delivers the benefits provided by Medicare in exchange for a payment by the Health Care Financing Administration, or HCFA. Ordinarily, HCFA would pay for the Medicare benefits.

In addition, a Medicare HMO will also offer additional health care benefits beyond those provided by Medicare. When a Medicare HMO is offered, the retiree will typically have an annual choice to join the HMO or receive benefits under Medicare and an alternative employer-sponsored retiree medical program. In many instances, the amount paid by the retiree for coverage under a Medicare HMO is less than the amount that would be paid by the retiree for the combination of Medicare and the employer-sponsored plan, which gives retirees incentives to join these plans.

The effectiveness of providing retirees incentives to join Medicare HMOs depends largely on where those retirees are located. The recent withdrawal of insurers and managed care companies from many Medicare HMO markets has affected a significant number of retirees. Approximately 6 million of the current 39 million Medicare beneficiaries are enrolled in HMOs. As many as 12% of those now enrolled in these HMOs are affected by the most recent withdrawals, which will be effective Jan. 1, 2001.

As would be expected, Medicare HMOs are pulling out of markets that have proved to be unprofitable. Health insurers say inadequate federal funding resulting from the government's formula for calculating capitated reimbursement rates and rising health care costs are to blame for their lackluster financial results. Other Medicare HMOs that have not withdrawn from their markets have raised the premiums they charge to participants, or they have introduced premiums for plans that previously had none.

The unprofitable markets tend to be in more-rural locations with lower concentrations of Medicare beneficiaries and lower per capita reimbursement rates from Medicare. At the same time, Medicare HMOs continue to be widely available in more-urban markets that have higher concentrations of seniors and higher reimbursement levels from Medicare.

Although a reduction in enrollees of 12% is significant—and may be overstated, as an undetermined number of these enrollees may have alternate Medicare HMOs in their area to join—the vast majority of retirees enrolled in Medicare HMOs will not be affected by these withdrawals. In fact, nationwide, nearly 75% of all Medicare beneficiaries have access to at least one Medicare HMO. For many employers, providing financial incentives to join Medicare HMOs—such as reducing or eliminating the required retiree contribution for coverage—remains a very viable approach to managing the cost of retiree health care. As is the case with active plans, the appropriate level of employer subsidy will need to be reviewed on an HMO-by-HMO basis.

Employers should bear in mind that over the longer term, Medicare HMOs will not be the "silver bullet" in the fight to contain retiree health costs. Nevertheless, they appear to be able to offer significant cost-saving opportunities for employers. The longer-term savings might be expected to range from 20% to 30%. In addition, by enrolling in these plans, retirees can enjoy certain advantages compared to typical employer-sponsored indemnity plans. These benefits include lower cost-sharing levels for covered medical expenses, and prescription drug coverage that is comparable to that offered in employer-sponsored plans and is better than the coverage offered in standard Medigap plans.

Expect further changes in this dynamic market. Medicare reimbursement methodologies are likely to be revised and refined as the government responds to pressure to finance the health care needs of the elderly, especially in the area of prescription drugs. Employers should expect to review and monitor their HMO offerings on an annual basis. They may wish to consider the potential long-term viability of Medicare HMOs in a given market before deciding whether to offer a particular HMO. Factors associated with long-term viability include Medicare reimbursement levels in that market, commercial HMO penetration and excess provider capacity.

Another way in which employers should be positioned to respond to this evolving situation is to provide flexibility to retirees in entering and exiting employer-sponsored retiree health care plans. Employers should review—and, if necessary, implement—rules and administrative processes that facilitate their retirees' ability to change their health care options.

Employers should also continue to look at other approaches to managing retiree health care costs. These include:

- Making use of managed care options available to the pre-age-65 retiree population.
- Focusing on cost containment for the prescription drug component of the benefit through plan design, formularies and other targeted approaches.
- Continuing to review cost-sharing strategies.

By no means should employers abandon offering incentives to retirees to enroll in Medicare HMOs. Employers that remain with this approach will continue to have the opportunities to enjoy significant savings in the managed care environment of Medicare HMOs compared against the unmanaged fee-for-service environment in the rest of the Medicare landscape. BI

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

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

This month's column on actuarial issues in the benefits field is written by William J. Miner, an actuary with Watson Wyatt Worldwide in Chicago. Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore., answers actuarial questions in the casualty field. Christopher E. Mandel, senior director of risk management at Tricon Global Restaurants Inc. in Louisville, Ky., answers questions on risk management. Dennis J. Nirtaut, managing director of compensation and benefits for Arthur Andersen L.L.P. in Chicago, answers questions on employee benefit plans.

Mr. Miner

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.

Faulty workmanship not covered under CGL

LEGAL BRIEFS

A lawsuit by a building owner against a contractor alleging damages caused by faulty workmanship is not within the coverage provided by the contractor's general liability policy unless such coverage is specifically included in the policy, the Supreme Court of Appeals of West Virginia has ruled.

Gerald and Mary Skanes contracted with Pioneer Home Improvement Inc. to do some work on their home, including the installation of new siding. The Skanes made an initial payment to Pioneer prior to the commencement of construction. Although the work was not performed to the Skanes' satisfaction, they paid the second installment at Pioneer's urging. Relations deteriorated further, leading Pioneer to terminate work.

The Skanes refused to pay the balance of the contract and sued Pioneer for breach of contract. Pioneer had a commercial general liability policy issued by Erie Insurance Property & Casualty Co., which included coverage for a completed-operation hazard. That hazard was defined as personal injury and property damage occurring away from premises the policyholder owns or rents, arising out of work that has been completed or abandoned by the policyholder. Erie declined coverage. Pioneer brought suit seeking a declaration from the court that the CGL policy covered its liability for the cost to correct the faulty workmanship on the Skanes' house. The trial court ruled against Pioneer.

The appellate court said that CGL policies do not provide protection for poor workmanship; instead, these policies protect a policyholder from liability due to personal injury or property damage to others caused by the policyholder's negligence. Damages to a building sustained by an owner as the result of a breach of construction contract due to the contractor's faulty workmanship are a business risk to be borne by the contractor, not by his commercial general liability insurer, the court said. The lower court decision was affirmed.

Erie Ins. vs. Pioneer Home Improvement, Supreme Court of Appeals of West Virginia, Dec. 10, 1999 (*BI*/02/Au. -$10)

This abstract was prepared by Mayo H. Stiegler. Copies of the decision are available by sending a $10 check payable to Mayo H. Stiegler, to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Provide the listed number for each opinion.

Jumbo

Continued from page 2

The estimated selling price for an Airbus A3XX would be approximately $200 million, compared with approximately $170 million for a Boeing 747-400.

Boeing also has raised the possibility of developing a larger aircraft with greater capacity—essentially a stretched version of its 747—but has not decided whether to build the superjumbo aircraft.

While aircraft manufacturers deal with the technical and economic issues involved in developing superjumbo aircraft, the insurance industry will face issues of its own when these aircraft take to the skies.

"From an insurance standpoint, the issue of that many people in a single aircraft in the event of an unfortunate mishap would certainly pose a significant concern," said aviation lawyer Christopher R. Barth, of counsel at the Lord, Bissell & Brook law firm in Chicago.

"The question still remains whether there is sufficient coverage currently being offered to insure the single loss of an A3XX," Mr. Barth said.

He noted that a recently settled aviation liability claim saw insurers paying out $230 million, "and that was on 100 people that were lost." With the superjumbos, 'you're talking multiples of that," Mr. Barth said.

At that rate, an insured liability loss in the neighborhood of $2 billion from a single superjumbo disaster is certainly conceivable.

"Right now, the policies are being written in the $1.5 billion range for the large carriers," Mr. Barth said. "People may argue that that's enough coverage, but certainly that needs to be examined."

But Bill Behan, president of aviation industry broker AirSure Ltd. in Golden, Colo., said he doesn't believe the insurance challenges posed by the A3XX would be insurmountable.

"The overwhelming response is that it just takes a few more players to participate in an airline's placement," Mr. Behan said.

For example, he said, if the lead company on an airline's aviation liability program is currently taking 20% on $1 billion in limits, the addition of superjumbos to the fleet "just means that that company might be reluctant to take 20% but will take 15%."

"It's a question of capacity in the marketplace," Mr. Behan said. "There's certainly ample capacity, as evidenced by the number of aviation underwriters losing money the past few years."

"Obviously, increased seating capacity may require the airline that acquires these aircraft to seek additional support in the marketplace," Mr. Behan said.

But, he suggested, the jump in capacity and liability would not be as great as what airlines and insurers faced when Boeing's 747s were introduced to airline fleets in the 1970s.

The jump in exposure from the smaller Boeing 707s and 727s to the 747 "was dramatic," Mr. Behan said. "Now they know they can do it."

In fact, the move to jumbo jets such as the 747 not only prompted airlines to increase their insurance limits but also changed the way they insured their aviation risks.

With the arrival of the 747, aviation liability programs moved from a "horizontal" approach, in which a single carrier insured an initial layer of risk with additional insurers covering layers above it, to the current "vertical" program structure, with a group of insurers splitting losses from the first dollar on a percentage basis.

"We're writing 747s now with 400 people aboard, and the insurance industry adjusted to that" said one aviation insurance executive. "Now it's just a matter of pricing the exposure."

An insured liability loss of around $2 billion from a single superjumbo disaster is conceivable, says lawyer Christopher R. Barth.

"A lot will depend on where the marketplace is at the time," the aviation executive said. "Right now we're in a very competitive marketplace."

Whether aviation underwriters will be able to raise rates to address the increased level of risk when the first superjumbos take off around 2010 remains to be seen, according to Mr. Barth.

"It's going to be tough for the insurers because, right now, the market remains soft," he said. "It's not easy to go out there and start raising premium, because the risks have increased without an anticipation of some lost business."

The additional exposures created by flying superjumbos is "an issue that needs to be clearly examined by the insurers and their reinsurers" to ensure that rates are adequate for the increased risk, Mr. Barth said.

The increased risks posed by superjumbos aren't limited to the airlines flying them. The double-decker planes' size and their passenger loads also will pose additional exposures for airports.

"One of the concerns that we have, and I've heard others voice the same thing, is dealing with the magnitude of 500 to 600 people in the airport terminals" for a single flight, the aviation insurance underwriter said.

"The question that was raised in speaking with other associates in the business and (National Transportation Safety Board) members and former members, is that evacuation is a very difficult process if you're talking about an accident that is on the ground," the insurance company executive said. "I think the potential for getting people out of the airplane in an accident situation will be just that much more difficult than it is already."

Mary L. Stewart, risk manager for the Metropolitan Washington Airports Authority in Alexandria, Va., said, "These things are 550 passengers, and you don't know how much the full capacity's going to be in them yet, so that would lead you to believe that if you haven't thought about increasing your limits of liability, then you should."

Ms. Stewart said a recent study conducted by the Washington authority showed that airports in the Northeastern United States currently carry the highest liability limits among U.S. airports.

The authority's London underwriters explained that the trend toward higher limits in the region was based on the weather conditions those airports face, their proximity to water and the litigious atmosphere in the United States.

Many of those same airports would no doubt be among those served by the superjumbos.

"When you look at these superjumbo jets, I think that these people that are operating these airports in the Northeast United States would be the ones who would have to look at increasing their limits," Ms. Stewart said.

The added passenger loads posed by the superjumbos will increase exposures for airports before the passengers ever board the aircraft. More passengers means a greater risk of slips and falls, for example.

The issue is particularly troublesome at airports that rely on mobile lounges, such as Washington's Dulles International Airport, or those employing trains or buses to get passengers to gate areas.

"The potential is there, and the potential can increase when your aisles aren't wide enough to accommodate, or people start trying to push and shove to get into a limited means of transportation," Ms. Stewart said. "You have to start taking all these things into consideration."

"The more that you get people anxiously waiting for something or waiting for the next plane to take them to their destination, all of that increases your potential liability," the risk manager said. "The drunk passenger who's been able to drink because he's been waiting for three hours, all of that starts to snowball."

While both airlines and airports will have to examine the increased risks superjumbos will pose and move to address them, the sense is that both will do so and that the insurance industry will respond with adequate capacity to cover the increased exposures.

"There's a lot of issues here that will have to be dealt with," the aviation insurance executive said. "As far as their being able to buy insurance for it from a liability standpoint, I'm confident they'll be able to do that." BI

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GLOBAL BRIEFS

American International Group Inc. has named Ian D. Cormack to the new position of chief executive officer of its European operations. Mr. Cormack, who will be based in London, was previously with Citibank in London, where he was global industry head for the investment industry. In his new role at AIG, Mr. Cormack will oversee insurance, financial services and asset management. . . .Terry Paradine has been appointed CEO of **Marsh Inc.'s U.K. operations**. Mr. Paradine, currently chairman of Marsh's Asia-Pacific operations, will join the brokerage's European board and European executive committee. Robert Solomon, chairman of Marsh's International Specialty Operations, will assume responsibility for the Asia-Pacific division. . . .Bob Scott, CEO of London-based multiline insurer CGNU P.L.C., has been appointed chairman of the **Assn. of British Insurers**, a U.K. trade association. Mr. Scott succeeds Sandy Leitch, CEO of Zurich Financial Services Group Inc. . . .Jerome Faure has been promoted to president and CEO of **SCOR U.S. Group**. Mr. Faure has been executive vp of SCOR U.S. since 1997. He succeeds Jerome Karter, who will become vice chairman of the SCOR U.S. board of directors. . . .**Electronic signatures** are now admissible in U.K. courts of law. Under Section 7 of the U.K. Electronic Communications Act 2000, which took effect on July 25, e-signatures are now as admissible as handwritten signatures. The U.K. Department of Trade and Industry said that the new law should increase confidence among businesses conducting e-commerce-related business. . . .The insurance industry could save $20 billion if it developed **online insurance exchanges**, according to a new report by London-based KPMG Consulting. Online exchanges could be used to process about $170 billion of claims, which would result in reduced transaction costs, the study said. . . .London-based **CGNU P.L.C.** is exiting the German commercial insurance market. CGNU plans to sell General Accident Versicherungs A.G. to Cologne-based Gerling-Konzern Lebensversicherungs A.G. CGNU said it hoped to complete the sale, whose terms were not announced, by the end of the year. . . .Stress results in 360 million lost work days each year in the United Kingdom, according to a study by the U.K. Health and Safety Executive, a government-funded body responsible for workplace health and safety. The "Mental Health and Stress in the Workplace" report said that **stress-related absence** costs U.K. industry about £8 billion ($12.14 billion) per year. . . .Mulheim, Germany-based Aon Jauch & Huebener Holdings A.G. is to join forces with Frankfurt-based online broker InsuranceCity A.G. to offer **online affinity group insurance services**. The joint venture will mainly target the staff of major corporations. Customers will be able to take out policies electronically via the Internet or an intranet. The new venture, which will be called Aon InsuranceCity GmbH, will be headquartered in Frankfurt and will begin writing business in the fall. . .The United States and Japan struck a comprehensive trade agreement last week that should lead to **increased foreign participation in Japan's insurance market**. Among the agreements were Japan's commitment to accelerate the processing of licenses, product and rate applications and notifications; increased written guidance and transparency on insurance regulation and requirements for foreign insurers, additional staff resources at Japan's Financial Services Agency to speed up the various approval processes required of foreign insurers; and measures to advance commercial lines deregulation initiatives.

Surplus, solvency margin up

Runoff reinsurer for Lloyd's concentrated on settling pollution claims

By SARAH VEYSEY

LONDON—The last fiscal year was a good one for Equitas Ltd., according to Chief Executive Officer Michael Crall, though its shifting claims composition is creating some uncertainty about its future.

For the 12 months ending March 31, accumulated surplus at Equitas, the runoff reinsurer for Lloyd's of London's pre-1993 long-tail liabilities, rose 1.6% to £784 million ($1.3 billion), from a year earlier. Net claims outstanding fell by 13.1% to £7.0 billion ($11.3 billion), compared with last year. The company's solvency margin—its accumulated surplus expressed as a percentage of its net claims outstanding—increased to 11.2% from 9.6%.

"These results reflect further good progress at Equitas. Excluding extraordinary credits, the contribution to surplus from our core activities was comparable to that achieved in previous years," said Equitas Chairman Hugh Stevenson.

"Furthermore, our solvency margin strengthened substantially as a result of the reduction in net claims outstanding," Mr. Stevenson said.

Mr. Crall

Equitas has made good progress in terms of its evolution, Mr. Crall said. "The organization has come together faster and better than could have been expected," he said. "The difference between this and other years is that we have been doing more operational work, executing the business plan. We are beginning to approach the world-class status we aspire to."

Mr. Crall said that, over the past year, Equitas has begun to be more assertive about settling asbestos, pollution and health—or APH—claims. The reinsurer has been particularly active in the area of pollution claims, he said, noting that "we are looking to settle those as quickly as we possibly can."

"When we were formed, I think many people thought Equitas would take the policy of stalling, which is what a lot of runoff companies have tended to do. We have turned that policy on its head," Mr. Crall said.

In the past year, Equitas has closed 128—or just over 25%—of the 509 open direct pollution claims pending on April 1, 1999, he said. "Furthermore, we settled 40% of pollution claims with reserves in excess of £10 million ($16 million) at April 1, 1999," he said. Taking into account new claims, the number of open pollution claims decreased by more than 20%, to 404, during the past year.

Mr. Crall said that progress also was being made in the area of what Equitas terms "balance-of-account claims," which en-

See **Equitas** *on page 35*

Australian blasts plan to draft new standard

By KATE TILLEY

BRISBANE, Australia—European risk managers are "reinventing the wheel" by exploring how to develop a new generic standard for risk management, according to Kevin Knight, the president of the Australian Institute of Risk Management.

Instead, he said, the Australian and New Zealand standard, AS/NZS 4360, ought to be used globally as a basis from which other, industry-specific risk management standards can be developed.

The AUSTRALIAN INSTITUTE of R·I·S·K MANAGEMENT

"The tendency of so many in Europe and North America to want to reinvent the process, as if AS/NZS 4360 did not exist, is an incredible waste of resources and borders on stupidity," said Mr. Knight, a past chairman and current board member of the International Federation of Risk & Insurance Management Organizations, and risk management coordinator for the Queensland Education Department.

According to the newly released report of the European Commission's Joint Research Center's four-day international workshop, held in Italy May 22-25, "No generic standard across different industries exists."

But Mr. Knight said AS/NZS 4360 has been available since November 1995 and is widely used in both the public and private sectors in Australia and New Zealand. The National Health Service in Great Britain also has adopted it as the basis for corporate and clinical governance programs.

Mr. Knight, a member of the Standards Australia and New Zealand technical committee responsible for developing AS/NZS 4360, said the consultative process through which the standard was developed was "time-consuming and occasionally frustrating."

However, it meant the final document was "clearly the product of the discipline covered by the standard and its adoption is viewed as best practice and voluntarily accepted."

See **Standard** *on next page*

Risk execs urged to raise IT role

By CAROLYN ALDRED

LONDON—Despite the fact that many U.K. companies now maintain specialty information technology departments or employ IT consultants, corporate risk managers must be involved in the management of these risks, many executives contend.

A risk manager's role is to coordinate the specialists and "consider the big picture" in managing risk, said Stuart Martin, chairman of the Assn. of Insurance & Risk Managers' e-commerce special-interest group.

It is important for risk managers to bring together all departments involved, including IT specialists, finance, legal and human resources, and help them identify and manage the areas of risk, said Mr. Martin.

Standard risk management techniques can be applied to IT and e-commerce risks, he said.

IT security "is a very specialist area. I don't think it's something that traditional risk managers should attempt to be involved in. What risk managers should be interested in is making sure the company has a good IT manager and good external advice and to be constantly monitoring security," said Mark Butterworth, group insurance risk manager for Prudential Corp. P.L.C. in London and former chairman of AIRMIC.

"There is a need for very experienced IT players to be trained in risk concepts," Mr. Butterworth said.

But others in the IT security sector argue that the understanding of risk is fundamental, more important than IT skills for someone with responsibility for IT security.

"The best people to deal with com-

See **Security** *on next page*

IT abuses rampant

Study reports widespread losses from cybercrime

A recent survey on cybercrime conducted by information security company Integralis highlights the risks British companies face as the use of technology and the Internet increase.

Theale, England-based Integralis, a subsidiary of the German-Anglo Articon-Integralis Group Ltd., surveyed the directors of 1,000 leading U.K. companies.

According to Integralis, of the 150 company directors who responded to the survey, 72% stated that their individual companies had lost thousands of pounds as a consequence of "cybercrime" in the past three years. For 16%, the company losses had run into tens of thousands of pounds; for 6%, hundreds of thousands; and 1% estimated that it had cost them millions of pounds.

In total, 56% of those who responded said their companies had lost money through Internet abuse; 79% had been the victims of virus contamination; 15% had experienced the theft of company information using information technology; 10% had had data or networks sabotaged; 10% had intercepted e-mails with some form of criminal content; 6% had experienced financial fraud; and 15% had service denied through cybercrime.

Information security policies on internal breaches had been adopted by 73% of companies who responded, but 10% of the responding directors said their companies had no information security policies at all. Thirty percent of respondents did not know that company directors can be prosecuted for cybercrimes committed by their own employees on their company networks.

Among respondents, 55% identified cybercrime as being a significant threat to their company. Meanwhile, 32% of the company directors reported having at least one disgruntled employee pass confidential company information to a third party; 50% reported one or more employees accidentally distribute confidential information; and 62% said they had had at least one employee distribute offensive e-mail, such as pornography.

—By Carolyn Aldred

Security

Continued from previous page
puter risk are not the technos, who are not used to dealing with risk, but someone who is used to using the concept of risk. The risk often is not the technology but the people using it or with access to it," said a senior computer security auditor who did not wish to be named.

"When I come to audit a company on its computer security, I want to be introduced to a member of the board who has overall responsibility for security—an accountant, financial director, risk manager or head of security. IT security has to be part of the whole of a company's risk management, not just left to the IT department," he said.

"The world is changing. If a building burns down, it is unlikely to be the same disaster as when a company loses its database," the security auditor said.

A company's risk management approach should include attention to its IT-related exposures, agreed Charles Johnson, a London-based director in PricewaterhouseCoopers' operational risk services practice.

Many businesses today depend greatly on data and computer technology, and managing the risk of computer failure or loss of data and ensuring business continuity is crucial to a company's future, Mr. Johnson said.

Furthermore, many of the actions companies need to take to minimize the loss of business due to IT failure, system disruption or misuse involve basic risk management principles, he said. IT risk management procedures that mirror basic risk management practices include the preparation of business continuity plans, the specification of procedures for outsourced functions, the maintenance of secure work environments with restricted access, the maintenance of audit trails to allow for the investigation of incidents and the regular storage of backup records in locations that are safe from natural disasters.

"We treated setting up the site the same way we would have looked at the risks of setting up a new company—applying the same processes, due diligence and standard risk management techniques," he said.

Another risk manager acutely aware of the IT risks a company can

'The world is changing. If a building burns down, it is unlikely to be the same disaster as when a company loses its database,' a security auditor says.

Just as good risk manager makes sure that a company has access to whatever resources will speed its recovery from disasters, so must a risk manager at a company that is totally reliant on its computer systems, such as an Internet-based company, maintain the resources that would provide recovery from an electronic breakdown in a few minutes, Mr. Johnson said. This could include having a primary computer system in one location and a duplicate backup system in another, he said.

As corporate risk manager of Farnborough-based aviation electronics company BAE Systems, Mr. Martin has been working closely with IT specialists examining Internet and e-commerce risks.

The company is setting up an industry Web portal and working with other companies to establish an Internet trading site.

BAE's risk department "pulled in the finance and IT departments to look at risk and realized no one had considered the big picture" when it came to risk management, Mr. Martin said.

face is Danica Boag. Ms. Boag is insurance manager for the London-based publishing company Reed Elsevier P.L.C.

Most of Reed's publications now are published online, which makes IT failure or abuse a damaging risk. "Also, the loss or theft of any of our customer lists would be disastrous," Ms. Boag said.

Generally, the management of the risk is left to the IT directors and the business units themselves, Ms. Boag said, pointing out that the business units follow best-practice guidelines. And the company's auditors also ensure that the risk is managed. But Ms. Boag ensures that the risk is protected as much as possible.

Currently, she is negotiating with insurers about Reed Elsevier's IT coverage.

Although a handful of insurers currently offer cyber-specific products, Ms. Boag said she would prefer to avoid buying separate policies.

"We are negotiating with our insurers to extend the definition of 'property' to cover intangible products, ' she said. Ms. Boag pointed out that, because her publishing company is simply transferring its product to the Internet, it is already familiar with many of the applicable risks, such as copyright risk, and has the policies and procedures in place to deal with them.

For Internet and IT risks, the "insurance market is well behind the requirements of industry," said AIRMIC's Mr. Martin.

"There is very limited cover, and it is very expensive. The insurance market generally doesn't understand the risks and the underwriting processes involved. At the moment, insurers are just trying to plug the gaps in standard policies," he said.

"The insurance industry has a long way to go, but it doesn't have a choice. The exposures and demand is there; it is going to have to come up with something. Some insurers are becoming more aware of the issue," Mr. Martin said.

For many companies, information and knowledge are their greatest assets, and IT security often is crucial to retaining such assets, said Bill Waite, managing director of the London-based Risk Advisory Group.

Unfortunately, "very few companies have proper information security policies in place, and staff often are reluctant to comply with such policies, such as changing passwords," Mr. Waite said.

Risk Advisory Group, which was founded in 1997, typically is called in to work with an organization after an incident of information theft, fraud or unintentional loss has occurred.

In 80% of cases, the incident was caused by an employee, Mr. Waite said. Industrial espionage involving the theft of sensitive business information is on the increase; such thefts are made easier by IT, he said.

"There is a huge degree of naivete about the value of information, and (there is) too high a degree of trust," Mr. Waite said.

Companies need to be made aware of the value of knowledge; to determine which employees need to know what, and on what basis; and to put strict controls around the flow of information, he said. BI

Standard

Continued from previous page
Mr. Knight said the committee intended the standard to be generic and independent of any specific industry or economic sector. Since then, industry-specific guidelines have been developed in Australia, as well as guidelines on the application of the risk management process to areas such as outsourcing, environment and business continuity management.

Mr. Knight said the European Commission's workshop debated issues that were resolved in Australia and New Zealand in 1992. He blamed "regional jealousies" and a reluctance among some European and North American risk management practitioners to accept that "the antipodes have done it first."

Mr. Knight said British risk managers also are planning to develop another generic risk management standard. The Assn. of Insurance and Risk Managers, the Assn. of Local Authority Risk Managers and the Institute of Risk Management have jointly commissioned a team to create a new standard for the United Kingdom (*BI*, May 8). BI

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LEGAL NOTICES

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION OF RCA SYNDICATE #1 LTD.) NO: 00 CH 07217

NOTICE OF CLAIM FILING DEADLINE AND PROCEDURES

PLEASE TAKE NOTICE, that on June 5, 2000, the Circuit Court of Cook County, Illinois, entered an Order of Liquidation With a Finding of Insolvency against RCA Syndicate #1 Ltd. ("RCA Syndicate"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of RCA Syndicate ("Liquidator").

TAKE FURTHER NOTICE, that on June 16, 2000 the Circuit Court of Cook County, Illinois, entered an Order Fixing Rights and Liabilities and Providing for the Filing of Claims and the Setting of Claim Filing Deadlines ("Fixing Order"). Pursuant to the Fixing Order, all rights and liabilities of RCA Syndicate and its policyholders, creditors and stockholders, and all other persons interested in its property or assets, are fixed as of June 5, 2000, unless otherwise provided in prior or subsequent orders of the Court.

TAKE FURTHER NOTICE, that all persons, companies or entities who have, or may have claims, against RCA Syndicate, its property or assets, or against an RCA Syndicate insured or policyholder, shall have the right to present and file with the Liquidator proper proofs of claim on or before June 5, 2001 at 4:30 p.m. (C.D.T.).

TAKE FURTHER NOTICE, that any insured under an insurance policy issued by RCA Syndicate shall have the right to present and file with the Liquidator a proper proof of claim setting forth a contingent claim on or before June 5, 2001 at 4:30 p.m. (C.D.T.). No contingent claim shall be allowed for purposes of participating in any distribution of estate assets that may be made at the fourth priority level [215 ILCS 5/205(1)(d)] unless such claim has been liquidated and the insured claimant has presented and filed evidence of payment of such claim to the Liquidator on or before June 5, 2002 at 4:30 p.m. (C.D.T.). Any contingent claim for which a proper proof of claim is filed on or before June 5, 2001 at 4:30 p.m. (C.D.T.), but which is not liquidated on or before June 5, 2002 at 4:30 p.m. (C.D.T.), may be estimated pursuant to 215 ILCS 5/209(4)(b) for purposes of participating in any distribution of estate assets that may be made at the fifth priority level [215 ILCS 5/205(1)(e)] unless otherwise directed by the court.

TAKE FURTHER NOTICE, that the form and required content of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with, and may be obtained from, the Liquidator of RCA Syndicate, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to RCA Syndicate relating to all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST RCA SYNDICATE, ITS PROPERTY OR ASSETS, OR AGAINST AN RCA SYNDICATE POLICYHOLDER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE JUNE 5, 2001 AT 4:30 P.M. (C.D.T.)

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Equitas

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compass most non-APH claims. "However, balance-of-account claims tend to be settled comparatively quickly, with the inevitable result that APH claims make up an increasing share of our reserves each year," he said. "APH claims represent 65% of net discounted liabilities at March 31, 2000, compared with 40% when we began operations. As the proportion of APH claims in our total reserves increases, Equitas is exposed to potentially greater volatility and uncertainty in its financial position going forward."

Equitas has strengthened its reserves for future asbestos claims. Last year, the reinsurer added £711 million ($1.15 billion) to its claims reserves. This increase was prompted by a noticeable increase in the number of underlying asbestos claims, said an Equitas spokesman. The spokesman said it was too early to tell whether the increase in asbestos claims marks the beginning of a trend, but said that the move to increase asbestos reserves was a precautionary measure. "We are taking a cautious approach to this development—the increase in direct asbestos claims filings. If we find no need for it, we will release the reserves in future years, but we think this is the cautious and correct step to take in view of what we have seen," the spokesman said.

Mr. Crall was quick to refute reports in the U.K. press that Equitas may be hit hard by tobacco claims arising from lawsuits in the United States. "We continue to track issues which could lead to new claims, including tobacco liability, though we continue to believe that tobacco claims will not create a significant liability for Equitas," he said. "Furthermore, we have not identified any previously unknown health hazard which we believe could create a material liability."

Mr. Crall described as "basically speculative" an article in the U.K. press that suggested that the outcome of a lawsuit filed by Liggett Group Inc. might encourage tobacco companies to lodge claims with their insurers. According to that article, the outcome of the case, which is being brought by Durham, N.C.-based tobacco manufacturer Liggett against 30 insurers, could prompt other tobacco companies to follow suit; the trial is scheduled to begin in November in Delaware.

Mr. Crall said that Equitas had examined policy wordings in great detail and was confident that any tobacco company claims would not hit the reinsurer badly.

Mr. Crall said that Equitas could never rule out the possibility of unforeseen claims arising.

"Given the range of policies that Lloyd's wrote, there is always the possibility of something. But, with each year that passes, the possibility of that happening decreases. In the three and one-half years since we have been going, we have seen no threat of new hazards."

According to Mr. Stevenson, the group's auditors "properly point to the uncertainties which are fundamental to the long-tail nature of the asbestos, pollution and health hazard claims" that represent two-thirds of Equitas' outstanding liabilities. "We have little or no control over many important external factors, such as legal developments, judicial decisions and social trends—especially in the United States—all of which could threaten our stability," he said.

The outcome of the *Jaffray vs. Lloyd's* fraud case will have no impact on Equitas, said Mr. Crall. The case involves more than 200 names who refused to sign up to the 1996 reconstruction and renewal program and did not pay premiums into Equitas. "We are not party to (the case). The outcome of the case will not affect Equitas," he said.

Mr. Crall did not rule out the possibility that Equitas might one day be acquired by another company, but he said that such a development was a long way off. "There are no shares to purchase. But it is not inconceivable that, at some time in the future—for example, in 20 or 30 years time—there will still be claims," he said. "But Equitas will be very small, so there would be little point in it remaining free-standing." BI

Chairman

Continued from page 1

executive capacity.

"My three years at Lloyd's have been fascinating, as our market has responded to the many challenges faced by the insurance industry worldwide. With the problems of the recent past behind us and an impressive set of initiatives under way, I feel I leave the market in great shape for the future," Mr. Taylor said in a statement.

Prior to 1992, the position of chairman at Lloyd's was a part-time one. It became a full-time job in 1992, with the appointment of Sir David Rowland, due to the exceptional circumstances the market faced at that time, according to Lloyd's. In 1992, Lloyd's was grappling with huge underwriting losses and proposals for restructuring the market.

The change in the chairman's role will mean greater prominence for Lloyd's chief executive officer, Nick Prettejohn, a Lloyd's spokesman said.

"Lloyd's has much to thank Max for over last three years," Mr. Prettejohn said in a statement. "His energy and enthusiasm for the role, his leadership in the Lloyd's-(International Underwriting Assn.) forum, and his tireless promotion of the Lloyd's brand around the world have helped to position our market at center stage of the world's insurance industry."

"I shall be sad to see him leave at the end of this year, but I fully understand his decision to move on to fresh challenges," Mr. Prettejohn said. BI

Concorde

Continued from page 1

British Airways, which operates seven Concordes, canceled two Concorde flights last Tuesday, following the Air France crash, but it later resumed flights.

Only days before the crash, both airlines had confirmed that microscopic cracks had been found in the wings of their Concorde fleets. British Airways, which found cracks in all of its Concordes, grounded one of its planes, but both airlines said that the cracks in the other jets were not serious enough to warrant taking them out of service.

At the time of the crash, the normally all-first-class aircraft was on a charter flight, taking customers of a German tour company to New York. The Concorde flight had been chartered by a German tour group, Peter Deilmann Shipping Co., which specializes in arranging luxury cruises.

Underwriters and brokers have been reluctant to estimate the possible liability payments resulting from the crash, due both to the sensitivity of the subject and to uncertainty about how the wealth of the flight's passengers could affect payouts.

One aviation market source, who asked not to be identified, said that estimates that total claims could reach $350 million, which had been reported in some press stories, were far too high. He said liability claims would probably not exceed $150 million.

He said his assessment of liability is based on the fact that any court cases brought by families of the victims will probably be heard in Europe, and not in the United States, where awards tend to be larger. Additionally, he said, a European Union agreement on compensation for air-travel accidents—the 1997 European Council Regulation No. 2027—imposes a liability limit of 100,000 euros ($94,260) per passenger.

Lee Kreindler, a specialist in aviation liability matters and a senior partner in the New York law firm of Kreindler & Kreindler, agreed that the likelihood that claims won't be heard in U.S. courts should mitigate the level of liability payments.

Mr. Kreindler explained that, under Clause 28 of the Warsaw Convention, an international pact that also will govern payouts from this crash, four criteria dictate the forum where legal action can be pursued: where the ticket was sold, where the airline is based, the location of the airline's principal place of business, and the final destination on the ticket. If it is assumed that the Air France passengers had round-trip tickets, in order to return to Europe, none of these factors, he said, would enable any Concorde claimant to take a case to a U.S. court.

The likelihood that claims won't be heard in U.S. courts should mitigate the level of liability payments, says Lee Kreindler.

The hull of the Air France Concorde was insured for $30 million, and the airline has an unknown quantity of liability insurance. Major airlines typically carry up to $1.5 billion in liability limits.

According to a spokesman for the Paris-based Federation Francaise des Societes d'Assurances, an insurance trade group, the Air France account is placed on a combined hull-and-liability basis, so insurance and reinsurance participants share in both exposures.

The combined coverage for the airline was led in Paris by La Reunion Aerienne, which had 50% of the program's primary layer. La Reunion Aerienne is an aviation pool that includes Groupama-GAN; Mutuelle du Mans Assurance; Abeille Assurances, a subsidiary of CGNU P.L.C.; and Assicurazioni Generali S.p.A.

The FFSA spokesman said that the remaining primary layer was shared 30% by Assurances Generale de France and its German parent, Allianz A.G. Holding; and 20% by France's largest insurer, AXA Group S.A.

Almost half—47%—of the program's reinsurance was placed in the London market, of which 15% was underwritten at Lloyd's of London, a Lloyd's spokeswoman said. The reinsurance coverage was led in the London market by British Aviation Insurance Group Ltd., and the entire reinsurance program was brokered in London by HLF Insurance Holdings Ltd.

A spokesman for AGF said the wealth of the passengers will be a factor in the liability payments to their families.

Graham Nichols, chief executive officer of Westminster Aviation Ltd. in London, which has a "small share" of Air France's reinsurance program, agreed. Overall liability payments will be influenced by the fact that the Concorde is a "first class plus" aircraft, which tends to carry wealthier passengers, he said. He declined to estimate the potential level of payments from the crash.

Although the plane had been chartered at the time of the crash, the airline's liability is likely to be determined by the conditions of coverage on the passengers' tickets, said Mr. Nichols.

The FFSA said in a statement that liability limits for Air France are governed by both the Warsaw Convention and the European Council Regulation No. 2027. In addition to setting per-passenger liability limits, the European Council regulation also will require Air France to give claimants an advance payment of at least 140,000 francs ($20,118) per passenger to meet their immediate needs. This advance will not affect the claimants' rights to pursue later compensation.

Air France is also one of about 150 airline signatories to the International Air Transport Assn.'s Intercarrier Agreement. The agreement removes the requirement that a claimant prove negligence against an airline in order to seek compensation above the passenger liability limits set in the Warsaw Convention.

An IATA spokesman explained that the Intercarrier Agreement allows for compensation that is "reasonable and just," which, he said, is determined by such factors as the earnings potential of a crash victim and his or her standard of living and place of residence.

At a time when aviation rates already are slowly firming, along with a general hardening of global property/casualty insurance markets, aviation underwriters see the Concorde loss more as a factor likely to reinforce their resolve to raise rates than as an occurrence that will, in itself, force rates to rise.

David Whiter, senior class underwriter-aviation at Brockbank Syndicate Management Ltd. in London, said that, while the Concorde loss will affect sentiment in the market, it is unlikely, in itself, to bring about higher rates. A loss such as this will affect the market in the aggregate and over time, he said.

"I doubt that a single loss affects things, but in a market that's rising, any serious accident can affect sentiment," Mr. Whiter said. He said that a general increase in aviation rates that is already underway "will gather momentum, especially toward the last quarter of the year."

While adverse publicity and grounded flights are likely to have some short-term impact on the revenues of the two airlines, analysts believe that the effects will not be long lasting.

Guy Kekwick, airline analyst with Goldman Sachs & Co. in London, said, "I can't see any medium- or long-term impact on the earnings of either airline. Concorde is a relatively small part of their overall fleets."

•

Sarah Veysey contributed to this report.

Swissair lawsuits are being settled

LONDON—Some of the large liability claims brought on behalf of victims of the September 1998 crash of Swissair flight 111 have been settled, and more are likely to be agreed to out of court.

Lee Kreindler, senior partner and aviation liability lawyer in the New York law firm of Kreindler & Kreindler, said that 15 to 20 cases have been settled so far. Mr. Kreindler, who is the chairman of the plaintiffs' committee for the Swissair claimants, said he is still attempting to resolve claims. He said that he "would expect most of the cases to be settled, if handled properly."

Litigation of eight cases has begun in federal court in Philadelphia. Mr. Kreindler represents plaintiffs in 82 of the approximately 150 cases pending in U.S. courts as a result of the crash off the Canadian coast; all 229 passengers and crew members on board the Swissair flight were killed.

Graham Nichols, chief executive officer of London-based Westminster Aviation Insurance Group Ltd., has also said he is aware that "a couple" of higher-value Swissair claims have been settled.

Mr. Nichols said that he believe that more claims will be settled out of court, because, with the passage of time, it grows less likely that investigators will determine the cause of the fire that brought down the plane. Claimants have little likelihood of gaining new supportive evidence by postponing their settlements, he said.

—By Edwin Unsworth

ADVERTISER

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Pension

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ate Majority Leader Trent Lott, R-Miss., perhaps sensing the popularity of the pension legislation, has said that the bill might be bundled in a broader budget measure.

That budget bill then could be loaded down with other provisions that the Clinton administration opposes, possibly leading to a veto. Assuming the veto was not overridden, Republicans would have new political ammunition: telling voters that the administration came out against a bill that would have allowed employees to save more for their retirement.

"In a supercharged political year, any type of major legislation can be difficult to pass. So, many things can happen," Mr. Saveth noted.

• Time. When legislators return to Washington in the fall, they will have only about four weeks before Congress adjourns to allow members to hit the campaign trail. That might not leave enough time for Congress to complete action on the bill.

"The schedule is very crowded. The bill will need a push," said Janice Gregory, vp-pensions with the Washington-based ERISA Industry Committee.

• Leadership. While Reps. Rob Portman, R-Ohio, and Ben Cardin, D-Md., have been championing the pension legislation in the House for years, the Senate lacks strong proponents of pension reform.

Even though considerable obstacles remain, benefit lobbyists say odds still favor passage of the bill.

"I am very optimistic. This is a very bipartisan issue and a popular issue. Members can go home and say they have done something for retirement savings," said Angela Arnett, senior counsel-federal relations at the American Council of Life Insurers in Washington.

"I think prospects are excellent in the Senate. We had 401 members of the House who believed that voting for the bill would increase their re-election prospects. We believe many members of the Senate will come to the same conclusion," said Mark Ugoretz, president of the ERISA Industry Committee. Mr. Ugoretz said ERIC members are being asked to write to their senators to urge their support for the measure.

If the measure is passed, the pension reforms will be welcomed by both employers and employees.

"This would be really terrific news. In many ways, this would be a dream come true for plan sponsors and participants alike," said Fred Rumack, director of taxes and legal services for Buck Consultants Inc. in New York.

"There really is something for everyone," adds Rita Metras, director of total compensation at Eastman Kodak Co. in Rochester, N.Y.

Perhaps the most striking change—and one that would be a direct reversal of legislation passed during the 1930s—would be an increase in the maximum benefits that could be provided through defined benefit and defined contribution plans.

Those increases include:

• Gradually raising to $15,000 from $10,500 the maximum annual salary deferral that could be made to 401(k) plans.

Employees 50 and older also could contribute an extra $5,000 annually to 401(k) plan through a so-called catch-up provision. Kodak's Ms. Metras noted that this provision would be especially beneficial to women who left the workforce to raise children and only now have the opportunity to save for retirement.

• Increasing to $200,000 from $170,000 the amount of annual employee compensation employers can consider in calculating pension benefits—a change that could significantly increase benefits.

• Raising to $160,000 from $135,000 the maximum annual benefit that can be funded through a defined benefit plan, while raising to $40,000 from $30,000 the maximum annual contribution that can be made to defined contribution plans.

Through these increases, employers—particularly smaller businesses—will have a greater incentive to maintain or expand their pension plans, Ms. Metras said.

But the legislation would do far more than increase pension benefits. It would eliminate or modify many of what benefit experts say are senseless rules that serve only to raise administrative costs and make offering pension plans more complicated.

Some of those administrative-related changes involve:

• Non-discrimination testing. One significant change would ease non-discrimination testing procedures for 401(k) plans that allow both pretax and aftertax contributions. This would be accomplished by allowing employers to use the same basic test—used to compare contributions of highly compensated and rank-and-file employees—on both pretax and aftertax contributions.

By contrast, current law requires a complex testing procedure for savings plans that allow both pretax and aftertax contributions.

In addition, in testing other types of defined benefit and defined contribution plans, plans would not be automatically considered discriminatory if they failed certain numerical tests. Employers must run those tests to prove that the plans do not cover too great a percentage of highly paid employees and that benefit formulas do not favor the higher-paid employees.

For plans that did not pass those tests, the measure would allow employers to try to prove through "facts and circumstances" that the plans were non-discriminatory.

"This is an avenue employers do not now have. An employer can make its best case," said Buck's Mr. Rumack.

• Portability. Account balances in 401(k) plans could be transferred to 403(b) plans—and vice versa—when employees move between the private and non-profit sectors. The 403(b) plans are the non-profit world's rough equivalent of 401(k) plans.

"Why shouldn't employees be able to transfer funds from one tax-favored vehicle to another? Employees changing jobs should be able to consolidate their retirement savings," said Watson Wyatt's Mr. Brown.

• The same-desk rule. This rule involves situations where an employer may, for example, spin off a unit to another company.

If an employee remains in essentially the same job that he or she held prior to the spinoff, the employee could not close out the account balance in his or her former employer's 401(k) plan. That means the account is essentially frozen, with an employee unable to make new contributions to the account and an employer barred from making matching contributions.

"Employees want to know why they can't take the money with them," said Kodak's Ms. Metras.

While the Internal Revenue Service did broaden situations in which the same-desk rule would no longer apply, benefit managers say the relief is too cumbersome. The House bill would repeal the same-desk rule.

In other changes, the House bill would allow employees to make aftertax contributions to 401(k) plans, with very favorable tax breaks.

As long as the money remained in the plan for at least five years, employees age 59½ or older could withdraw tax-free the contribution and the investment earnings, a huge tax break for younger employees who contribute to the plan.

"This is an eye-popping benefit and would be wildly popular," predicted Mr. Rumack. BI

COMMENTARY

Folk songs with a retro charm

Do you think it would be impossible to laugh at some new lyrics of old familiar songs now dubbed "Reinsurance Folk Songs?"

Some people look at me like I am crazy when I tell them that my favorite CD to listen to this summer is a collection of songs satirizing life in the reinsurance fast lane. "You've been hanging around those reinsurers way too long," the looks on their faces seem to say.

True enough, you need to be inside the reinsurance beltway to understand many of the verses. But it doesn't take much background to get a chuckle out of just about every one of the 11 cuts on this tuneful CD.

So for the skeptical, I'm going to share just a few of my favorite verses from the CD, with a little introduction to help some of you who may not immediately recall the players or the events that inspired Mark Hinkley of Odyssey Re to write these words.

Remembering that several years ago the former management at American Re-Insurance Co. did very well financially when it was sold to Munich Reinsurance Co. for a tidy sum of money, start humming Don McLean's "American Pie," and then sing:

"Bye Bye American Re.
I guess you heard we sold the place and it wasn't free.
I can hear you mutter and I frankly agree,
When's this going to happen to me?
When's this going to happen to me?


Kathryn J. McIntyre

Bye Bye American Re.
We regret that as senior management we all had to flee.
No one mentioned you were from Germany.
Good luck maintaining 99.3.
Any problem, just call Centre Re."

Flash forward to the more recent purchase of General Reinsurance Corp. by Berkshire Hathaway's Warren Buffett, and hum Gershwin's "Summertime."

"Summertime and the living is not easy.
When I bought General Re I must have been high.
I made them so rich that they don't come to work now.
It's just Ronnie, and Tommy and Charlie and I."

Last year, General Electric Corp. transferred one of its non-insurance executives to run its Employers Reinsurance Corp. subsidiary, much to the surprise of those who think a background in the insurance/reinsurance industry is a prerequisite to running a reinsurance company. To the tune of Leiber and Stoller's "Kansas City," sing out loud:

"I'm going to Kansas City. I've been sent there by GE.
I was so great at selling light bulbs, they said go run ERC.
How hard could it be?
And there's way too many actuaries,
And I'm going to kill me some.
Oh, I'm going to Kansas City. It's a reinsurance enigma.
I'm sure they are going love me when I introduce Six-Sigma.
But they got way too many claims guys and I'm going to kill me some."

Bermuda-bashing has been a longstanding pastime in the insurance industry by those who think that it is impossible to run a serious insurance or reinsurance company in the land of sun and sand. Conjure up that catchy duet from Andrew Lloyd Weber's "Phantom of the Opera," and sing out:

"Welcome to Bermuda. Let me be your broker please.
Your boss will never grasp this. I hear he is from Minneapolis.
All I want is freedom, rate form and SEC.
You'll get a fat commission to buy that boat for fishing.
I am a broker, so I do love fishing. Why don't you become my crew?
We'll give your boss exactly what he's wishing.
Let me put your name on my tattoo. That's all I ask."

And from another cut of this CD, based on "Day by Day," from Godspell, I leave you with this verse:

"Day by day, week by week, quarter by quarter, these things we seek:
To keep the top line growing, to keep the cash flow flowing,
Prevent the loss reserves from growing,
So the analysts will cheer."

There's much more, some so irreverent I decided not to share it in print.

Copies of the CD, which was cut to commemorate the 10th anniversary of The Angus Robinson Jr. Memorial Foundation and generate funds for its scholarship fund, are available for $25 (including postage) by writing The Angus Robinson Jr. Memorial Foundation, 166 High Meadow Road, Southport, Conn. 04690.

Publisher and Editorial Director Kathryn J. McIntyre's commentary appears fortnightly and at www.businessinsurance.com. She can be reached at kmcintyre@crain.com.

Blanch

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whom estimated that the departed executives together brought in as much as 25% of Blanch's new business in 1999.

Chairman Ted Blanch Jr. referred questions to Blanch General Counsel Daniel P. O'Keefe, who called the 25% figure "pure guesswork" and said it would "very much surprise me if those numbers were accurate."

Mr. O'Keefe downplayed the effect of the resignations. "We are an international, New York Stock Exchange-traded company. We are going to have turnover. . . It's not an abnormal number of people," he said. "I wouldn't read too much into that."

He added that Blanch does not expect to lose much revenue from the exit of its Capital Markets executives and that as "accounts have moved to Benfield—there have just been a very small handful so far—we have gained (new) accounts. . . .Our brokers are out doing a very good job of producing business."

In earlier public comments, Mr. Blanch had acknowledged the importance of Messrs. Fox and Karon's departures but cited Blanch's "enormous bench strength" and reported that the two men's duties were being assumed by Blanch President and Chief Operating Officer Chris Walker and Vice Chairman Kaj Ahlmann, a former chairman and chief executive of Employers Reinsurance Corp.

"People throughout the company have stepped up," Mr. Blanch said.

Even as that happens, though, Blanch is not having a good year.

Its troubles began in 1999, stemming partly from the collapse of the Unicover Managers Inc. workers compensation reinsurance facilities and problems with other workers comp carve-out covers. In addition to having to eliminate $4 million of Unicover commissions from its 1999 fourth-quarter revenues, Blanch also decided to write off its investment in Insurance Holdings of America Inc., a company formed to market products to members of the Sam's Club affiliate of Wal-Mart Stores Inc.

In comments to securities analysts in January, Mr. Blanch noted that "for what it's worth, our senior executives have absorbed the (earnings) impact of IHA in our incentive plan and will receive no bonuses this year."

Another distraction, according to former employees, was Blanch's effort to sell the company last year. In its own court filings in its case against Messrs. Fox and Karon, Blanch discloses that it was in negotiations with an unnamed "potential suitor" and that the talks fell apart in late 1999.

Mr. O'Keefe declined to comment on the negotiations.

The next blow came in March, with the unexpected resignations of Mr. Fox, president of brokerage unit E.W. Blanch Co. Inc. and a key producer, and Mr. Karon, executive vp of Blanch Co.

As it announced Mr. Fox's resignation March 20, Blanch also surprised investors with the news that it would miss its quarterly earnings target. Blanch's shares plunged from about $55 to $19.38 by the end of that week. On Friday, Blanch shares closed at $27.25.

For the first quarter, Blanch reported an 8.2% drop in revenues, to $56.9 million, and a 77.2% decline in earnings, to $2.2 million, from the same period in 1999. The company blamed, among other things, its failure to replace $14 million in revenues from workers comp programs and "large non-recurring transactions."

Stock analysts asked about the impact of Mr. Fox's departure in a March 22 conference call with Blanch officials, focusing on his relationship with Blanch client Allstate Insurance Group.

Mr. Walker replied that "none of our relationships are one-person. So we have depth behind Rod and to the side of Rod and above Rod."

Asked why Mr. Fox left, Mr. Walker explained during the conference call that, as part of an internal restructuring, "We identified some specific assignments for Rod, for Kaj and for me and for Ted, and when those assignments were laid out, we all bought in. But at some stage it just didn't fit, and Rod elected to leave."

In litigation that has erupted since, though, Blanch offers a very different view of the resignations.

After Mr. Fox initially sued Blanch in a Dallas County district court for a ruling on the validity of a non-compete agreement in his Blanch contract, Blanch countersued Messrs. Fox and Karon and Benfield Greig.

In its filings, Blanch charges that the two men, motivated by greed, began conspiring to move to Benfield as early as the spring of 1999. Messrs. Fox and Karon met with Benfield officials in New York in February 1999 and over the next few months worked out deals in which they would receive multimillion-dollar signing bonuses, a 49% stake in a new Benfield U.S. subsidiary and equity in the London-based parent, according to the filings.

The talks were delayed last fall as Blanch entered "serious" negotiations to sell the brokerage, and Messrs. Fox and Karon realized they stood to gain millions of dollars in a sale, Blanch alleges. By last November, though, the sale talks had broken off, and Messrs. Fox and Karon resumed discussions with Benfield, the filings charge.

By March 10, Blanch had begun a series of meetings to discuss its "increasingly negative first-quarter outlook," and Mr. Fox said that "he personally would close certain large revenue deals that would be necessary to achieve the projected first-quarter revenues," according to Blanch.

Mr. Fox never intended to do this, Blanch alleges, and instead submitted his resignation 10 days later along with Mr. Karon.

Meanwhile, Mr. Fox had been meeting with Tower Hill, a Gainesville, Fla., MGA and Blanch's largest account, to convince it to move to Benfield, Blanch charges.

Accusing Messrs. Fox and Karon of breaching fiduciary duties and non-compete agreements in their employment contracts, Blanch sought an injunction barring them from soliciting its clients or "poaching" employees.

Dallas County Judge Bob Jenevein ruled June 13 that the Blanch non-compete restrictions are legally unenforceable but also found that Blanch would likely prevail in its breach-of-fiduciary-duty claim. The judge enjoined Messrs. Fox and Karon from soliciting Blanch employees or using confidential Blanch information.

At Blanch's request, the judge earlier this month sealed filings in the case, and responses from Mr. Fox, Mr. Karon and Benfield Greig were not available.

Messrs. Fox and Karon, however, have said they did not finally decide to leave Blanch until March 11 or 12, Blanch's filings show.

In a statement on behalf of the three defendants, a lawyer for Benfield flatly denied Blanch's charges.

"There is no evidence that Messrs. Fox and Karon breached any fiduciary duties to Blanch. There is no evidence that they improperly solicited clients or that they improperly used or disseminated any Blanch proprietary information. There is not a shred of evidence that they or Benfield Greig did anything wrong," said Philip M. Berkowitz, a lawyer with Salans, Hertzfeld, Heilbronn, Christy & Viener in New York.

Meanwhile, recent months have shown that Messrs. Fox and Karon were not alone in deciding to leave.

The question of additional defections came up in Blanch's March 22 conference call with analysts. Asked if the elimination of 1999 bonuses and Blanch's first-quarter travails might bring more flight, Mr. Walker replied, "We don't expect defection. . . .We've got a very professional workforce . . . .They're committed to the company, but they're also very committed to our customers, and we're not going to leave customers hanging."

In fact, though, a dozen Blanch officers have left since March. They include:

- Robert Bredahl, former head of Blanch Capital Markets, who joined venture capital firm Internet Capital Group in Wayne, Pa.
- Enda McDonnell, a former Blanch senior vp and retrocessional specialist who worked with the Capital Markets group; Stefano Nicolini, a former vp; Andrew Baur, a former vp; and John Gefaell, a senior account representative. All joined Willis Re.
- Andrew Bustillo, a former executive vp, and David Cameron, a former senior vp in charge of worldwide property business. Both joined Guy Carpenter & Co., Mr. Cameron as senior vp of its Special Property Team.
- Marc Lauricella, a former senior vp on the Tower Hill account, who joined Tower Hill.
- Thomas Spitalny, a former vp who joined a Bermuda-based reinsurance unit of AB Volvo, a Blanch client.
- Hunt Roeder, a former senior vp with Blanch Capital Markets, who left to join Bank of America in New York.
- Jack Vogel, another former Capital Markets senior vp, who left to join a Swiss Reinsurance Co. unit in Armonk, N.Y.

Former officers who agreed to discuss Blanch cited various reasons for leaving, including changes in their duties stemming from Blanch's internal reorganization.

Most agreed, though, that their compensation became a key factor.

"Not only did (brokers) not get bonuses, but their equity position was pretty much worthless" after Blanch's stock price dropped, one executive said.

Mr. McDonnell, the former senior vp, sued Blanch in New York federal court after he quit, charging that Blanch refused to pay him more than $800,000 in bonus due under his contract, representing 20% of the new business he said he generated in 1999.

Blanch has denied any contractual obligation—claiming the 1999 bonus payable to Mr. McDonnell was discretionary—and countersued him, charging that he has violated his non-compete agreement since joining Willis Re.

While Blanch sought an injunction against Mr. McDonnell similar to the one it sought against Messrs. Fox and Karon, U.S. District Judge William H. Pauley III recently rejected the request, ruling that Mr. McDonnell's non-compete agreement was "unreasonably broad" and unenforceable.

Blanch's Mr. O'Keefe said that the executive departures are not unusual and added that it remains committed to the Capital Markets unit despite the resignations at the operation. "We are not disbanding our Capital Markets group. We are analyzing the extent to which we are going to staff it up and what location or locations it should operate from," he said.

Meanwhile, Blanch officials express optimism that the worst is behind them.

The second quarter saw a 9.7% increase in revenues to $64.1 million and a 3.9% increase in earnings to $8.2 million. For the first half, though, revenues were up 0.5%, to $121 million, and earnings were down 40.5%, to $10.3 million.

"We continue to be pleased with our progress, and especially with the benefits of our restructuring of the business," Mr. Blanch said in a statement. "The new structure is working." BI

Cascade

Continued from page 2

would not be sent to prison. They instead agreed that he would be placed on probation and pay a $100,000 fine.

A federal grand jury indicted Mr. Brown and five others about 10 months ago on charges related to what prosecutors have called a "sham settlement" that allowed Mr. Disiere to avoid a $27 million suit by the state (*BI*, Oct. 4, 1999).

Mr. Brown faces 43 counts of conspiracy, mail fraud, wire fraud, insurance fraud and witness tampering in the case. In addition, he faces another 13 charges of making false statements to federal officials. The commissioner and his co-defendants have maintained their innocence since the indictments.

Two other defendants also reached plea agreements with prosecutors. Louisiana District Court Judge Alfred Foster "Foxy" Sanders III and Robert Bourgeois, former director of the Louisiana Receivership Office Inc., pleaded guilty not long after the indictments.

Mr. Brown said last week that charges should be dropped against him because the defendants who struck deals were the ones responsible for the settlement that allowed Mr. Disiere to avoid litigation.

"The indictment makes it clear that I didn't have the authority to settle the case," said Mr. Brown. He said the "three principals involved in this matter were the three trying to settle the case," referring to the defendants who have pleaded guilty. Mr. Brown said he believes the government should drop its claims against him.

The document that was filed with Mr. Disiere's plea agreement, called a factual basis, "doesn't raise any questions about me or cause me any concern," said Mr. Brown.

Salvador R. Perricone, assistant U.S. Attorney in New Orleans, said a gag order prevents him from discussing the government's plans for the upcoming trial. "We plan on going to trial Sept. 18th, and the government's ready," he said.

'The indictment makes it clear that I didn't have the authority to settle the case,' says Jim Brown.

Cascade, an automobile insurance company, was placed in rehabilitation shortly after it began writing in Louisiana in 1993 and was later ordered liquidated by Mr. Brown.

In late 1996, a special master appointed by the court recommended to Judge Sanders that a $27 million civil racketeering suit should be filed against Mr. Disiere related to activities that led to Cascade's failure.

The indictments allege a complex scheme of favor-swapping in which Mr. Brown, in return for his influence in having the suit dropped against Cascade, wanted Mr. Edwards to persuade Judge Sanders to return control of insurer liquidations to the state Insurance Department.

Mr. Edwards, practicing law after his term as governor ended in 1996, had been hired that year by Mr. Disiere to handle matters related to Cascade.

In late 1996, prosecutors say, Mr. Disiere and Mr. Bourgeois reached an oral agreement whereby the racketeering suit would not be filed. A written settlement protected by a confidentiality agreement was approved by a state court judge who was selected by Judge Sanders and was unfamiliar with the case.

Mr. Disiere's plea agreement is at odds with Mr. Brown's assertion that he was not involved in the settlement.

Documents filed with the agreement allege that Mr. Disiere had a "lengthy meeting" with Mr. Brown, who said "he would help Disiere if he could." The papers further allege that Mr. Brown was involved in "numerous conversations" regarding an acceptable amount to settle the case.

The documents state that Mr. Disiere talked with the commissioner in mid-1996 about Cascade's problems and the two, along with Mr. Weems, discussed the racketeering suit and settlement issues.

The papers call the Louisiana Receivership Office a "patronage machine" and say Mr. Brown wanted it under his control because he could "issue contracts to anyone he wished because LRO had access to millions of dollars from insurance companies placed under Brown's control." BI

Bias

Continued from page 2

On appeal, Harvard asserted that "a finding of pretext *permits* but does not *compel* a finding of discrimination," according to the opinion.

The Massachusetts high court agreed with Harvard. It ruled that, even if a jury believes that a defendant's stated reason for an action is a pretext, it could still conclude the action was for a nondiscriminatory reason and rule in favor of the defendant. "The instruction should not have been given, because it stripped the jury of its fact-finding role," the opinion states.

In reaching its decision, the court clarified a decision it rendered in 1995 that had been interpreted by Massachusetts courts to mean that, once the plaintiff showed the employer's reason was a pretext, the jury was required to rule for the plaintiff.

The decision comes one month after a U.S. Supreme Court ruling made it easier for plaintiffs to prevail in job discrimination suits under federal law. In that case, *Reeves vs. Sanderson Plumbing Products Inc.*, a unanimous court held that plaintiffs do not have to show additional proof of discrimination after demonstrating that the employer's reason was a pretext for discrimination (*BI*, June 19). BI

The 'Big One' might jolt CEA

By JOANNE WOJCIK

SACRAMENTO, Calif.—The California Earthquake Authority is currently in a very strong position, with the capacity to withstand all but the most extreme earthquake, a new report concludes.

The CEA may need to revise its current rating structure, however, to ensure its continued viability, according to the report conducted by Tillinghast-Towers Perrin.

A 1-in-100-years aggregate loss would consume only 39% of the CEA's current $7.5 billion claims-paying capacity, the actuarial analysis found.

While the study did not specify the magnitude of such a quake, a CEA spokesman said the earthquake authority would be able to absorb losses from a quake equivalent to the 1906 San Francisco temblor.

An earthquake in the 1-in-1,000-years probability level, however, not only could bankrupt the CEA, but likely would bankrupt the insurance market overall, the report concluded.

"Based on those comparisons, we conclude that the CEA's current capacity to pay claims is as good or better than that of private catastrophe insurers," said the report, which is scheduled to be presented at the CEA's board meeting Aug. 24.

Because of the CEA's solid financial position and the high cost of reinsurance, the report suggests that the CEA board consider alternatives, such as capital risk transfer.

"Under the circumstances, we suggest the CEA consider whether it might be appropriate to reduce the amount of reinsurance coverage that it purchases," the report said. "Reducing the overall reinsurance costs by reducing the amount of reinsurance coverage would allow the CEA to 'bank' the cost savings, thereby accumulating capital at a faster rate."

However, the report acknowledged that "while we did conclude that the current reinsurance program is expensive, in other respects we found it to be a well-constructed, diversified program."

The report also suggested that the CEA board consider revising its rating structure to prevent adverse selection.

Over the past two years, private insurers have captured a 10% share of the market by offering lower prices and better terms to better risks.

"In those instances where the specialty insurer's rates are lower than the CEA's, the business will migrate to the specialty insurer. In those instances where the converse is the case, the business will migrate to the CEA. Assuming that the specialty insurers' rating scheme accurately captures differences in vulnerability, the net effect will be for the CEA to end up insuring the risks with the highest vulnerability," the report states.

Therefore, "the situation needs to be monitored closely," the report asserted.

The CEA, formed in 1996, holds a 65.7% share of California's residential earthquake market.

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Free copies of the report, "California Earthquake Authority—Actuarial, Financial and Management Team Review," are available by calling 916-492-4300.

UPDATES

Few U.S. cyber risks insured

Continued from page 2

Almost 88% regularly change passwords; 80% have an in-house computer security team; 80% monitor employee Internet use; and 72.7% educate employees about hackers, according to the survey.

A smaller percentage of respondents—69.1%—reported that they have installed encryption systems, and 60% monitor employee e-mails, the survey found.

R.J. Reynolds pension change

WINSTON-SALEM, N.C.—A small number of current and former employees of R.J. Reynolds Tobacco Co. can opt for more security in their pension plans under a new company offer.

The tobacco company is offering some employees and retirees who have high salaries or have worked for the company for long periods of time the option of taking their funds out of the company's unqualified pension plans as either a lump sum or an annuity. The offer is being made to fewer than 200 individuals who have more than 25% of their pension assets in unqualified plans, according to a spokesman for R.J. Reynolds. Unqualified pension plans do not meet certain Internal Revenue Service criteria for favorable tax treatment.

According to R.J. Reynolds, the retirement benefits in the participants' unqualified plans exceeded the maximum amounts guaranteed by the federal Pension Benefit Guaranty Corp.

Nearly all R.J. Reynolds employees are covered by plans that are guaranteed by a fully funded trust or the PBGC, said the spokesman.

The spokesman said the move to protect the pension funds is not related to the $145 billion punitive damages award that was assessed against tobacco makers, including R.J. Reynolds, by a Florida state court jury last month.

Brockbank to retire at year end

LONDON—Mark Brockbank, a high-profile figure at Lloyd's of London, will step down as chief executive officer of the Brockbank Group P.L.C. at the end of the year.

Although Mr. Brockbank, 48, will retire from the agency, he will act as a consultant to XL Capital Ltd., the Bermuda-based parent of the Lloyd's managing agency.

Responsibility for Brockbank will be passed to Nicholas M. Brown, currently head of the XL unit NAC Re Corp., who has been named chief executive for the insurance operations of XL.

Mr. Brockbank was a prominent underwriter in the London market in the 1990s. At one time, Brockbank syndicate 861 was the largest at Lloyd's. XL acquired Brockbank in 1998 through the purchase of Mid Ocean Reinsurance Co. Ltd., which had purchased the managing agency in 1997.

In addition to Mr. Brown's appointment, several other executive changes and new positions were announced by XL last Wednesday.

Henry C.V. Keeling, president and CEO of XL Mid Ocean Reinsurance Ltd., was named CEO for reinsurance operations.

Robert R. Lusardi, chief financial officer of XL, was named CEO for financial products and services. He will remain CFO until a successor is appointed.

K. Bruce Connell, president and CEO of XL Capital Products, was named group underwriting officer.

The new management structure will increase the efficiency of the company, said Brian M. O'Hara, president and CEO of XL Capital.

Former Aetna CEO dead at 93

HARTFORD, Conn.—Olcott D. Smith, former chairman and chief executive officer of Aetna Life & Casualty Co., died July 24 at age 93.

Mr. Smith led Aetna from 1963 to 1972. During that time the insurer expanded its financial services and international business.

He also brought management changes to Aetna, according to a company statement.

"For nine years as chairman, he guided the company with a strong sense of organization. He instituted the management by objectives system, which places sharper focus on cost effectiveness, goals and accountability for attaining them," Aetna's statement said.

Mr. Smith also had an interest in civic and social affairs. During his chairmanship, Aetna formed its urban affairs department and its corporate social responsibility department.

After retiring as an Aetna executive, Mr. Smith was chairman of its executive committee until 1977.

Briefly noted

Roberto R. Romulo has been named chairman of Philam Insurance Co. Inc., a Philippines-based subsidiary of American International Group Inc. Mr. Romulo had previously been a Southeast Asia executive of International Business Machines Corp. . . . A.M. Best Co. has lowered its **rating of Arig Reinsurance Co. B.S.C.** to A- from A, due to the Bahrain-based reinsurer's poor 1999 results, which included a combined ratio of 213.1%. Arig's results were particularly affected by losses at its U.K. subsidiary and costs related to putting the unit into runoff, a Best statement said. . . . Shareholders of **ReliaStar Financial Corp.** last Thursday approved the $6.1 billion acquisition of the company by the Netherlands-based insurer ING Groep N.V. The acquisition is expected to close in September. . . . Omaha, Neb.-based surplus lines insurer Acceptance Insurance Cos. Inc. completed the sale of its specialty insurer subsidiary **Redland Insurance Co.** to Clarendon Insurance Group, a unit of Hannover Re Group, late last week. Under the agreement, Clarendon purchased the stock of Redland for an unspecified amount of cash, and Acceptance retained all Redland assets associated with its crop insurance operations, with the option to repurchase the specialty insurer under certain circumstances.

FTR FOR THE RECORD

Excerpts from *BI*'s Daily Online Updates, July 24 - July 28, 2000

AIG POSTS GAINS American International Group Inc. reported gross revenues of $22.32 billion for the first half of 2000, an 11.5% increase over the comparable period in 1999. Profits rose 11.2% to $2.48 billion. AIG's worldwide property/casualty net written premiums increased 5.9% to $8.73 billion. Overall, AIG's results have benefited from a hardening insurance market, Chairman and Chief Executive Officer Maurice R. Greenberg, said in a statement. "While the trend is in the right direction, it is important to remember that rates declined significantly over the past eight or nine years, and, therefore, further increases are necessary," Mr. Greenberg said. The sharpest rate increases are occurring in health care liability, property and surplus lines, he noted.

NCCI JOINS WEB VENTURE The National Council on Compensation Insurance is hoping to speed the depopulation of workers compensation residual market pools through an online partnership. On Aug. 1, the NCCI and insureon.com Inc. will launch a service that will allow insurers to place online bids for risks written by the pools. Monthly lists of expiring policies written by the pools will be provided by the service without charge. Agents and brokers also will have access to the expiration lists. Intermediaries will be able to represent buyers at the site and accept quotes from insurers through the service. insureon.com is an online facility through which commercial insurance is bought and sold. It currently is available only to California agents, though it is being rolled out to other states.

CRASH BLAMED ON PILOT ERROR The 1997 crash of a Federal Express Corp. jet at the Newark International Airport in Newark, N.J., was likely caused by pilot error, a National Transportation Safety Board report says. The pilot should have aborted his attempt to land after he became concerned about the length of the runway, according to the report, which was released last week. Instead, the pilot continued with the landing, which caused the right landing strut to fully compress and the fuel tanks on the right wing subsequently caught fire, the report said. "The probable cause of this accident was the captain's overcontrol of the airplane during the landing and his failure to execute a go-around," the report said. The plane was destroyed in the subsequent fire. Two crew members and three passengers escaped with minor injuries. The MD-11 jet, manufactured by McDonnell Douglas Corp., was carrying 145,000 pounds of cargo. FedEx had $1 billion of liability coverage, which was led in the London market.

PHOTO: AFP

The wreckage of a FedEx cargo jet smolders on a New Jersey runway.

ST. PAUL'S NET INCOME JUMPS Price increases in the property/casualty marketplace contributed to a 13.4% rise in revenues for The St. Paul Cos. Inc. in the first half of 2000. At the same time revenues increased to $4.36 billion, St. Paul's net income rose 54.3%, to $569.0 million, over the comparable period last year. A company statement indicated that the insurer's property/casualty insurance operations exceeded expectations, with double-digit price increases and high retention rates resulting in growth for the first time in three years. Net written premiums for St. Paul's property/casualty operations rose 6% to $2.89 billion for the first half. Insurance prices in St. Paul's commercial lines group were up 11.5% in June, and premium retention rates remain near 80%, indicating that price increases continue to be accepted by the marketplace, according to St. Paul. Net written premiums for the business unit remained basically flat in the first six months, decreasing a scant 0.3% to $795.1 million.

TEMPEST RE USA NAMES EXECS Tempest Re USA has recruited four casualty underwriters to aid its drive to become a significant broker market reinsurer, said Chief Executive Officer Jacques Q. Bonneau. Tempest Re USA was established last year as part of ACE Ltd.'s plan to convert its reinsurance arm, Tempest Reinsurance Co., into a multiline reinsurer from a property catastrophe reinsurer. Bruce L. Kessler has been named senior vp, casualty. Mr. Kessler was previously a casualty underwriter at American Re-Insurance Co. James E. Wixtead is senior vp, casualty. Mr. Wixtead was formerly a workers compensation underwriter at Gerling Global Reinsurance Corp. Thomas A. Greene is senior vp, casualty. Mr. Greene was previously a professional liability and directors and officers liability underwriter at Trenwick American Re. David L. Drury is senior vp/chief actuary. Mr. Drury was formerly the head of Stockton Reinsurance Ltd.'s London office, where he specialized in finite reinsurance.

BOND ISSUE COVERED Zurich U.S. has issued its first political risk insurance coverage for a capital markets transaction, covering an El Salvador electric utility's bond issue. The program covers AES CLESA y Compania's $65 million of privately placed senior notes for the entire 12-year tenor of the bonds. AES CLESA, a unit of global power company The AES Corp., serves more than 200,000 customers in western El Salvador. Bond rating agency Fitch IBCA gave the bond issue a BBB- rating due to Zurich U.S.'s coverage, the insurer said in a statement. The notes will be used to retire existing AES CLESA debt and to continue capital investments.

CHUBB RESULTS MIXED Chubb Corp. has reported operating income of $330.6 million for the first half of 2000, a 0.2% increase from a year earlier. First-half net income, which includes realized investment gains, fell 11.0% to $338.3 million from the same period of 1999. For the second quarter, Chubb's operating income of $180.7 million was a 10.5% increase from the second quarter of 1999. Net income for the three-month period ending June 30 was $184.6 million, a 4.5% decline from Chubb's net income in the second quarter of 1999. Chubb's reported first-half property and casualty net premiums written increased 9.9%, to nearly $3.12 billion. The Warren, N.J.-based company's combined ratio of 100.2% for the first half was a slight deterioration from the 99.7% combined ratio in the first half of 1999.

BRIEFLY NOTED Standard & Poor's Corp. has withdrawn its A- financial strength rating of the **Washington Cities Insurance Authority** at the public entity insurance pool's request. . . .**Transatlantic Holdings Inc.** reported gross revenues of $910.4 million for the first six months of 2000, a 12.6% increase over the comparable period in 1999. Profits at the reinsurer fell 19.6% to $107.4 million, however, due a reduction in realized capital gains in 2000, the company said. . . .**Everest Re Group Ltd.** reported gross premiums written of $326.2 million in the second quarter of 2000, a 15.2% increase over the same period in 1999. Profits increased 7.7% to $38.1 million. . . .CNA Financial Corp.'s excess and surplus lines division, CNA E&S, is launching a new general **liability insurance program for apartment owners.** The Northeast Habitational Risk program is written by CNA units on an admitted basis through managing general agent American Marketing Center in New York. Coverage is available to apartment owners in New York, New Jersey and Pennsylvania. Limits vary by type of liability coverage purchased, which include garagekeepers legal liability, fire damages legal liability, employee benefits liability, auto liability and general liability. BI

To get breaking news as it occurs, visit Business Insurance's free online Updates at www.businessinsurance.com. All of the material in the For The Record column, as well as other content in this week's issue, is generated from daily news postings that appeared on the Web site in the previous week.

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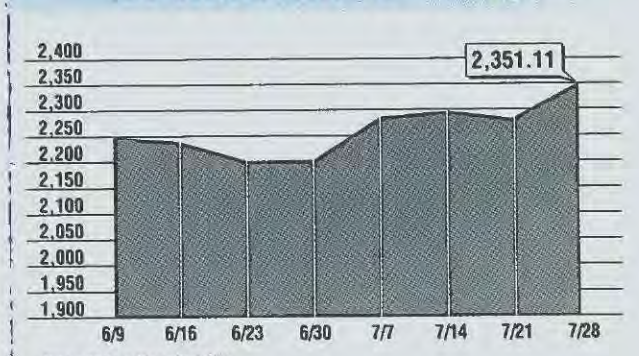
BI Industry Stock Report JULY 24, 2000, THROUGH JULY 28, 2000

BROKERS		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
Aon Corp.	NYS	34.88	14.34	-12.81	43.13	20.69	6893
Brown & Brown	NYS	47.44	-6.30	23.82	52.50	30.75	139
Clark Bardes Holdings	NDQ	10.00	-8.05	-30.43	21.00	8.88	264
E.W. Blanch Holdings Inc.	NYS	27.25	24.57	-55.51	71.75	16.56	1287
Gallagher Arthur J. & Co.	NYS	48.94	11.22	51.16	48.94	23.06	1358
Hilb, Rogal & Hamilton	NYS	37.75	6.15	33.63	38.19	20.75	147
Kaye Group Inc.	NDQ	6.19	-10.81	-26.12	11.88	5.00	9
Marsh & McLennan	NYS	117.31	6.17	22.60	120.88	61.75	5158
BROKERS	AVERAGE		5.17	8.26			
INSURERS/REINSURERS							
ACE Ltd.	NYS	35.50	14.06	-12.73	37.25	14.06	9605
Accel International Corp.	NDQ	0.63	0.00	-37.50	1.88	0.50	25
Acceptance Insurance Cos.	NYS	4.75	10.14	-17.39	15.94	2.75	54
AEGON N.V.	NYS	38.13	-0.49	-20.16	49.13	31.50	643
Aetna Life & Casualty	NYS	55.44	-3.17	-0.67	89.94	38.50	5080
AFLAC Inc.	NYS	53.44	7.41	13.25	54.31	33.56	3708
Allmerica Financial Corp.	NYS	59.56	7.44	7.08	64.81	35.06	930
Allstate Corp.	NYS	27.56	11.36	14.55	37.94	17.19	14071
Ambac Financial Group	NYS	62.88	2.65	20.48	67.38	38.88	2244
American Financial Group	NYS	24.31	1.83	-7.82	35.44	18.38	456
American General	NYS	69.13	6.86	-8.90	82.19	45.63	5104
American Intl Group	NYS	128.31	8.62	18.67	132.63	78.56	16458
American Safety Insurance	NYS	4.56	1.39	-29.81	8.56	3.75	12
Argonaut Group	NDQ	15.19	-4.71	-23.58	26.63	15.19	152
AXA-UAP Group	NYS	73.38	-1.59	3.35	81.50	53.75	381
Baldwin & Lyons Inc.	NDQ	15.50	-2.75	-29.94	23.94	15.25	7
Berkley W.R. Corp.	NDQ	23.88	20.13	14.37	27.94	14.00	1094
Berkshire Hathaway Inc.	NYS	57000.00	6.94	1.60	69300.00	40800.00	5
Capitol Transamerica Corp.	NAS	11.50	2.22	14.29	15.25	9.38	22
Chubb Corp.	NYS	74.00	12.55	31.41	77.00	43.25	9980
CIGNA Corp.	NYS	98.25	1.22	21.96	103.06	60.75	3372
Cincinnati Financial Corp.	NYS	37.25	8.56	6.86	43.31	26.19	1784
Citigroup	NYS	68.31	-3.79	22.67	72.00	41.19	31647
CNA Financial Corp.	NYS	37.88	4.30	-2.73	42.13	24.56	479
CNA Surety	NYS	10.75	-8.51	-17.31	15.50	9.75	221
EMC Insurance Group Inc.	NDQ	9.38	4.17	2.74	13.38	6.81	4
ESG Re Limited	NDQ	3.44	-10.57	-50.45	16.75	3.19	61
Enhance Financial Services	NYS	15.81	5.42	-2.69	22.63	8.63	408
Everest Reinsurance	NYS	39.38	9.95	76.47	39.38	20.50	1758
Fremont General Corp.	NYS	4.13	1.54	-44.07	19.56	3.88	1081
Frontier Insurance Group	NYS	0.47	-31.82	-85.36	15.81	0.47	1200
Gainsco Inc.	NYS	4.25	-4.23	-20.93	6.94	4.19	88
Harleysville Group	NDQ	17.94	-1.71	25.88	20.75	11.63	102
HSB Group Inc.	NYS	34.50	15.24	2.03	42.25	21.50	699
HCC Insurance Holdings	NYS	20.50	6.15	55.45	25.13	8.00	493
ING Groep N.V.	NYS	66.50	1.82	9.02	69.00	46.81	444
IPC Holdings Ltd.	NDQ	15.75	21.74	5.88	22.50	9.75	240
Hartford Financial Services	NYS	63.69	10.04	34.43	66.25	29.38	8824
John Hancock Financial Service	NYS	23.13	0.27	36.03	24.75	13.44	3739
LaSalle Re Holdings Ltd.	NYS	16.88	16.38	2.27	18.63	10.88	385
Lincoln National	NYS	44.75	3.32	11.88	57.50	22.63	4468
MAIC Holdings Inc.	NYS	12.31	-0.51	-41.89	29.05	10.00	177
Markel Corp.	NYS	151.00	2.03	-2.58	192.00	111.50	61
MBIA Insurance Group	NYS	55.94	5.54	5.92	66.94	36.31	1733
Meadowbrook Insur. Group	NYS	5.00	1.27	-23.81	14.06	4.50	55
MetLife	NYS	20.31	-2.11	42.54	22.06	14.25	5450
Mutual Risk Mgmt. Ltd.	NYS	15.94	2.82	-5.20	35.50	9.81	645
Navigators Group	NDQ	10.00	3.90	2.56	16.00	8.63	135
NYMagic Inc.	NYS	15.00	-3.61	13.74	16.13	12.25	21
Ohio Casualty Corp.	NDQ	8.56	-4.86	-46.69	18.63	8.56	831
Old Republic Int'l	NYS	22.25	22.76	63.30	22.25	10.63	5737
Partner Re Ltd.	NYS	39.81	5.81	22.74	40.00	28.38	1494
Penn-America Group Inc.	NYS	7.50	3.45	-3.23	10.38	6.63	4
PMA Capital Corporation	NDQ	16.25	-11.56	-18.24	21.00	15.50	45
Philadelphia Cons. Holding	NDQ	16.41	2.54	13.15	24.44	10.81	506
PXRE Corp.	NYS	13.00	0.48	0.00	19.56	9.94	124
Reliance Group Holdings	NYS	0.19	-14.29	-97.17	7.75	0.13	13106
ReliaStar Financial Corp.	NYS	53.06	0.47	35.41	53.13	23.75	2935
RenaissanceRe Holdings Ltd.	NYS	47.19	6.94	15.44	47.63	33.19	237
RLI Corp.	NYS	34.19	-1.26	0.55	38.63	26.25	52
St. Paul Cos.	NYS	44.75	19.53	32.84	44.88	21.31	9621
SCOR	NYS	42.69	-1.16	-3.53	53.63	38.38	18
SAFECO Corp.	NDQ	22.81	7.04	-8.29	44.50	18.00	5374
SCPIE Holdings Inc.	NYS	20.00	-6.43	-37.74	36.94	19.00	NA
Seibels Bruce Group	NDQ	1.06	-26.09	-39.29	5.69	0.75	53
Selective Ins. Group	NDQ	18.31	-0.34	6.55	22.50	14.63	221
Tokio Marine & Fire	NDQ	51.75	0.73	-12.47	67.00	45.00	89
Torchmark Corp.	NYS	25.06	1.26	-13.76	36.94	18.75	1974
Transatlantic Holdings	NYS	85.06	3.58	8.97	91.56	68.75	99
Trenwick Group Inc.	NYS	17.38	15.83	2.58	25.06	12.00	411
Unico American Corp.	NDQ	6.25	-3.85	-10.71	10.50	4.50	86
United Fire & Casualty	NDQ	18.25	-9.03	-19.34	26.50	15.50	51
Unitrin	NDQ	29.19	2.41	-22.43	42.38	27.25	724
UNUM Corp.	NYS	23.50	19.75	-26.71	56.88	11.94	8193
Vesta Insurance Co.	NYS	5.44	-12.12	-40.32	7.88	3.44	200
XL Capital Ltd.	NYS	65.06	15.54	25.42	65.50	39.00	3681
Zenith National Ins.	NYS	23.31	1.63	13.03	26.00	18.75	28
INSURERS/REINSURERS	AVERAGE		2.36	0.86			
HEALTH MAINTENANCE ORGANIZATIONS							
Foundation Health Systems Inc.	NYS	14.56	1.75	46.54	16.94	6.25	1360
Humana Inc.	NYS	7.06	-6.61	-13.74	13.19	4.75	2633
Oxford Health Plans	NDQ	23.50	-0.79	85.22	27.19	9.75	13981
Pacificare Health Sys.	NDQ	62.56	2.88	18.04	72.31	31.13	1665
Sierra Health Services	NYS	3.19	-12.07	-52.34	14.56	2.75	568
United HealthGroup	NYS	81.19	-4.49	52.82	91.94	39.38	5527
Wellpoint Health Networks	NYS	86.56	2.74	31.28	87.88	48.25	2418
HMOs	AVERAGE		-2.37	23.98			
ALL COMPANIES	AVERAGE		1.72	11.03			

BI Insurance Index



Base=100 on Dec. 29, 1978

Top advancing issues: E.W. Blanch Holdings Inc., Old Republic Int'l, IPC Holdings Ltd. Leading decliners: Frontier Insurance Group, Seibels Bruce Group, Reliance Group Holdings. Most active issue: Citigroup. The *BI* index increased 3.0%; the Dow Jones 30 Industrials decreased 2.1%; the S&P 500 went down 4.1%, and the NYSE Composite dropped 2.5%. Average P/E: Brokers, 20.3; Insurers/reinsurers, 17.4; HMOs, 14.1.

Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.

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