MARCH 20, 2000

Business Insurance®

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

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Updates

Smith & Wesson safety steps to nullify some gun lawsuits

WASHINGTON—Smith & Wesson Corp. will change the way its guns are designed, distributed and marketed under an agreement reached with the Clinton administration that calls for federal, state and local governments to drop lawsuits against the company.

The administration had threatened to sue Smith & Wesson if the gunmaker did not agree to the changes. Smith & Wesson and other gun manufacturers have been named in various U.S. product liability suits that

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Hewitt starts health care e-business

By JERRY GEISEL

CHICAGO—Hewitt Associates L.L.C. is launching a new e-commerce venture that could revolutionize the way employers purchase and deliver health care benefits to employees and retirees.

The online service has the potential to dramatically simplify the offering and administration of health plans, which would lead to reduced costs, while giving participants more choices and information about health plans.

The new venture—Sageo—will use Hewitt's scale and expertise in benefit outsourcing, its technological sophistication and its long-standing relationships with health plans to provide complete administration of health programs.

The service will eliminate for employers the time and expense of enrolling participants, collecting premiums, transferring premiums to insurers and communicating benefits to participants.

At the same time, Sageo will enable plan participants to compare and select health care plans online and obtain a wealth of online health care information supplied by the Mayo Clinic.

sageo

a Hewitt eBusiness

Sageo has lined up commitments from health maintenance organizations, preferred provider organizations, point-of-service plans and traditional indemnity plans in about 100 markets to offer standardized benefit designs by plan type.

Beginning this fall, initially retirees—and, later, employees—at companies that have contracted with Sageo will be able to choose and enroll over the Internet in participating health plans.

With standardized benefit designs, retirees will be able to select plans on the basis of such variables as cost, access to care, quality of care and member satisfaction. Information on these variables, such as how large one plan's provider network is compared with other plans, would be displayed online.

Information and assistance to participants also could be obtained through a Sageo customer care center. Sageo has established a customer care center in Orlando, Fla., staffed by employees who all previously worked for Hewitt Associates.

"With a level playing field, plans can be selected on the basis of something that is critical to participants, such as a good disease management program," said Michael Jayner, director of sales

See **Sageo** *on page 35*

IC&S to rise from ashes

New investor takes reins of troubled offshore insurer

By DOUGLAS McLEOD

AUCKLAND, New Zealand —Years of insurance industry mergers and acquisitions may have left the impression that only the strongest companies survive. Impressions can be mistaken, though.

Consider International Casualty & Surety Co. Ltd. of New Zealand, a small marine, aviation and surplus lines insurer that seemingly defies notions of insurance market Darwinism.

In its eight years of existence, IC&S has survived financial ties to an allegedly fraudulent predecessor company, repeated juggling of a capital base that has featured worthless or overvalued assets, a D rating from A.M. Best Co., and the conviction of its president on bankruptcy fraud charges.

Now, improbably, IC&S is poised for a comeback: The insurer has been sold to a businessman in St. Kitts, British West Indies, who has announced plans to recapitalize and relaunch it under new management.

Whether its prospects are brightening, however, remains to be seen.

The St. Kitts businessman, M. Irvin Boncamper, previously was the auditor and a shareholder of Keyes International Insurance Co. Ltd., which at one time claimed a net worth of $2.4 billion but nonetheless left at least two unpaid claims after going out of business in the 1990s, documents show.

Mr. Boncamper was named with several other defendants in a civil fraud lawsuit filed last year by one of those claimants, an Israeli company that has been unable to collect on a $1.5 million Keyes International surety bond.

In an interview, Mr. Boncamper confirmed that he is now chairman and owner of IC&S but said he could not answer questions about the insurer's

See **IC&S** *on page 36*

More insurers funding research

New coverage stance

By JOANNE WOJCIK KOCHANIEC

Trying to shield themselves from expanded liability under proposed federal patient protection legislation, many insurers and HMOs are reversing earlier positions and now voluntarily funding research into experimental medical treatments.

Critics say the effort is merely a defensive posture, providing the health insurance industry with ammunition to defend allegations that it unjustifiably denies certain treatments.

Some industry observers argue, though, that it's good business for insurers to finance such research, because it advances the practice of evidence-based medicine and may lead to the discovery of new and improved treatment that can reduce health care costs.

Industry funding of experimental medical treatments "is not altruistic on their part at all," said John Erb, area vp at consultant Gallagher Benefits Services in Boca Raton, Fla. "This is business."

Insurers, though, "are not just looking at cost," said Helen Darling, senior consultant at Watson Wyatt Worldwide in Stamford, Conn., and a member of a Blue Cross & Blue Shield Assn.-sponsored medical technology review panel. "The whole purpose is to look at the technology and whether it's better than conventional treatment."

For years, health insurers and HMOs have been criticized and sometimes sued for refusing to cover certain medical treatments

See **Research** *on page 37*

NAIC sets a new agenda

Blueprint for reform draws wide support

By MEG FLETCHER

CHICAGO—The National Assn. of Insurance Commissioners has embraced a new blueprint for implementing federal financial modernization legislation, while also adopting goals to address other state regulatory priorities.

The blueprint was publicly unveiled last week during the NAIC's spring meeting in Chicago, held March 11-15, after several months of confidential drafting

NAIC

(*BI*, Feb. 7).

The five-page document, "Statement of Intent: The Future of Insurance Regulation," already has garnered broad support among regulators, 49 of whom have formally signed it. Meanwhile, Arizona and Hawaii are considering signing the statement, an NAIC spokesman said.

Industry representatives also generally support the regulators' blueprint.

According to the statement, fostering "efficient, market-oriented regulation of the business of insurance" is one of the best ways for regulators to meet their primary goal of protecting insurance consumers "proactively and aggressively," while also aiding companies.

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NEWSPAPER

05

Updates

Smith & Wesson suits dropped

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seek to recover public costs related to shootings.

Among the municipalities agreeing to drop their suits are Atlanta, St. Louis, Los Angeles and Miami. Others may agree to the deal later.

The Springfield, Mass.-based gunmaker agreed, among other things, to develop safety locking devices for handguns within 60 days and internal locking devices within 24 months.

Smith & Wesson will dedicate 2% of its revenues to the development of technology that can limit a gun's use to its proper owner and agreed to take action against dealers or distributors who sell disproportionate numbers of guns that turn up in crimes within three years of the sale. No sales can be made to dealers who do not require gun purchasers to demonstrate that they can safely handle and store firearms.

Boeing, strikers reach pact

SEATTLE—The Boeing Co. announced Friday it has reached a tentative settlement with its striking engineers.

To bring about a settlement, the company withdrew its prior demand that union members contribute toward their health care premiums.

If ratified by the union's rank and file, the deal would end the five-week strike by more than 17,000 engineers who are members of the Society of Professional Engineering Employees in Aerospace.

One major contention between Boeing and the union was the company's plan to charge the union workers a percentage of their health care premiums. Currently, union members pay none of the cost of the health care and other insurance benefits; Boeing's non-union members pay 10% of their health care premiums. The two sides also disagreed over pay raises and employee bonuses.

Shortly after the union rejected a third offer Feb. 26, Boeing declared the talks deadlocked. That offer would have required the striking workers to pay 5% of their health care premiums in 2001 and 10% in 2002.

But the two sides resumed negotiations last week, overseen by federal mediator C. Richard Barnes, concluding with Friday's agreement.

Under terms of the proposed three-year agreement, union members will not have to contribute toward health benefits. The health plan under the new pact mirrors the one from the expired contract, with one exception—union members now receive domestic partner benefits.

On another point of contention, retiree benefits, Boeing withdrew its earlier demand and dropped a plan to convert the union's defined benefit retirement plan to a hybrid plan. In addition, Boeing will increase its minimum monthly benefit from to $50 per month per year of service from $40.

"These were tough negotiations," Phil Condit, Boeing's chairman and chief executive officer, said in a written statement. "Both sides worked very hard and compromised. The result is a very positive offer to take to the SPEEA engineers and technical community that also protects the long-term competitive position of the Boeing Co."

Union members were to vote Sunday on whether to accept the deal.

State's certification in question

CHICAGO—The Tennessee Insurance Department is reviewing its options after failing to meet "second-round" certification standards under a National Assn. of Insurance Commissioners' program that confidentially reviews and publicly accredits insurance departments.

Tennessee previously received its first-round certification, which is good for five years.

The confidential denial of second-round certification came at the NAIC's meeting in Chicago last week. Tennessee Insurance Commissioner Anne Pope would say only that "the matter still is under advisement."

Ms. Pope, who took office in November as a gubernatorial appointee, replaced Douglas Sizemore, who resigned to return to the private sector.

The change in commissioners occurred after Martin R. Frankel, a debarred stockbroker, allegedly siphoned $200 million from several life insurers, including a company domiciled in Tennessee (*BI*, Dec. 20, 1999). He has been indicted on fraud and money-laundering charges.

Vermont Commissioner Elizabeth Costle, the chair of the NAIC's Financial Regulation Standards and Accreditation Committee, which oversees the accreditation program, declined to comment.

NAIC regulators generally refuse to discuss a state's regulatory deficiencies, adhering to a policy of keeping state-specific assessment information confidential until accreditation is earned and announced.

Under NAIC appeals rules, a state has 30 days to request an appeal.

Late last year, the NAIC subcommittee also refused to grant second-round accreditation to Washington state and West Virginia. Washington state is appealing the decision (*BI*, Dec. 13, 1999).

Suit targets HMO rate setting

NEW YORK—A new class-action suit charges that United HealthCare Corp. and Metropolitan Life Insurance Co. underpay physicians, forcing patients to pay more than the contractually agreed-upon amount for out-of-network medical care.

The suit, filed last Wednesday by the American Medical Assn. and the Medical Society of the State of New York, charges that the two insurers used data that they knew to be flawed in calculating the "usual, customary and reasonable charge" they paid to physicians.

As a result, members of the health maintenance organization plans

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Errors & omissions

- Due to an editing error, the number of total installations for SBPA Systems Inc. in the March 6 Directory of Employee Benefit Information Systems was incorrect. SBPA has 62 total installations.
- A Global Brief on page 29 states that the Milford Haven Port Authority was seeking to overturn a £4 million ($6.3 million) fine related to a 1996 oil spill. After the page had gone to press, a U.K. appeal court reduced the fine to £750,000 ($1.2 million).

Close vote spells uncertainty

Asbestos fund clears panel

By MARK A. HOFMANN

WASHINGTON—The outlook for legislation that would create a federally administered pool to compensate people suffering from asbestos-related illnesses remains far from clear after the House Judiciary Committee's close vote in favor of the measure.

The asbestos measure, which was sponsored by Judiciary Committee Chairman Henry Hyde, R-Ill., would create an asbestos compensation fund administered by the Department of Justice to compensate victims of asbestos-related illnesses found medically eligible to seek compensation. Supporters say that this approach would streamline the compensation process by taking such cases out of the courts, at least initially. Under the proposal, those eligible for compensation from the fund, which would be financed by companies that have been defendants in asbestos-related lawsuits, would be offered a settlement.

"In order to file an asbestos claim, you have to get a certificate of medical eligibility to show you are sick. The bill sets the medical criteria, the whole point being that this would screen out the people who are not sick and let the sick people proceed with their claims," said John Arlington, assistant vp with the American Insurance Assn. in Washington. The AIA has been tracking the legislation closely but has taken no position on the bill, said Mr. Arlington.

Eligibility would be based on the broadest medical criteria for victims ever proposed, said Rep.

See **Asbestos** *on page 35*

Aetna to split into two

Announcement follows rejection of WellPoint/ING offer

By JUDY GREENWALD

HARTFORD, Conn.—Employers that obtain their health care coverage from Aetna U.S. Healthcare are likely to benefit from parent Aetna Inc.'s plans to split its health and financial services businesses into two separate publicly held companies.

Although the move will not immediately affect day-to-day operations, the separation could ultimately give Aetna U.S. Healthcare better focus on the health care business, observers say.

"If restructuring provides additional focus, then we're for it," said Bruce Taylor, director of health care for Fairfax, Va.-based GTE Corp.

Aetna said last week it plans to separate its global health and global financial services businesses into two independent publicly traded companies as soon as an orderly separation can be achieved. The company said this will be part of a series of steps designed to enhance shareholder value and the quality of services to its 47 million customers.

Chairman and Chief Executive Officer William H. Donaldson said in a statement that, with the separation, "each company can achieve a stronger focus on its customers, improve performance, more closely align management

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1999 HMO results reviewed on page 35

Clearer contracts urged for HMOs

By MARK A. HOFMANN

WASHINGTON—Clearer contracts might have spared managed care plans some of the legal assault they currently face, according to an expert on health care law.

The managed care industry hasn't operated under contracts that spelled out exactly which services would be covered, relying instead on a "consensus" understanding that "managed care" would involve cost and care restrictions, said Clark C. Havighurst, William Neal Reynolds Professor at Duke University Law School in Durham, N.C.

Health maintenance organizations had feared that courts wouldn't uphold contracts that limited care, Mr. Havighurst said. His remarks were made during a discussion on the rise of class-action lawsuits against health care providers, held at the American Enterprise Institute last week in Washington.

Currently, "there's a lot of HMO blood in the water, and we know who that attracts," he said.

"I think managed care companies have a lot to explain," said Mr. Havighurst, who stressed that he did

See **Contracts** *on page 26*

1999 reforms spur change

New risks, opportunities: S&P

By RODD ZOLKOS

SAN ANTONIO—The insurance industry will see the pace of consolidation accelerate in the wake of last year's passage of the Financial Services Modernization Act, an analyst says.

While this may be threatening to some insurance companies, the convergence of various financial services made possible by the new law will benefit many of the companies involved by creating more diversified operations and more effective distribution systems, says Mark Puccia, managing director in the insurance ratings area at Standard & Poor's Corp. in New York.

Speaking at Standard & Poor's Insurance and

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Inside

- Congress and the president should expend less effort trying to make political points and more effort seeing that a relatively non-controversial pension package is enacted, this week's editorial says. **PAGE 8**
- While OSHA's new workplace ergonomics rules may be in place by the end of this year, questions still remain about vague definitions, the need for broad mandates, and possible conflicts between the rules and the exclusive-remedy provisions of state no-fault workers compensation systems. **PAGE 23**
- Lloyd's of London's victory in an Ontario court against a group of Canadian names will enable the market to begin collecting more than $31 million owed to it by names who refused to accept the market's 1996 reconstruction and renewal plan. **PAGE 29**
- Editor Paul Winston says that genetic initiatives reveal patent absurdities. **PAGE 37**

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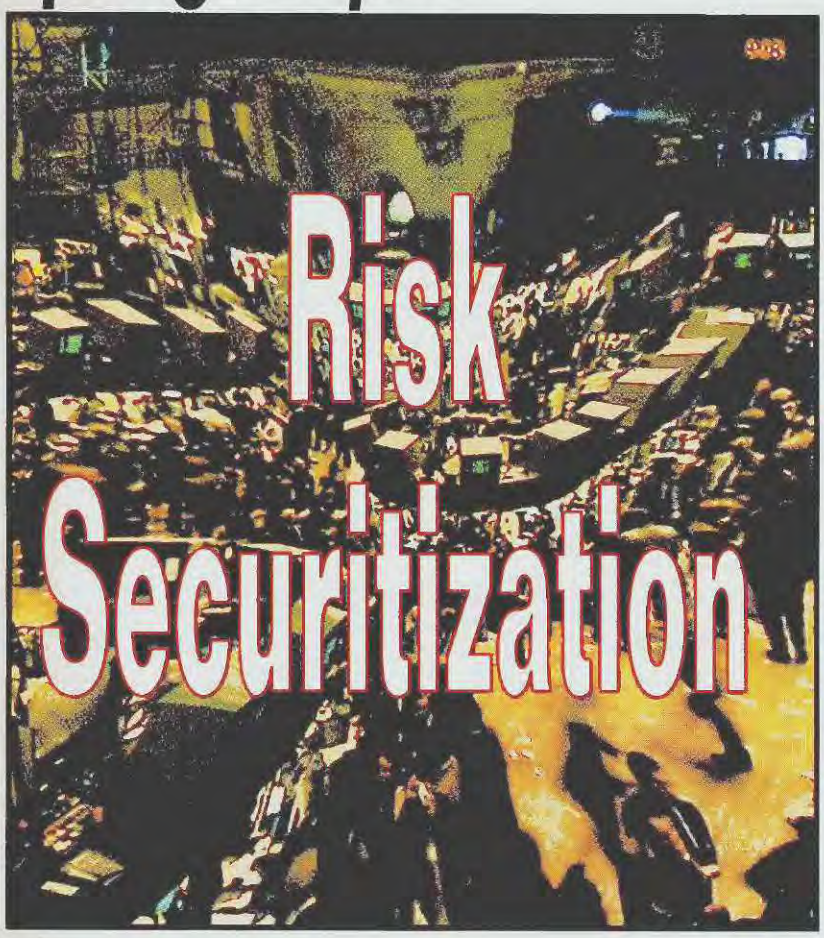
Business Insurance (ISSN 0007-6864) Vol. 34, No. 12, is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Periodicals postage is paid at Chicago and at additional mailing offices. POSTMASTER: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207. $4 a copy and $89 a year in U.S. $108 in Canada and Mexico (includes GST). All other countries $209 a year (includes expedited air delivery). Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 0293512, GST No. 136760444. Printed in U.S.A. Copyright 2000 by Crain Communications Inc.



Risk financing alternatives increasing as market grows

By RODD ZOLKOS

Although the market for alternative risk financing techniques is growing more slowly than many of its proponents would like, evidence that these approaches are a permanent fixture continues to build.

From catastrophe bonds to weather derivatives, credit wraps to integrated risk programs, the market is broad and diverse; and it is these characteristics that provide the market's principal appeal—the flexibility to address complex risk transfer issues with the most efficient tools.

At the same time more insurers, reinsurers, brokers and bankers are showing interest in the alternative risk financing arena, a growing number of businesses also are beginning to systematically study their risks, the first step toward taking advantage of the new risk transfer opportunities becoming available.

"The compartmentalization between banking, insurance and even investment banking is kind of blurring very quickly," said Ed Guzik, head of product development at Swiss Re New Markets Corp. in New York.

"For example, treasury people realize that purchasing insurance—purchasing risk transfer in the form of insurance—is almost identical to purchasing a derivative product," Mr. Guzik said.

"As such, they've come to the conclusion that the product with the highest efficiency. . .is the product that should serve them in the long run."

"Things seem to be getting more flexible," said Carl Groth, senior vp and director of alternative risk transfer at Willis Risk Solutions. in New York. "It's like we're at a point where I believe the industry is going to start changing much more rapidly."

The development of the new risk financing options is driven by both the supply and the demand sides of the equation.

On the one hand, risk financing providers are eager to find new business opportunities.

From Swiss Re's perspective, "As an entity, we are trying to offer a broad spectrum of products," noted Mr. Guzik.

"From a big, macro picture, I think there's a general agreement that the (traditional) market is overcapitalized," said Mr. Groth of Willis. "But insurance has started thinking about investor returns. . .so they're thinking about new ways to underwrite risk."

From the demand side, "There is the growing awareness that a risk needs capital," Mr. Guzik

See **Options** *on page 12*

Exchange products seeing slow trading

By GAVIN SOUTER

Exchange-based insurance products developed in recent years have been somewhat slow to get off the ground.

Although several exchanges have offered derivative contracts since the mid-1990s to cover insurance risks, none so far has posted a significant volume of trades.

Few insurers, reinsurers or policyholders have been drawn away from the traditional insurance markets, where capacity remains abundant and relatively cheap.

As long as those traditional markets manage to weather major natural catastrophes, the allure of the exchange-based products will remain limited, observers say.

Also stifling the growth of the exchange-based contracts is the limited number of contracts available, one expert noted. Dealers, he said, are unable to secure a suitable hedge by laying off one contract against another.

Although the various exchanges have had a good opportunity to establish a widely used set of new risk financing products, that has not been achieved, said Morton Lane, senior managing director, capital markets division at Gerling Global Financial Products in New York.

The main problem with the existing exchanges is that they do not offer a sufficiently diverse array of products, he said. The only way to control the risks in the catastrophe options is to have a diversified portfolio of other contracts, and none of the exchanges currently offers a sufficiently broad range of options to provide for that hedge, he said.

Florida windstorm options, for example, cannot be bought and then hedged in the same way that International Business Machines Corp. stock options contracts can be hedged with IBM stock, Mr. Lane explained.

The exchanges might be more attractive to investors if, in addition to natural catastrophe options, they included options on other risks, he said. Those might include, for example, satellite, aviation and crop indexes, Mr. Lane said. "For the insurance buyer, such exchange instruments would not represent the perfect risk transfer vehicle, but as long as they are quantifiable and indexable, they may represent a good surrogate," he said.

The exchanges could also be used to create a derivatives market for over-the-counter securitized deals, if there are regular issuers of catastrophe bonds, Mr. Lane said.

The soft insurance market has also hindered the growth of exchange-based insurance products, said Sean F. Mooney, senior vp and chief economist at Guy Carpenter & Co., the reinsurance brokerage unit of Marsh Inc. in New York.

See **Exchange** *on page 6*

Top priority on bottom line

More companies seeking to manage business risks

By SALLY ROBERTS

As the concept of enterprise risk management continues to evolve, risk managers are beginning to focus on the exposures most likely to affect their company's bottom line—namely, business risks.

Although such exposures as decreases in customer demand, increases in costs of raw materials and problems in distribution have been traditionally absorbed by corporations as costs of doing business, there is little doubt that these risks can severely affect earnings.

In fact, New York-based Mercer Management Consulting recently found that, of the 100 Fortune 1000 companies that suffered losses of more than 25% of shareholder value from 1993 to 1998 , 95% of the losses were primarily caused by strategic, operational or financial risks. The most frequent primary cause of the stock drops—occurring at 24 of the 100 corporations studied—was a shortfall in customer demand, Mercer found. Competitive pressure and the cost of overruns were the primary causes for stock drops at 12 and 11 companies, respectively.

Experts say that, as more corporations focus on their business risks and as technology continues to evolve to better identify and analyze these risks, more corporations are exploring various risk transfer options.

In addition to several standalone policies that offer insurance protection when such business risks trigger earnings shortfalls, several companies, including Winnipeg, Manitoba-based United Grain Growers Ltd. and Boston-based FMR Corp., have recently transferred operational risks to the insurance market as part of overall customized enterprise risk programs.

Experts say that these types of deals remain more the exception than the rule in the market right now, but the trend is gathering momentum.

"We see the theoretical becoming more of the practical every-

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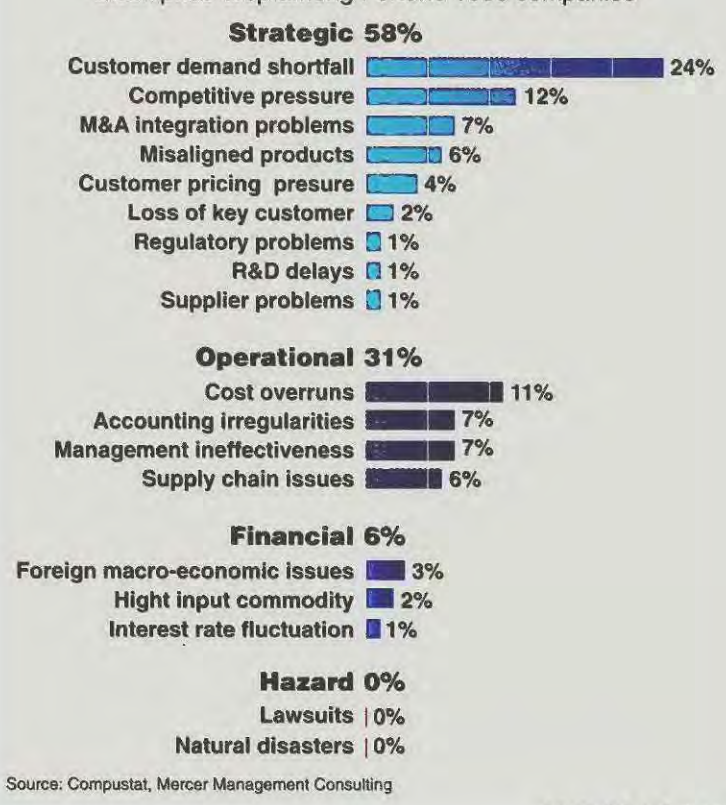
Analyzing the impact of risks

MMC study examined risks that caused prolonged stock price drop among Fortune 1000 companies



Source: Compustat, Mercer Management Consulting

GRAPHIC BY JOHN HALL

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Spotlight Editor: Rodd Zolkos

State regulators eyeing securitization developments

By MARK A. HOFMANN

If large-scale securitization of property/casualty insurance transactions is just around the corner, state regulators want to be ready when it finally arrives.

Just last week, regulators attending the National Assn. of Insurance Commissioners' quarterly meeting in Chicago discussed the mechanics of one of the newest and most complex of securitized risk transactions—the use of index-based derivatives in hedging property/casualty insurance transactions. The NAIC relied on technical advice from the American Academy of Actuaries in tackling the issue.

. "The use of index-based products for hedging insurance exposures is new for both regulators and the insurance industry," said Frederick O. Kist, chairman of the American Academy of Actuaries' index securitization task force, which gave a "white paper" on the subject to the NAIC late last year and presented related material at last week's meeting.

'The regulators are asking the right questions, and they're learning about it, but this is an entirely new area, with new vocabulary,' says Frederick O. Kist.

"The regulators are asking the right questions, and they're learning about it, but this is an entirely new area, with new vocabulary and vernacular," said Mr. Kist, who is also senior vp and chief actuary of CNA Financial Corp. in Chicago.

This review is not the NAIC's first venture into risk securitization. The NAIC formed a securitization working group in late 1998 to deal with regulatory questions arising from the issue. That working group's head—Illinois Chief Deputy Director of Insurance Arnold Dutcher—said it was charged with carrying out a "pretty global mission—to study the whole issue of securitization."

Regulators approved a model law regarding so-called "protected cell" insurance companies, and they have been debating possible future forms of special-purpose reinsurance vehicles. Both of these facilities would come into play to protect insurers against catastrophic losses.

The regulation of securitized risk transfer isn't exactly a big issue for most risk managers, however.

The deals have "never really seemed to spark much interest, given the capacity that's already present," said William Kelly, managing director of J.P. Morgan & Co. in New York, responsible for corporate risk and insurance management. Mr. Kelly is also a former president of the New York-based Risk & Insurance Management Society Inc.

"If we do get into levels of billions of dollars of insurance and true protection against life-threatening events for major institutions, then securitization might provide a new level of capacity that doesn't now exist," he said.

Buyer interest could increase when the potential benefits of risk securitization are realized, say some observers.

"To the extent that it provides additional capacity for the direct writers, it will permit the buyers to have a larger market in which to buy insurance," said Phil Schwartz, vp-financial reporting for the American Insurance Assn. in Washington.

"I think it might encourage the insurance industry to expand its product offering in the integrated risk products. The risk transfer may cover a broader spectrum of risk than a traditional insurance product," said Mr. Kist of the AAA.

"There may be additional capacity that may be offered to the buyer," he added.

Right now, though, "we can't even describe the animal, let alone how we're going to regulate it," Mr. Kelly said.

The idea of securitization has drawn general support from insurers, though there are some significant differences of opinion on the details of how securitization should work.

"We really don't have concerns. We are supportive of securitization options. The reason we're supportive is we feel it is just an additional flexible way to deal with risk transfer—that's ultimately what this is, just not done in the traditional reinsurance form," said Joe Pomilia, assistant vp-financial reporting for the National Assn. of Independent Insurers in Des Plaines, Ill.

In fact, having the option of offering securitized products could be a matter of survival for traditional insurers as they compete with non-traditional sources of risk transfer, such as banks.

"Insurance companies need to find ways to be more efficient, or banks will take over the business," said the AIA's Mr. Schwartz.

"I don't think there's a problem with regulating it at the state level," he said. "The products that are being contemplated are an alternative to reinsurance, which receives less regulatory scrutiny because both parties are sophisticated businesspeople."

Using protected cell approach for risk securitization has particularly drawn support from across the industry. Legislatures in three states—Illinois, Rhode Island and South Carolina—have already approved bills permitting the creation of protected cell facilities. Under this facility, an insurer can segregate assets and liabilities for a specific risk, such as a catastrophe exposure, from other business activities of the insurer. The risk to be

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What can we do to help you?

Regulate

Continued from page 4

securitized would reside in the cell, as would the proceeds of whatever security is issued to finance the risk.

"We're in favor of the protected-cell concept and the special-purpose reinsurance vehicle," said Mr. Pomilia.

"I think the current vision is these securitization vehicles will primarily be used to transfer high-level catastrophe risk. As everyone has seen over the years, the industry has continued to struggle with that exposure. We're always looking for creative market solutions to the issue," Mr. Pomilia said.

But so-called "onshore special-purpose reinsurance vehicles" have proved to be more controversial.

"The insurance industry is not all on the same page in respect to this concept," observed the NAIC's Mr. Dutcher.

These vehicles are drawing opposition from traditional reinsurers, noted Debra Hall, senior vp and general counsel for the Reinsurance Assn. of America in Washington.

"We believe regulators are being asked to create, in essence, a non-taxed, barely regulated entity that's going to compete against traditional reinsurers. We think this creates an unlevel playing field," Ms. Hall said.

"You don't need onshore special reinsurance vehicles to create insurance securitization," she said, adding that the reinsurance industry is awash in capacity.

She cautioned buyers of all sorts that, "while insurance securitization maybe available at some times, it may not at others." Risk managers and insurers alike should be "concerned about the uncertainty." BI

Exchange

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"The traditional market has been so competitive that people are not looking for other ways of doing business," he said.

At least in concept, the exchange-based deals are generally similar to the mortgage-backed securities that have been a huge success since they were introduced in the 1970s. "There is a belief that alternative means of transferring risks will grow, but it is difficult to predict when," Mr. Mooney said.

Currently, the trading that is taking place typically involves established insurers and reinsurers, so the exchanges have not brought substantial new capacity to the marketplace, he said.

Guy Carpenter provided the index for the Bermuda Commodities Exchange reinsurance products. The BCE did not take off, however, and was suspended last year after two years of little activity.

The oldest of the insurance-related, exchange-based derivative products are the catastrophe options traded on the Chicago Board of Trade, which began trading the options in 1996.

Initially, there was substantial interest in the options, but the soft traditional market has hampered use of the contracts to hedge catastrophe exposures, said Carlton Purty, an independent broker at the CBOT who trades in options.

No catastrophe option trades have been completed at the CBOT so far this year, he said. Last year, there was increased interest in the contracts because of Hurricane Floyd, but few contracts were traded, Mr. Purty said.

"I think a major, major catastrophe will have to happen before they really take off," he said.

The contracts offer real protection, and options dealers are keen to trade in a new niche, but the conventional insurance and reinsurance markets are so soft that few companies are turning to alternative coverage options, Mr. Purty said.

The Catastrophe Risk Exchange, located in Princeton, N.J., has radically changed its structure since it was originally announced in mid-1996, and it is well positioned to expand, said Frank Sweeney, chief operating officer.

CATEX initially planned to be a computer-based facility for reinsurers that would enable them to exchange catastrophe risks and to build balanced portfolios.

But by the time the exchange was operational in November 1996, it was clear that most reinsurers and insurers interested in CATEX wanted only to buy and sell conventional reinsurance, Mr. Sweeney said.

Although there was some interest in risk swapping, only a handful of risks were posted on the system, and none was traded, Mr. Sweeney said.

Consequently, CATEX has become chiefly a "cash for cover" exchange, he said, noting that the risks reinsured on the exchange include property catastrophe coverage, aviation and liability coverages. CATEX also trades industry loss warranties, where coverage is triggered by an actual loss combined with an industry loss over an agreed threshold.

Other adjustments to the exchange included making it accessible through the Internet in November 1998. And late last year, CATEX offered users the ability to set up smaller networks, allowing them form groups whose members do business only with one another.

Since its inception, CATEX has completed about 450 trades, totaling $400 million in premium and more than $3 billion in limits, he said. CATEX's roughly 160 subscribers include reinsurers, insurers and corporate entities that purchase coverage through their captives, Mr. Sweeney said.

"We obviously have a long way to go, but we are pretty satisfied with what we have achieved so far," Mr. Sweeney said.

The exchange sees increased activity after major losses, as cedents seek to buy replacement coverage to offset depletions in their existing cover, he said. For example, Mr. Sweeney said, there was a flurry of activity after the European windstorms in December last year.

Last September, the Chicago Mercantile Exchange entered the field of insurance-related derivatives when it began offering weather derivatives.

Thus far, 420 futures contracts have been traded, said Larry Grannan, senior director in product marketing at the CME.

Such contracts are designed to allow businesses to hedge against weather-related losses. For example, a utility may sell less power in a mild winter, and it would be able to use the futures to hedge a resultant fall in revenues.

The exchange first offered heat-based indexes for Atlanta, Chicago, Cincinnati and New York. In January, it added Philadelphia, Dallas, Des Moines, Las Vegas, Tucson and Portland, and it began offering contracts based on cold weather.

Currently, most of the trades are between securities dealers themselves, but, eventually, the contracts will likely be used more extensively by utilities and insurers, Mr. Grannan said.

In addition, the futures contracts could be used as hedges for over-the-counter securitized deals, he said. BI

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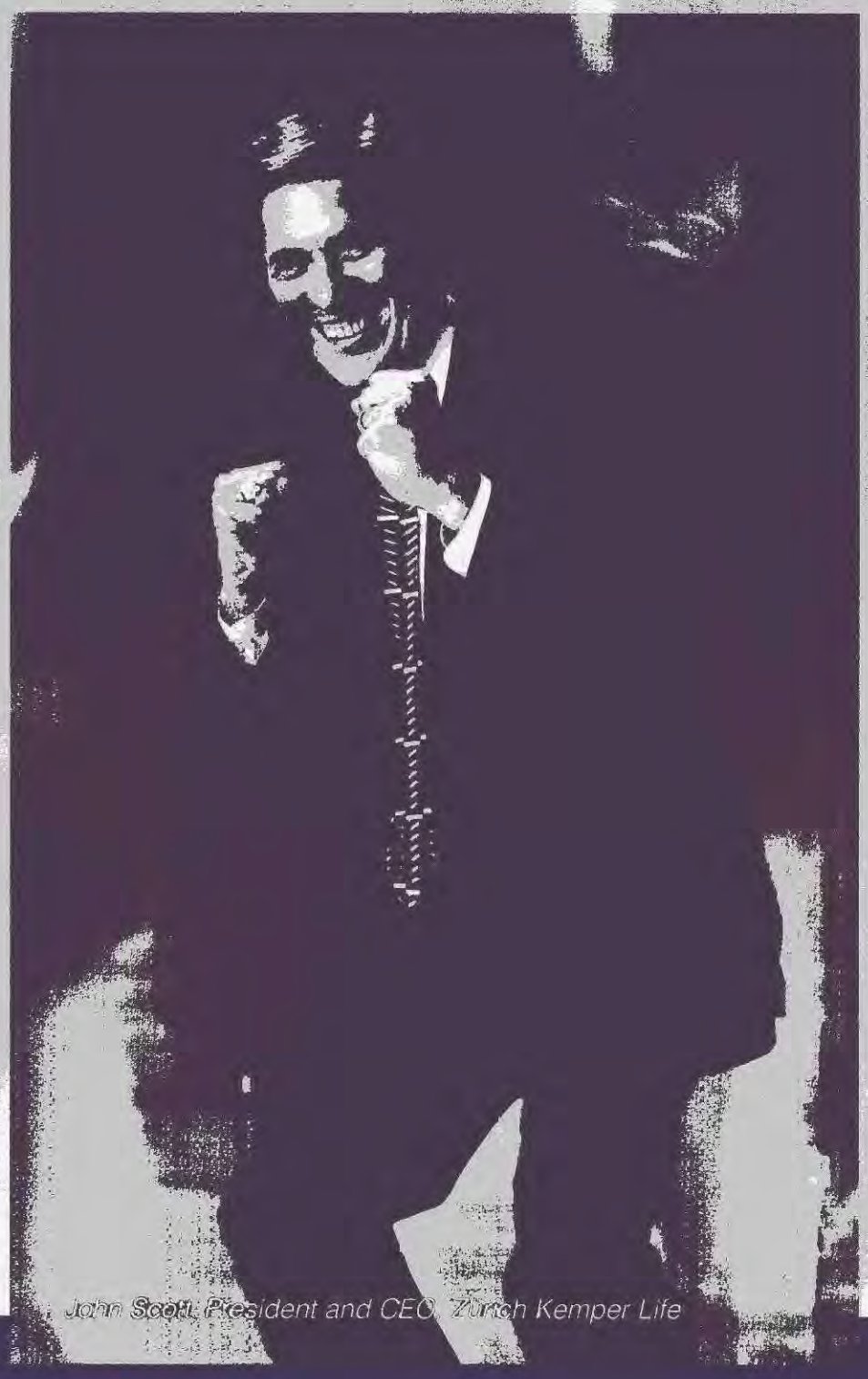

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Opinions

Reform getting off track

IT WOULD SEEM a relatively easy matter for Congress to give final approval and for President Clinton to sign a recent pension reform package, given that the measures enjoy broad bipartisan support.

Unfortunately, however, in the often-poisonous climate in Washington—where Republicans, Democrats and the administration seem more interested in trying to score political points with the public than in working for the common good—passage of what is a relatively noncontroversial measure is anything but a given.

The Senate and now the House have both passed pension reform measures that are similar to one another. The challenge now is to make sure they become law.

Pension provisions in each bill were largely drawn from a measure—backed by Republicans and Democrats alike—earlier introduced by Reps. Ben Cardin, D-Md., and Rob Portman, R-Ohio.

Unwilling to keep things simple, however, Republicans attached the pension provisions to broader tax bills that would raise the federal minimum wage and provide certain tax breaks, such as a reduction in estate taxes.

The Clinton administration wants the minimum wage increased, but it wants the increase passed as a standalone bill. Republicans, for their part, grudgingly will support a hike in the minimum wage, but only if it is part of broader tax-cut legislation. As a result, the pension reform proposals, which enjoy broad support, are stalled while lawmakers and the president are at an impasse.

Although the pension package is by no means perfect, it should, with some minor tinkering, be enacted. This could happen if both sides are willing to compromise and find a middle ground on the tax issue. Perhaps, for example, the tax cuts in the bill could be slimmed down to try to accommodate administration objections.

But failing that, lawmakers should find a less controversial legislative vehicle for the pension package as soon as possible, rather than let this opportunity go to waste because of political maneuvering.

At the heart of both the House and Senate pension packages are provisions that would increase the contributions employees could make to all types of pension plans.

These contribution increases, are not, as some in the administration have suggested, tax breaks targeted at the well-to-do. In fact, the increases do not even come close to restoring the much higher contribution limits that once existed. Congress drastically slashed those limits during the 1980s and early 1990s, when legislators targeted tax-exempt benefits in an attempt to raise revenue during a time of massive federal budget deficits.

Consider 401(k) plans. As recently as 1986, it was possible for an employee to defer—assuming certain other requirements were met—up to $30,000 a year to the retirement savings plans.

As part of a 1986 tax law, though, the maximum limit was slashed to $7,500, and today it is only $10,000—a third of what it was 14 years ago. The Senate bill would modestly raise the limit to $15,000—still only half of what it was in 1986—while the House would boost the limit to $14,000.

These increases are good social and pension policy. It is in the national interest for employees to be able to save more for their retirement while they are working.

It also is good policy to allow employees age 50 or older to make additional contributions to 401(k) and other savings plans, compared with what younger workers may contribute. Backers of this provision, which is contained in both bills, say it would chiefly aid women returning to the workforce after years of child-raising, during which they might have been unable to contribute to an employer's savings plan.

The pension reform measures also would eliminate ridiculous federal rules that currently serve only to make pension plan administration costly and confusing.

One provision addresses a problem that arises, for example, when an employee moves from a university to a private employer. While employed at the university, the employee likely was covered by a 403(b) plan, the tax-exempt world's rough equivalent of a 401(k) plan. Shouldn't that employee be allowed, if he or she likes, to transfer the 403(b) account balance into the 401(k) plan? Logic would say yes, but current law forbids it. The two tax bills would, in a nod toward common sense, permit such transfers.

Another example stems from non-discrimination rules. Employers and their advisers have become pretty adept at running the basic non-discrimination test on their 401(k) plans. When a savings plan allows both pretax and aftertax contributions, however, an entirely different—and far more complex—non-discrimination testing procedure is required. It would make far more sense to allow employers to run the same non-discrimination test on all parts of a savings plan, as both tax bills would permit.

To be sure, the pension provisions are far from perfect. We are skeptical, for example, about the ease of enforcing a provision that would let employers prove through "facts and circumstances" that their pension plans were non-discriminatory. We suspect such a provision would be nearly impossible to apply in an objective, consistent manner. That provision should be jettisoned.

In spite of minor flaws, both the House and Senate bills are good reform packages that include proposals that would aid employers and employees alike. The administration and Congress must find a way for these pension reforms to become law.

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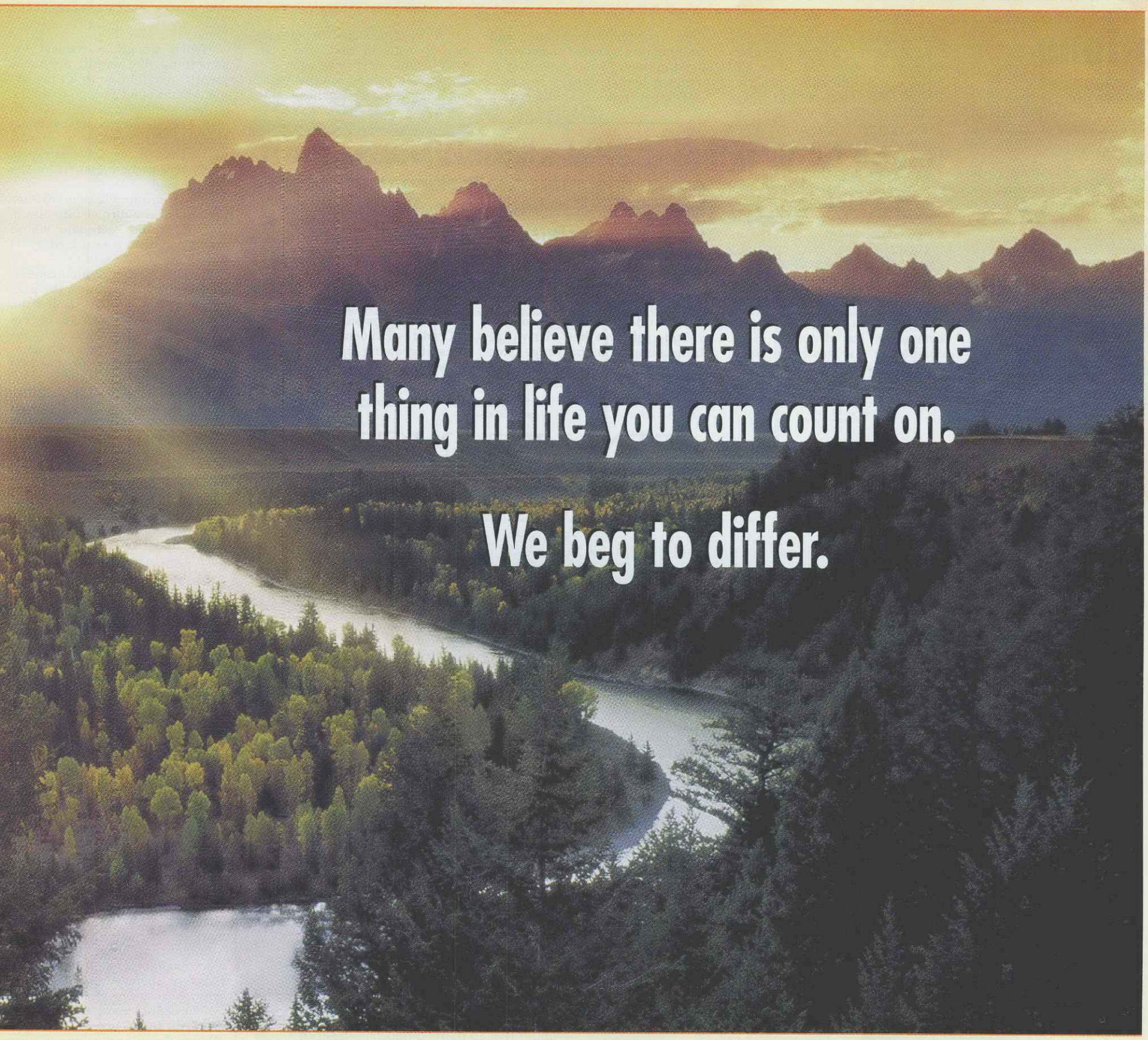

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Options

Continued from page 12
as a basket unless you do a study of how it hits your organization and how it potentially affects your stock price."

That education is key, Mr. Guzik said, in terms of an organization understanding its own risks as well as how some of the new products can address them.

"When you look at the actual number of deals that have been done . . .there are a few, but not as many as you might expect, given the amount of effort that has been put into this area over the past three to five years," he said. "What we need, as a market, is time to educate the buyers."

In addition, the industry must achieve greater transparency in the alternative products' pricing before they will become more widely used, Mr. Guzik said.

"Most of these products are custom made, custom designed,' he said, and the amount of time and effort that goes into crafting them "is actually quite substantial."

"And therefore, the cost of these products is not only reflecting the cost of capital but also the cost of the time and effort of the underwriters," Mr. Guzik said. "Greater transparency—I don't know that it would open the floodgates, but it would broaden the pipeline for these products."

The perception that the alternative approaches are too expensive compared to buying conventional insurance in the current soft market has been the biggest obstacle to their gaining favor, Mr. Groth suggested.

"The hindrances and the barriers for integrated programs have been, well, the insurance market is soft and risk managers are pleased with the cost reductions in their programs," he said. "So there hasn't been a lot of incentive to fix something that isn't broken."

Some new products 'are very exotic. But what was exotic two years ago isn't exotic anymore,' says Jayan D. Dhru.

But Marsh's Mr. Sanderson said he is heartened by the number of companies that are at least studying their exposures and the potential solutions.

"I know the marketplace is frustrated because they haven't seen a lot of them," he said. "But a good chunk of this is 'I want to see it, I want to understand it before I go about fixing it.' And the market doesn't see these until they get to fixing it."

Although the pace may be slower than some might prefer, the alternative risk financing market appears bound to continue growing.

Jayan U. Dhru, head of the insurance capital markets group at Standard & Poor's Corp. in New York, said that bankers and insurance companies constantly approach Standard & Poor's with new risk financing products.

"We have not seen all the new products, but we are willing to see any new product that comes on board," he said. "Some of these are very exotic, but what was exotic two years ago isn't exotic anymore."

"There is no way back. We have to move in that direction," Swiss Re's Mr. Guzik said. "Buyers will press for some additional values. There's no doubt in my mind."

Meanwhile, however, "We also need to kind of streamline some of the delivery processes we have in place and also admit to the market that some of these products that we've been working on will not fly, and others will not fly at this time," Mr. Guzik said.

"I think what we all need to do, all of us people playing in this alternative risk market, is go through some post-mortems and go over those deals on which we spent a lot of money and a lot of time and, for whatever reason, didn't (complete) and ask ourselves 'Why?' " he said.

"And in identifying the reasons why those deals didn't come to fruition, we might find answers to crafting risk financing approaches that better meet market needs." BI

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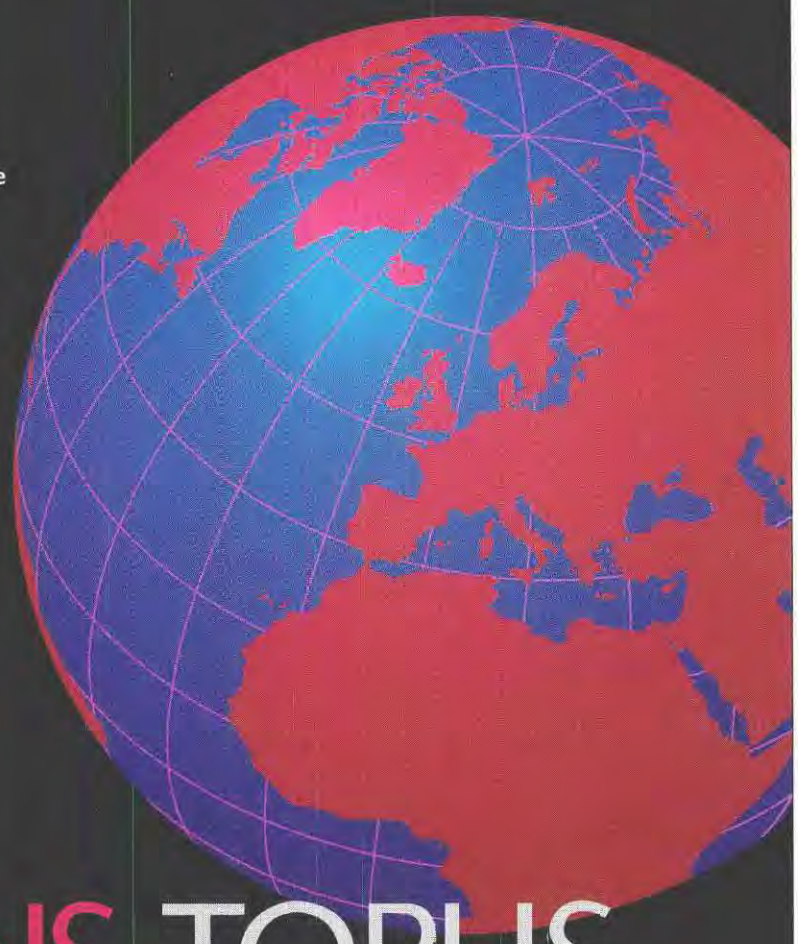

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Enterprise

Continued from page 3
day," said John Gantz, a principal in charge of global corporate marketing for Swiss Re New Markets in New York, which helped craft the programs for UGG and FMR.

Carl Groth, senior vp and alternative risk transfer director for Willis Risk Solutions in New York, which worked with Swiss Re on UGG's program, noted that "most companies out there are taking a look, at various levels of interest."

"It is new, and any given company has a number of priorities," Mr. Groth said. "Some companies have a casual interest, and some have a serious interest."

"I see operational risks and operational risk transfer to the insurance industry as a big deal, and it will be a bigger deal in the future," predicted Bernard Friemann, president of the financial risk management division of Reliance National Insurance Co. in New York.

"There is no doubt in my mind that the snowball is starting to gather speed, as more of these types of solutions are done," Mr. Friemann said.

Marty Scherzer, managing director of Marsh Risk Finance, a unit of Marsh Inc. in New York, said that "firms are recognizing that there are more opportunities to address risks that they previously thought were unaddressable." As a result, "firms have devoted more senior management time, more money and a higher level of interest in trying to figure out ways. . .to address those risks."

At the same time, "the market is developing specialty products to address business risk problems and is working with clients in a consultative mode to customize solutions with insurance, capital markets and risk mitigation techniques," Mr. Scherzer said.

Experts stress, however, that the focus on business risks is a byproduct of the larger enterprise risk management movement, which many employers have recently embraced. Regardless of whether a company transfers its business risks, it is important that it analyze its entire risk landscape and truly understand the risk drivers in the company, experts say.

When the concept of enterprise risk management first emerged, the focus was whether a corporation was purchasing risk transfer products in the most-efficient way, explained Randy Nornes, managing director and enterprise

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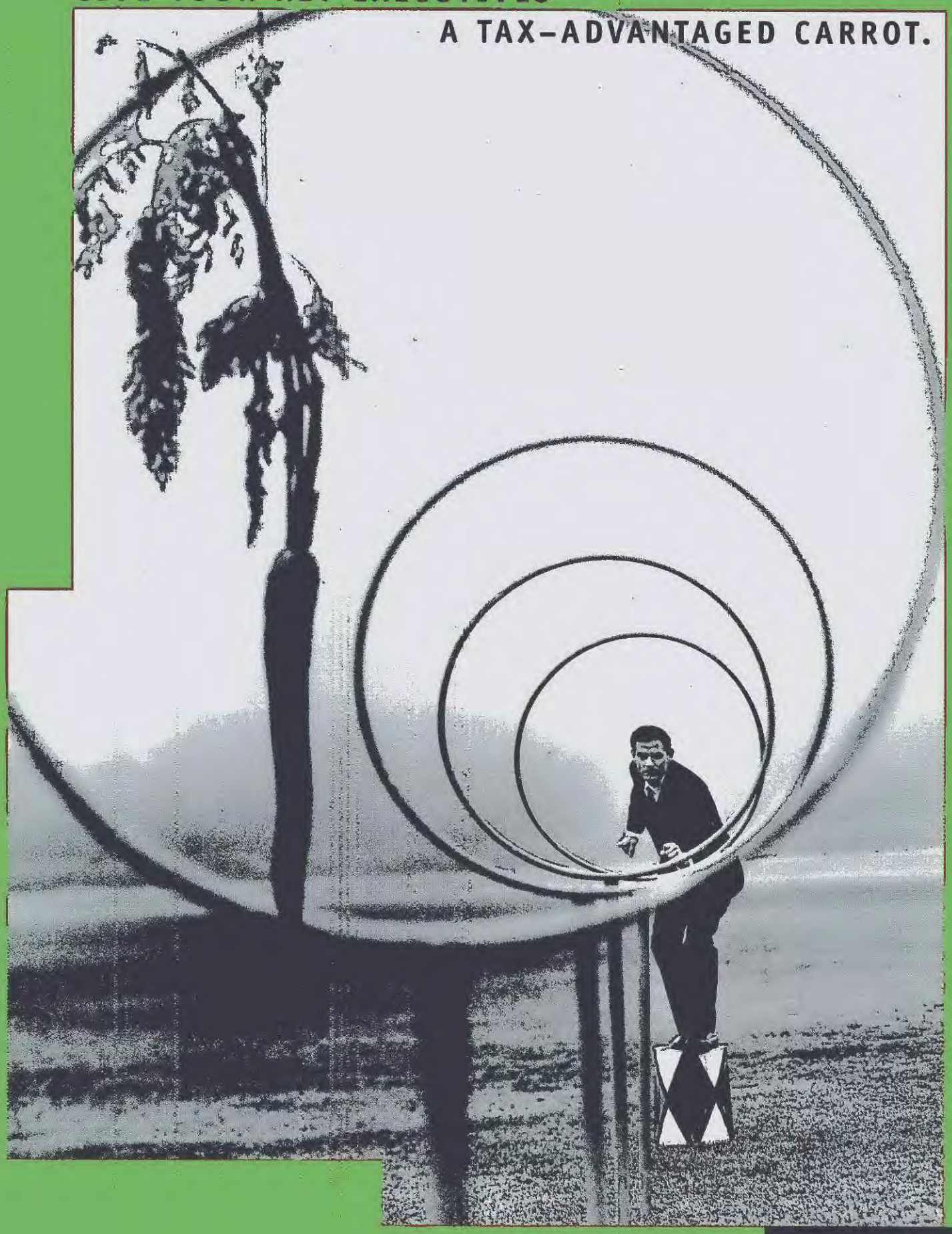

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Enterprise

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risk practice leader for Aon Group Inc. in Chicago. Within the last year, however, "the focus has shifted dramatically," he said. Senior management is now viewing risk as a critical element of the business and "as a baseline decision-making tool," he said.

This is a cultural change within corporations to take a team approach to viewing risks, he said.

Whether those risks are eventually transferred into an integrated policy or a stand-alone insurance policy doesn't matter, Mr. Nornes said. "It's a huge breakthrough for firms to want to look at all the risks of the corporation."

This presents opportunities for risk managers, according to Susan R. Meltzer, president of the Risk & Insurance Management Society Inc. "The need for risk management has been underlined at the senior management and the board of directors level," she said.

"The key that has come out of this is that the board needs to understand the full array of risks that face the organization. Risk managers need to adapt their understanding of risk and their ability to report on risk in a way that is meaningful to senior management," said Ms. Meltzer, who is assistant vp-insurance and risk management for Sun Life Assurance Co. of Canada in Toronto.

United Grain Growers took a team approach when it formed an executive committee to reassess its total risk portfolio about three years ago, explained Michael J. McAndless, risk manager.

"This is not a one-person initiative," he said. "It's really a cross-functional, multirisk, multifaceted job that requires skills brought to the table by the treasurer, the CFO, the risk manager, the operational managers and analytical types," he said.

After identifying 47 areas of risk, UGG's committee narrowed the list to the top six. Of those six, only one—environmental risk—was traditionally insurable, Mr. McAndless. After determining that it could manage four of the other operating risks internally, UGG decided that in addition to environmental risk it needed to try to transfer its weather exposure off its balance sheet.

In the end, UGG developed a three-year integrated program that covers most of its property/

casualty exposures, as well as coverage for downturns in its grain-handling business. Since variables other than weather existed that affected UGG's grain-handling revenue, the policy is triggered when its grain-handling volume falls below a volume index set by a Canadian national commission (*BI*, Nov. 15, 1999).

FMR Corp., better known as Fidelity Investments, also recently secured a catastrophe program that includes coverage for such operational risks as system failures, counterparty risk and rogue trading within the company (*BI*, Nov. 8, 1999).

While operational risk coverage for UGG and FMR is part of larger enterprise programs, at least one industry is taking advantage of stand-alone earnings protection insurance policies.

A number of ski resorts have bought policies to hedge one of their biggest business risks—drops in the number of paid skier-days, said Joseph M. McNasby, president of MDM Group Associates Inc., a Steamboat, Colo.-based managing general agency.

Three years ago, MDM developed

Senior management is now viewing risk 'as a baseline decision-making tool,' says Aon's Randy Nornes.

an all-risk earnings protection policy that covers a ski resort's loss of income due to a significant reduction in paid skier-days resulting from any cause or combination of causes not specifically excluded. These causes may include a lack of snow, ice storms, road closures, a poor economy, airline strikes and problems with airports. The policy excludes property damage, fraud, pollution and other losses that are within the resort's control.

"This takes the crystal ball away from the business owner," Mr. McNasby said of the policy. "If you can protect yourself from all these unknowns, then you can eliminate a substantial amount of financial risk that can severely affect the value of the company's earnings."

MDM's policy is triggered when the number of paid skier-days—minus the number of season tickets and complimentary tickets issued—falls below a number agreed upon at the beginning of the ski season.

The policy, which is subject to deductibles and coinsurance, has limits up to $50 million and is underwritten through Lloyd's of London syndicates and other London offices of various insurers, Mr. McNasby said. It is distributed through other brokers, such as Aon Group Inc., Willis Group Ltd. and Acordia Inc.

Vail Resorts Inc., which bought the earnings protection policy for the first time this season, announced in January that the policy will help the resort offset lower-than-expected financial results for its 1999/2000 ski season. Crested Butte Mountain Resort in Crested Butte, Colo., also bought the policy for the first time this season (*BI*, Feb. 14).

Mr. McNasby said that 18 major ski resorts have bought the policy, and "we're getting calls like it's no tomorrow from the rest of them."

In addition to ski resorts, MDM also is targeting airlines, cruise ships, state fairs and expositions, Mr. McNasby said.

Like the paid skier-day policy, policy triggers are based on the number of passengers and attendees.

In addition to MDM, at least two other insurers offer stand-alone earnings protection policies that cover business risks.

Tamarack American, New York-based Great American Insurance Co.'s specialty unit, recently unveiled a policy called RevenueGuard, which offers up to $50 million in coverage against revenue hits from any of nine defined enterprise loss events. These events include losses caused by new market competitors, currency fluctuations and changes in consumer buying habits (*BI*, Jan. 31).

Sherif M. Zakhary, senior vp and head of Tamarack's executive protection/financial products division, said that, although Tamarack has yet to bind a policy, he is "more than optimistic" that it will this year.

"We are well in the process of getting the applications filled out and educating companies and brokers that are interested," Mr. Zakhary said.

Meanwhile, Reliance National last year introduced an "Enterprise Earnings Protection Insurance" policy that responds to an earnings shortfall due to operational business risks, financial exposures and/or natural and man-made hazards beyond management's control. The all-risk policy has limits of up to $50 million (*BI*, Feb. 1, 1999).

While the insurer has yet to bind a full EEPI policy, Reliance National is confident that it will do so in 2000.

"During the last year, we spent most of our time educating brokers and clients about the concept of our product," Mr. Friemann said. "We found that lots of brokers and clients already had initiatives going to identify operational risks and were doing things to try to understand, mitigate and decide whether risk transfer was the right answer," he said.

"It's a big thing to bite off and chew, and it takes a while to get your mind around the concept. . . and get comfortable with the issue," Mr. Friemann said. BI

BI's directory of risk securitization specialists

A

AIG Structured Finance

70 Pine St.
New York, N.Y. 10270;
212-770-7629; fax: 212-797-8032
www.aig.com

Parent: American International Group Inc.
Risk securitization services began: 1996.
Services
Risk securitization consulting 10%
Underwriting/distribution of risk securitization offerings 90%
Staff
Total 10
Risk securitization professionals 9
Clients
Total 10
U.S. clients 60%
Non-U.S. clients 40%
Securitization deals
Issues brought to market in 1999 12
Estimated aggregate volume for 2000 ..... $3,000,000,000
Instruments used: swaps, blended/integrated risk programs, index-linked securities, credit enhancement; residual value.
Services provided: risk securitization design, analytics/risk quantification, tax advice, legal advice, underwriting of securities, analysis of risk financing alternatives.
Risks: catastrophe, residual value, earnings shortfalls, credit.
Officers: Matthew Cooleen, president; Michael Canter, senior vp.

American Protection Property & Casualty Agency Inc.

500 W. Madison St., Suite 1100
Chicago, Ill. 60661;
312-559-8515; fax: 312-559-8520

Parent: Kemper Insurance Cos.
Risk securitization services began: 1998.
Staff
Risk securitization professionals 6
Clients
U.S. clients 100%
Securitization deals
Aggregate volume of capacity in 1999 ..... $100,000,000
Instruments used: catastrophe bonds, swaps.
Services provided: creation of special purpose vehicles, management of special purpose vehicles on the INEX Insurance Exchange for on-shore securitizations.
Risks: catastrophe, general first-party property.
Officers: Donald W. Mosier, vp.
Contact: Donald W. Mosier, dmosier@kemperinsurance.com; Glenn G. Carlson, ggcarlson@kemperinsurance.com.

American Re Securities Corp.

555 College Road E.
Princeton, N.J. 08543-5241;
609-243-4200; fax: 609-951-8017
www.amre.com

Parent: American Re Corp.
Risk securitization services began: 1999.
Instruments used: catastrophe bonds, swaps, physical event-linked securities, blended/integrated risk programs, index-linked securities.
Services provided: risk securitization design, analytics/risk quantification, underwriting of securities, creation of special purpose vehicles, analysis of risk financing alternatives, distribution/sale of securities.
Risks: catastrophe.
Officers: Dominick Addesso, senior vp; Kenneth Bock, Charles W. Kerner, managing directors.
Contact: Charles W. Kerner; 609-275-2170.

Aon Capital Markets

123 N. Wacker Drive, Eighth Floor
Chicago, Ill. 60606;
312-701-3357; fax: 312-701-3450
www.aon.com

Parent: Aon Corp.
Risk securitization services began: 1994.
Services
Risk securitization consulting 33%
Underwriting/distribution of risk securitization offerings 56%
Other 11%
Staff
Total 40
Risk securitization professionals 26
Clients
Total 10
U.S. clients 50%
Non-U.S. clients 50%
Securitization deals
Issues brought to market in 1999 7
Aggregate volume of capacity in 1999 ..... $600,000,000
Estimated issues for 2000 15
Estimated aggregate volume for 2000 ..... $1,200,000,000
Instruments used: catastrophe bonds, catastrophe equity put options.
Services provided: risk securitization design, analytics/risk quantification, tax advice, underwriting of securities, creation of special purpose vehicles, analysis of risk financing alternatives, actuarial advice, distribution/sale of securities.
Risks: catastrophe, earnings shortfalls, enterprise risks, general casualty, credit, capital access problems.
Officers: Kevin R. Callahan, CEO; Nigel Sedgwick, managing director-European operations; Tony Rettino, managing director-North American operations.
Contact: Tony Rettino; 312-701-3909.

Applied Insurance Research Inc. (AIR)

101 Huntington Ave.
Boston, Mass. 02199;
617-267-6645; fax: 617-267-8284
www.air-worldwide.com

Risk securitization services began: 1996.
Services
Risk securitization consulting 5%
Other 95%
Staff
Total 80
Risk securitization professionals 6*
Clients
Total 4
U.S. clients 75%
Non-U.S. clients 25%
Securitization deals
Issues brought to market in 1999 4
Aggregate volume of capacity in 1999 ..... $430,000,000
Instruments used: catastrophe bonds.
Services provided: analytics/risk quantification, analysis of risk financing alternatives, natural hazard modeling/analysis,
Risks: catastrophe.
Officers: Karen M. Clark, president/CEO; Vivek Basrur, senior vp.
Contact: S. Ming Lee, mlee@air-worldwide.com.
**Estimate.*

C

Castlebridge Partners L.L.C.

900 W. Jackson Blvd., Suite 7E
Chicago, Ill. 60607;
312-377-1284; fax: 312-377-1270

Risk securitization services began: 1996.
Services
Risk securitization consulting 50%
Other 50%
Staff
Total 10
Risk securitization professionals 5
Clients
Total 10
Services provided: risk securitization design, analytics/risk quantification, creation of special purpose vehicles, analysis of risk financing alternatives, regulatory advice, pricing and structuring, creative transactions.
Risks: catastrophe, environmental liabilities, residual value, weather.
Officers: James Gosselin, Paul Murray, Ethan Kahn.
Contact: Paul Murray, paul@castlebridge.com.

E

EQECAT

1111 Broadway
Oakland, Calif. 94607;
510-817-3100; fax: 510-663-1050
www.eqe.com

Parent: EQE International.
1999 revenues
Total $65,000,000
Staff
Total 500
Risk securitization professionals 10
Clients
Total 5
U.S. clients 20%
Non-U.S. clients 80%
Instruments used: catastrophe bonds.
Services provided: natural hazard modeling/analysis.
Risks: catastrophe.
Officers: Doug Frazier, chairman/CEO; Peter Yanev, president-EQE International; James J. Johnson, president-EQECAT.
Contact: Dennis Kuzak, dek@eqe.com; Mike Vallejos, mav@eqe.com.

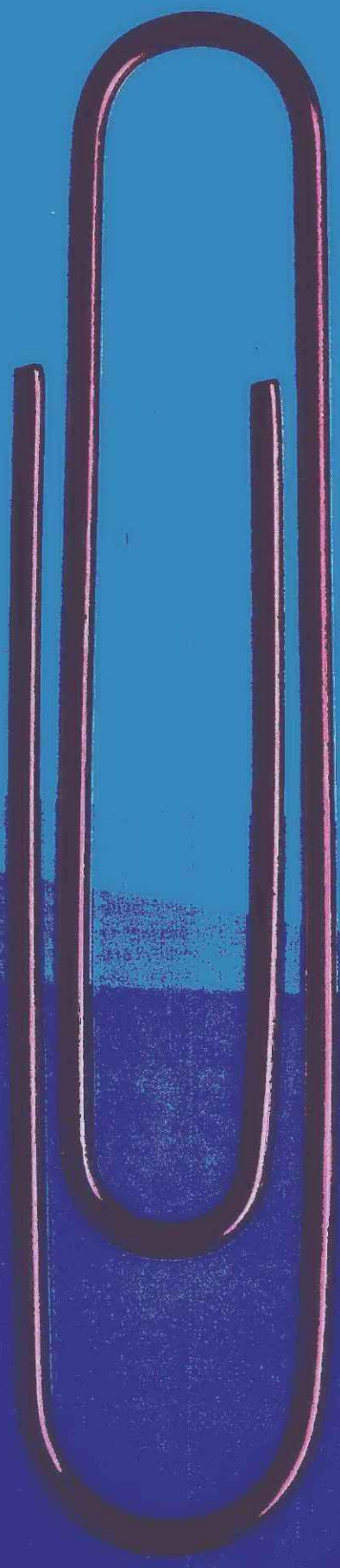
Enterprise Risk Solutions

666 Fifth Ave., 16th Floor
New York, N.Y. 10103;
212-328-7900; fax: 212-541-8958
www.erisks.com

Risk securitization services began: 1999.
Services
Risk securitization consulting 25%
Other 75%
Staff
Total 20
Risk securitization professionals 15
Services provided: risk securitization design, analytics/risk quantification, analysis of risk financing alternatives, natural hazard modeling/analysis, actuarial advice, brokerage for integrated risk management products, enterprise risk service bureau.
Risks: catastrophe, workers comp, environmental liabilities, residual value, earnings shortfalls, enterprise risks, general first-party property, general casualty, asbestos liabilities, credit, capital access problems.
Officers: John Drzik, chairman; James Lam, president-ERS Consulting; Peter Nakada, president-eRisks.com.
Contact: Bob Mackay.

Continued on page 18

Paper clip?



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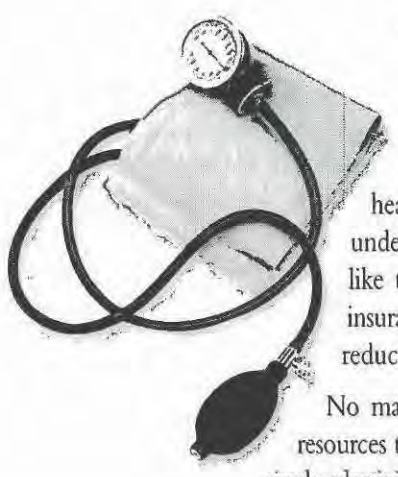
New Math for Healthcare Providers



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Insurer Topics

A special editorial section sent exclusively to insurers and reinsurers

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21st century phasing out former axioms page 20H

Accounting proposals may spur M&A page 20H

Record rates of agency mergers, acquisitions forecast

By SALLY ROBERTS
and RODD ZOLKOS

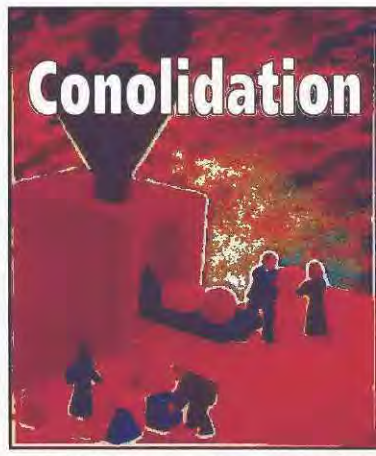
Merger and acquisition activity among insurance intermediaries will continue at a record pace this year, while the rate for deals among insurers may slow, consultants and analysts say.

The recent passage of the federal Financial Services Modernization Act, which removes many of the barriers that have prevented banks, insurers and securities firms from affiliating with one another, will prompt a flurry of bank/agency acquisitions beginning this year, according to agency consultants.

Insurance company interest in purchasing intermediaries—so-called vertical integration—also is on the rise, consultants say, as many insurers look to develop multiple distribution channels.

In addition, agents and brokers are likely to continue to acquire other agencies in 2000, as smaller firms grapple with the capital requirements needed to invest in talent and technology and increasing premium volume requirements from insurers.

"In the past, there was one channel of acquisition activity; now there are three," noted



John M. Wepler, vp-merger and acquisition services for Marsh Berry & Co. Inc. in Concord, Ohio.

"There is so much momentum" in mergers and acquisitions right now, Mr. Wepler said. He predicted that there will be more agency consolidation this year than in any prior year.

In fact, Marsh Berry forecasts that, by the end of 2010, the number of insurance agencies remaining in the marketplace will dwindle to 11,107, from the current population of 21,822. That development also will result in a greater proportion of larger firms. Marsh Berry predicts that, by 2010, the number of agencies with more than $10 million in annual revenues will jump to 393, from 211 in 2000. And those 393 agencies in 2010 will represent 61.7% of the entire insurance brokerage marketplace.

The story is a bit different for insurers, though, according to at least one analyst.

Barbara Stewart, president of Stewart Economics in Atlanta, said that the depressed condition of many insurance companies' stock price will likely make it more difficult for them to engage in consolidation in the year ahead.

"With stock prices of insurance companies where they are—I'm thinking primarily in the property/casualty area, and, I'm sure, in life, too—it's just not an easy time to do this," Ms. Stewart said. "My guess is that's going to put a crimp in the plans some companies have of doing these things."

According to SNL Securities L.L.C., a Charlottesville, Va.-based financial services research and publishing firm, the number of acquisitions reported in 1999 involving an insurer target was down 36%, to 113 deals, compared with 176 deals in 1998. In 1997, 154 insurer deals were reported.

Douglas J. Elliott, a managing director and head of the insur-

See **Mergers** *on page 20D*

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Mergers

Continued from page 20B

ance practice at Sandler O'Neill & Partners L.P. in New York, said he believes that the drop in insurance company acquisitions last year is related to declining company values. But the slowdown in acquisitions has more to do with selling companies having to adjust to a lower purchase price than they might previously have expected to draw.

"I think we're over that now," he said.

"Basically, everyone at this point recognizes that the insurance industry needs to go through continued consolidation," Mr. Elliott said. Although there is an ongoing role for niche players in the insurance market, "I don't think you can really justify 1,500 or 2,000 individual insurance companies."

"Once an industry like this starts moving in a direction that makes economic sense, it has a certain momentum," Mr. Elliott said.

One area of consolidation that does not seem to be occurring is activity between banks and insurance companies.

Jack Gohsler, a senior vp at Conning & Co. in Hartford, Conn., said that he doesn't see the modernization law spurring much merger and acquisition activity between banks and insurers in the immediate future.

"Longer term, we expect the Financial Services Modernization Act is really going to change the landscape," he said. "Short term, we expect more mergers and acquisitions within the (insurance) industry itself."

'Everyone at this point recognizes that the insurance industry needs to go through continued consolidation,' says Douglas J. Elliott of Sandler O'Neill & Partners L.P.

Ms. Stewart noted that property/casualty insurance is unlike any other business banks currently engage in, which is one more reason that P/C companies aren't attractive acquisition prospects for banks right now.

The weak financial fundamentals of the property/casualty industry are the key factor Ms. Stewart sees contributing to a downward trend in merger and acquisition activity in the industry in the near future.

Although the number of insurer deals has been declining, the number of acquisitions in which an agency or brokerage was a target has increased steadily since 1997, according to SNL.

In 1999, 225 producer acquisitions were reported. This compares with 184 in 1998 and 107 in 1997.

"I think the year 2000 will dwarf the prior three years," in terms of the number of agency transactions, and banks will be leading this acquisition activity, Marsh Berry's Mr. Wepler predicted.

"Right now, with very few exceptions, every single bank that we come into contact with that doesn't have any property/casualty insurance (agency) presence is planning either to make an acquisition or establish a joint venture with an insurance agency," he said.

Vince Trapani, president of consultant Hales & Co. in San Francisco, agreed.

"Banks. . .are very interested in insurance brokers" right now, he said. They are "very aggressive buyers with very little capital constraints." Furthermore, "insurance brokerage is not a mystery to them; it's just another financial service to them," he said.

"I think, in our business, merger and acquisition activity will continue to accelerate," Mr. Trapani said.

Carol Hammes, president of the Middleton Group in Pine, Colo., said, "Initially, I felt that a lot of smaller agencies that refused to upgrade their computers for Y2K had decided they would rather sell out, but I haven't seen much activity."

Instead, she said, the activity is coming from banks. "Everyone seems to be wanting to buy an insurance agency," she said.

Overall, "I don't know if there will be more acquisitions this year or not. Certainly from our perspective. . .you can't be a small agency anymore."

In addition to interest from banks, insurers also are keeping an eye on buying agencies, consultants say.

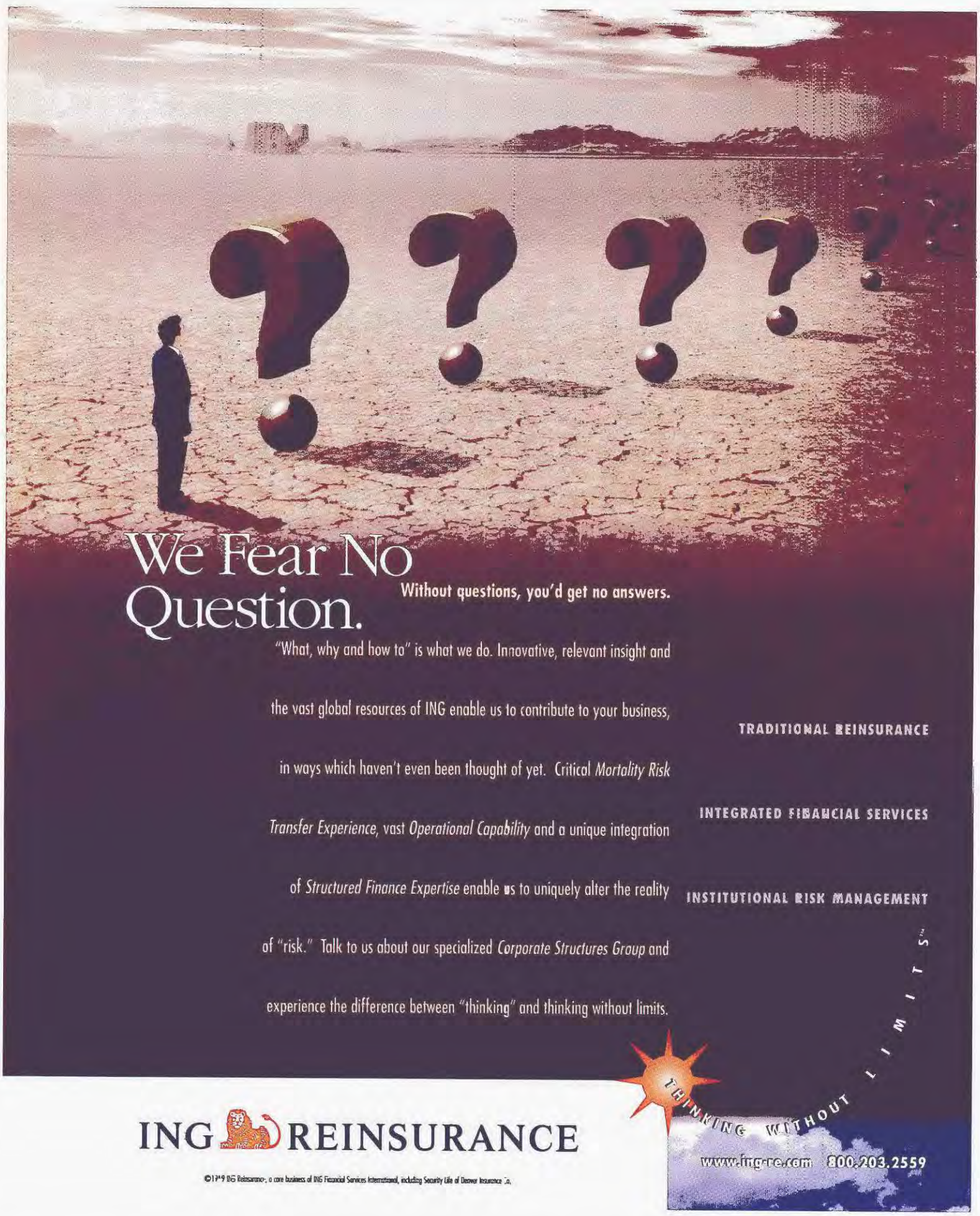
"There are a number of insurers interested in acquiring an agency on a national basis," Mr. Wepler said.

In the competitive insurance environment, insurers want to build multiple distribution channels to sell their products more effectively, consultants say.

Ms. Hammes said that she has begun to see some insurers making capital available to buy an agency or buy a majority interest in an agency.

"I heard a rumor that one insurer is making $25 million available for agencies," she said.

Ms. Hammes predicted that, in the new world of financial convergence, insurers will either buy or take equity interest in agencies and then form joint ventures with banks, combining the marketing efforts of all three. BI



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Insurers seek uniform privacy guidelines

Trade groups voice concern over varied state rulemaking efforts

By RODD ZOLKOS

While the new federal financial services modernization law specifically addresses the privacy of consumer financial information, a provision of the law allowing states to set additional requirements poses concerns for the insurance industry.

In the worst-case scenario, companies could face a regulatory nightmare of 51 different sets of conflicting privacy laws.

"It's a concern. It's a top priority for our membership," said Robert Zeman, vp-legislative affairs at the National Assn. of Independent Insurers in Des Plaines, Ill.

"If the flow of information is restricted too much, it could affect some of the industry's activities, like fighting fraud," Mr. Zeman said. "The states should take care and not move too quickly in enacting measures that address the topic."

At least one agency association is also lending its voice to the issue.

"We are very involved in the privacy issue, both on a state and a federal level," said Robert A. Rusbuldt, executive vp of the Independent Insurance Agents of America Inc. based in Alexandria, Va.

"We've met with the AIA and the (American Council of Life Insurance) and individual insurance companies to reach a consensus on how to deal with the privacy issue," he remarked. "We have no problem with states making their own decisions. . .but there is a time and place for uniformity, and we believe this is one of those times."

Anne Wallace, a manager in the Washington office of KPMG L.L.P., works with various financial industry clients, "And what I'm finding is the depository institutions make more use of financial information and are sharing more, both internally and outside."

"To some extent, it seems like the insurance industry has less of that kind of pressure than the depository institutions have," Ms. Wallace said. "But what we see happening to insurance companies is that, at the state level, the activity is getting much more intense and much more diversified."

The National Assn. of Insurance Commissioners was to hold a public hearing on the privacy provisions of the Gramm-Leach-Bliley Act this month at its spring meeting in Chicago.

Associations representing the industry, such as the NAII, the Alliance of American Insurers and the National Assn of Mutual Insurance Cos., see that as a positive development. They say they believe that the NAIC's promotion of model privacy language as the basis for state legislation should help bring about the uniformity they seek in the new regulations.

The NAIC's privacy model has already been adopted by 17 states. "We think the NAIC model on privacy is a good place to start," Mr. Zeman said. "If it needs to be modified further at the state level, so be it, but let's use that as a point to start."

But Ms. Wallace is less encouraged by the NAIC's actions, given the time constraints confronting insurers under the Gramm-Leach-Bliley Act's privacy requirements.

The privacy mandates of the new Gramm-Leach-Bliley Act are to take effect on Nov. 12, one year after the act's passage.

"It seems like (the NAIC is) still struggling with some very basic issues at a time when the clock is really ticking and our clients are wondering whether they are going to get any kind of definitive guidance from the organization before the Gramm-Leach deadline," she said. "The (Federal Trade Commission) has already released its proposal and the NAIC is still discussing."

Rey Becker, vp of property/casualty at the Alliance of American Insurers in Downers Grove, Ill., noted that the Gramm-Leach-Bliley Act's protections are "not a radical concept."

Gramm-Leach-Bliley states that affiliated companies within a financial industry holding-company arrangement can share a client's financial information. But the act mandates that notice be given to the client before that information can be distributed to companies outside the holding company "family."

Mr. Becker said that, with the enactment of the new federal act, consumers in many states immediately got greater protection of the privacy of their financial information than they'd ever had before.

But with new developments in communication and information technology making it ever easier to obtain information, privacy has become a hot-button topic in recent months, prompting a movement in many states to enact their own consumer privacy measures.

"We have legislation in a number of states," the NAII's Mr. Zeman said. "Not exactly a flood. Montana's enactment last year seems to be the only enactment so far but we've got it in play in a lot of states."

"This didn't just come out of thin air," Mr. Becker said. "People have genuine concerns. People have genuine misconceptions, in many cases."

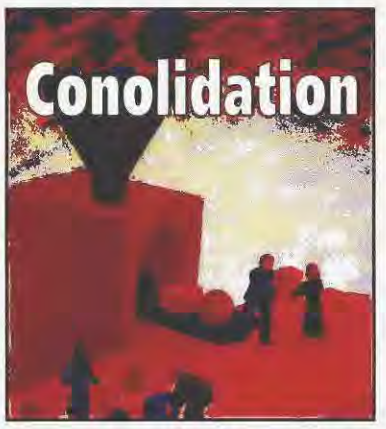
"Both at the state level and at the federal level, there is increasing talk that there will be more legislation," KPMG's Ms. Wallace said. "The financial industry thought that, with the passage of Gramm-Leach, that would be it, and the federal government would give it time to work. Now I wouldn't bet on that."

"The point that it's an election year shouldn't be lost here," said Ann W. Spragens, senior vp and general counsel of the Alliance. "I think (consumer privacy) will be one of the key positioning issues at the state level and, maybe, the national level."

"Privacy is coming up in so many contexts, and it's a very important issue, no doubt about it," Mr Zeman said. "But we are cautioning legislatures not to do anything knee-jerk that goes too far."

Mr. Becker said the state privacy proposals fall into several basic categories.

One is "opt-in" provisions. Unlike the "opt-out" provisions of Gramm-Leach-Bliley, which would allow consumers to choose not to have their information shared



among companies, these measures would prohibit the sharing of information unless a consumer specifically gives permission.

Such bills are being considered in Arizona, California, Delaware, Massachusetts, Minnesota and Washington, according the Alliance. Montana enacted such a law last year.

Another set of bills, including measures in California, Massachusetts and New Jersey, would bar discrimination against those consumers who choose not to allow the sharing of their financial information.

A bill restricting the collection of information has surfaced in Washington, according to Mr. Becker, and a similar measure was enacted last year in Montana.

Some bills with "admirable intentions," such as those that address identity theft, are cause for concern, because they could have unintended consequences, the Alliance suggests.

Among the states considering measures that would criminalize efforts to obtain personal financial information for fraudulent or criminal purposes are California, Delaware, Hawaii, Kentucky, Pennsylvania, South Carolina, Tennessee, Utah and Washington.

But some fear that flaws in the wording of such measures could also criminalize the efforts of law-abiding businesspeoples.

"Unintended consequences are a grave concern across this spectrum," Ms. Spragens said.

Other bills of concern to the industry are in the area of enforcement of consumer privacy. If passed, some of the new laws would encourage attorney involvement, by creating a civil right of action in privacy cases, and others would mandate the involvement of state attorneys general, duplicating existing insurance department oversight.

"What we don't want to have happen is 51 different states passing laws and 51 different sets of hoops for people to jump through in order to be able to use this information," Mr. Becker said.

"I think almost any reasonable person you talk to recognizes the desirability of uniformity," he said. "But they don't necessarily recognize the cost of the lack of uniformity."

And, said Mr. Zeman, while his organization is emphasizing its commitment to a state-based system of insurance regulation, the NAII is also stressing "our concern that the states maintain some semblance of uniformity." BI

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M&A

Continued from page 20H

structure, culture and governance.

Assess your company's strengths and weaknesses, and get your house in order.

Companies tend to bring unnecessary baggage into a combination, including businesses that don't quite fit, legacy IT systems, employee levels that are out of line with the industry and expense ratios that are too high. It's difficult to fix businesses in the midst of trying to combine them.

Get your team in place now. You can't afford not to assign one of your most valuable senior managers to run the combination. Next, you need to determine who is going to take on that individual's previous responsibilities. It's important to "build the bench," so the business doesn't suffer while top talent focuses on making the combination work.

Firms with successful merger track records typically had program management offices that ensured the use of consistent integration tools, a common language and a defined priority of merger tasks.

In addition to putting in place the right structure and tools, a program management office is a visible sign that senior management is committed to the success of the merger and has a workable plan.

In order for a firm to go successfully through a merger, it must clearly outline the program management office's responsibilities, including knowing who will staff the office and figuring out who will do what—and why. When it comes time to begin the merger integration process, the program management office is ready to move based on plans, already in place, that office staff can adapt to fit the situation.

As part of this preparation, it is critical to develop the ability to quickly spot and deal with risks in a fast-moving, highly charged environment.

Be sure there are opportunities for people to bring risks to light in an apolitical atmosphere. One proven approach is to develop a risk management system that focuses on key organizational and operational risks and provides guidelines for dealing with the inevitable problems that arise.

To keep things moving in the right direction and on schedule, build in a system of ongoing measures to review progress and evaluate performance.

Another important step that often is overlooked is thinking through the impact of a combination to customer loyalty and the retention of key employees. While some short-term disruption is often the price of any move toward long-term gain, attention to these issues now can keep disarray to a minimum.

Be prepared to make personnel decisions as quickly as is practical, and don't try to appoint two people to run a single function—it almost never works.

One of the most critical aspects of any combination is simply good communications—going in, in the heat of the action, and coming out.

It's a good idea to make communications strategies part of the M&A plan from the outset. Keep in mind, too, that communication inside the companies can be every bit as important—in some ways more so—than that outside.

It is important to create an environment where both leaders and employees can question what the combination means to their areas—and get answers to those questions.

Will the inevitable consolidation and convergence of the financial services industry be an orderly procession or a mad dash? Right now, it's a tough call. But one thing is certain—all companies should be prepared to move quickly and efficiently when the M&A race begins. BI

Joseph D. Teplitz and Holly D. Overcamp are New York-based business consultants at Arthur Andersen L.L.P. who focus on mergers and integration for the financial services industry.

IT Briefs

Broadcast seminar

MALVERN, Pa.—The CPCU Society will present a live satellite broadcast May 24 examining the implications of the Gramm-Leach-Bliley Financial Services Modernization Act.

The two-part broadcast, which will take place from 1 p.m. to 4 p.m. EDT, is expected to air in 48 locations across the country. It will feature experts from the insurance, banking, regulatory and consumer protection sectors.

The first part of the program will examine major issues arising from the new law, including new redomestication and demutualization rules, safe-harbor provisions, the likelihood of megamergers that would create financial services behemoths, and the impact of future distribution systems on strategies and operations.

The second part will examine financial privacy rules and public policy, solvency monitoring and standard-setting issues, state regulation, the role of technology, virtual insurers, and changing consumer appetites and buying patterns.

Registration fees are $85 for CPCU Society members; $99 for members of the Risk & Insurance Management Society Inc., the Independent Insurance Agents of America, the National Assn. of Professional Insurance Agents, and the Insurance Risk Management Institute; and $109 for all others.

Registration forms can be downloaded from www.cpcusociety.org, or call 800-932-2728 to register by phone.

Also, a two-videocassette edition of a previous CPCU Society broadcast seminar, which focuses on hidden liabilities in mergers and acquisitions, is now available for $85 for society members and $109 for non-members, plus $3 for shipping and handling.

For more information or to place an order, contact the society member resource center at the above number.

IEF names manager

INDIANAPOLIS—The Insurance Education Foundation has named Debra W. Kelleher as the organization's new manager. Ms. Kelleher took the new post Feb. 23.

Previously, Ms. Kelleher served as president and chairman of the Arthritis Foundation in Cincinnati from 1981 to 1998.

She is currently a member of the board and secretary of the Indiana Chapter of the Arthritis Foundation and is active in the Network of Business Women and the National Society of Fundraising Executives.

The Indianapolis-based Insurance Education Foundation is a non-profit organization devoted to promoting the understanding of insurance and its role in society through the education of secondary school teachers and students.

The IEF recently bestowed its first Crystal Apple Award on Robert T. Herres, chairman and chief executive officer of San Antonio-based United Services Automobile Assn., for his leadership and devotion to education, notably financial and insurance education.

The award was presented in February at the opening banquet of the fourth annual property/casualty Joint Industry Forum in New York.

For more information about the foundation, contact Ms. Kelleher at P.O. Box 68700, Indianapolis, Ind. 46268; by phone at 800-433-4811; or visit the foundation's Web site at www.ins-ed-fdn.org.

NAII workshop

DES PLAINES, Ill.—The National Assn. of Independent Insurers is sponsoring a financial workshop for member companies April 2-4 in Hilton Head Island, S.C.

The workshop will provide up-to-date information on recently adopted legislation and regulation affecting insurance company professionals.

Key speakers and panels will also discuss statutory accounting and the best ways for companies to comply with new financial accounting standards. Other topics to be discussed at the workshop include new tax regulations, the impact of the Financial Services Modernization Act and e-commerce issues.

The program is geared toward senior financial/taxation executives. Interested NAII members should contact Joseph Pomilia, assistant vp-financial reporting, at 847-297-7800 ext. 302, for additional information.

Fleet safety seminar

DOWNERS GROVE, Ill.—The Alliance of American Insurers will present a vehicle fleet safety seminar May 2-4 at the Wyndham Garden Hotel in Brookfield, Wis.

The three-day seminar will focus on U.S. Department of Transportation over-the-road motor carrier compliance, audit policies and procedures, accident handling and countermeasures, drug and alcohol screening, commercial vehicle inspection, implementation of a compliant safety program, hazardous materials requirements, vehicle maintenance program inspection and driver training and retraining.

John C. Cheruka, president of Commercial Vehicle Safety & Accident Specialists, will conduct the seminar. CVAS has provided safety consulting services, expert witness and accident reconstruction services for more than 25 years.

The enrollment fee for the seminar is $450 for Alliance members and $545 for non-members. Attendance is limited. For more information, contact Judy Polizzi at 630-724-2141.

UIPF appoints exec

INDIANAPOLIS—Suzanne Reade has been named president of the Urban Insurance Partners Foundation, a non-profit group founded by insurance companies to address urban insurance issues.

Ms. Reade had previously worked for CNA Financial Corp., where she was responsible for public affairs. While there, she developed multi-industry coalitions on various issues. In addition, she was instrumental in developing a model community-development program in Chicago.

Before joining the insurance industry, Ms. Reade was a founder of the New York Public Interest Research Group, where she led successful campaigns on banking regulation and other consumer issues.

Among the organizations supporting the Indianapolis-based foundation are Nationwide Insurance, Liberty Mutual Insurance Co., Allstate Insurance Co., Farm Bureau Mutual Insurance Co. (Kansas), Farmers Insurance Group, General Reinsurance Corp., the American Insurance Assn. and the National Assn. of Mutual Insurance Cos. BI

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Insurer Topics

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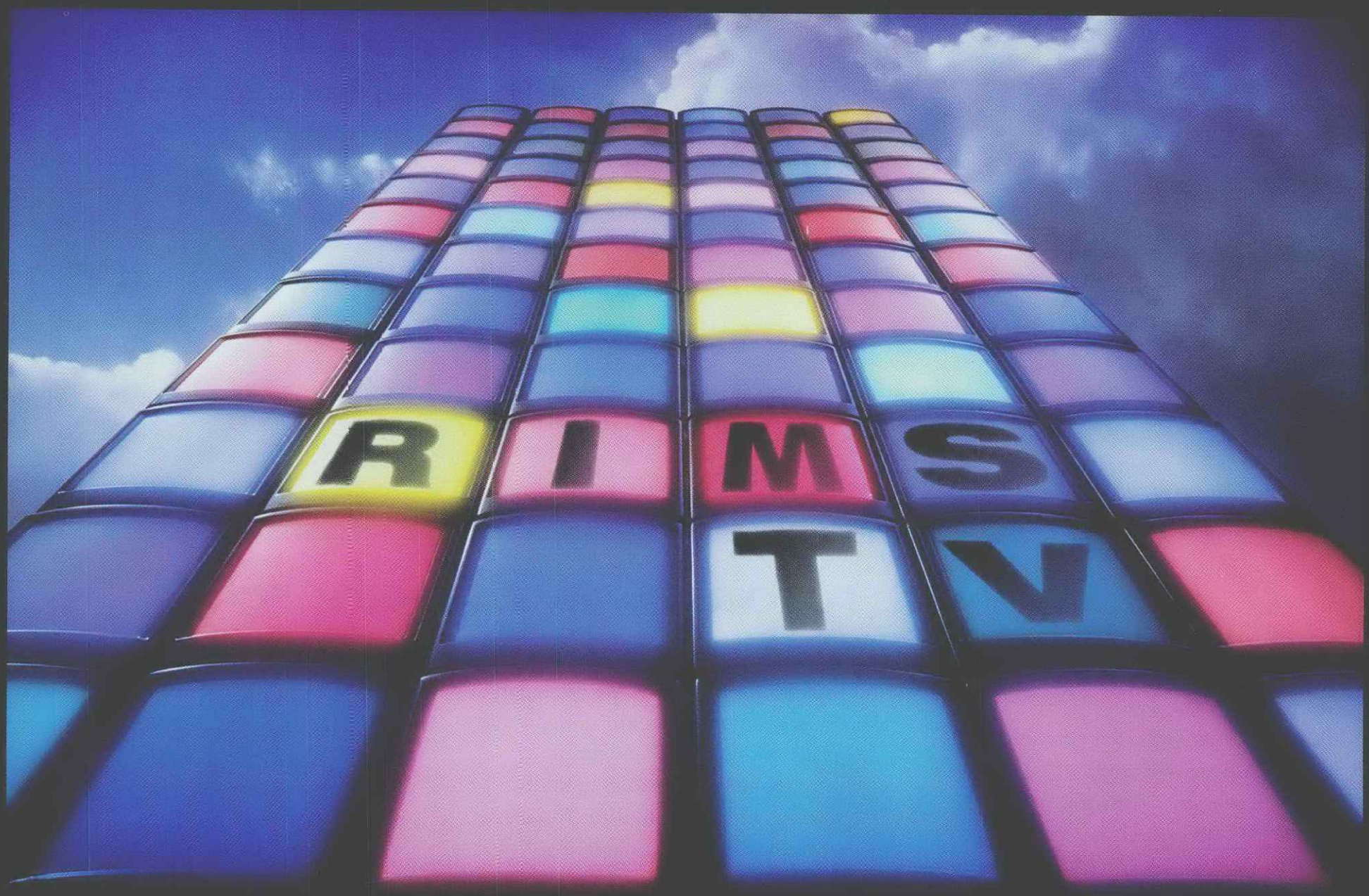

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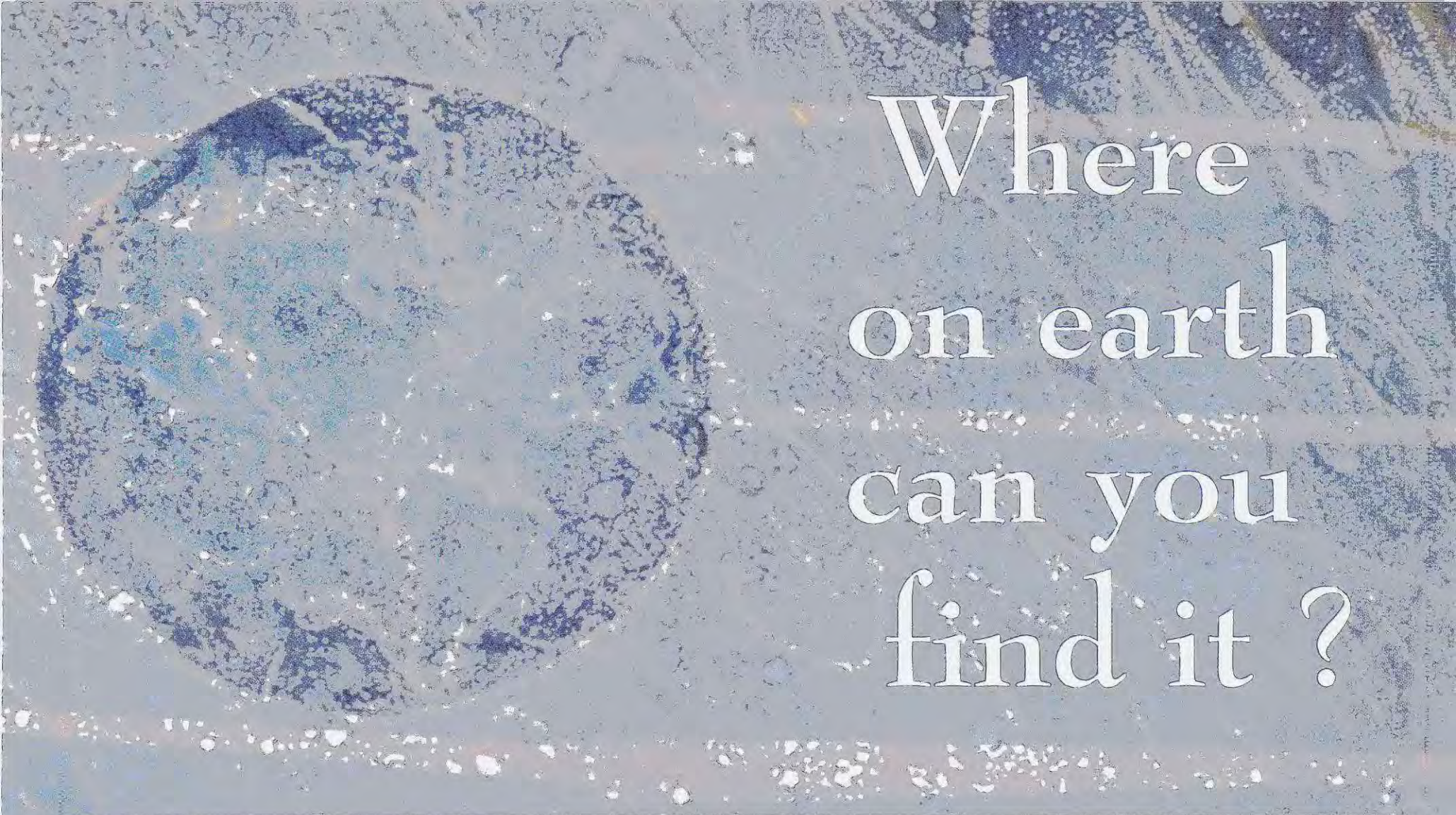

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Issue Date	Directory
Feb 1	Utilization Review/ Case Managers
Feb 15	Third-Party Administrators
Mar 1	Benefit Information Systems
Mar 15	Risk Management Consultants
Apr 12	Captive Managers
May 10	401(k) Plan Administrators
May 24	Environmental Risk Management Consultants
Jun 7	Alternative Risk Financing Facilities
Jun 28	EAPs & Dependent Care Resource & Referral Services
Jul 19	Agents & Brokers
Aug 2	Prescription Benefit Managers
Aug 16	Property Loss Control Consultants
Aug 30	Leading Reinsurers Worldwide
Oct 4	Surplus Lines Insurers & Wholesalers
Oct 18	Safety Consultants & Rehabilitation Services
Oct 25	International Insurers & Benefit Networks
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Feb 21	Third-Party Administrators
Mar 6	Benefit Information Systems
Mar 20	Risk Securitization Specialists
Apr 3	Risk Management Consultants
May 1	Captive Managers
May 22	401(k) Plan Administrators
Jun 26	EAPs & Dependent Care Resource & Referral Services
Jul 17	Agents & Brokers
Jul 31	Prescription Benefit Managers
Aug 14	Property Loss Control Consultants
Aug 28	Leading Reinsurers Worldwide
Sep 11	Surplus Lines Insurers & Wholesalers
Sep 18	Benefit Networks
Oct 16	Safety Consultants & Rehabilitation Services
Oct 23	Reinsurance Brokers
Nov 13	Policyholder-owned Facilities; International P/C Insurers
Dec 4	Risk Management Information Systems
Dec 11	Benefit Consultants

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Business Insurance

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Contact: Christopher McGhee; cmcghee@marshmacsecurities.com.

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Risk securitization services began: 2000.
1999 revenues
Total $94,200,000
Staff
Total 831
Risk securitization professionals 3
Securitization deals
Estimated aggregate volume for 2000 ..... $200,000,000
Services provided: risk securitization design, creation of special-purpose vehicles, analysis of risk financing alternatives, credit enhancement structures.
Officers: Duncan Ashurst, executive vp; Lee McLaughlin, vp.
Contact: Duncan Ashurst, 312-280-3818, dashurst@nnng.com; Lee McLaughlin, 312-280-5637, lmclaugh@nnng.com.

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Contact: J. Bernard Friemann, 212-858-9749; Alex Krutov, 212-858-6387, alex.krutov@reliancenational.com.

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Services provided: risk securitization design, underwriting of securities, analysis of risk financing alternatives, natural hazard modeling/analysis, distribution/sale of securities.
Risks: catastrophe, credit, capital access problems.
Officers: James Olivo, principal; Gail Belonsky, director.
Contact: Gary Sullivan, director-corporate communication.

W

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New York, N.Y. 10005;
212-820-7600; fax: 212-344-0586
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Parent: Willis Group Ltd.
Risk securitization services began: 1998.
Services
Risk securitization consulting 2%
Other 98%
Staff
Total 210
Risk securitization professionals 5
Clients
Total 10
Instruments used: swaps, physical event-linked securities, blended/integrated risk programs, index-linked securities.
Services provided: risk securitization design, analytics/risk quantification, creation of special-purpose vehicles, analysis of risk financing alternatives, natural hazard modeling/analysis, actuarial advice, distribution/sale of securities.
Risks: catastrophe, enterprise risks, credit, capital access problems, weather.
Officers: George Reeth, president; Mark Hvidsten, executive vp; Stuart Mercer, senior vp.
Contact: Stuart Mercer, 212-820-7630, mercer_sw@willis.com; Mark Hvidsten, 212-820-7619, hvidsten_mt@willis.com.

X

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Services
Risk securitization consulting 5%
Other 95%
1999 revenues
Total $2,510,987,000
Risk securitization consulting .. $125,000,000
Staff
Total 4,000
Risk securitization professionals 300
Clients
U.S. clients 25%
Non-U.S. clients 75%
Securitization deals
Estimated aggregate volume for 2000 ..... $1,500,000,000
Instruments used: catastrophe bonds, blended/integrated risk programs.
Services provided: risk securitization design, analytics/risk quantification, creation of special purpose vehicles, analysis of risk financing alternatives, natural hazard modeling/analysis.
Risks: catastrophe, workers comp, environmental liabilities, enterprise risks, general first-party property, general casualty, asbestos liabilities, credit, capital access problems.
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Deadline — April 7

EAP/Dependent Care Resources*
Issue date — June 26
Deadline — May 26

Agents & Brokers*
Issue date — July 17
Deadline — June 2

For more information or to receive a questionnaire for inclusion in any of the directories, please contact Directory Editor Kevin Edison at 312-649-5279, or print a questionnaire from the directory area of the *Business Insurance* Web site, www.businessinsurance.com.

*surveys will be mailed and available on the Web site in late April.

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OSHA's ergonomics plan too broad

By D.W. "Bill" Schrempf

NEW WORKPLACE ERGONOMICS RULES proposed by the Occupational Safety and Health Administration could be in place by the end of this year. While certainly well-intentioned and based on genuine concern about worker injuries, the new proposals also present significant gaps in terms of how and why the rules will be applied—and at what cost.

As a result, months after OSHA first made a draft of the proposed regulations available for study and comment, there still are questions about vague definitions, the demonstrable need for such broad mandates, and how such new federal rules might conflict with the exclusive remedy provisions of state no-fault workers compensation systems that have been in place for the better part of the last century.

In making the case for new rules, OSHA points to the large number of work-related musculoskeletal disorders—or MSDs—that result from cumulative injuries and diseases, rather than from traumatic accidents. Examples of MSDs are some types of back sprains and strains as well as carpal tunnel syndrome. According to the Bureau of Labor Statistics, the latest statistics from 1997 show that U.S. workers experienced more than 626,000 lost workdays because of MSDs, which account for about one-third of all lost-workday injuries and illnesses.

Analysis of the National Council on Compensation Insurance's statistical database, though, does not corroborate OSHA's estimates.

Examining the NCCI's Detailed Claim Information from all major insurers shows that cumulative stress injuries account for 19.3% of lost workdays—significantly lower than OSHA's estimates. Perhaps more to the point, these injuries are already compensated by state workers compensation systems—meaning that injured workers are getting the medical attention they need and their lost wages are being replaced. At the same time, employers are given an economic incentive to make safety a higher priority.

In financial terms, OSHA estimates that these disorders cost employers between $15 billion and $20 billion each year, and that other expenses associated with MSDs could increase this figure to between $45 billion and $54 billion a year. OSHA expects the new measures to reduce lost work and compensation costs by $9 billion annually, while costing employers an estimated $4.2 billion a year. Obviously, the cost savings from the program would sharply be reduced—perhaps halved—if OSHA's assumptions on the frequency of MSD cases are cut in half.

At first glance, it's hard to argue with OSHA's intentions—exaggerated as their arguments may be. What business doesn't want to protect its workers and reduce its workers comp expenses? As with most expansive new policies, however, such simple propositions are inevitably filled with tripwires that can cause more harm than good.

Further complicating the issue is that, in seeking to institute the ergonomics rules, OSHA seems to be defining an entirely new class of workplace injuries that warrant greater compensation than other workplace injuries.

For example, in most states, a worker injured by falling off of a ladder would typically receive two-thirds of his or her pay during recovery. Yet, under the OSHA guidelines for ergonomic injuries, if the same worker suffered a "repetitive motion" injury, he or she would be entitled to 90% of aftertax earnings, plus full benefits while recovering away from work. If the employee is restricted from the type of work done previously but is still at work—so-called light duty—the company is obligated to maintain 100% of aftertax earnings.

Shortfalls between the two-thirds typically required by state workers comp laws and the 100% required by OSHA would not be covered by workers comp insurance and would be made up out of the employer's pocket. If the injury were not compensable under the workers comp system—a real possibility under OSHA's language—all of the benefits would come directly from the employer's pocket.

The new rules also define, albeit in vague terms, what employers must do to anticipate and avoid ergonomics-related injuries.

First, employers must name a key individual to be responsible for ergonomics and to ensure that company policies do not discourage employees from reporting problems. Companies must also disclose hazards to workers and provide information on risk factors and symptoms of MSDs. And these are just the first steps. Once a single ergonomic disorder is reported at its worksite, an employer would be required not only to address the situation, but also to establish a companywide, comprehensive loss control program.

Fashioning actions out of this policy will prove difficult, given the broad definitions and weak standards OSHA has used to define whether an injury is truly work-related.

"Back pain," for example, would be a compensable MSD under the new rules. Yet most qualified medical professionals know that back pain can stem from any number of problems—some as simple as sleeping on a sagging mattress or wearing ill-fitting shoes. To OSHA, it doesn't matter. The workplace does not have to be the sole cause of the injury; mere "contribution" to an employee's existing pain may be enough for the rules to kick in.

Again, such rules and definitions are troubling in that they create an entirely new class of compensable injuries and, at the same time, undermine existing state laws that call for rigorous documentation of the exact cause and nature of on-the-job injuries.

Finally, creating such a new class of injury unnecessarily opens the door to claims of bad faith and bad medicine. As Washington attorney Eugene Scalia noted in the Wall Street Journal, "(The) California Orthopedic Assn. opposed an ergonomics rule in that state on the grounds that 'no convincing scientific studies. . .show that repetitive strain injury exists.' "

The American Society for Hand Surgery told OSHA that "current medical literature does not. . .establish a causal relationship between specific work activities and the development of well-recognized disease entities." It warned: "Premature rules. . .could prove deleterious to the physical and psychological well-being of workers."

Perhaps the most troubling aspect of the new OSHA rules is that they seem to be wielding the proverbial cannon to destroy an ever-shrinking flea.

The Labor Department's own numbers show that workplace injuries and illnesses are at an all-time low. In December, the BLS reported the injury and illness rate had dropped to 6.7 cases per 100 full-time equivalent workers, the lowest rate since the agency began reporting workplace injury and illness statistics in the early 1970s. And repetitive trauma disorders accounted for only 4% of the total workplace injury and illness cases reported in 1998.

The numbers provide clear evidence that workers, employers and insurers all understand the need to provide safe workplaces and that cooperative efforts to create such environments are succeeding. So why is OSHA acting now?

State workers comp programs have effectively dealt with workplace safety and have compensated injured employees in this country for the better part of a century. Before OSHA—or any other federal agency—acts to set aside that successful effort, they should pause to consider both the ramifications and the need.

When OSHA recently withdrew a policy interpretation that stated employers were responsible for health and safety violations that occur in employees' home offices, Labor Secretary Alexis M. Herman called for a national dialogue to determine the "rules of the road" to reflect the changing nature of work.

"We really need to know more about this subject," Ms. Herman was quoted as saying. "The nature of work is changing. We need to examine what it is."

That same reasoned and cautious approach should also apply when defining ergonomics injuries and their proper compensation. After all, too much cure can be just as dangerous as too little. BI

D.W. "Bill" Schrempf is president and chief executive officer of the National Council on Compensation Insurance in Boca Raton, Fla.

Using competitor's drawings not 'advertising injury'

Alleged unfair competition by misappropriating trade secrets falls outside the advertising injury coverage of commercial general liability policies, the 3rd U.S. Circuit Court of Appeals has ruled.

Frog, Switch & Manufacturing Co. Inc. was covered under CGL policies from Travelers Insurance Co. and U.S. Fire Insurance Co. Travelers issued a basic policy with an advertising injury limit of $1 million, and U.S. Fire issued an excess policy that covered claims that exceeded the retained limit. Under the policies, the insurers agreed to cover damages for "advertising injury" committed in the course of advertising Frog's goods, products or services.

"Advertising injury" is "injury that arises out of your advertising activity as a result of. . .misappropriation of advertising ideas or styles of doing business."

Subsequently, a competitor sued Frog, claiming Frog had misappropriated design drawings for dipper buckets and then used those drawings to advertise the buckets Frog produced. Frog gave timely notice of the suit and requested defense, but both insurers refused. Frog settled the suit for $2.6 million and then sued its insurers, alleging breach of contract and bad faith. The trial court dismissed Frog's suit.

The appellate court said the definition of "advertising injury" in standard business insurance policies has troubled and in some cases confounded courts for years. The court noted that this case involved allegations that Frog stole various ideas and advertised the results of that theft.

The court said the question is whether the advertising converts the theft into "advertising injury." The court concluded that it did not, and that, by the plain terms of the policies, the insurers had no duty to defend. The court also ruled that Frog could not maintain actions for bad-faith denial of coverage. The trial court decision was affirmed.

Frog, Switch & Manufacturing Co. vs. Travelers Insurance Co., 3rd U.S. Circuit Court of Appeals, Sept. 30, 1999. (*BI*/01/M. — $10)

Comp benefits upheld

An employee's pregnancy is not a superseding, intervening event in a work-related injury, according to the Supreme Court of Vermont.

A nurse who injured her shoulder in a work-related injury in 1995 began receiving disability benefits. Nearly two years later, in mid-1997, her treating physician recommended that she have surgery on her shoulder to address her work-related symptoms. The employee was pregnant at the time, however, and as a result, the doctor recommended delaying the operation. The employee gave birth to her child in February 1998, and had the shoulder surgery the following June.

The employer's effort to discontinue her disability benefits as of August 1997 was rejected by the compensation commissioner.

The Supreme Court of Vermont, hearing the appeal, said the employee's pregnancy indirectly prolonged the period during which she was employable but did not change the fact that her injury had rendered her unable to work.

Wood vs. Fletcher Allen Health Care, Supreme Court of Vermont, July 30, 1999. (*BI*/02/M. — $10)

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

Financial reform brings new challenges

By RODD ZOLKOS

SAN ANTONIO—The convergence of financial services industries doesn't pose an immediate threat to commercial insurers, but they should be prepared for some changes.

Speaking at Standard & Poor's Corp.'s Insurance and Banking Seminar earlier this month in San Antonio, two S&P analysts outlined some of the new challenges that insurers will face, as well as detailing some existing ones.

Vandana Sharma, a director in the insurance ratings area at S&P in New York, noted that commercial lines insurers can offer customers underwriting expertise, loss control expertise and claims management services, all of which are skills banks don't currently possess.

What's more, she said, an alternative insurance market is already developed, with insurance and investment products already being effectively combined to develop financial solutions.

"So, in the near term, it's hard to see where the convergence of financial services is going to change the world of commercial lines insurance," Ms. Sharma said.

On the personal lines front, however, banks have the potential of leveraging their existing client bases, reaping benefits from data mining and the ability to cross market a broader portfolio of products.

They also have the potential to benefit from economies of scale realized by combining back office systems and developing customer service synergies. Consequently, Ms. Sharma said, personal lines insurance products offer the greatest near-term potential for financial institutions.

With the financial services sector changing, Ms. Sharma said the roles of financial institutions are blurring. As those changes occur, the possibility of disintermediation may become a bigger threat to commercial lines carriers as large industrial clients might be able to obtain risk transfer directly through the capital markets.

As the financial services sector evolves, consumer preferences will drive product innovation, Ms. Sharma said. "Customer service is going to drive a lot of innovations."

Meanwhile, improvements in information technology are driving down the costs of building a multiproduct platform. "Technology makes it possible for us to implement a true multi-

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dimensional operating platform," she said.

With industry convergence, the competitive landscape for insurers has changed, and turf wars are only beginning, Ms. Sharma said. "Everybody has to develop a strategy and a strategy they can implement," she said. "The ultimate goal is increasing shareholder value."

And companies need both short- and long-term solutions for dealing with the impact of financial services convergence, Ms. Sharma said.

"It may or may not impact them in the near term," she said. "But they'd better have a solution in the near term for how they're going to deal with it."

Finally, she noted, since companies are venturing into uncharted territory, they need to exercise considerable caution.

Of course the changes are occurring at a time when the property/casualty insurance industry is already facing tough business conditions, said Matthew T. Coyle, a director in insurance ratings services at S&P in New York.

He noted that during the 10 years from 1988 to 1998, while the U.S. property/casualty industry's capitalization increased 183%, net premiums written increased only 39%.

In 1999, though, rates began to firm and several insurers moved to strengthen reserves, primarily insurers in the California workers compensation market, Mr. Coyle said. "We think this is only the beginning," he said.

He also predicted that a trend toward merger and acquisition activity evidenced in 1999 will continue.

Illustrating the industry's condition, Mr. Coyle noted that in 1999 Standard & Poor's downgraded 1.5 times as many insurers' ratings as it upgraded.

For 2000 Mr. Coyle said he sees more downgrades of insurers caused by continued compression of margins and capital quality issues. In that scenario expense management becomes crucial for insurers, and consolidation is likely to continue as a result.

"Not surprising, all the outlooks for all the sectors, aside from personal lines, are negative," Mr. Coyle said. Benefiting personal lines, he noted, is that those companies "have been more proactive in putting through rate (increases)." BI

Seminar draws 250

SAN ANTONIO—Standard & Poor's Corp.'s Insurance and Banking Seminar drew approximately 250 attendees to the Hyatt Hill Country Resort in San Antonio March 5-7.

The theme of the gathering was "Thriving or Surviving in the Wake of Financial Services Modernization: The Industry Impact."

Programs included sessions examining strategies for dealing with financial industry convergence, the analysis of insurance companies and banks in a rapidly changing global environment, and capital markets solutions for insurance risks.

The seminar also included roundtable sessions that gave participants a chance to discuss ratings issues with Standard & Poor's analysts in various industry sectors.

Next year's conference is scheduled for March 11-13 at the Doral Golf Resort and Spa in Miami.

One step at a time

Caution urged in consolidation moves

By RODD ZOLKOS

SAN ANTONIO—To be successful, mergers and acquisitions must be carefully thought out, and even then there's no guarantee they'll succeed, according to a panel of top industry executives.

Speaking at this year's Standard & Poor's Corp. Insurance and Banking Seminar earlier this month in San Antonio, Maurice R. Greenberg, chairman and chief executive officer of New York-based American International Group Inc., noted that size alone is not a good enough reason for acquisitions.

"I think consolidation, to be successful, has got to be very thoughtfully planned," Mr. Greenberg said. "Simply doing it to get bigger—you're not going to be successful."

Still, size will be a factor for companies looking to cope with industry consolidation and convergence in the years ahead, said David D'Alessandro, chief operating officer and CEO-elect of John Hancock Financial Services Inc. in Boston.

"I think it's going to be extraordinarily difficult for companies Hancock's size to get big enough," he said. "The question isn't get bigger, it's get big enough."

John S. Reed, chairman and co-CEO of Citigroup, noted that even in the best-planned mergers, bringing two organizations together is a challenging venture. He cited the experiences of his own company's efforts to combine Citicorp and the Travelers Group.

"Clearly, it's immensely difficult," Mr. Reed said. "We won't know how it's going to turn out for the next two or three years. I think the jury's out," he said.

"I had a very clear model in my mind as to why this merger made sense from our point of view. I think that model is still valid," Mr. Reed said. "But I would be lying to you if I said, 'Hey, we've got this thing all boxed together. We know where it's going.' We don't."

Despite the careful plans, changes in the market may affect whether the merger that created Citigroup ultimately succeeds, Mr. Reed said.

Discussing the potential impact of last year's federal Financial Services Modernization Act, Mr. D'Alessandro said he expects there will be a flurry of insurance company acquisitions by banks.

"In the wake of H.R. 10, I think we will see the banks come," he said. "Many of (the acquisitions) will be irrational on the part of the banks."

He doesn't expect much acquisition activity moving the other way, however. "I think there are very few insurance companies that will be able to afford banks, to begin with," Mr. D'Alessandro said. "I think it's much more likely to be the other way around."

AIG's Mr. Greenberg suggested that acquisitions aren't necessary to reap the benefits of cross-marketing banking and insurance, and even might be detrimental in some cases.

"You don't have to buy one or the other in order to market products," he said. "In fact, if we owned a bank, we'd probably be foreclosed from marketing products through other banks."

The new federal law has had little impact on AIG, the company's chairman said. "We did not find that the repeal of Glass-Steagall meant anything to us one way or another," Mr. Greenberg said. "We are already doing everything we wanted to do."

Mr. D'Alessandro offered a similar view about the potential impact of a bank acquisition.

"We would be concerned about a bank buying us because we would think the other banks would cut us off," he remarked. "And we think the bank should be concerned about that."

Mr. Reed said there definitely are benefits to be gained from cross-marketing banking and insurance. Citigroup has "significantly improved" its branches' performance by using them as sales points for traditional banking and investment products as well as insurance products, he said.

Looking forward, Mr. Greenberg suggested that despite the trend toward convergence and consolidation, companies with low returns on equity might not be attractive acquisition targets unless the acquiring company is convinced it can help that company grow.

Mr. Reed said the need to increase revenue will continue to drive many companies' acquisition decisions, however. "We live in a world where the stock market decides performance," he said. "We don't have inflation, so you can't get it through pricing." BI

Strategy

Continued from page 2

Banking Seminar earlier this month in San Antonio, Mr. Puccia noted that the reforms bring the U.S. financial structure more closely in line with that in Europe.

Examples of bank-insurance combinations in Europe thus far, however, have demonstrated only limited benefits, he noted.

While the new law may speed financial industry convergence in the United States, such activity has already been under way for sometime, said Mark Bachmann, a managing director in the financial institutions ratings area at S&P. Market realities drove the legislation, he said.

"Many banks are already firmly established as insurance distribution points," said Mr. Puccia. "What banks are doing is looking at insurance as fee income generators."

And the convergence of insurers with banks and the capital markets is well along, "with reinsurers at a critical nexus" through the delivery of risk securitization services, Mr. Puccia added.

"Where you're starting to see this convergence already in full tilt would be with the capital markets and the insurance world," he said.

Integrated risk solutions are another example of convergence between financial institutions and insurance. "Basically it's providing whatever solution a client needs through a variety of products that are out there," Mr. Puccia said.

As the pace of financial services convergence quickens, it brings its own implications for insurance companies, as they strive to adapt to the changing landscape, the analysts said.

Adaptation strategies often have risk implications that companies overlook in the hype and excitement of implementing them, Mr. Bachmann noted.

Ultimately, convergence will probably bring with it both positives and negatives for insurance companies, he said.

Among the positives is increased diversity. "Diversity for us is certainly one of the most important," he said, noting it can help "bulletproof" a company's revenue stream.

Diversity alone, though, won't be enough to guarantee survival, Mr. Bachmann said. "The financial services firms that succeed in the years ahead will have to achieve more than simple diversity as they consolidate," he said.

Franchise power is another potential plus, he said. Such franchise power provides "momentum" that "tends to drive stable and multifaceted earnings growth," he said, and helps companies survive times of market turmoil.

The potential downsides of convergence are the loss of innovation, the loss of control and diseconomies of scale.

In the case of scale, Mr. Bachmann noted that mergers that create larger, diversified organizations also often create demand for new layers of management, which can decrease efficiency.

"However, nobody can go after all this upside without risking the pitfalls," Mr. Bachmann said.

The entry of banks into the insurance area also poses a potential risk for insurance companies, Mr. Puccia remarked. Those in the most immediate peril might be companies narrowly focusing on term life insurance and individual annuities, as banks use their vast customer databases and distribution systems to cross-sell such "low advice-based products."

"We think those players in the insurance business who are commodity driven...are most at risk," Mr. Puccia said.

In many cases, though, rather than see banks actually acquiring insurers, "we expect a lot of banks and insurance companies to actually partner," he said.

As risk securitization advances, disintermediation of insurers and reinsurers also is a real threat, said Mr. Puccia, adding that this risk may grow as banks more directly enter this market.

For now, property/casualty insurers and health insurance companies probably face less of a threat from financial industry convergence than insurers engaged in more commodity-type areas, such as life and annuity underwriting, Mr. Puccia said. Banks have less interest in those fields, he explained. "Property/casualty's doing a great job of keeping the banks out by losing money," he said.

While there is some bank interest in selling personal lines property/casualty coverage, the underwriting risks are scaring off most banks, Mr. Puccia said.

An increase in demutualization efforts is another consequence of financial services consolidation, the analysts said.

For many mutual insurers, there is the feeling that they must make the change to gain currency in the form of common stock to make acquisitions, Mr. Puccia said. "A lot of mutuals have been looking at demutualization as a way to get into the game, a way to have a currency."

The changing landscape will take its toll on many mutual insurers, he predicted.

"Our view is many of the mutuals will not survive as independent entities," Mr. Puccia said. "We're not saying it's a dying breed; it's a diminishing breed."

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Global Briefs

The U.K. **General Insurance Standards Council**, the proposed self-regulatory entity for insurance intermediaries and brokers, will be launched July 3. At the end of May, the GISC intends to publish its rulebook, which will include the GISC code, practice requirements and disciplinary procedures, said Chairman Anthony Howland Jackson. Applications for membership will then be accepted. . . .The New York-based Insurance Services Office Inc. has granted **Lloyd's of London** a license to use all of ISO's information and consulting services for U.S. insurance and reinsurance business. The agreement will give underwriters at Lloyd's access to the full range of ISO services available via the Internet. Julian James, managing director of Lloyd's North America, said the deal underscores Lloyd's commitment to the U.S. market. . . .**Lloyd's U.S. premium volume** rose 17% in 1999 to $4.8 billion. In 1999, property business accounted for 38% of Lloyd's total U.S. volume; general liability for 25%; accident and health, 11%; aviation, 10%; and marine, 7%. Reinsurance accounted for more than $2 billion of Lloyd's U.S. premiums in 1999. . . .The Milford Haven Port Authority is seeking to overturn a £4 million ($6.3 million) fine imposed on it following the **1996 Sea Empress oil spill**. After the spill, which involved more than 21 million gallons of oil, the Port Authority was taken to court by the U.K. Environment Agency and found guilty of contravening the 1991 Water Resources Act. The Port Authority has argued that, under a memorandum of understanding between the U.K. Environment Agency and the Maritime & Coastguard Agency, the Maritime & Coastguard Agency should be responsible for bringing prosecutions for offenses such as discharges from ships. . . . French reinsurer SCOR S.A. has placed **$200 million of catastrophe bonds** to provide coverage for Japanese and U.S. earthquake and European windstorm risks. The securitization deal, said to be the largest cat bond offering to date by a European insurer or reinsurer, provides SCOR with retrocessional cover for three years. SCOR placed the bonds via Irish-domiciled special-purpose vehicle Atlas Re. Goldman Sachs & Co. was the lead manager, and Marsh & McLennan Securities International was the co-manager. . . .The British Insurers International Committee and the German Insurance Assn. have come up with a set of proposals that ultimately would facilitate **cross-border reinsurance** business in the European Union. The BIIC/GDV proposals are also backed by the Federation Francaise des Societes d'Assurances. Reinsurance was not included in original legislation intended to harmonize the insurance sector in the European Union. . . .**CGU P.L.C.** has acquired 50% of Internet start-up company IQUO, which helps insurers develop the capability to provide online auto coverage. Initially, IQUO will provide services solely to CGU, but CGU plans eventually to promote these systems to other insurers. . . .The **Assn. of Insurance & Risk Managers** has been appointed adviser to the National Audit Office, the spending watchdog of the U.K. Parliamentary. . . .**Dutch bank ABN AMRO** has entered into a partnership with U.K. broker Jardine Lloyd Thompson Group P.L.C. The two will work together in the area of international risk and insurance management, the bank said.

U.K. law governs Canadian names

By SARAH VEYSEY

TORONTO—Lloyd's of London's victory in an Ontario court against a group of Canadian names will enable the market to begin collecting more than £20 million ($31.6 million) owed to it by the names, who refused to accept the market's 1996 reconstruction and renewal plan.

The Ontario Superior Court of Justice in Toronto ruled last week that English court judgments in March 1998 against five Canadian names should be recognized in Ontario. The English courts had ruled that Lloyd's could bring enforcement orders against names who rejected the R&R plan and refused to pay premiums to Equitas, the runoff reinsurer set up for Lloyd's pre-1993 long-tail liabilities.

An additional 83 Canadian names had agreed to be bound by the court's decision in this case.

Disputes between names and Lloyd's are subject to U.K. law because of an agreement called the "forum clause," a Lloyd's spokesman explained. When names join Lloyd's, they agree to the clause, which states that any disagreements between names and Lloyd's will be decided by U.K. law. This clause was introduced because of the complications caused by Lloyd's international membership, he said. He said that Lloyd's was not surprised by the Ontario court's decision to accept the legality of the forum clause.

The Canadian names had argued that they did not get a fair trial in England and said that Lloyd's had contravened the Ontario Securities Act.

The names claimed that Lloyd's had contravened Ontario Securities Law because it did not file a prospectus which is required under Canadian law. "The breach of securities code is principally what we are disappointed with" by the decision, said Glenn Smith, attorney for the Canadian names.

Names sign a document stating that any disputes they have against Lloyd's should be governed by U.K. law, said Theodore Grippo, an attorney with Pembroke & Brown in Chicago, who represents the American Names Assn.

The problem, Mr. Grippo said, is that, "because they are solicited within their own countries, they believe that there is a threshold of protection that exists.

"This is the belief that names certainly had in the United States, and I believe also had in Canada. The names' belief was that if someone came into the country and solicited for his business, while he signed a document saying that English law will govern any future disputes he has with Lloyd's, he assumed—as it turns out in error and to his peril—that Lloyd's would have complied with the (local) law before the solicitation began," Mr. Grippo said.

"In this case, the names believed

See **Names** *on page 32*

Strict liability sought

E.U. to consider polluter-pays principle

By CAROLYN ALDRED

Polluters should be held strictly liable for damage to the environment as well as to property and people, according to a white paper adopted recently by the European Commission.

The long-awaited "White Paper on Environmental Liability" outlines a future E.C. environmental liability program that aims to implement the "polluter pays" principle throughout the 15 member states of the European Union. It recommends that the European Commission produce a directive on environmental liability to implement strict liability for hazardous operations.

Risk managers, insurers and others who wish to comment on the recommendations have until July 1 to do so.

The white paper proposes an environmental liability system based on strict liability when damage is caused by a hazardous activity to property, persons or protected habitats. As a result, companies operating hazardous operations would no longer will able to argue that they were not negligent or that they complied with regulations.

Although the white paper does not define hazardous activities, it includes among them any operation regulated under the following European Commission legislation: the Integrated Pollution Prevention and Control Directive; the revised Seveso II Directive, which covers major accident hazards; the transport of dangerous substances and the release and marketing of genetically modified organisms; legislation that concerns dangerous substances; and legislation that establishes discharge and emission limits for hazardous substances in the water and air.

Non-hazardous activities include any operations or incidents that do not fall under such environmental legislation.

The white paper also recommends the introduction of fault-based li-

See **Polluter** *on next page*

Product liability proposals

E.U. reform debated

By STACY SHAPIRO

BRUSSELS, Belgium—Lively debate in the European Parliament is likely at the end of this month, when two parliamentary committees express opposing views on proposed changes to the European Union's product liability directive.

Modifications being called for to the 1985 product liability directive would include changes in the burden of proof, elimination of the state-of-the-art defense and removing financial limits for which manufacturers are liable.

All of the proposed changes could "substantially increase product liability claims," said John Inwood, senior casualty underwriter for Zurich International in London.

Such changes, particularly the elimination of the state-of-the-art defense, would stifle innovation and increase costs, including those related to product liability claims, according to the Confederation of British Industry. The CBI represents 200,000 U.K. companies that employ 7 million people. The directive has worked well since it was introduced, and there is no need for any major amendments, the CBI said.

The debate in the European Parliament, scheduled for March 29, is part of an overall plan by the European Commission to revise the product liability directive to address new risks. The process began last July, when the European Commission published a "green paper" with proposed revision and amendment options. At the end of January, dozens of consumer, business and legal organizations, responded to the discussion document. The European Commission is expected to publish its conclusions at the end of this year about whether the product liability directive should be amended.

While the European Commission has been soliciting public opinion, the European Parliament's Committee on Legal Affairs and the Internal Market and its Committee on the Environment, Public Health and Consumer Policy have been examining the product liability document. The two committees will present their views to the European Parliament on March 29.

Members of the Committee on the Environment, Public Health and Consumer Policy want some major revisions made to the product liability directive. They

See **Directive** *on page 32*

PHOTO: AFP

A Qantas 747-400 aircraft overran the runway in Bangkok during heavy storms.

Jet accident still probed as repairs end

By PAULA WESTON

BANGKOK, Thailand—Qantas Airways Ltd. expects a 747-400 jet, damaged after it ran off the end of a Bangkok runway last September, to be back in service soon, perhaps before the accident's cause is determined.

The Canberra, Australia-based Australian Transport Safety Bureau, an agency of the Australian federal government incorporating the Bureau of Air Safety Investigation, is still investigating the cause of the accident.

A spokeswoman for Sydney, Australia-based Qantas said that the aircraft has been under repair since the Sept. 23 accident at the Don Muang airport.

The spokeswoman said the plane, built in 1990, is fully insured, and the insurer made the decision to repair, rather than replace, the badly damaged aircraft.

Coverage was placed with Paris-based La Reunion Aerienne for a total hull value of $180 million (*BI*, Oct. 4, 1999). London-based Heath Group P.L.C., which has since merged with Lambert Fenchurch Group P.L.C., brokered the coverage.

Qantas refers to the event involving Flight QF1 as an "incident," but the ATSB classifies it as an "accident" under Australia's Air Navigation Act and air investigation standards of the Geneva-based International Civil Aviation Organization.

The Qantas spokeswoman said the jet was now in the "final phase" of repair.

Qantas would not comment on industry damage estimates of $150 million Australian ($92.2 million), nor would the airline release details of repair costs.

"It is premature to say too much at this stage,"

See **Qantas** *on next page*

Polluter

Continued from previous page
ability for non-hazardous activities that cause damage to nationally or E.C.-protected areas and species.

"These days, we are confronted with cases of severe damage to the environment resulting from human acts. The recent accident with the Erika oil tanker and the incident, a few years ago, near the Donana nature reserve in the south of Spain, are only two examples of cases where human activities have resulted in substantial damage to the environment, involving the suffering and death of hundreds of thousands of birds and other animals," the European Commission states in a press release accompanying the publication of the white paper.

On Dec. 12, 1999, the Erika oil tanker broke apart and released about 10,000 metric tons of oil that fouled the coast of northwestern France, triggering an outcry for tighter international shipping controls (*BI*, Feb. 7).

The incident near the Donana nature reserve in southern Spain involved contaminated water that was released from a tailings pond when a dike burst at the Los Frailes mine, resulting in 8 million tons of acidic mud being spilled into the Rio Guadiamar (*BI*, May 11, 1998).

"So far, the member states of the European Union have established national environmental liability regimes that cover damage to persons and goods, and they have introduced laws to deal with liability for, and cleanup of, contaminated sites. However, until now, these national regimes have not really addressed the issue of liability for damage to nature," the E.C. statement notes. As a result, "the introduction of liability for damage to nature, as proposed in the white paper, is expected to bring about a change in attitude that should result in an increased level of prevention and precaution."

Regarding the adoption of the white paper, Environment Commissioner Margot Wallstroem stated: "We have now laid the foundations for an environmental liability regime for Europe. Legislation in this field will provide common rules to ensure that polluters will effectively be held responsible for environmental damage they cause."

The introduction of strict liability and the extension of liability to protected habitats would be the biggest worries for risk managers responsible for hazardous installations. Another concern for them, however, is the proposal that recognized public-interest groups have the right to seek injunctions requiring potential or actual polluters to prevent environmental damage and to restore the damaged environment. The groups also would be able to claim reimbursement of their costs for preventive actions.

"The suggestion that pressure groups should have the right to step in and enforce action against polluters if an environmental regulator fails to exercise its powers and duties is an innovative and potentially alarming concept, the practical implications of which could be very significant," said Stephen Sykes, legal director of the London-based environmental liability underwriter Certa (U.K.) Ltd.

"We are very concerned about non-government organizations being allowed to serve an injunction if they think an activity is causing environmental damage," said a spokeswoman for the Confederation of British Industry.

In an initial response to the white paper issued Feb. 28, the CBI urged the European Commission to "reconsider its proposals." The CBI will examine the white paper in detail and submit a full response during the consultation period, a statement noted.

However, according to the statement, the CBI's initial reaction is that:

- The European Commission "will have to make a stronger case to convince business that its proposals will benefit the environment."
- The European Commission "has not produced evidence to show that the disparities in national laws are distorting competition within the single market." Legislation in the European Commission is designed to ensure fair competition.
- The white paper "fails to explain why this additional layer of regulation, which goes beyond the existing legislation, will provide better protection for the environment."
- The European Commission "ignores the uncertainties which E.U. legislation based on its proposals would cause for manufacturing, insurers, lenders and those companies making acquisitions."

The Assn. of Insurance & Risk Managers will be looking at the white paper and making detailed comments to the European Commission, if necessary, said a spokesman.

Risk managers and insurers should make sure they read the white paper and comment to the European Commission on its proposals, advised Valerie M. Fogleman, partner and head of the environmental liability group at London-based law firm Barlow Lyde & Gilbert.

"I would strongly advise risk managers to look at it and comment. It's still got a long way to go," but now is the time for businesses to make their views known, Ms. Fogleman said.

The deadline for comments is July 1. If the European Commission then decides to proceed, it will adopt a proposal for one or more directives detailing environmental liability legislation that should be adopted in each of the 15 E.U. states.

The proposed legislation must then be passed by the Council of Ministers, comprising in this case the Minister of the Environment from the governments of all 15 member states; and by the European Parliament, which comprises more than 700 "Members of the European Parliament" from all E.U. states.

If the European Commission imposes liability along the lines of the white paper, it would mean significant changes in national laws.

For example, the white paper suggests strict liability for personal injuries caused by exposure to pollutants from regulated hazardous activity. This is in contrast to English law, which requires a claimant to prove negligence by the polluter, according to Ms. Fogleman.

The white paper also suggests reducing the burden of proof for claimants in personal injury and property damage actions for pollution caused by non-hazardous activities, in contrast to English law.

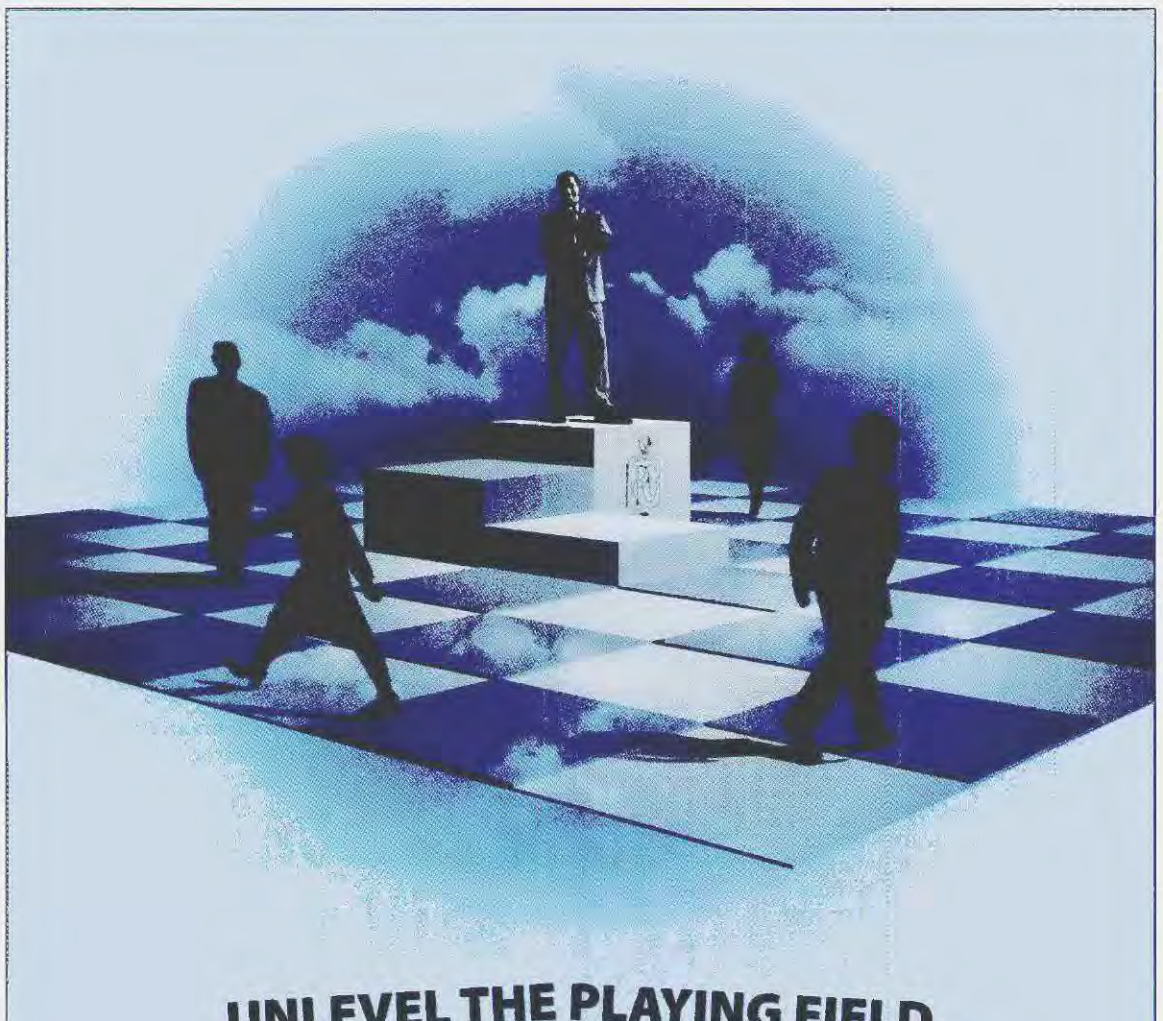
Both these moves would probably result in increased claims and increased demand for specialized environmental insurance policies, Ms. Fogleman predicted.

"Perhaps the biggest issue, however, is the effect of the regime on the inclusion of cover for sudden-and-accidental pollution in public liability policies. At the very least, the potential introduction of an E.C. environmental liability regime should spur the use of questionnaires on environmental issues prior to issuing public liability policies for businesses that conduct dangerous activities," said Ms. Fogleman.

The London-based Assn. of British Insurers and the Paris-based Federation of European Insurance Assns. and Comite Europeen des Assurances will be commenting on the white paper in detail before the July 1 deadline, said spokesmen.

●

The white paper is available on the Web site of the European Commission at http://europa.eu.int/comm/environment/liability/index.htm. Responses to the white paper should be mailed to the Directorate General for Environment, Nuclear Safety and Civil Protection; Legal Affairs Unit (DG ENV B 3), Rue de la Loi 200, 1049 Brussels, Belgium, or sent by e-mail to Carla.DEVRIES@cec.eu.int or Charlotta.COLLIANDER@cec.eu.int.



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Qantas

Continued from previous page
the spokeswoman said.

At the time of the accident last year, James Strong, Qantas' chief executive officer, said the aircraft's nose, landing gear, engines and "possibly some areas of the fuselage" had been damaged. He said further details would not be available until all information and reports had been gathered and reviewed by Qantas and relevant authorities.

An initial inquiry by the Thai authorities was taken over by ATSB in November.

Mr. Strong said Qantas was not given access to the flight data recorder until six weeks after the incident, due to delays in the initial inquiry.

Qantas investigators, meanwhile, have been looking at "every aspect of the flight, including the landing procedures and runway conditions at Bangkok," he said.

In November, Mr. Strong said an interim report by ATSB supported Qantas' contention that "the full inquiry is likely to find there were a number of factors involved."

ATSB Deputy Director Alan Stray confirmed that the inquiry is still under way. Mr. Stray said the interim report contained "factual evidence only," which would be analyzed in the full inquiry.

An ATSB spokesman said that once the inquiry was complete, the findings would be presented to the Thai government, as the is ATSB conducting the investigation at its request.

Mr. Strong also said in November that Qantas is looking to improve arrangements for passengers "in situations such as those which occurred in Bangkok."

No passengers were hurt, but they had to wait in Bangkok until a replacement aircraft was flown in from Sydney the following day.

"Information provided by passengers indicates that, while in some cases our procedures (for stranded passengers) worked well, in others, there is need for better resources and arrangements," Mr. Strong said. BI

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Directive

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are motivated, in part, by the scandal surrounding "mad cow disease."

In particular, the consumer policy committee wants to see:

- An easing of the burden of proof. Under the current directive, the victim must prove that the damage is the result of a defect in the product.

The consumer policy committee says the burden of proof now favors manufacturers.

- The elimination of the "development risks" defense, also known as the state-of-the-art defense. Under the directive, the maker of a defective product is absolved of liability if it can prove that the most-technical and most-scientific knowledge available at the time the product was put in use could not have revealed the defect.

The European Commission has asked manufacturers to supply data to help it determine whether the elimination of such a defense would "discourage producers from innovation." The European Commission also wants to know "whether it would still be feasible to insure this kind of risk in the insurance market."

But such a defense, said the consumer policy committee, shifts the risks of innovative products to consumers. If these risks are too volatile to insure, then they are also "equally insurmountable for consumers," said the committee.

- Eliminating financial limits for liability. The product liability directive states that victims may be compensated only for property damage exceeding 500 euros ($484) per person. Member states also can impose an aggregate limit of 70 million euros ($67.8 million) in the case of personal injuries caused by identical items with the same defect, such as in class actions.

The consumer policy committee said that these financial limits are "difficult to reconcile with consumers' expectations that they will be compensated in full for damage suffered as a result of a defective product."

- A lengthening of the time in which victims can file claims. The directive currently imposes a statute of limitation of 10 years from the date in which a product was put into circulation. After that, a manufacturer's liability ceases.
- Compensation for mental injuries added to the directive.

The European Commission also is questioning whether manufacturers should have to buy product liability insurance, but the consumer policy committee did not address this concern.

The Committee on Legal Affairs and the Internal Market said in a March 1 report, however, that the directive should be revised only after the European Commission has assembled factual evidence showing that it is inadequate.

If the European Commission discovers during its consultation period that there are "serious gaps or defects in the legal regime established by the directive," then amendments should be considered to plug up those gaps, said the report.

"More generally, however, it would be unwise and inappropriate for Parliament to countenance any move towards radical or large-scale alteration in the product liability regime in the light of information currently available," said the legal committee.

The legal committee said that factual data must be collected methodically to show the impact of the current product liability regime and the balance it strikes between manufacturers' and consumers' interests.

Both the Assn. of British Insurers in London and Comite Europeen des Assurances in Paris confirmed that neither association collects data about product liability claims in the European Union. The CEA is considering asking the major E.U. insurers to provide claims data directly to the CEA in order to develop comprehensive information about product liability claims in Europe, said a spokesman.

According to the legal committee's report, a review of the various product liability regimes throughout the European Union could be a starting point in reconciling the vast differences among its 15 member states. Member states vary, for example, when it comes to procedural laws governing class actions and contingency fees, the legal committee noted.

Therefore, the report said, the E.C. green paper on the product liability directive "should be welcomed as a start to this process, not its conclusion." BI

Names

Continued from page 29

that English law was unfair because there are certain special protections in English law that apply only to Lloyd's," he said. But Justice Katherine Swinton ruled that the English court ruling against the names was fair and should be allowed to stand in Ontario.

Mr. Grippo noted that some U.S. courts have examined English law and allowed cases against Lloyd's to be heard. Early next year, *West vs. Lloyd's*, a case similar to the Jaffray suit, will be heard in California, he said.

The Canadian names had also argued that the English court judgments should not be recognized because of the Jaffray case, which involves allegations that Lloyd's fraudulently misled names about the seriousness of asbestos-related claims threatening the market in the 1980s.

Justice Swinton, however, ruled that the fraud allegations were "not sufficient basis on which to deny the enforcement of the judgments." None of the 88 names involved in the Ontario case is taking part in the Jaffray suit.

Philip Holden, head of Lloyd's financial recovery unit, said that Lloyd's would now seek to enforce English court judgments against U.S. names who had refused to pay premiums to Equitas. "It is our duty to pursue these debts on behalf of our policyholders and thousands of names who were prepared to pay," he said.

"The judgment is wrong and we are appealing," said Jacki Levin, head of the Canadian Names Assn.

If the names lose the appeal, they will then petition the Supreme Court of Canada to hear their case, said Mr. Smith.

Ms. Levin said the Canadian names were following the Jaffray trial with interest but were unable to bring a fraud case against Lloyd's in Canada because the court has ruled that Lloyd's cannot be sued in Canada. "But we have been alleging fraud since 1991," she said.

Meanwhile, Lloyd's opened its defense in the *Jaffray vs. Lloyd's* fraud trial on March 16. In his opening remarks, Charles Aldous, an attorney representing Lloyd's, said: "If you cut through the hyperbole surrounding the names' case, it is difficult to see what their case is."

He said that "fundamental conceptual difficulties" in the names' arguments were put forward by attorney Simon Goldblatt in the preceding two weeks (*BI*, March 13; March 6).

Mr. Aldous claimed that the scale of the fraud alleged by the names would have been "extremely difficult, if not impossible, to carry out." He said that the level of fraud that the names allege took place would have had to involve not just committee members and syndicates, but also claims managers and auditors.

He noted that many of the 33 senior figures at Lloyd's between 1978 and 1988, whom the names allege were involved in misrepresentations, had asbestos-related losses themselves. He added that some of those individuals increased their underwriting participation on syndicates exposed to asbestos-related losses. "There is no point in committing a fraud if it is the fraudsters who make the losses," he said.

Justice Peter Creswell asked Mr. Aldous whether those on Lloyd's ruling committee and who were underwriting on syndicates exposed to asbestos-related losses faced a conflict of interest and should therefore have abstained from decision-making on the regulation of Lloyd's.

Mr. Aldous replied that all members of the committee knew what position the others were in, so a conflict of interest could not be hidden. He said the committee members were "interested in putting the interests of Lloyd's first."

But, when questioned by the judge, Mr. Aldous was forced to concede that there may have been some misconduct.

Cross-examinations are expected to begin in the case this week.

Meanwhile, A.M. Best Co. has predicted that Lloyd's losses for the 1999 year of account could top £1 billion ($1.62 billion). For 1997, which closed at year-end 1999 under Lloyd's three-year accounting system, Best forecast a £400 million ($646.1 million) pure underwriting loss, and for 1998 a pure underwriting loss of £700 million to £725 million ($1.13 billion to $1.17 billion).

In September 1999, Lloyd's predicted an underwriting loss of £434 million ($701.0 million) for the 1999 year of account. BI

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Aetna

Continued from page 2

with shareholders and independently evaluate strategic options. Each of our two core businesses has great potential, and each will be better able to realize that potential as a separate company."

Aetna also said its board of directors has unanimously rejected an unsolicited invitation from WellPoint Health Networks Inc. and ING America Insurance Holdings Inc. to start discussing a $70-per-share purchase of Aetna (*BI*, March 6).

Thousand Oaks, Calif.-based WellPoint responded in a statement that it was disappointed by Aetna's decision and that it continues to believe that the terms discussed in the joint WellPoint and ING letter of Feb. 24 "represent outstanding value for Aetna's shareholders." A WellPoint spokesman would not comment as to whether WellPoint and ING plan to make a formal offer to acquire Aetna.

In addition to the planned split, other steps that Aetna said it plans to take include:

- A comprehensive review of the company's health business model and strategies.

Mr. Donaldson said the company "will examine our business model in view of a rapidly changing environment that increasingly emphasizes choice and empowerment. Our goal is to improve relations with physicians and hospitals, do a better job of meeting the expectations of customers and patients and enhance our financial performance."

Some observers expect Aetna to follow the example of Minneapolis-based UnitedHealthcare, which last year dropped its prior-approval requirements for treatment decisions in its health maintenance organization (*BI*, Nov. 15, 1999).

- The sale of international assets that do not fit with the strategies of the financial services and health businesses.

Mr. Donaldson has said the company hopes to sell some of its international units for $500 million to $1.5 billion.

- The completion of plans to take advantage of strategic health care opportunities on the Internet.
- The acceleration of Aetna's existing cost reduction program, as well as additional reductions resulting from its restructuring and strategic review.

'There's the possibility that it'll be easier for them to manage themselves with a small organization,' says Helen Darling.

Mr. Donaldson has said the company hopes to save $100 million to $150 million before taxes this year from cost-cutting measures.

Aetna's moves came in response to its declining stock price and subsequent investor unhappiness, which led to the resignation earlier this month of Richard L. Huber as chairman, president and CEO and his replacement by Mr. Donaldson, who is a co-founder of the investment banking firm Donaldson, Lufkin & Jenrette.

Aetna's health care business strategy has been endangered by a changed environment, said Ken Jacobsen, the Atlanta-based national director of the Segal Co.'s health care practice.

"Aetna's big bet was to absorb the managed care discipline of U.S. Healthcare" and exercise greater market clout through its acquisition of that operation, as well as its earlier purchase of NYLCare Health Plans Inc. and Prudential HealthCare, said Mr. Jacobsen.

Although at the time it seemed as though it had "placed a good bet," Aetna's strategy has been undermined by a backlash against HMOs that includes anti-managed care legislation, a consumer revolt and a loosening of managed care restrictions, as well as a resurgence of provider clout, said Mr. Jacobsen.

Aetna's problems may stem from biting off too much, too fast, one observer suggests.

Tom Billett, senior vp at Health Pages Inc., an Internet health information company based in New York, said that Aetna overpaid for the Prudential plans and has had difficulty in integrating both the Prudential and NYLCare plans.

If you look at the history of the HMO industry in the United States, "many of the players who have failed have been those that have grown too fast," said Mr. Billett. "I don't think the fact that they're splitting the company necessarily means that they're. . .in the clear now," he added.

There are still many unanswered questions surrounding the planned spinoff of Aetna's health care operations, including how much capital and debt the new company will have, what its internal structure and investment strategy will be, whether the operation can be self-sustaining and whether Aetna may eventually decide to sell the operation after all.

Health care analyst Doug Sherlock, of the Gwynedd, Pa.-based Sherlock Co., said the split should have little impact on the firm's day-to-day operations.

"If you think about the way health plans operate, they're highly decentralized. The health plan in Pennsylvania operates dramatically differently than the health plan in Texas. Both are relatively autonomous, but the local CEO has to be sensitive to the needs and values of local consumers and relationships with local providers, and that's where all the managerial hard work takes place, at the local level," Mr. Sherlock said.

Employers could benefit if the health care business is split off into a separate company that has management's undivided attention, one consultant says.

Helen Darling, senior consultant, benefits and health care, for Watson Wyatt Worldwide in Stamford, Conn., said, "There's the possibility that it'll be easier for them to manage themselves with a small organization."

Within a large company, she said, "there's always competition for resources, investments, management attention, so I think a split will allow the heads of the organization to focus solely on health care, and I think that could be a very good thing."

Furthermore, in light of the circumstances under which Mr. Huber left Aetna, whoever is put in charge of the health business "has probably already had an object lesson on the need to rebuild relationships with providers, doctors and hospitals, and with their large customers," said Ms. Darling.

'Maybe this will allow Aetna to focus on making it better, so I hope it bodes well for the employer,' says Barry Barnett.

Separating the company is " a chance to turn around the culture and make it more openly customer-focused and collaborative with providers," she said.

With the split-up, "they'll be able to focus more on their issues of health care and delivery systems, improving relationships on the provider side and providing quality service to members," agreed Barry Barnett, a principal with PricewaterhouseCoopers L.L.C. in New York.

"Maybe this will allow Aetna to focus on making it better, so I hope it bodes well for the employer," Mr. Barnett said.

"I think this gives Aetna the ability to make a fresh start. . .and probably their largest (needed) area of improvement is in provider relations," including the company's contracting strategy, said Ken Sperling, a Norwalk, Conn.-based principal at Hewitt Associates L.L.C.

Under the company's all-products strategy, a provider who participates in one Aetna product must participate in all, including its HMO, preferred provider organization and Medicare risk products, he said. "Providers have resisted this type of contract vehemently in some markets and it's led to some disruption, and I think Aetna will be rethinking that strategy."

There will also be a greater focus on choice for employees, said Mr. Sperling, though he added: "There's also a difficult balance that they have to walk between cost controls and broad access and, unfortunately for Aetna, employers want both; and right now there's no real solution on what that balance should be."

In spite of Aetna's plans, the health care business still could be acquired by another company.

Jeff Chanin, a principal with Mercer Inc.'s health care group practice in New York said that, while Aetna's management has said it plans to operate as a split company, "it could be a volatile situation."

An acquisition could still be made by WellPoint and ING, by another major regional player or by a firm now outside the health care business, said Mr. Chanin, who said he believes the operation's acquisition by another national player may raise antitrust concerns, given Aetna's commanding size in the market.

Patrick Finnegan, senior vp with rating agency Moody's Investors Service Inc. in New York, said splitting up the businesses could make the sale of the company's component parts easier than having a group of parties come and bid for the entire firm. "It allows them to consider, I think, more alternatives," Mr. Finnegan said. BI

Rate hikes, improved results fuel HMO optimism

By JUDY GREENWALD

The rate hikes that were a major factor behind many health maintenance organizations' strong performance in 1999 likely will continue to fuel improved results this year.

In today's healthy economy, with its competitive, tight job market, employers are expected to continue to pay higher rates, at least in the short term, rather than pare down the benefits they offer employees to keep costs stable.

"I think that, fundamentally, the outlook hasn't been this good" for HMOs in several years, said David Olson, vp-investor relations for Woodland Hills, Calif.-based Foundation Health Systems Inc. "There's good pricing discipline in the industry, with a few exceptions. I think we're recognizing that there is medical cost inflation, and we're trying to adjust to that."

"I think the outlook for 2000 is positive" for managed care plans, agreed Richard Shaw, an analyst with A.M. Best Co. in Oldwick, N.J. "You're going to see overall, probably, a return to profitability on a greater number of plans than you did in 1999, because now they've been able to implement price increases, which will, hopefully, return them to a modest level of profitability."

"I think 2000 is going to be a good year as well," said Arun Kumar, vp at Chase Securities Inc. in New York. Beyond that, he said, "2001 could also be a fairly decent year. I don't think there'll be any surprises until 2002."

Mr. Kumar added, however, that the industry is still awaiting some major events, including a possible federal law that would allow lawsuits against managed care plans; the resolution of class-action suits filed against insurers; and the U.S. Supreme Court's pending decision in a managed care case, *Pegram vs. Herdrich* (*BI*, Feb. 28), which could affect how managed care firms operate.

Others agree that the industry's outlook is promising.

"Pricing continues to be robust, in the sense that companies are aggressively making significant price increases in all of their product lines," said Patrick Finnegan, senior vp at Moody's Investors Service Inc. in New York.

It seems that "companies are sticking to achieving price increases consistently with their loss experience, and our sense is they've been largely successful," said Douglas L. Meyer, an analyst with Duff & Phelps Credit Rating Agency in Chicago.

And this year will see "more of the same," said Rob Mains, an analyst with Advest Inc. in Albany, N.Y. "The industry's got two things working for it—it's got good premium rate increases, and the cost controls are working well enough."

HMO Results

"We see 2000 as being another year of improvement, because they got even-heftier rate increases" for next year, though there remain certain areas where competition is still strong and pricing discipline is lacking, said Jack Reichman, director at rating agency Standard & Poor's Corp. in New York.

Among the year-end results reported were:

- St. Louis-based Right CHOICE Managed Care Inc. reported $17.2 million in net income, compared with $5.7 million in 1998—a 204.2% improvement.
- Foundation Health Systems reported $142.4 million in net income for 1999, compared with a $185.2 million loss in 1998.
- Trumbull, Conn.-based Oxford Health Plans Inc. continued its recovery, posting $319.9 million in net income, compared with a $596.8 million loss in 1998.
- Santa Ana, Calif.-based PacifiCare Health Systems Inc. saw its net income increase 37.6% in 1999 to $278.5 million.
- Hartford, Conn.-based Aetna U.S. Healthcare—an Aetna Inc. unit that may become a separate, publicly traded company (see story, page 1)—reported a 34.1% increase in operating earnings to $459.7 million for 1999. The results reflect Aetna's acquisition of Prudential HealthCare last August.
- Thousand Oaks, Calif.-based WellPoint Health Networks reported $278.5 million in net income for 1999, up 20.4% from 1998. WellPoint recently made a joint bid with ING America Holdings Inc. to acquire Aetna, but that offer was rejected.
- Philadelphia-based CIGNA Corp.'s employee health care, life and disability benefits business segment—which includes its HMO and indemnity operations—saw an 18% increase in operating income to $728 million.
- Minneapolis-based UnitedHealthGroup reported $568 million in net earnings for the year, up 5.6% from 1998.
- Oakland, Calif.-based Kaiser Permanente reported a $6 million net loss and a $125 million operating loss for 1999. This compares with 1998's $288 million net loss and $434 million operating loss.
- Milwaukee-based United Wisconsin Services Inc. reported a $29 million loss for 1999, compared with $15.9 million in net income in 1998.
- Louisville, Ky.-based Humana Inc. reported a $382 million net loss for 1999, which reflects a $495 million fourth-quarter special charge. Humana posted $129 million in net income in 1998.

"Most of them have had pretty good results," including UnitedHealth, WellPoint, FHS, Aetna and CIGNA, said Chase Securities' Mr. Kumar. "Even Oxford turned around, it appears, although it will not be known for another six months or so how well they turned the corner."

"What we saw was a turnaround," with many companies starting to show profitability as a result of price hikes they pushed through last year, said Best's Mr. Shaw.

"Companies that have had problems continue to have problems," and those companies that have done well continue to do well, said Mark Jamilkowski, an analyst with Hartford, Conn.-based Conning & Co. They are "taking full advantage of the current pricing environments, are actually adding to their margins and adding to their reserves, so they're becoming even stronger financially."

Michael J. Barry, an analyst with Fitch IBCA Investors Service in New York, said, "The primary driver has been whether or not these companies can get rate increases, and they have been able to." But, Mr. Barry added, "the good news there is somewhat offset by continued medical cost

See **HMOs** *on next page*

HMOs

Continued from previous page

inflation, particularly driven by prescription costs," which continues to be a challenge for the industry.

Rate hikes will not continue indefinitely, said Mr. Jamilkowski. "I would expect there to be more pricing effort in 2001. But, at some point, whether it's 2001 or 2002, I am expecting there to be something of a backlash. . .whether it's the Blue Cross & Blue Shield taking the impetus and starting another pricing cycle, or whether it's the employers saying, 'I'm not taking another pricing increase of that magnitude,' " said Mr. Jamilkowski.

"It's a matter of logic," he added. "I just don't see how it will continue at this pace."

Mr. Kumar said, though, that in a strong economy, "people are not going to complain" about rate hikes in the 8% to 9% range. It's when rates are raised 20% to 25% that "you start getting rebellion from constituencies," he said.

"Health care costs are rising, and we have to price for those costs now," said John Penshorn, UnitedHealth's director of capital market communications in Minneapolis. A lower level of benefits can ameliorate rate hikes, but "frankly, with national unemployment hovering around 4%, employers have not been looking to reduce health benefits. They're competing for workers and instead have been willing to shoulder the increase."

"I think you'll hear a lot of noise from employers about this issue," said Foundation's Mr. Olson. "I think what we clearly have to demonstrate is two things—one is that we're pricing to cost trends; and two, that employees in a full-employment economy are not going to want a smaller pallet, if you will, of product offerings. And the more you open access, the more costs are going to go up. It's just that simple."

Rebecca Bergman Mack, PacifiCare's investor relations manager, said the company is now successfully introducing rate hikes averaging 6% to 7% for 2001, comparable to those introduced for this year. "From what I've been hearing, unless the economy takes a downturn, we expect the current trends to hold," said Ms. Mack.

Meanwhile, HMO stock prices are down 8.5% for the year to date through March 10, according to *BI*'s Stock Index of seven companies.

The only reason the industry's best environment since the early 1990's has not been reflected in stock prices is "the two L's"—litigation and legislation, observed Mr. Mains.

The threat of federal legislation that would permit patients to sue managed care firms "will probably be put to rest one way or another this year, and it sounds like the industry might even come out OK on that," said Mr. Mains. It is also "pretty clear" that the *Pegram* case will be overturned in the industry's favor by the Supreme Court, he said.

The threat investors are more concerned about is the spate of class-action lawsuits being filed against health insurers, said Mr. Mains. "There's a steady drum beat of civil-action lawyers trying to extort something out of the industry, and what's important to realize is that we are probably a year—if not years—off for many of these cases coming to trial if, in fact, any of the classes are certified," said Mr. Mains. "Whether that's enough to help out the industry, I don't know."

Mr. Olson also noted that the case before the Supreme Court and the class-action lawsuits "are having a fundamental impact on stock prices" and on investors' attitude toward the industry, and there will not be a significant stock rally until these issues are resolved.

On the issue of federal legislation, Mr. Olson said, "we continue to believe that there's a reasonable compromise" that can be reached.

Analysts expect continued consolidation activity this year, though not necessarily among the large national players.

"In general, I think you'll see a pickup in consolidation activity in 2000-2001, as companies expand margins and take advantage of the pricing environment, using that leverage to pick and choose the best properties," said Mr. Jamilkowski.

Although acquisitions will "remain a way of life, I think you've seen, to date, most of the large acquisitions that are going to occur in the sector," Mr. Finnegan said.

"I think larger companies have seen problems with integration and realize they could be buying significant financial problems just for the sake of gaining market share. It's not worth it," he said.

Instead of making acquisitions solely to build additional scale, those companies that already have scale "can sit back and make selective regional acquisitions without pursuing large-growth opportunities," said Mr. Finnegan. BI

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Business Insurance

Sageo

Continued from page 1

and marketing for the Consortium in Columbia, Md., a marketing arm for Blue Cross & Blue Shield that concentrate on national accounts. The Blues plans are among the companies participating in Sageo.

For employers, Sageo would dramatically change and reduce their role as providers of health care benefits to retirees. After it decided which plans would be offered, an employer's role would essentially be that of paying for coverage. All enrollment, communications and participant questions would be handled through Sageo.

"This is a full administrative solution," said Tom Schmitz, Sageo's chief executive officer in Chicago. Previously, Mr. Schmitz directed Hewitt's outsourcing business. Hewitt's outsourcing business is, by far, the largest of the nation's benefit consultants and accounts for more than half of Hewitt's revenues.

That reduced role is one some employers say they would welcome.

"Sageo would do everything. That would make things easier for us and is a pretty compelling story to tell," said Michael Kriner, director of health care and disability management for Dayton, Ohio-based NCR Corp., which is interested in Sageo.

Insurers and health plans say their overhead will be slashed with Sageo acting as the point of contact for many employers, along with standardized benefit designs and online capabilities.

"We see this as a very cost-effective way of doing business. Instead of dealing with dozens of customers, we deal with one. This is the direction in which health care is going," said Christopher Ciano, senior vp and general manager for Health Net, a managed care organization in Woodland Hills, Calif., which is a Sageo participant.

"You have a single point of contact, with all kinds of reduced administrative expenses," said David Taaffe, senior vp-national accounts for PacifiCare Health Systems Inc. in Cypress, Calif., which also is a Sageo participant.

Indeed, Jack Bruner, Sageo's chief strategist in Chicago, said that, with its electronic interface set up to handle enrollment and billing, "it takes very little effort on the part of health plans to be part of Sageo."

In fact, Mr. Bruner said, with Sageo handling all plan administration and communications, an employer could significantly increase the number of health plans it offers to retirees without adding to its overhead.

"While an employer now might offer retirees one or two plan choices, it might increase that to four or five," he said.

So far, Sageo has commitments from health plans that cover about 60% of all participants in group plans, a percentage that should increase to about 80% by 2002, Mr. Bruner predicts.

Sageo, with its emphasis on standardized benefit designs, one-source administration and electronic display and transfer of information, will represent a sea change from the way retiree health care plans are offered, selected and administered today.

'Ultimately, there could be a community of retirees exchanging information' on health care issues.

— Tom Schmitz

Currently, for example, customization of plan design is the norm. While that means an employer can, if it has the clout, negotiate to get the design it wants, it also vastly complicates and increases plan administration costs for health insurers.

In contrast, by standardizing plan design, which could be used by dozens, if not ultimately hundreds, of employers, plan administration costs can be cut.

"It becomes a lot easier to train people and answer questions if you have one design and not 10 designs. There is an opportunity to reduce overhead, perhaps by 5% to 10%," said the Consortium's Mr. Jayner.

At the same time, plan standardization makes comparison shopping among plans much easier for participants, and their focus can be on whether a plan best meets their needs as well as how a plan operates.

In fact, Sageo executives emphasize that Sageo is not just about selecting and enrolling in a plan but also a way for participants to use plan benefits.

"You get a travel map. Say you have diabetes. You can find out what kind of disease management programs hospitals in a plan network offer," Mr. Bruner said.

As part of Sageo, participants also will be able to receive online health care information from the Mayo Clinic. For example, if a retiree is diagnosed with cancer, he or she could access Sageo to obtain the latest information from the Rochester, Minn.-based medical facility about the disease, treatment possibilities and support groups.

In addition, participating retirees, who will have their own Sageo e-mail accounts, will be able to share and exchange health care information with other retirees. "Ultimately, there could be a community of retirees exchanging information" on health care issues, Mr. Schmitz said.

While retirees are less likely than active employees to use computers or the Internet, the elderly are the fastest growing group of computer users, Sageo executives note.

About 30% of retirees now use the Internet, but that figure is expected to increase to 70% in five years, Sageo executives say.

Although Sageo's initial emphasis will be health care, over the next two years retirees and employees will be able to obtain financial, legal and other life-management services.

For now, though, Sageo intends to provide a "rich online experience for retirees that is characterized by comprehensive, quality information services and guidance to help them access and use their health benefits in the best way possible," Mr. Schmitz said in a statement. BI

Asbestos

Continued from page 2

Hyde. In addition, victims of asbestos-related lung cancer would be eligible for settlements even if they had a history of smoking.

Settlements would be determined on an individual basis. If a claimant considered his or her settlement offer to be too small, the claimant would have to go through arbitration. If the claimant also rejected the arbitrator's decision, though, he or she could still seek redress in federal court.

If the out-of-court process works as planned, claimants would receive their settlements within a matter of a few months rather than the average four-year period associated with lawsuits, according to material provided by Rep. Hyde's office.

Rep. Hyde struggled to bring the bill to a vote. Consideration was delayed repeatedly in recent weeks, and then Rep. Hyde had to dispense with more than 100 proposed amendments before the final vote.

The narrowness of Thursday's 18-to-15 vote indicates a rough ride ahead for the measure. Two of the committee's Republicans broke ranks and voted against the bill, and the vote of one of the bill's chief Democratic opponents, Rep. Robert Scott, D-Va., was recorded in favor of the bill after the congressman changed his vote to favor the measure in an ill-fated parliamentary maneuver to try to kill it on a second vote.

The 17-to-16 vote was 'not exactly a ringing endorsement of the legislation,' says John Arlington of the AIA.

"It was actually a 17-to-16 vote, not exactly a ringing endorsement of the legislation," said Mr. Arlington.

Even if the bill passes the House, its future remains very murky. The White House, the trial bar and organized labor oppose it. Similar Senate legislation, sponsored by Sen. John Ashcroft, R-Mo., has yet to be voted on by even a subcommittee. Further complicating the situation is the fact that at least two vulnerable incumbent Republican senators have been targeted by opponents as lacking compassion for asbestos victims.

Passage of the bill drew expected reactions from the groups that had been lobbying most heavily both for and against it.

"In the current court system, asbestos victims often face years of delay and lose an average of 66 cents of every dollar awarded in attorneys' fees and costs. We are pleased that the Judiciary Committee has recognized the severity of this litigation crisis and passed H.R. 1283, heeding the repeated calls of the U.S. Supreme Court to enact a legislative remedy," said Conrad Mallett, the former chief justice of the Michigan Supreme Court, in a written statement. Mr. Mallett serves as chairman of the Washington-based Coalition for Asbestos Resolution.

Not surprisingly, Joan Claybrook, president of Washington-based Public Citizen—a consumer group founded by Ralph Nader—blasted the vote in a statement.

"This is corporate welfare at its worst. The bill is a bonanza for the defendants, shifting the cost of asbestos illnesses and deaths from the wrongdoers to the workers they so calculatedly and callously injured," Ms. Claybrook said.

After passing the asbestos bill, the Judiciary Committee began discussing the Quality Health Care Coalition Act, which would amend federal antitrust law to permit independent physicians to negotiate collectively with managed care plans and insurers.

Many employer groups oppose the measure, which was introduced by Rep. Tom Campbell, R-Calif., because they fear it would raise health care costs and allow physicians to act as cartels. The Judiciary Committee is expected to vote on the bill later this week. BI

Climate change roundtable scheduled

NEW YORK—Risk managers will meet with government agencies later this month to discuss the connection between climate changes and rising losses from natural disasters.

The roundtable will be held March 28 in New York and will be attended by representatives from the Risk & Insurance Management Society Inc., the Public Risk Management Assn., the U.S. Environmental Protection Agency, the U.S. Federal Emergency Management Administration and the U.S. Department of Energy.

The groups hope to gain a better understanding of the potential impact of climate changes and the risks to the insurance industry. They will discuss options for mitigating losses and develop methods for communicating the risks of catastrophes to the public.

Lance Ewing, chairman of RIMS' external affairs team, said in a statement that RIMS can, through its participation, help demonstrate that "risk management has a direct impact in non-traditional risk and exposure areas."

—By Michael Bradford

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IC&S

Continued from page 1

recapitalization or business plans. "We are still in the process of getting this information," he said.

He also confirmed that Keyes International is no longer in business but said he does not know what became of the insurer and denied any ownership or management role with it. "We were really not involved in Keyes or its management," he said.

Mr. Boncamper declined to answer further questions about Keyes.

If IC&S rises again after a planned redomestication to St. Kitts, it will be another surprising twist in an unusual life story.

The insurer was formed in New Zealand in 1992 by Jesse Maynard, the Oklahoma-based owner of a Turks & Caicos Islands underwriter, First Assurance & Casualty Co. Ltd., alleged in various suits to be fraudulent. First Assurance filed for bankruptcy in Oklahoma City in 1993 after being deluged with small-business claims from the 1992 Los Angeles riots (*BI*, Jan. 6, 1997).

Before its collapse, First Assurance provided a large part of IC&S' initial capital of about $11 million New Zealand ($5.7 million), and Mr. Maynard intended the New Zealand company to take over First Assurance's California business.

First Assurance's court-appointed bankruptcy trustee later sued IC&S and others to recover the contributed capital, charging that IC&S was part of an ongoing fraudulent conspiracy.

By 1993, Mr. Maynard had resigned as an IC&S director. He was replaced by Samuel B. Love, who managed the insurer through a Scottsdale, Ariz., underwriting office and who had earlier helped manage First Assurance. Mr. Love and a partner, Donald P. Havenar, owned IC&S through a Cayman Islands-based holding company, Catus Energy Ltd.

Over the next five years, IC&S wrote several million dollars a year in marine and other insurance premiums on the strength of capital and surplus that IC&S shifted regularly among obscure—and sometimes worthless—over-the-counter and non-public stocks and notes.

Assets that IC&S has reported in annual financial statements since 1993 have included:

- $2.1 million in stock of a bankrupt tire recycling company.
- $2 million in stock of a company that was shut down by the Texas Insurance Department and that itself had claimed to be capitalized with millions of dollars of government bonds from a non-existent island nation, the Dominion of Melchizedek.
- $1.6 million in stock of a money-losing oil and gas company headed by First Assurance's former auditor.

The New Zealand insurer's latest financial statement, for year-end 1998, reports invested assets in face amounts totaling $20 million. These include a $10 million "letter of guarantee" from a Mexican credit union, Union de Credito Metropolitana S.A. de C.V.

A.M. Best, which assigned IC&S a D rating in 1998, found that the guarantee "severely diminished the quality" of the insurer's capital and surplus.

Last April, in fact, the Mexican federal government moved to revoke Metropolitana's authority to act as a credit union, according to a Mexican government publication.

Throughout this period, Mr. Love insisted the balance sheet changes were making IC&S a stronger company: "We'll be around next year and the year after and the year after," he said in 1997.

By late 1998, though, IC&S officials were facing other troubles. Messrs. Love and Havenar were indicted—along with Mr. Maynard and others—on federal charges of siphoning millions of dollars out of First Assurance both before and after its bankruptcy filing.

Mr. Love continued to operate IC&S while awaiting trial but was convicted with Mr. Maynard last year and sentenced in February to 63 months in prison, with Mr. Maynard receiving a 78-month sentence. Mr. Havenar, who was arrested in Mexico, remains in jail there pending extradition.

With the convictions, IC&S went on the block.

A buyer comes forward

Once put up for sale, IC&S attracted bids, despite a highly competitive insurance market that has small players at a huge disadvantage.

In a proposed deal late last year, IC&S was to have been acquired by Magnus Holdings Ltd., an Isle of Man company operated from Tempe, Ariz., by John Thomas Kreitzer. IC&S would have been Magnus' first insurance acquisition, Mr. Kreitzer said.

He announced plans to recapitalize IC&S with $10 million in cash and 10 million non-publicly traded shares of stock—valued at $100 million—in a Boynton Beach, Fla., company called ZeoSync Corp. Incorporated last August, ZeoSync reportedly is developing new computer data compression and storage technology and set the $10 per share "benchmark" price for its own stock.

Mr. Kreitzer also lined up former U.S. Rep. Barry M. Goldwater Jr., son of the late U.S. senator from Arizona, to act as an IC&S director, Mr. Goldwater confirmed.

While Mr. Kreitzer says his wealthy Illinois family helped with his plans for IC&S, court documents from the mid-1990s do not reflect a high degree of personal wealth.

'It's had some problems,' Fred Wiggins, a consultant, says of IC&S, but 'we want an image of integrity.'

In 1995, Mr. Kreitzer testified under a grant of immunity in the federal trial of several men charged with operating a telemarketing fraud from Orlando, Fla., Washington and Beverly Hills, Calif., according to Roger W. Burke Jr., a Washington-based assistant U.S. attorney.

Mr. Kreitzer, a computer technician, testified about an information system he helped set up for the defendants, Mr. Burke said. Mr. Kreitzer himself was not charged with any wrongdoing, he noted.

At the time, though, Mr. Kreitzer filed a financial affidavit in Orlando federal court to support his request for a court-appointed lawyer.

In the affidavit, Mr. Kreitzer said he earned $900 per month as a self-employed consultant, had no property and only $52 in cash in a bank account and was in default on more than $80,000 in debts on "credit cards, leases, etc.," court records show.

Earlier, in January 1994, MCI Communications Corp. had won a $17,688 default judgment for unpaid phone services against Mr. Kreitzer and an Orlando-area travel company he helped operate, court records show.

In an interview earlier this year, Mr. Kreitzer said the financial affidavit did not reflect his actual worth, which included assets held in trusts and corporations.

"Everything I do is through corporations and trusts," he said.

He also said he sought a public defender "mainly to protest the whole situation."

"There was no charge that I did anything wrong in that case," Mr. Kreitzer said. "I could have afforded to have the best representation if I had decided that it was something I needed representation for."

"I was a victim and drug through the dirt and came up clean," he added. "Given that I have such high internal integrity, to have that brought up again just really disgusts me."

The MCI judgment, he explained, resulted from a transfer of the travel company to new owners, who failed to remove his name from the phone service and consequently stuck him with the bill.

By the end of last year, Mr. Goldwater had bowed out of plans to join the IC&S board, and in January the deal between the insurer and Magnus Holdings fell apart.

Within about a month, though, IC&S had struck a new deal.

IC&S acquired

On Feb. 21, the New Zealand insurer was sold to Axis Financial Services Ltd., according to a memo to brokers from Mr. Boncamper, the St. Kitts-based accountant and new IC&S chairman.

"You will be pleased to know that the new owners will be recapitalizing with liquid assets and considerably strengthening the management of the company," Mr. Boncamper wrote.

During the restructuring, IC&S will suspend writing new business, he added.

Fred Wiggins, a Santa Fe, Texas, financial consultant working for IC&S, said the new capital will include $17.8 million in certificates of deposit that he said he believes are from Mexican banks. "This is liquid capital. This is not land in Florida," he said.

The insurer's recapitalization and business plans were still being worked out this month in meetings with Mr. Boncamper in St. Kitts, he added.

"It's had some problems," Mr. Wiggins said of IC&S. But "we want an image of integrity."

While confirming that he is the owner of IC&S "at this point in time," Mr. Boncamper would not discuss the new capital or whether ownership of the insurer would change.

Mr. Boncamper is the principal of Accounting & Financial Management Services Ltd., a St. Kitts company that offers an array of services, including offshore company management, real estate, offshore credit and debit card arrangements and aid in obtaining St. Kitts citizenship for "persons of economic means."

In the mid-1990s, Mr. Boncamper was a shareholder and director of Keyes International Insurance, for which he also acted as auditor, documents show.

Keyes was operated from Hollywood, Fla., by George H. Williamson, the insurer's chairman and also a shareholder; and Bruce Forrester, managing director, according to St. Kitts government records and Keyes' documents.

For a little-known Caribbean insurer, Keyes appeared to be massively capitalized:

An Oct. 31, 1995, balance sheet audited by Mr. Boncamper reported total assets of $2.6 billion, including $1 billion in CDs; $1.2 billion in U.S. Treasury bills; $373.9 million in U.S. real estate held in trust; and $11.8 million in "marketable securities."

With only $177.9 million in reported liabilities, Keyes' net capital amounted to $2.42 billion, according to the statement.

Despite its purported financial resources, Keyes did not last long. By 1998, it had failed to pay at least one large claim and had ceased operating.

Keyes was named in a fraud lawsuit filed last year in U.S. District Court in New York by Tuttnauer Co. Ltd., a Jerusalem-based medical products manufacturer that was also the largest creditor in the bankruptcy of 47th St. Photo, a New York City electronics retailer.

In late 1995, Tuttnauer had loaned money to a company operating 47th St. Photo. In exchange, the company had given Tuttnauer a $1.5 million promissory note backed by a surety bond from Keyes guaranteeing repayment.

The 47th St. operating company defaulted in early 1997, and Tuttnauer tried to recover from Keyes, but without luck.

In its lawsuit, Tuttnauer charges that Mr. Boncamper provided Keyes' financial statements and said he had independently reviewed the insurer's structure and assets and found it to be solvent. Mr. Boncamper did not disclose that he was a Keyes shareholder, the suit says.

After the default, Tuttnauer discovered that Keyes was not solvent "and, in fact, had no assets," the suit alleges.

In an interview last week, Mr. Boncamper said he acted only as a nominee director of Keyes and that Mr. Williamson and Mr. Forrester were the owners. He declined to comment on the Tuttnauer suit or answer further questions about Keyes, though, in correspondence with Tuttnauer lawyers, he denied wrongdoing and referred questions to Mr. Williamson.

Mr. Williamson's Florida phone numbers are no longer in service, and neither he nor Mr. Forrester could be reached. BI

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Commentary

Nothing to declare except my genes

The wacky world of genetic engineering and research has taken several strange twists and turns in recent weeks.

This research—which includes both efforts to tinker with the genetic makeup of inanimate objects, such as crops, and animate objects, such as humans—has a tremendous potential to change society.

It also, however, will create many new liabilities for companies and their insurers in the years to come. Consider the furor in Europe over genetically modified food, for example, and it's easy to imagine the tide of claims to come alleging bodily injury from such "unnatural" modifications.

If one also considers the current fight for continued access to simple medical treatment information, it's easy to foresee a coming battle for insurers to gain access to a policyholder or claimant's genetic information.

In light of the potential changes wrought by genetics, I believe it's worth keeping pace with developments in the field. There are several of note:

- Last week, the leaders of Great Britain and the United States issued a joint statement calling for research into the human genome to be made available free to researchers and scientists. This knowledge about the essential makeup of the human code that governs everything from hair color to susceptibility to hereditary disease is too important to be left in the hands of private companies, they argue.

Paul D. Winston

The announcement immediately sent the stocks of biotechnology companies, which are hoping to corner the market on that knowledge, into a tailspin. D&O liability underwriters for biotech companies should brace for a new round of shareholder class actions in the wake of these stock plunges. Never mind that no amount of loss control can restrain politicians from opening their mouths.

- The Manhattan District Attorney last week indicted a string of DNA for a series of sexual assaults in New York. While law enforcement officials have no idea who the suspect is, they have been able to link the crimes based on DNA evidence from each of the victims.

The next step in catching this criminal is to get a DNA sample from each of the approximately 7.5 million residents of the New York metropolitan region. Or, they could just wait a few years until such information is routinely entered as part of medical records and run a simple computer search.

- While human cloning for transplants is considered taboo, the same Scottish company that cloned Dolly the sheep several years ago has now cloned a pig for animal-to-human transplant purposes. Although the alpha pig was not given a similarly cute moniker, its five identical piglets were named: Millie, Christa, Alexis, Carrel and Dotcom.

Once a pig is genetically modified to produce organs suitable for humans, its genetic code now can be cloned to produce infinite identical offspring. I've been called a swine before, but it now is possible for that to be true.

- The British Patent Office was in the news earlier this month because it approved a biotechnology patent that mistakenly omitted a critical word. According to the National Law Journal, the patent office approved a "method of preparing a transgenic animal"—that is, a creature created for the purpose of harvesting its organs for transplant purposes—but omitted the word "non-human."

As a result, researchers would be able to genetically manipulate humans—i.e., clone people—for the purpose of creating transplantable organs, though such a practice is illegal under European Union law.

- On Feb. 29, a British woman filed an application with the British Patent Office for herself, seeking to capitalize on her unique genetic makeup.

"It has taken 30 years of hard labor for me to discover and invent myself, and now I wish to protect my invention from unauthorized exploitation, genetic or otherwise," she told the Guardian newspaper.

The woman reportedly was angered at the thought of other companies rushing to the patent office to gain the exclusive rights to gene sequences that may or may not be part of her genetic code.

The prospect of having to pay royalties on our bodies to some shady biotechnology company should be of concern to us all. To date, as much as 70% of the 100,000 or so genes that make up your average human already may be subject to patent applications, according to the Washington Post. In other words, it may be too late for us to cash in on our unique attributes.

Much has been made of identity theft in the media of late, but this may be nothing compared with the patenting of human life. I hope my life insurance has a trademark infringement rider, in case I get sued.

Editor Paul D. Winston's commentary appears fortnightly. He can be reached at pwinston@crain.com

Research

Continued from page 1

that they deemed experimental and unproven.

At least one of those experimental treatments—high-dose chemotherapy and bone marrow transplant—has been shown to be no more effective than conventional treatment for breast cancer, though insurers have faced numerous legal challenges over their refusal to finance the treatment.

HDC/BMT is one of the most aggressive and expensive procedures available today for treating breast cancer, costing $150,000 or more—about 10 times the cost of standard chemotherapy. The non-surgical procedure, which has been available for about a decade, can be fatal because it virtually destroys a patient's immune system.

When first introduced, many insurers and HMOs refused to cover the treatment, excluding it as "experimental" or "investigational."

After a California jury in 1993 ordered Health Net to pay $89 million to the widower of a breast cancer patient who was denied the HDC/BMT procedure, however, insurers began approving requests for the procedure rather than face the risk of similar legal challenges.

Since then, several states have adopted laws requiring insurers and HMOs to cover the procedure, even though a South African study that supported its effectiveness has since been discredited. A team of U.S. investigators last year found disparities and inconsistencies between the records and the data used to support the South African researcher's findings.

Ironically, that research, conducted by Werner Bezwoda of Johannesburg, was partially funded by a grant from Aetna Inc.

"Historically, before managed care, insurers did not pay for experimental treatment even if it was part of a study," acknowledged Dr. Don Young, chief operating officer and medical director at the Health Insurance Assn. of America in Washington.

Today, however, most insurers will cover treatment provided in "high-quality clinical trials where there is definite uncertainty about the outcome," he said.

For example, the National Cancer Institute in 1997 reached an agreement with several health insurers in Wisconsin and Minnesota to provide coverage to more than 200,000 people in the region if they were participants in a cooperative group-sponsored cancer clinical study. The cooperative groups are NCI-supported networks of academic and community-based physicians, scientists and health care professionals across the country working together to discover the best treatments for cancer.

Dr. Young stressed that "these studies are not being designed or conducted by the insurance industry. The insurers are paying the cost of patient care and trials are being designed by the NCI and independent researchers with substantial oversight and controls in place."

Besides helping to pay for experimental treatment that is part of a clinical trial, at least one national health insurance organization—the Chicago-based Blue Cross & Blue Shield Assn.—has formed its own technology assessment committee to review the latest medical research based on criteria that can be used to make coverage decisions.

While the committee originally comprised just BC/BS member plans, it was expanded in 1993. It now has 17 members, including insurers, medical school professors, an economist, an ethicist and a consumer—Ms. Darling, who joined the group five years ago when she was the benefits manager at Stamford, Conn.-based Xerox Corp.

"I think all health plans ought to be subscribing to this kind of process," she said. "This will help them respond to queries about why they don't cover certain treatments."

The BC/BS group, called the Technology Evaluation Center, or "Tech" for short, doesn't focus on the cost of a particular treatment, but rather on whether it meets five criteria:

- Was it approved by the appropriate regulatory authority, if necessary?
- Can the outcome be measured?
- Is the outcome beneficial?
- Is it at least as good as the conventional treatment?
- Is it available outside of an experimental setting?

Tech meets quarterly to review eight to 12 new topics, depending on their complexity, and submits the findings to subscribing health plans, according to Dr. Allan Korn, senior vp and chief medical officer for the BC/BS Assn. in Chicago.

'These studies are not being designed or conducted by the insurance industry,' says Dr. Don Young.

The reports reach health plans that cover more than 120 million lives throughout the United States. Among the subscribing health plans are all 49 Blues plans, Kaiser Permanente, Humana, Mutual of Omaha, PacifiCare, Health Partners of the Midwest, Principal Mutual Life Insurance Co., George Washington University Health Plan, Harvard Pilgrim Health Plan, United Healthcare of Wisconsin and Private Healthcare Systems Inc.

While Tech does not dictate coverage decisions on behalf of BC/BS Assn. members or for its other subscribers, "the insurers use this to make coverage decisions that are evidence-based," Dr. Korn said.

He added that in many ways the process is a lot more objective than that conducted by drug companies and for-profit treatment facilities that often stand to benefit from the outcome of research into new and experimental treatments.

While most insurers generally only fund research into experimental treatment, at least one HMO—Oakland, Calif.-based Kaiser Permanente—has its own clinical trial program.

"We certainly are anxious to try out the most promising treatments and evaluate them," said Dr. Louis Fehrenbacher, Kaiser's medical director of oncology clinical trials, who is based in Vallejo, Calif.

This year, nearly 200 of Kaiser's California enrollees will be involved in clinical trials involving chemotherapy, hormonal therapy, breast cancer prevention using tamoxifen, radiation, chemotherapy and the National Surgical Adjuvant Breast Project, which stems from an NCI study that found lumpectomy with radiation to be just as effective as mastectomy in treating localized breast cancer. Kaiser also does epidemiologic research into the causes of cancer.

The study results often are disseminated to Kaiser doctors before they are published in professional medical journals, allowing the HMO's doctors to be among the first to administer cutting-edge treatments with the HMO's blessing, Dr. Fehrenbacher suggested.

"Our motive is to find out what the best therapies are and offer those to our patients," he said.

Besides insurers and HMOs, some employers—such as members of the Buyers Health Care Action Group in Bloomington, Minn.—annually review scientific evidence into the efficacy of provocative new treatments before deciding whether to cover them.

"We struggle with the same issues as the insurance industry," explained Steve Wetzell, executive director of the group of 30 self-insured employers representing about 135,000 covered lives.

Because insurers, HMOs and employers are all involved in medical research at so many levels, it's impossible to determine exactly how much health care payers are funneling into experimental treatment research, Dr. Young said.

The fact that the industry is funding such research at all, though, makes some patient advocates' hair stand on end.

"It's pretty unsavory for the insurance industry to pump money into research projects designed to ultimately save money by showing a treatment to be experimental and not efficacious," said Jamie Court, director of Santa Monica, Calif.-based Consumers for Quality Care and author of "Making a Killing: HMOs and the Threat to Your Health."

"The question of who should fund such research is really a societal question," said Dr. Arnold Milstein, medical director for the Pacific Business Group on Health, an employer coalition based in San Francisco.

"You could make the argument that those who are most likely to benefit from it should fund it," he said. "But there should always be some type of oversight and standards for the conduct of the research so one can have confidence in the outcome."

Health plans "have a moral obligation to contribute to scientific research and determination of medical best practices," asserted Lawrence Rose, a San Francisco-based attorney who regularly represents insurers and HMOs in disputes over coverage for experimental treatment.

"I don't think they have anything inappropriate to gain" by funding such research, he said. Instead, "they have the opportunity to provide a tremendous benefit to the rest of us as potential patients."

Gallagher's Mr. Erb agreed—but with reservations—that it is possible for the health insurance industry to fund such research without creating a conflict of interest.

"In the old days, health plans typically would wait for Medicare to approve something before deciding whether to cover it," he recalled. "This gave them a buffer, but it took a long time."

"Now, with the pace of research so rapid, they're finding they can save money and enhance the quality of life of their members" by funding research of their own, Mr. Erb said.

"It's preferable to relying on someone else to do it, especially if that someone else is HCFA," he said. "But it depends on what the findings are" as to whether there's a conflict of interest.

"If every study finds no value in the treatment provided, then I'd be suspicious," Mr. Erb said. BI

NAIC

Continued from page 1

As a result of rapid changes in world financial markets that are fueled by enhanced technology and globalization, "insurance regulators are committed to modernize insurance regulation to meet the realities of an increasingly dynamic and internationally competitive financial services marketplace," according to the statement.

Under the blueprint, regulators' top priorities for implementing the federal financial modernization law will require them to:

- Review state laws, such as licensure and demutualization statutes, to determine which require regulatory or statutory changes to achieve functional regulation that would apply to both insurers and banks.
- Streamline licensing for producers by focusing first on multistate reciprocity. Uniformity, however, remains the NAIC's ideal long-term solution.

The NAIC plans to use its Insurance Regulatory Information Network as a central clearinghouse for non-resident licensing information. If that is accomplished before mid-November 2002, the NAIC will be able to prevent federal creation of the National Assn. of Registered Agents and Brokers (*BI*, Dec. 20, 1999), as mandated by the Gramm-Leach-Bliley Act.

- Analyze the NAIC's financial examination process for national insurers and explore regulating such multicompany insurers as groups, with enhanced coordination among the states.
- Develop an agreement for the sharing of regulatory information among states and some federal regulators.

The NAIC's top priorities for other matters this year will require regulators to:

- Implement a "speed to market" approach for insurance products, including "a system of deference to the state of domicile using one-stop filing for products issued on a multistate basis, where appropriate," according to the statement.

The effort will include NAIC development and implementation of "state-based uniform standards for policy form and rate filings for appropriate product lines," where possible. In addition, the NAIC will consider reviewing market barriers for other, unspecified lines of coverage that do not lend themselves to the use of uniform standards.

"We will take steps to shift the focus of states away from a prior-approval system, where appropriate," the NAIC said.

In addition, the NAIC plans to develop a data repository for filings, a system for tracking data and, possibly, a state certification process.

- Encourage the implementation of regulatory re-engineering policies, beginning with evaluating specific states' progress in commercial lines reform, and then comparing those moves with the requirements of the Property and Casualty Model Rate and Policy Form Law and a companion regulation. Depending on the results, regulators "will consider amending the model and taking other steps to achieve greater uniformity and consistent application of rate and form requirements."

The NAIC's Statement of Intent says regulators are 'committed to modernize insurance regulation.'

Regulators' actions to aid large, sophisticated policyholders should reflect the fact that uniform regulatory procedures offer "compelling" benefits for both buyers and sellers of insurance, according to the NAIC.

The NAIC will continue to explore avenues "to reduce unnecessary requirements" and "explore increased reliance on the benefits of open competition."

- Examine states' current market conduct programs to identify issues and concerns, which will help determine the merits of "voluntary uniform national standards as a basis for market conduct examinations and enforcement actions."
- Promote consumer protections for e-commerce by encouraging states to adopt the Uniform Electronic Transactions Act.
- Explore regulatory options for the treatment of national insurance companies, including expanding existing programs to streamline licensing and developing an "e-repository for company applications to facilitate one-stop filing."

NAIC regulators also will "develop a proposal for a state-based system that could provide the same efficiencies as a federal charter for insurance companies."

The NAIC's commitment to this blueprint is underscored by the fact that it established nine new working groups to implement it, according to NAIC President George Nichols III.

Five working groups were established to deal with the federal financial modernization law, while four additional groups were set up to address other regulatory priorities.

The working groups have various deadlines but generally expect to complete their work by the end of this year. The privacy working group, however, must complete its recommendations by mid-November because of related deadlines in the federal modernization law.

Mr. Nichols, who also is the Kentucky insurance commissioner, said he has urged all commissioners to participate personally in the working groups, rather than sending staff members, as a way to ensure effective communication.

"We have a solid structure with commissioner involvement on each working group and will provide an open forum for discussion in each working group," Mr. Nichols said during an industry liaison meeting last week.

"I think what has happened since December has been radical, based on my five years at the NAIC," said NAIC vp Kathleen Sebelius, the Kansas insurance commissioner. "This is an optimistic agenda, but I sense a willingness on the part of everyone to roll up their sleeves," she added.

Industry representatives are generally supportive of the NAIC's new blueprint.

"It's a very exciting time," said Stephen E. Rahn, vp and director of state relations, legislative and regulatory management for Lincoln Financial Group in Fort Wayne, Ind.

Paul Mattera, vp and assistant general counsel for Liberty Mutual Insurance Co. in Boston, said he is "optimistic" about the NAIC's latest project, particularly because direct participation by insurance commissioners will allow for "high-level policy setting." BI

Conflict seen in model laws

CHICAGO—A controversial package of model laws and regulations for rate and form filings will be considered for adoption by the full National Assn. of Insurance Commissioners in June, in spite of new NAIC initiatives aimed at streamlining regulation.

The 40-page Property and Casualty Model Rate and Policy Form Law and a three-page companion regulation has survived nearly 18 months of sharp industry criticism, as well as the NAIC's release at the same meeting of a new blueprint for regulatory re-assessment.

Both the model law and regulations on rate and form filings were adopted last week by the working group's parent, the NAIC's Property/Casualty Insurance Committee.

"We've adopted it, so it's moving" toward adoption by the full NAIC membership, said committee chair Darla L. Lyon, the South Dakota insurance commissioner, following the meeting in Chicago last week.

"Having the full NAIC adopt the working group's model rate and form law and regulation is appropriate because it contains many improvements. However, the Property/Casualty Committee will continue to review it, in keeping with its new charge," said Eric Nordman, the NAIC's director of research.

That new charge, which was adopted at the meeting, will require that the Property/Casualty Committee later revisit the proposed model law and regulation in light of the NAIC's new "speed to market" initiative and its new "Statement of Intent," both of which also were presented at the NAIC's spring meeting in Chicago.

"There is a conflict between the model law and regulation and the 'speed to market' " initiative, said Larry Kibbee, vp and director of public affairs for the Alliance of American Insurers in Downers Grove, Ill.

Adoption by the full NAIC "would send the wrong message," said Phillip Schwartz, vp-financial reporting and associate general counsel with the American Insurance Assn. in Washington.

The model law would allow a state insurance commissioner to determine the appropriate method of regulation but, unless otherwise stated, would require a regulator's prior approval of forms and a file-and-use system for rates.

In contrast, the NAIC's new regulatory reassessment effort suggests giving greater regulatory freedom to market forces.

The model regulation would exempt large commercial policyholders that meet at least two of several qualifying criteria.

Brokers were pleased to see that a long-sought change was made to the model regulation approved by the working group.

After much discussion, drafters agreed to water down a prohibition in the regulation to granting exemptions to a risk manager who may have a "conflicting economic interest in the policy being negotiated or procured," such as a broker serving in that role for a policyholder.

—By Meg Fletcher

Updates

Suit targets HMO rate setting

Continued from page 2

operated by UHC and Met Life paid substantially more than the 20% of charges they were contractually required to pay under the terms of the plans, according the suit, filed in the Supreme Court of the State of New York in Manhattan.

The insurance contracts provide for paying physicians using the lowest amount from three factors: a physician's actual charge; a physician's usual charge; or a usual, customary and reasonable charge, or UCR, which is supposed to reflect rates charged by similarly trained physicians in the same area, court papers say.

The insurers "purposefully used data that pervasively understate the UCR amount, and therefore understate the amounts (the insurers) have to pay. Such practice has the necessary and foreseeable effect of forcing (HMO members) to pay hundreds, and sometimes thousands, of dollars over the understated UCR," the suit charges.

Since 1997, the insurers had used data produced by Health Insurance Assn. of America to determine the UCR, despite a disclaimer from the HIAA that "there is neither a stated nor implied 'usual and customary' charge," the suit alleges.

Among other things, the data included charges for medical procedures performed in other geographical areas where provider charges were lower, the suit says.

Frontier Insurance downgraded

ROCK HILL, N.Y.—A.M. Best Co. has downgraded its rating of Frontier Insurance Group Inc. to B from B++, citing the "poor capitalization" of Frontier's insurance units and "weak financial condition" of the holding company.

While the insurance units received $80 million of the $160 million proceeds of Frontier's January sale of Lyndon Insurance Group, the units' capitalization remains vulnerable to possible ongoing reserve deficiencies, Best said. The parent company, meanwhile, suffers from "high financial leverage and marginal near-term liquidity and financial flexibility," Best found.

Frontier used another $75 million of the Lyndon sale proceeds to repay bank debt but has entered into a more-restrictive amended agreement with its lenders, according to Best. The agreement may require Frontier to sell assets to meet near-term obligations and leaves little margin for poor operating results or adverse reserve development.

Although the performance of one Frontier unit, United Capitol Insurance Co., has been "excellent," the weakness of the company overall could affect it, according to Best.

The rating agency also warned that Frontier's rating could be downgraded again if it does not succeed in its current efforts to sell assets to improve liquidity or if operating results continue to deteriorate.

Harry W. Rhulen, Frontier's president and chief operating officer, expressed disappointment about the downgrade.

"Frontier is continuing to take the necessary steps to strengthen our financial position, including the re-underwriting and analysis of our medical malpractice book and removing other poor-performing business," Mr. Rhulen said in a statement.

Frontier is also considering the divestiture of assets "that no longer fit with our core business focus," he confirmed.

Amid a rising stock market late last week, Frontier shares fell to $1.56 from more than $2 per share at the beginning of the week.

Am Re threatened with fines

NEW YORK—American Re-Insurance Co. will face fines of $1,000 a day unless it produces lists of all unpaid Holocaust-era life policies issued by a subsidiary of its parent, Munich Reinsurance Co., New York's top insurance regulator said last Thursday.

The New York State Holocaust Claims Processing Office has more than 130 unpaid policies worth $1.5 million issued by Munich Re unit Victoria Lebensversicherung A.G., said Superintendent of Insurance Neil D. Levin.

Neither American Re nor Munich Re has control over Victoria, an American Re spokesman said. Although Munich Re owns 60% of Victoria's stock, it does not hold a majority of seats on the insurer's board, "so Munich Re can't order the company to pay claims," he said.

"But that is beside the point, because Victoria has voluntarily provided documents to the New York Insurance Department and they show that there are no open Holocaust-related claims," he said.

The department based its estimate of 130 policies on incomplete records, the spokesman said.

Barham to retire from Marsh

NEW YORK—Norman Barham will retire as vice chairman of Marsh Inc. at the end of May.

Mr. Barham, 58, also will step down as a director of parent company Marsh & McLennan Cos. Inc.

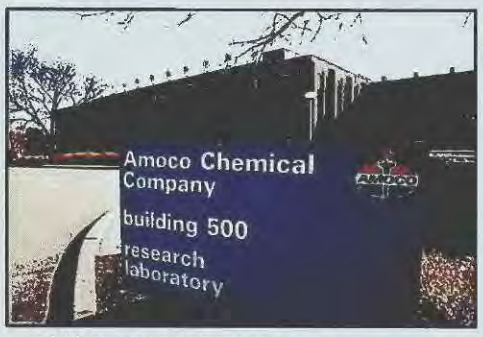
Mr. Barham came to New York-based Marsh after it bought rival broker Johnson & Higgins for $1.8 billion in 1997. He joined J&H in 1975, eventually rising to the position of president of the privately owned brokerage. Mr. Barham is the fourth of five former J&H senior executives to leave Marsh since the purchase. And he is the last to hold an executive position at the brokerage.

Richard A. Nielsen, the former vice chairman and chief operating officer of J&H, retired in 1997; and Executive Vps Joseph P. Platt and John W. Gussenhoven were not given executive or board positions at Marsh after the merger. David A. Olsen, J&H's former chairman and chief executive officer, remains on the Marsh & McLennan board.

Earlier last week, Saxon Riley, former chairman of Sedgwick Group P.L.C., also left the Marsh & McLennan board.

FTR FOR THE RECORD

Excerpts from *BI*'s Online Updates, March 13-17, 2000



CANCER SUITS SETTLED BP Amoco P.L.C. has settled five of six lawsuits brought on behalf of former employees who had worked in the company's Naperville, Ill., facility and were diagnosed with brain cancer. BP Amoco is self-insured for the settlements, which were not disclosed. Five of the six claimants have died.

MICH. PATIENT BILL Patient protection legislation establishing an external review system for health care coverage denials was introduced last week in the Michigan Assembly. Among other things, H.B. 5511 would require health insurers and health maintenance organizations to notify the insurance commissioner whenever they receive complaints from patients regarding coverage decisions. Plans also would have to give patients written information about how to obtain an external review of a coverage denial. Plans that failed to do so would be fined as much as $5,000 for each violation. However, the bill would prohibit patients from suing health plans until after they have completed the independent review process.

FSA BOUGHT Dexia Group, Europe's largest municipal lender, will acquire financial guarantee underwriter Financial Security Assurance Holdings Ltd. for $2.6 billion in cash. The deal, in which Dexia will pay $76 per FSA share, is expected to close in the second quarter. Three large FSA shareholders have already approved the transaction; a fourth, Tokio Marine & Fire Insurance Co., is expected to approve it shortly. The four control a total of 44% of FSA's voting stock.

iBENEFITS EXPANDS A developer of Internet-based benefit administration systems, El Segundo-based iBenefits, has added seven regional offices in the United States. The new offices—in Los Angeles; Denver; Washington; Fort Lauderdale, Fla.; Chicago; Boston; and New York—augment the company's existing offices in Atlanta, Irvine, Calif.; and San Francisco.

HMO LAYOFFS Sierra Health Services Inc. laid off 80 Texas employees last week as part of a major restructuring of its Dallas/Fort Worth operations. The layoffs mark the second wave of downsizing at the health maintenance organization since it acquired the assets of Kaiser Foundation Health Plan of Texas in November 1998. The restructuring plan, which began last week, is expected to take 60 days to complete and result in estimated savings of $5 million per year.

SIGNET STAR EXIT Signet Star Reinsurance Co. is winding down its Latin American and Caribbean underwriting due to heavy natural catastrophe losses. Signet, a unit of W.R. Berkley Corp., wrote net premiums of $12 million to $15 million in reinsurance on Latin American and Caribbean risks last year, according to William R. Berkley, chairman and chief executive officer of the parent company. He called the amount of business affected "incidental," noting that Signet wrote more than $300 million in net premiums last year.

NEW GUARANTEE INSURER XL Capital Ltd. has established a new financial guarantee insurer in New York with a projected $100 million in capital. XL Capital Assurance Inc., which will be headed by David C. Stevens as president and chief operating officer, will provide credit enhancements for asset-backed securitizations and infrastructure project financing. Currently XL Assurance has $85 million in capital but that will soon be raised to $100 million, Mr. Stevens said. Additionally, the unit will have extensive reinsurance backing from XL units in Bermuda, he said.

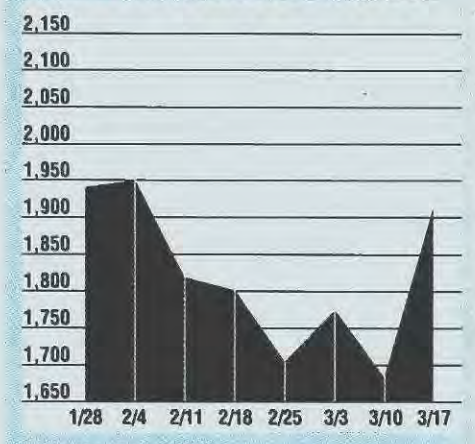
DATA STANDARD The Public Risk Database Project has released Version 1.0 of the PRDP Liability Claims Data Standard, a voluntary system for coding and collecting liability claims data in a common format. The organization designed the standard to enable the sharing of claims data between public entities, to ease data movement between risk management information systems and to facilitate the submission of data to the PRDP's Data Warehouse, which is scheduled to begin accepting data in July. Visitors to the PRDP's Web site, www.prdp.org, can download the standard free.

E&O ONLINE A new company is offering professional liability insurance over the Internet. Launched last week, www.ePolicy.com will allow users to submit an application and purchase a policy in a matter of minutes. Coverage is written with three insurers—Interstate Insurance Group, a unit of Fireman's Fund Insurance Co.; TIG Specialty; and Kemper Casualty Co. The Torrance, Calif.-based company, which is targeting small businesses, will expand its product offerings to include a businessowners policy and workers comp insurance later this year.

BRIEFLY NOTED Indiana Gov. Frank O'Bannon vetoed a bill, H.B. 1150, that would have reduced the insurance premium tax to 1.3% from the current 2% over five years. . . .American International Group Inc. announced a share buy-back program for up to 25 million shares over an unspecified period. . . .Shareholders of Markel Corp. and Terra Nova (Bermuda) Holdings Ltd. approved the merger of the two companies. . . .Washington Gov. Gary Locke last week signed into law a **patients' rights law** that will allow consumers to sue their HMOs. All policies issued on or after July 2001 will be affected.

www.businessinsurance.com

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.

PCS catastrophe options

As of March 17

Call spread	Price bid/ask
National Annual 2000	
60/80	5.0/—
100/150	7.5/—
150C	6.0/—
190/195	0.3/0.5
200/250	3.7/—
Midwest June 2000	
10/20	0.8/3.3
20/30	0.4/1.5

Call spread	Price bid/ask
California Annual 2000	
150/155	0.1/0.3
Western Annual 2000	
150/155	0.2/0.4
300/350	0.4/—
Eastern September 2000	
40/60	1.5/—
80/100	1.0/—

Total volume: 0 Total open interest: 792

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high-low
Legal & Gen	159	13.8	4.1	2.6	237-130
Royal & Sun	345	63.4	24.7	7.4	633-296
Brokers					
Lmbrt Fenchurch	142	14.0	4.2	3.0	145-58
JLT	272	11.2	13.3	4.9	286-166

Note: Prices are March 17 closings; other numbers from March 16.

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

BI Industry Stock Report MARCH 13, 2000, THROUGH MARCH 17, 2000

BROKERS		Price	Weekly % change	Year to date % change	Year to date High	Low	Vol.(000)
Aon Corp.	NYS	27.13	25.80	-32.19	46.66	20.69	5500
Clark Bardes Holdings	NDQ	14.44	-0.43	0.43	21.00	11.63	50
E.W. Blanch Holdings Inc.	NYS	56.13	11.41	-8.37	71.75	44.50	460
Gallagher Arthur J. & Co.	NYS	30.38	27.39	-53.09	33.13	22.56	863
Hilb, Rogal & Hamilton	NYS	27.00	-2.48	-4.42	29.13	15.56	76
Kaye Group Inc.	NDQ	7.00	-8.94	-16.42	11.88	5.00	35
Marsh & McLennan	NYS	95.94	28.67	0.26	104.75	61.75	7763
Brown & Brown	NYS	36.75	11.36	-4.08	40.63	29.31	60
BROKERS	AVERAGE		11.24	-14.35			
INSURERS/REINSURERS							
ACE Ltd.	NYS	17.88	18.18	7.12	35.25	14.06	8386
Accel International Corp.	NDQ	0.75	-14.29	-25.00	2.88	0.50	4
Acceptance Insurance Cos.	NYS	3.94	0.00	-31.52	17.06	2.75	496
AEGON N.V.	NYS	73.56	10.62	-22.97	104.00	63.00	608
Aetna Life & Casualty	NYS	53.88	-3.79	-3.47	99.88	38.50	8028
AFLAC Inc.	NYS	42.19	20.11	-10.60	56.75	33.56	5505
Allmerica Financial Corp.	NYS	45.94	26.72	-17.42	64.81	35.06	1117
Allstate Corp.	NYS	21.31	18.82	-11.43	40.75	17.19	26713
Ambac Financial Group	NYS	50.56	21.84	-3.11	63.00	38.88	2979
American Financial Group	NYS	22.63	11.38	-14.22	38.38	18.38	470
American General	NYS	52.25	10.58	-31.14	82.19	45.63	7836
American Intl Group	NYS	98.81	19.05	-8.61	114.50	78.56	27017
American Safety Insurance	NYS	6.13	-9.26	-5.77	10.00	5.88	95
Argonaut Group	NDQ	18.88	4.86	-5.03	27.94	16.88	291
AXA-UAP Group	NYS	66.25	6.21	-6.69	73.63	53.75	437
Baldwin & Lyons Inc.	NDQ	17.13	3.79	-22.60	24.05	16.25	602
Berkley W.R. Corp.	NDQ	15.94	6.25	-23.65	29.13	14.00	560
Berkshire Hathaway Inc.	NYS	54100.00	30.99	-3.57	79200.00	40800.00	5
Capitol Transamerica Corp.	NAS	12.00	1.59	19.25	16.00	9.38	29
Chubb Corp.	NYS	54.00	19.17	-4.11	76.38	43.25	3511
CIGNA Corp.	NYS	63.38	-0.59	-21.33	98.63	61.06	5687
Cincinnati Financial Corp.	NYS	31.50	17.21	-1.18	42.50	26.19	1900
Citigroup	NYS	56.81	16.09	2.02	60.13	38.30	77916
CNA Financial Corp.	NYS	28.31	8.63	-27.29	45.31	24.56	736
CNA Surety	NYS	11.75	6.82	-9.62	15.56	9.75	127
EMC Insurance Group Inc.	NDQ	8.50	6.25	-6.85	13.38	7.63	22
ESG Re Limited	NDQ	3.69	-9.23	-46.85	20.06	3.19	688
Enhance Financial Services	NYS	14.50	22.75	-10.77	24.75	10.75	816
Everest Reinsurance	NYS	28.75	20.42	28.85	35.88	20.50	1487
Fremont General Corp.	NYS	6.50	14.29	-11.86	21.75	4.69	2163
Frontier Insurance Group	NYS	1.63	-21.21	-52.73	17.25	1.63	1596
Gainsco Inc.	NYS	5.88	2.17	9.30	6.94	3.94	104
Harleysville Group	NDQ	12.63	0.00	-11.40	21.38	11.63	195
HSB Group Inc.	NYS	23.88	5.82	-29.39	42.25	21.50	946
HCC Insurance Holdings	NYS	13.38	9.74	1.42	25.13	8.00	933
ING Groep N.V.	NYS	51.50	5.51	-15.57	63.94	46.81	656
IPC Holdings Ltd.	NDQ	12.94	2.99	-13.03	22.50	9.75	809
Hartford Financial Services	NYS	37.50	22.95	-20.84	66.44	29.38	5277
LaSalle Re Holdings Ltd.	NYS	12.88	9.57	-21.97	19.88	10.88	87
Lincoln National	NYS	29.19	16.46	-27.03	57.50	22.63	6808
MAIC Holdings Inc.	NYS	19.88	15.64	-6.19	29.05	16.63	125
Markel Corp.	NYS	128.50	10.78	-17.10	193.00	111.50	97
MBIA Insurance Group	NYS	48.31	22.89	-8.52	71.88	36.31	3545
Meadowbrook Insur. Group	NYS	5.38	-2.27	-18.10	17.13	4.75	62
MMI Cos. Inc.	NYS	9.81	0.64	13.77	17.44	3.31	317
Mutual Risk Mgmt. Ltd.	NYS	15.00	18.81	-10.78	43.25	9.81	1350
Navigators Group	NDQ	10.06	15.00	3.21	16.00	8.75	23
NYMagic Inc.	NYS	12.75	0.49	-3.32	19.50	12.00	39
Ohio Casualty Corp.	NDQ	12.00	3.23	-25.29	21.00	10.75	1311
Old Republic Int'l	NYS	11.88	6.74	-12.84	20.69	10.63	2312
Partner Re Ltd	NYS	35.25	12.80	8.67	43.63	28.38	337
Penn-America Group Inc.	NYS	7.94	6.72	2.42	11.44	6.63	345
PMA Capital Corporation	NDQ	18.81	8.27	-5.35	21.13	16.00	320
Philadelphia Cons. Holding	NDQ	14.88	2.15	2.59	25.50	10.81	153
PXRE Corp.	NYS	14.50	1.31	11.54	21.88	9.94	30
Reliance Group Holdings	NYS	3.44	0.00	-48.11	10.88	2.81	2396
ReliaStar Financial Corp.	NYS	31.81	25.37	-18.82	49.81	23.75	3532
RenaissanceRe Holdings Ltd.	NYS	37.94	5.02	-7.19	43.19	30.00	128
Risk Capital Holdings	NDQ	14.97	0.21	18.56	22.00	11.00	151
RLI Corp.	NYS	28.75	7.23	-15.44	38.81	26.25	109
St. Paul Cos.	NYS	27.56	19.84	-18.18	37.06	21.31	5887
SCOR	NYS	47.88	1.86	8.19	58.56	40.00	15
SAFECO Corp.	NDQ	21.00	13.13	-15.58	46.75	18.00	5332
SCPIE Holdings Inc.	NYS	30.50	1.67	-5.06	36.94	23.69	NA
Seibels Bruce Group	NDQ	1.84	5.36	5.36	6.25	1.47	136
Selective Ins. Group	NDQ	15.44	0.00	-10.18	22.50	14.63	181
Terra Nova Ins Co. Ltd.	NYS	22.13	6.95	-26.25	32.63	20.31	863
Tokio Marine & Fire	NDQ	51.00	-4.34	-13.74	67.00	45.00	77
Torchmark Corp.	NYS	22.19	16.01	-23.66	38.00	18.75	2892
Transatlantic Holdings	NYS	74.38	7.59	-4.72	80.50	68.75	96
Travelers Property Casualty	NYS	34.50	14.29	0.73	41.88	27.69	1442
Trenwick Group Inc.	NYS	13.88	8.29	-18.08	32.00	12.00	317
Unico American Corp.	NDQ	6.00	4.35	-14.29	11.13	5.25	19
United Fire & Casualty	NDQ	18.50	2.78	-18.23	30.50	17.38	19
Unitrin	NDQ	34.94	5.97	-7.14	42.38	30.50	532
UNUM Corp.	NYS	14.31	16.24	-55.36	56.88	11.94	10184
Vesta Insurance Co.	NYS	5.81	8.14	50.00	7.88	3.38	1338
XL Capital Ltd.	NYS	51.81	23.55	-0.12	67.19	39.00	2882
Zenith National Ins.	NYS	20.63	0.92	0.00	26.69	18.75	63
INSURERS/REINSURERS	AVERAGE		8.81	-10.32			
HEALTH MAINTENANCE ORGANIZATIONS							
Foundation Health Systems Inc.	NYS	8.00	-3.03	-19.50	20.06	6.25	2544
Humana Inc.	NYS	7.13	10.68	-12.98	19.50	5.88	2503
Oxford Health Plans	NDQ	14.44	-1.70	13.79	24.25	9.75	5749
Pacificare Health Sys.	NDQ	46.88	-1.32	-11.56	98.13	31.13	1286
Sierra Health Services	NYS	5.69	-4.21	-14.95	16.25	4.63	630
United HealthGroup	NYS	52.19	2.58	-1.76	70.00	39.38	4954
Wellpoint Health Networks	NYS	63.69	8.52	-3.41	97.00	48.25	1762
HMOs	AVERAGE		1.65	-7.20			
ALL COMPANIES	AVERAGE		7.23	-10.62			

Top advancing issues: Berkshire Hathaway Inc., Marsh & McLennan Cos. Inc., Arthur J. Gallagher & Co. Leading decliners: Frontier Insurance Group, Accel International Corp., American Safety Insurance. Most active issue: Citigroup. The *BI* Index jumped 13.6%; the Dow Jones 30 Industrials gained 7.3%; the S&P 500 went up 5.2%, and the NYSE Composite increased 6.2%. Average P/E: Brokers, 19.3; Insurers/reinsurers, 17.7; HMOs, 9.9.

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

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