

Business Insurance

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

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Judge allows negligence suit against HMO to proceed

NEW YORK—In what may be the first ruling of its kind in New York, health maintenance organizations may be held liable for negligence when they delay approving treatment, a state trial judge ruled.

Judge Herman Cahn denied a motion by Aetna U.S. Healthcare to dismiss the negligence section of a complaint, stating that health care companies should be held to a higher standard in fulfilling contractual obligations.

The suit arose from the death of a patient
See Updates on next page

Taking the quality leap

In 2001, the Leapfrog Group will ask health plans to implement the following in their services:

- Computerize prescription orders.
- Base hospital referrals on outcome evidence.
- Use only board-certified staff in ICUs.

Group aims to improve health safety

By JOANNE WOJCIK KOCHANIEC

Spurred on by evidence of a high frequency of medical errors, a newly formed group of large employers is working to encourage purchasers to make patient safety a top priority in their negotiations with health plans.

The employer group is calling itself the "Leapfrog Group" with the hopes of encouraging "huge leaps in the improvement of patient safety," explained Suzanne Delbanco, who was named executive director March 1.

"We want to save lives," said Bruce Bradley, director of managed care plans at General Motors Corp. in Detroit, who estimates that preventable medical errors cause 1.3 deaths per day among the 1.25 million people that GM insures.

The Leapfrog Group believes that eliminating medical errors is a measurable first step in an overall goal of improving health care quality.

"We believe employers in their role as purchasers need to be part of the effort to put quality on the agenda, measure performance and reward organizations that do a better job," he said. "If we don't, then we have no grounds for complaining that the quality's not optimal."

Although plans to create the Leapfrog Group were formalized in late 1999, when it received the sponsorship of the Washington-based Business Roundtable, its six founding members have been meeting informally for about two years, according to Dr. Arnold Milstein, medical director to the Pacific Business Group on Health and a consultant at William M. Mercer Inc. in San Francisco.

The group—which includes Mr. Bradley, Dr. Milstein and colleagues from such Fortune 500 employers as Irving, Texas-based GTE Corp., Denver-based U.S. West Inc., Fairfield, Conn.-based General Electric Co. and the Minn-

See Leapfrog on page 20

PBGC's cushion grows 40% in 1999

By JERRY GEISEL

WASHINGTON—Helped by a strong economy, higher interest rates and no terminations of big underfunded pension plans, the Pension Benefit Guaranty Corp.'s surplus continues to swell.

The PBGC's surplus—the difference between assets it holds and benefits it must pay to participants of failed corporate pension plans it has taken over—climbed to a record \$7.04 billion last year, up 40.5% from \$5.01 billion in 1998 and more than double its \$3.48 billion surplus in 1997, according to the agency's 1999 annual report, which will be released later this week.

"I was very satisfied with the year. We are continuing to build on our cushion," said PBGC Executive Director David Strauss.

The PBGC's robust health is good news for employers with defined benefit plans that
See PBGC on page 22

PBGC surplus still growing

Results for single-employer insurance program in billions of dollars



Source: Pension Benefit Guaranty Corp.

GRAPHIC BY JOHN HALL

NAIC seeks privacy input

States face deadline for advice to federal regulators

By MEG FLETCHER

CHICAGO—State insurance commissioners generally agree that there should be uniform laws regarding the privacy of consumer financial information, but are urgently seeking advice on how best to craft them.

Time is short, however, because the National Assn. of Insurance Commissioners' Financial Services Modernization Task Force plans to submit a response by Friday on proposed consumer privacy regulations contained in the Gramm-Leach-Bliley Act, the new federal law that removes barriers between banks and insurers.

Specifically, Title V of the act establishes several protections that federal and state agencies must implement in their role as functional regulators of financial institutions to ensure the security and confidentiality of consumer information.

The NAIC's response to those measures will be sent to the federal functional regulators that issued the pro-

posed consumer protection rules for public comment. These entities include the Federal Reserve Board, the Comptroller of the Currency and the Federal Deposit Insurance Corp.

NAIC

"As state regulators, we have an obligation to establish privacy regulations for the insurance industry," said Kathleen Sebelius, the NAIC's vp and chair of its Privacy Working Group. "We have an obligation to protect consumers," according to Ms. Sebelius, who is the Kansas insurance commissioner.

The NAIC already has taken several steps to solicit comment, including sending surveys to a broad range of interested parties and holding a two-hour public hearing. The group has also issued a statement seeking suggestions about how regulators should respond to three specific issues:

- Defining non-public information. Federal agencies have proposed that the financial services modernization

See Privacy on page 21

Unit to focus on integrated risks

New Marsh enterprise

By GAVIN SOUTER

NEW YORK—Marsh & McLennan Cos. Inc. has created a new unit to focus on delivering integrated risk management services to clients.

MMC Enterprise Risk will take a broad view of the risks facing a corporation and seek to use all of the resources of Marsh & McLennan's various units to help manage those risks.

Bob Khanna, a longtime executive

MMC

have a permanent staff of about 30 people and, when necessary, draw on staff at all M&M units, including: the insurance brokerage, Marsh Inc.; the benefits consultant, Mercer Con-

at Citigroup, will head the new unit as president and chief executive officer.

MMC Enterprise Risk will

sulting Group; and investment banking unit Marsh & McLennan Securities, according to Mr. Khanna.

"What we are trying to do is combine the transactional capabilities of Marsh with the advisory capabilities that we have all around Marsh & McLennan. . . . We have about 125 people at Marsh and Mercer focusing on making this happen," he said.

MMC Enterprise Risk will provide
See Enterprise on page 6

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Updates

HMO negligence suit OK'd

Continued from previous page

who was denied coverage for a drug treatment program. In January 1998, Robert Payton was admitted to a hospital after an accidental drug overdose. After leaving the hospital, he tried to enter an inpatient drug treatment program, but his insurer, Aetna U.S. Healthcare, notified him that his individual policy did not cover such treatment.

After seven months of appeals by Mr. Payton and approvals and reversals of approval by Aetna, an Aetna internal grievance appeal committee determined that Mr. Payton did have coverage. But Mr. Payton had died a week earlier from an accidental drug overdose. A suit brought on behalf of his estate in 1999 claimed that Aetna had been negligent in delaying approval for Mr. Payton's treatment and had breached the policy contract.

The judge upheld the negligence charges, stating that the delay in approving treatment, "if proven, may be found by the trier of fact to give rise to an inference of reckless disregard for decedent's health and well-being."

The decision also stated that HMOs should be held to a higher standard regarding their policy contracts than other organizations. "USHC is undoubtedly aware of the precarious health conditions involving the holders of its policies. Thus, it may be implied to have undertaken a duty of acting in its decision-making function with a high degree of care," according to the decision.

The plaintiff's attorney, David Trueman, hailed the verdict as a strong precedent to help individuals sue HMOs for denying coverage. "If they do something wrong, the courts will allow us to sue them for negligence and gross negligence," he said.

But Mr. Trueman noted that the ruling is limited, because Mr. Payton purchased an individual policy and did not receive coverage through an employer-sponsored plan, making the federal Employee Retirement Income Security Act inapplicable to this suit. If Mr. Payton's plan been covered by ERISA, the state negligence suit would have been precluded, he said.

The judge dismissed 11 counts of the suit, including one claiming that the HMO had committed medical malpractice.

An Aetna attorney refused to comment, and company officials could not be reached.

Tokio Marine sets new strategy

TOKYO—The Tokio Marine & Fire Insurance Co. Ltd. is creating a new Bermuda subsidiary to develop catastrophe reinsurance products and help the company diversify its cat exposures by exchanging risks with other companies.

The Tokyo-based insurer last week announced it plans to create a "corporate global risk management process" to better coordinate and diversify the company's catastrophe exposures, which currently are concentrated in Japan. The process will be coordinated among TMF's headquarters in Japan, a new unit to be formed in New York and the new Bermuda reinsurer, called Tokio Millennium Re Ltd.

In a statement, TMF said it "aims to enhance more-effective use of its capital by transacting a catastrophe reinsurance exchange, whereby TMF cedes Japanese catastrophe risks in exchange for that of the overseas."

TMF said it has already engaged in its first such transaction with State Farm Group of Bloomington, Ill., under which the two companies exchanged \$200 million of earthquake exposures. TMF said it is also exploring with Munich Reinsurance Co. potential mechanisms for laying off cat exposures with alternative risk transfer products.

The new Bermuda unit, Tokio Millennium, will be capitalized at \$125 million, is expected to begin operations in early April.

The new unit in New York, Integrated Solutions Group, will help develop integrated insurance products that reflect the convergence of insurance and financial markets, the company said.

Harvard Pilgrim rehab plan

BOSTON—Harvard Pilgrim Health Care will be permitted to boost its statutory net worth from a negative \$100 million to a positive \$137 million by carrying certain of its real estate assets at market value, under terms of a proposed rehabilitation plan filed last week with the Massachusetts Supreme Judicial Court.

The proposed plan is subject to a public hearing, which is expected to be held next month, as well as the court's approval. Under the plan, Harvard Pilgrim will be released from its temporary receivership and subject to an administrative supervision order issued by Massachusetts Insurance Commissioner Linda Ruthardt that is expected to continue for at least 24 months.

Ms. Ruthardt said that, under the proposed rehabilitation plan, "health care will continue uninterrupted to over 1 million members and payment made in full to all providers of health care services."

Terms of the plan call for Ms. Ruthardt to permit Harvard Pilgrim to switch to reporting its real estate at market value, rather than the current method of reporting these assets at their purchase price less depreciation. This would increase Harvard Pilgrim's statutory net worth by \$237 million, to \$137 million. An Insurance Department spokesman denied this could be characterized as financial sleight of hand. "We don't consider it that," he said.

Other elements of the plan include making payments to some of Harvard Pilgrim's general creditors, subject to Ms. Ruthardt's approval, and the appointment of a new board of directors, though management is expected to remain unchanged.

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Errors & omissions

• Due to a production error, several lines of information were omitted from XL Capital Ltd.'s listing in the March 20 directory of risk securitization specialists. A complete listing is on page 10.

IRS adds opportunities for amending flex plans

By JERRY GEISEL

WASHINGTON—New Internal Revenue Service rules will give employees in flexible benefit plans more opportunities to revoke or amend benefit elections because of "changes in status."

The new rules—one set issued as final regulations and the other issued as proposed rules—update 1984, 1989 and 1997 IRS rules governing flexible benefit plans. The 1997 IRS rules were never put into effect amid criticism from employers and benefit consultants that they were too narrow in scope.

By contrast, the latest batch of rules, published in the March 23 issue of the Federal Register, generally is drawing praise for its breadth.

"This is generally good news. This is a common-sense liberalization of the rules," said Henry Saveth, an attorney with William M. Mercer Inc. in New York.

"This is a huge improvement over 1997. Clearly, the IRS has listened to some of the concerns that were raised," agreed Mary Case, a principal with PricewaterhouseCoopers L.L.P. in New York.

Both the final and proposed rules detail the requirements that flexible benefit plans must follow for the plans to enjoy their special tax-favored status. The proposed rules generally deal with issues that the IRS has not previously considered.

Under the most common flexible benefit plan, known as a premium conversion plan, employees can pay for health care and life insurance premiums with pretax dollars. In other flexible plans, employees contribute pretax dollars to special accounts—known as flexible spending accounts—to pay for uncovered health care-related and other benefit expenses. In a full-fledged flex plan, employees receive credits to "pay" for various benefit options, which

See IRS on page 21

Increasing expectations

Insurers foresee new competition for highest service: PwC

By GAVIN SOUTER

Corporate policyholders will worry less about price and more about service when they seek insurance coverage five years from now, according to a survey of property/casualty insurance executives.

Whether insurers can meet this increased expectation for service will rely far more on technology and the Internet and on the greater use of outside providers than is the case today, survey respondents say.

Technology, in particular, will create a more-efficient market, where brokers will have to provide risk management advice and expertise rather than just placement services if they are to thrive, according to the survey, which was conducted by PricewaterhouseCoopers L.L.P. and the Economist Intelligence Unit.

"Property & Casualty: Mapping the Future," is based on the responses of 210 senior insurance executives in North America, Europe, Latin America and Asia who were surveyed last fall.

While price will still be important, the implementation of increasingly efficient operations that is currently changing the insurance industry will largely be completed within five years, re-

sulting in a smaller range of prices being charged. That will force insurers to instead compete based on service, predicted John S. Scheid, a partner at PricewaterhouseCoopers in New York.

"Today, customers are focused on price, but maybe because of the Internet and the other pressures to make insurers more efficient, things will be different in five years, and they will be more focused on things like risk management services," Mr. Scheid said.

Technology and the rise of e-commerce will be key drivers in creating more-efficient insurers, according to the survey.

See Future on page 22

Closing the books on 1999

P/C insurers look to future

By JUDY GREENWALD

The commercial property/casualty insurance industry is in a state of limbo.

Although rates are firming, their impact has not yet reached insurers' bottom lines. This transition is not expected to result in higher earnings until perhaps the second half of 2000, if not next year, analysts say.

In addition to continued pressure on profits, the rest of the year is expected to see more property/casualty insurers boosting depleted reserves, as well as additional merger and acquisition activity.

"I think it's going to be another tough year for the industry," said George Yonker, vp-finance at Seattle-based SAFECO Corp. Although insurers are in-

roducing rate increases, "it'll take some time for those to work their way to the bottom line," he said.

"Prices are clearly firming," said Dick Palczynski, group senior vp and chief actuary for the Hartford Financial Services Group Inc. in Hartford, Conn.

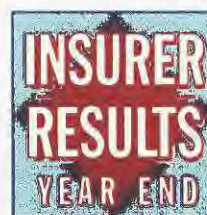
But higher rates will not immediately flow to the bottom line, he said.

"Perhaps starting with the latter half of 2000 and 2001, I think a lot of companies are going to have to use the price improvement to restore health to the balance sheet," including reserves, he said.

For those companies, said Mr. Palczynski, "I think the bottom-line recognition will be more in 2001."

Although managements continue to work on taking

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Inside

• The National Assn. of Insurance Commissioners must pick up the pace of its planned overhaul of state insurance regulation, this week's editorial says. **PAGE 8**

• External review of patient treatment appeals is a healthy way to address conflicts between payer and providers and sustain the tenets of sound scientific inquiry. **PAGE 12**

• U.K. Chancellor of the Exchequer Gordon Brown has called for taxing loss reserves set aside by property/casualty insurers and members of Lloyd's of London as part of the government's proposed 2001 budget. **PAGE 15**

• The 20th century ended with a bang, as 1999 was one of the worst years for catastrophe losses. **PAGE 15**

• Publisher Kathryn J. McIntyre finds there's no sympathy among risk managers for insurers that seek to change tax laws that benefit Bermuda-based companies. **PAGE 21**

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Improved P/C profits still distant: Picoult

By JUDY GREENWALD

SAN FRANCISCO—Property/casualty insurers may have to wait up to two more years before they begin to see material improvement in their bottom lines, an analyst says.

The industry also has a host of fundamental problems that must be addressed, he adds.

"It takes a long time to get into trouble and a long time to get out of trouble," said Myron Picoult, director and senior insurance analyst with Wasserstein Perella Securities Inc. in New York.

Mr. Picoult gave a broad review of his take on the industry's problems and challenges at a session of the National Insurance Symposium Leadership Conference, held earlier this month in San Francisco.



The conference was sponsored by Russell Miller Inc. and E.W. Blanch Holdings Inc.

Mr. Picoult said he has followed the insurance industry for 35 years and "this is the most frightful period I've ever seen, but it's also the most interesting."

It is frightful because of the "unbelievable level of stupidity" by some insurer managements, said Mr. Picoult. It is interesting, though, because, from missteps by many insurers, opportunities have been created for smaller and midsize companies, he observed.

Many insurer stocks currently are selling at or below book value, he said, while the industry goes through "some fundamental changes" that are greater than many are willing to accept.

See Problems on page 10

Plans must meet business goals

Workers help define flexible schedules

By LEE FLETCHER

Employers struggling to balance flexible work arrangements and worker productivity should use a simple strategy, some work/life professionals say: ask the employees.

Some employers that have turned to flexible work programs, such as compressed workweeks and telecommuting, to attract and retain employees have found that it is the workers who often are best suited to explain how flex arrangements can help the company meet its business goals.

For example, Sikorsky Aircraft Corp., a Stratford, Conn.-based unit of United Technologies Corp., has had a flex policy for years but now requires every employee who seeks flexible work arrangements to draw up a formal proposal, explained Marcia P. Ellis, Sikorsky's manager of human resources.

"The question of how are you going to get your work done goes to the employee, who is the expert at their job. The employee can say which parts of their job can lend themselves to being done in an environment other than the office," Ms. Ellis said.

Flexible arrangements work only when the focus is on meeting the business ob-

jective, rather than simply accommodating a worker's request, she said.

"What we started understanding was that when people came forward to request a flexible work arrangement, the question wasn't 'why do you want it?' but 'how are you going to get your work done?' So, we switched from why to how, because the reason is no longer important," Ms. Ellis said.

Edward M. Houghton, manager of employee relations and work/life for Pitney Bowes Inc., agreed that, in most cases, the person that knows the job best is the employee in the position. Pitney Bowes, based in Stamford, Conn., makes mailing and shipping products.

"There are a lot of things we do that do not require you to be in an office. For example, if you're doing performance appraisals or you're preparing a presentation—you're reviewing documents—sometimes (tasks) are better done someplace else with less interruption, with the ability to concentrate," Mr. Houghton said.

John VanCleve, work/life consultant with Lincolnshire, Ill.-based Hewitt Associates L.L.C., said that employees are finding creative ways to accomplish their work goals.

See Flex on page 20

Hueppi sees fight for human capital

By RODD ZOLKOS

CHICAGO—The future of financial services is being shaped by three revolutions—one in the capital markets, another in mass investments and a third in technology—that together raise the stakes in businesses' war for talent, according to one insurance executive.

"That war for talent is probably the most important thing. . . we need to deal with going forward," said Rolf Hueppi, chairman and chief executive officer of Zurich Financial Services Group of Zurich, Switzerland.

Mr. Hueppi discussed "Financial Services: An Industry Revolution and a War for Talent" last week as this year's speaker at the annual Walter E. Heller Lecture in International Business, sponsored by the Walter E. Heller College of Business Administration at Roosevelt University in Chicago.

With business becoming increasingly global and rapid advancements in information technology changing the way business is done, "having and holding onto people who can capture the essence of the vast information that is available. . . is a big challenge," Mr. Hueppi said.

"So, while financial capital is relatively easy to obtain, the shortage and constraint on our operation comes from the people side," he said.

Examining the three different revolutions at work on the financial services industry, Mr. Hueppi noted that "the rise of capital markets has been based on



Mr. Hueppi

flows of, literally, trillions of dollars in pension funds, collective pension funds and personal savings."

The result has been an investment wave that Mr. Hueppi said he sees as one of the most incredible democratizations that the world has ever seen. "People now have a voice in the economic system," he said.

Pension assets are the greatest single source of long-term capital, noted Mr. Hueppi. "The rise of more investment will also empower the ordinary citizen, the small investor, as well as the large investor," he said.

Meanwhile, for much of the 20th century and today, global capital markets have been replacing traditional methods of financing, Mr. Hueppi said, "a deep

See Hueppi on next page

Arizona patient law advances

PHOENIX—A sweeping patients' rights law will go into effect in Arizona this summer for health plans renewing after Dec. 31, despite Gov. Jane Hull's concern that the law may trigger health care cost increases of 6.1%.

Because of that concern, Gov. Hull late last week said she would not sign the law, H.B. 2600, but instead would allow it to become law by taking no action on the legislation.

Among other things, the law will give health plan enrollees the right to sue their plans for damages if enrollees suffer substantial harm due to denials or delays of covered care. The law also speeds up the formal review process in an enrollee's appeal of a health plan's coverage decision to three days from 30 days. The law, though, will not create any liability for the employers that purchased the coverage.

In addition, the law will forbid health plans from giving health care providers financial incentives to deny, delay or limit medically necessary care. A plan also may neither ter-

minate providers nor refuse to renew their contracts solely because they advocate for their patients.

The law will mandate a couple of significant improvements in coverage of medical drugs.

In many cases, health plans will have to cover the cost of cancer-treatment drugs that the government has not approved for the specific types of cancer being treated.

Several conditions apply, however: The drugs must be judged effective by at least two respected medical journals; no respected journal has concluded the drugs would be harmful; and the drugs already must be approved by the health plan for treating other forms of cancer.

A health plan also will have to cover a non-formulary prescription drug when the formulary drug has been either ineffective or harmful to an enrollee.

The law also will require health plans to cover chiropractic care.

—By Dave Lenckus

Sears wins OK for retiree benefit cuts

Summary plan document language, not policy, the governing factor, judge says

By MICHAEL PRINCE

CHICAGO—Reducing benefits for a retiree life insurance plan, even though an employer has termed it a lifetime benefit, does not violate federal law, a federal judge has ruled.

In a decision issued earlier this month, U.S. District Court Judge James Moran dismissed a class-action lawsuit filed by Sears, Roebuck & Co. retirees that alleged the drastic cutbacks in their retiree life insurance plan violated the federal Employee Retirement Income Security Act.

In his verdict, however, Judge Moran ruled in favor of Sears, saying the company had reserved the right to change the plan, as stated in its summary plan description, or SPD.

In September 1997, Sears amended its

group life insurance plan to reduce life insurance benefits for more than 84,000 retirees who have a maximum of \$100,000 to only \$5,000 in such coverage. This change covered all employees that retired after 1977, or about 65% of all company retirees.

Sears had announced that life insurance benefits would be scaled back gradually over a 10-year period and eliminated altogether for future retirees.

In response, retirees quickly filed suits that were certified as a class action in January 1999 by Judge Moran of the U.S. District Court in Chicago.

Sears, based in Hoffman Estates, Ill., says the cuts are expected to save the company \$60 million a year for 10 years and are needed to stay competitive with other retailers.

In the suit, the plaintiffs contend that the

change in the plan violates ERISA because the company said in its SPD that it would provide the life insurance, without cost to the employees, for life.

Sears moved to dismiss the suits, making "the straightforward argument that since its plan documents contain reservation of rights clauses, the life insurance benefits at issue here did not vest upon retirement," the decision by Judge Moran states.

In response, the plaintiffs argued that although the SPD given to employees by Sears gives the company the right to change the terms of the plan, including ending the plan, the life insurance policy itself does not contain such statements, and that the policy should be the governing document.

Judge Moran, in his 19-page decision, rejected the plaintiffs' arguments, saying "the

See Sears on page 6



PHOTO: STEVE LEONARD

Sears headquarters in Hoffman Estates, Ill.

Convergence in curriculum

Risk management students to get broad exposure

CHICAGO—Progress continues in Roosevelt University's development of a School of Finance and Financial Services within its Walter E. Heller College of Business Administration, which will include the university's program in risk management and insurance.

The school, which has campuses in downtown Chicago and suburban Schaumburg, Ill., now has both an undergraduate risk management and insurance program as well as a risk management and insurance concentration in its MBA program.

Steven Tippins joined the faculty of the Chicago-based university last year as director of

the university's existing programs in risk management and insurance, corporate finance and international finance.

Students will be able to draw from the various programs to obtain an education that integrates

knowledge of the various financial industry disciplines.

"If we do nothing more than integrate our courses, we have made an incredible leap in education," Mr. Tippins said. "Because we will have graduates who will understand things."

—By Rodd Zolkos

ROOSEVELT UNIVERSITY

the risk management, insurance and financial services program.

The university's plan in developing a School of Finance and Financial Services is to respond to the convergence under way in the financial services industry. The school is to include real estate, banking and financial markets concentrations, along with

Hueppi

Continued from previous page and permanent structural shift."

He noted that traditional products of both banks and insurers are being securitized and transferred to the capital markets. "Only 30% of all the corporate financial needs today come from banks," Mr. Hueppi said.

"This transition to capital markets-based financing is moving and is gaining momentum across Europe and also to Asia," he said, adding that unprecedented global competition has been a primary factor in invigorating the global capital markets over the past decade.

As for technology, while noting that the Internet and e-commerce remain in their early days, Mr. Hueppi said, "To me, that's already the historic way of doing

business."

"That's the way we used to do business before. We're just using a new vehicle to communicate and transfer data around the world," he said.

Business has yet to take full advantage, however, of those new technological tools, he said.

Mr. Hueppi also cited the impact of the convergence of financial services, which has led to the development of new instruments such as alternative risk financing tools and structured financial transactions.

And, he said, that convergence has led to insurance companies becoming involved in transactions one wouldn't have expected. "For instance, we were instrumental in the financing of airplanes for a Canadian airline," Mr. Hueppi said.

In the wake of all those changes, companies need to find new ways of managing business, new ways of mobilizing capital and new ways of harvesting and utilizing the intellectual capital that is available, Mr. Hueppi said.

And, he said, "What we need today are executives who understand just why that human factor is tomorrow's capital."

Despite its importance, technology alone won't address the customer's needs, he said.

"Any business needs very strong, professional talent," he said. "We need strong professionals. Much of the strong professional talent that is required in financial services will not be replaced by technology."

Despite all the changes affecting the financial services industry, Mr. Hueppi sounded optimistic about the future. "I believe that we have excellent opportunities to win in the future years," he said.

And, Mr. Hueppi said, he believes that the changes businesses are experiencing will "provide more opportunities for those who are willing to embrace them than they provide threats." **BI**



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Mike

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Smoker awarded \$1.7 million

SAN FRANCISCO—After a state court jury last week found that Philip Morris Cos. and R.J. Reynolds Tobacco Holdings Inc. misrepresented the health dangers of cigarettes, it ordered the companies to pay more than \$1.7 million in compensatory damages to a former smoker dying of lung cancer and to her husband.

A spokeswoman for the San Francisco-based law firm of Wartnick, Chaber, Harowitz, Smith & Tigerman, which is representing the plaintiff, said the punitive phase was to start last week and that witnesses would be called.

A statement released by Philip Morris said that the company intended to present additional evidence last week but could not comment further.

Last week's verdict is the tobacco industry's second loss in a row before state juries in California. Last year, another San Francisco jury awarded a former smoker with lung cancer \$1.5 million in compensatory damages and \$50 million in punitive damages.

The industry currently faces hundreds of additional lawsuits by ill smokers and the families of deceased smokers.

—By Lee Fletcher



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Enterprise

Continued from page 1

traditional and non-traditional products for insurance risks, interest rate risks, commodities risks, other financial risks such as a downturn in overseas markets, and offer advice and capital markets-based products for non-insurable risks, such as staff turnover and reputational risks, Mr. Khanna said.

"What we are trying to provide is one-stop shopping for all of the risks faced by a company," Mr. Khanna said.

"We are going to look at everything from a risk point of view and come up with strategies and transactions that address everything."

Typically, MMC Enterprise Risk will provide a quick overview of a client company's risks and pro-

vide the consulting and transactional services that are then requested, he said.

MMC Enterprise Risk's target clients will include chief financial officers and corporate treasury executives.

The new M&M unit currently operates from offices in New York, London and Toronto, but MMC Enterprise Risk plans to open offices in several more locations worldwide, according to Mr. Khanna.

Mr. Khanna was most recently president and chief executive officer of the personal lines division of Travelers Property Casualty Corp.

Previously, he had been chief planning officer of Citicorp, where he worked on that company's integration with Travelers, and for 10 years Mr. Khanna worked in the derivatives unit of Citibank. **BI**

Sears

Continued from page 3

language of the SPD cannot be dismissed so easily. The SPD forms an integral part of the plan documents and must be considered when determining whether an employer intended welfare benefits to vest."

"Furthermore, plaintiffs themselves rely on SPD language in support of their argument that Sears promised to provide lifelong insurance benefits to retirees," the opinion further states. "Therefore, it is appropriate for Sears to rely on SPD language in arguing that the life insurance benefits did not vest upon retirement."

Since the reservation of rights clause in the SPD was valid, the law permits Sears to change the plan, the decision states.

The court also dismissed the plaintiffs' other main argument, that be-

cause the retirees had paid the premiums for the life insurance while active employees, they purchased the rights to the retiree coverage.

The court's dismissal does not end the fighting over the benefit cuts, however. The plaintiffs have raised other grounds in their complaints that were not covered by the dismissal decision. These other avenues of attack have not been certified as a class action and would have to be pursued by each plaintiff individually.

A spokeswoman for Sears said the company was anticipating the favorable decision as the company tailored the benefit cuts to comply with the law.

"It validates our practices," she said.

The cuts by Sears are not unusual as many employers have looked to slash costs for their retiree benefits, said Rich Sinni, group health care practice leader for Watson Wyatt

Worldwide in New York.

"It is a trend and it's a trend that is sure to continue," he said.

A survey conducted in 1999 by Watson Wyatt in conjunction with the Washington Business Group on Health found that 32% of employers surveyed plan to reduce the company's contribution for future retiree health insurance benefits while 16% plan to eliminate future retiree benefits altogether.

Mr. Sinni also said that the decision is in line with others that have upheld employer reductions of health care benefits.

"This confirms what many employers have been thinking over the past few years," he said.

Mark Schmidtke, a partner with Ebenstein & Schmidtke in Valparaiso, Ind., said he's not surprised by the decision as many similar ones have been issued, particularly dealing with employers' reduction of retiree health care benefits.

The law in this area is fairly clear, he said, and states that because welfare benefits, such as retiree life insurance, do not vest, the employer can cut them, if the SPD contains a reservation of rights clause. If the clause exists, the plaintiffs "are pretty much doomed," he said.

An earlier decision by the 6th U.S. Circuit Court of Appeals upheld cuts by General Motors Corp. to its retiree health plan covering salaried employees. GM shifted much of the health care costs to the retirees despite promising them in writing the benefits would be free to them for life. But GM, like Sears, had reserved the right to change the plan as written in its SPD. The U.S. Supreme Court refused to review that decision (*BI*, Jan. 12, 1998; June 15, 1998). **BI**

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Kaiser settles strike

DENVER—Striking Kaiser Permanente employees in Colorado will lay down their picket signs and return to work Thursday, after accepting the health plan's latest contract offer.

Despite the 20-day strike by 1,000 pharmacists, nurses, optometrists and medical technologists in the Denver area, Kaiser Permanente didn't budge from its initial position on raises, maintaining the 12.8% increase it had initially offered over the life of the three-year contract.

Depending on the job classification, annual salary increases range from 2% to 9%. Salaries for 15-year employees will reach \$57,000 for registered nurses, \$77,000 for pharmacists, and \$93,000 for optometrists at the end of the three-year agreement.

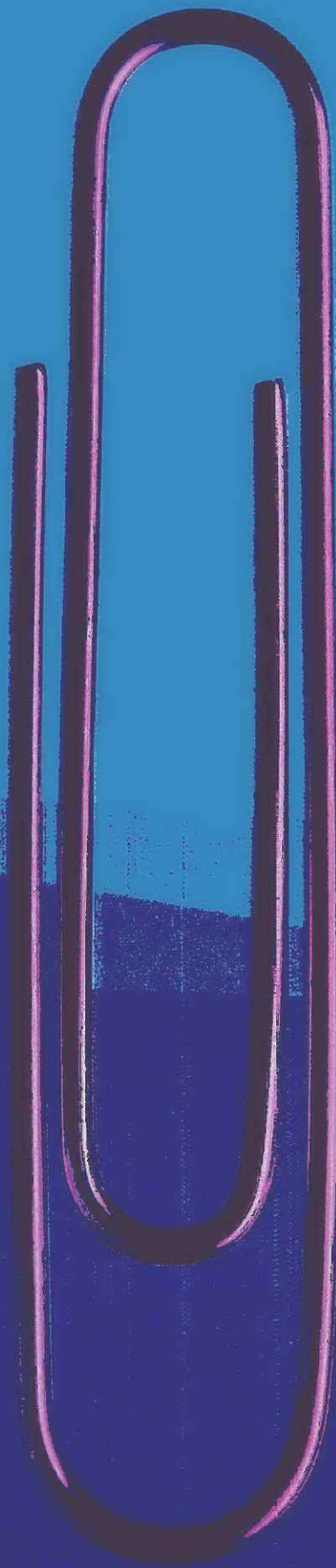
Kaiser Permanente did meet other demands of the striking workers, which generally focused on staffing levels and job security.

The contract creates a procedure for employees and managers to jointly work out staffing issues. If agreement is not reached, a staffing dispute can be taken to an arbitrator for a non-binding recommendation. The arbitrator may require penalty payments from Kaiser Permanente if it violates contract provisions affecting such matters as vacations and rest periods.

The agreement also ensures no one will lose a job to subcontracting and reimburses some professionals for their costs of obtaining certifications.

—By Joanne Wojcik Kochaniewicz

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Opinions

Full speed ahead on reform

STATE INSURANCE REGULATORS deserve congratulations for the ambitious goals they have set for themselves and the dramatic steps they already have taken to bring themselves and the function they perform into the 21st century.

Confronted with the threat of federal encroachment on their turf, thanks to passage of the Gramm-Leach-Bliley Act, state regulators could have reacted by taking only a few defensive steps in the areas of consumer privacy and producer licensing.

To their credit, regulators seem to recognize the need to go beyond merely reacting to the immediate threat to their role. As a result, they are trying to completely overhaul state insurance regulation and make it more relevant and effective. This overhaul is needed, because the same market forces that were a catalyst for passage of federal financial services modernization legislation also threaten to render the current system of regulation obsolete.

The challenge for regulators and their primary organization, the National Assn. of Insurance Commissioners, will be to accelerate the pace at which they consider and implement this initiative. They do not have the luxury of moving at the slow, deliberate pace that historically has characterized NAIC consideration of issues or reforms. If they do not keep up the pace of reform, they risk losing momentum for this initiative and watching it fail.

There is ample evidence of the dangers of the NAIC's slow-paced approach. Consider a package of model laws and regulations for rate and form filings that has yet to win final approval. These models have been under consideration for nearly 18 months. During the delay, the package has been overtaken by events and no longer fits with the NAIC's stated goals. To be sure, the models are an improvement over the prior rules, but their requirement, in some cases, of prior approval of forms runs contrary to deregulatory trends.

We are encouraged by the candor and leadership shown by several commissioners in this push for change, especially that of George Nichols III, the NAIC president. Clearly, it will take such leadership to get the many jurisdictions to coordinate their efforts and move rapidly toward a more-uniform national approach to many regulatory matters. That, we believe, is the most critical aspect of this regulatory reform effort and the key to successfully fending off federal intervention.

When people argue for a federal alternative to the current state-based system of regulation, few do so because they believe a federal regulator would be more efficient or better informed about insurance than are state regulators. Rather, it is because they see federal regulation as more centralized, less complex and less redundant than a patchwork system of more than 50 jurisdictions, many of which do not handle the same regulatory functions in the same manner.



The NAIC and state regulators must work to coordinate, streamline and standardize their efforts in as many ways possible to minimize the burdens and expense to insurers of complying with a fractured approach. Ultimately, this effort will lower the cost of insurance coverage to consumers, but it will not require states to abdicate their obligations to their citizens in the areas of policing market conduct and protecting policyholders.

The NAIC's blueprint for reform has suggested several areas where a centralized approach could be adopted by the states and might be preferable to the current system. These proposals include creating a national producer licensing process; deferring to an insurer's state of domicile for the regulation of products issued on a multistate basis; developing uniform standards for rate and form filings in certain lines; striving for greater uniformity in the commercial lines deregulation rules and laws adopted by states; and considering a state-based system for the uniform nationwide treatment of insurance companies.

If the states can pull off these reforms, they would go a long way toward deflating support for a federal alternative.

We can appreciate the enormous challenge regulators and the NAIC face, but that challenge must be met. The market they oversee has changed dramatically in recent years and continues to be changed by forces such as globalization, consolidation and technology. The state-based regulatory system must change with the industry it oversees, or it will risk the possibility of being passed by in favor of a more-effective regulatory framework.

Letters

RIMS seeks consensus on standards

To the editor: I came back across the Dec. 13, 1999, editorial opinion, "A Single Standard Needed," and I was reminded that a response to that column is needed.

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

One conclusion reached in the editorial was that "the key to getting to a single standard is getting the various parties to compromise and accept a minimum level of data standardization."

I think I can speak candidly for the Risk & Insurance Management Society Inc. and RIMS' technology advisory council by saying that we agree and are addressing the issue and that conclusion directly.

Specifically, RIMS is sponsoring a "Data Standards Summit" in Chicago April 17-18. The summit will, with the assistance of the University of Georgia and results from a related member survey, help to develop a consensus around minimum standards for workers com-

pensation and auto claims.

We also agree that success will be heavily dependent upon buyers' demands for this long-overdue coordinated attention to standards, which could make life easier and more cost-effective for buyers.

RIMS is optimistic about delivering meaningful results in this area as it puts more time and resources into technology concerns such as this, via the TAC.

Christopher E. Mandel

Vp, External Affairs

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Problems

Continued from page 2

There are still too many companies out there "dancing to that old mariachi band tune. If you don't think out of the box, and if you don't execute out of the box, you simply are not going to survive," he said.

"This is not a growth industry,"

though it may become one down the road if market forces get rid of, or "neutralize," enough companies, he warned.

Current earnings estimates by insurers are "way too high," and earnings im-

provement from current efforts to raise rates "won't be as rapid as everyone thinks," said Mr. Picoult.

Insurers' earnings estimates are too high for 2000 and 2001, he said, adding that "maybe this is a 2002 play."

Any higher rates on coverage written today are "going to take six to nine months to flow through to the earnings," Mr. Picoult said. But "losses don't wait, they just come in," he noted. "Analysts don't totally appreciate that."

Mr. Picoult said insurance is the only industry in which the cost of capital—the premiums received by insurers—is zero. If getting capital is so simple, however, "then how come so many of these companies screw it up? Why can't they get it right?" he asked rhetorically. "How did the industry get itself into this jam?"

One reason, he said, is that many insurers "threw away pricing dynamics."

Most managers "are market share-oriented. This has always been a market-share game. It's still a market-share game," Mr.

Picoult said.

However, he said, "there's nothing wrong with a smaller company that's more profitable."

Another problem is "they threw away the underwriting templates. I don't know where they threw it, but they threw it away," Mr. Picoult said.

A third reason, he said, is the industry's expense levels are "totally out of whack."

Mr. Picoult acknowledged, however, that Wall Street is "part of the problem."

The time frame Wall Street wants for gratification or its investment is "totally out of sync" with what insurers need to run their business, he said. "You can't run your business on a quarterly basis," he said. "For us, long term is through lunch," he said of stock analysts.

The quality of Wall Street research is another problem, Mr. Picoult said. Too many people do not understand what they are analyzing, and many reports to investors

simply regurgitate conference calls and press releases. "I think it's a material problem," he said.

Also speaking at the session was Thomas V. Chohnoky, a vp at Goldman Sachs & Co. in New York. Discussing the troubled Unicovert reinsurance pool, Mr. Chohnoky said "It's unbelievable that this industry could get messed up on something like workers comp carve-outs."

It appears, however, that the industry will be able to settle the Unicovert issue "pretty much independently" and that the losses will not be anywhere near as large as has been written about, he said.

"It will have an impact on workers comp pricing," said Mr. Chohnoky.

Workers comp pricing has started to move up in California, and it will probably be seen in other states as well. The bottom line, he said, is this "will not have much of an impact on the overall industry," he said.

Also speaking at the session was Weston M. Hicks, managing director at J.P. Morgan Securities Inc. in New York.

P/C trade unlikely to attract banks

By JUDY GREENWALD

SAN FRANCISCO—Financial services reform legislation approved by Congress last year is unlikely to generate any significant interest by banks in acquiring property/casualty insurers or brokerages.

This was the view of several speakers at the National Insurance Symposium Leadership Conference held in San Francisco earlier this month and co-sponsored by Russell Miller Inc. and E.W. Blanch Holdings Inc.

One agency owner, however, says several banks have approached his firm about a possible acquisition.

Speaking during an analysts' session, Thomas V. Chohnoky, a vp at Goldman Sachs & Co. in New York, said, "Banks are really not going to be buying very many non-life insurance companies."

They will be more interested with acquiring life insurance companies, where there are "more assets to be gathered," he said.

There are a couple of factors influencing banks' preferences, according to Mr. Chohnoky. First of all, when insurers' returns are compared with those of banks, "it's pretty pitiful. Why would you want to buy a lower (return-on-equity) business?" he asked.

Also, the insurance business is a lot less leveraged than the banking industry, "which is adding to these woeful returns," he said.

Furthermore, the two industries operate within different regulatory environments, which will cause problems in the future, said Mr. Chohnoky.

The model that makes sense is for banks to find insurers with which to form partnerships, said Mr. Chohnoky. It does not make sense, he said, for banks to "manufacture" the insurance product and then sell it.

In addition, he said, just imagine what would happen if a large corporate banking client were denied insurance coverage for a claim. "I think there are a lot of problems that could arise in that area," said Mr. Chohnoky.

"I do not believe for one moment that the large banks have an appetite to become risk takers," said Claude Y. Mercier, president and chief executive officer of New York-based Seabury & Smith Inc., a Marsh Inc. unit. Mr. Mercier spoke during an intermediary pan-

el at the conference.

There is too much uncertainty and volatility, and competition is too high, he said. Insurance's globalization is of no interest to the banks, he added.

Mr. Mercier also said insurers' returns on equity are "lousy" compared to what banks are used to.

"Abolition of the Glass-Steagall Act is not going to have that much of an impact on insurance intermediaries," said Mr. Mercier.

He predicted, however, that there will be opportunities for strategic alliances between regional banks and intermediaries, where the banks provide their services and the insurance intermediaries provide the insurance.

J. Hyatt Brown, chairman, president and CEO of Daytona, Beach, Fla.-based Brown & Brown Inc., said there is little concern today among brokers about banks owning insurance producers.

That's because, he said, there no longer are very many community banks. Few families are now powerful enough to own both banks and insurance agencies and attempt to steer business to their affiliated insurance agencies, said Mr. Brown.

Furthermore, many banks are nervous about getting into the risk-bearing business today, said Mr. Brown.

In addition, "there are, as we speak, in smoky dark rooms, plaintiffs attorneys who are looking at the possibility of class-action lawsuits" over coercion of customers by banks that do operate brokerages. "Bless their pointy little heads," he quipped.

Paul L. Gross, chairman emeritus of the Paramus, N.J.-based NIA Group, said, however, that since revocation of the Glass-Steagall Act, he has had two major national banks and two regional banks approach him about selling out to them.

"It is unbelievable, because they don't really care whether I'm making a profit or not. They just want to know the revenue numbers, where are the offices, how many clients have I've got—and those are the key questions."

"There's an enormous movement by banks into the insurance business" in the New Jersey, New York and Connecticut area of the country, according to Mr. Gross.

"Every agency is being solicited," he said.



Insurers 'threw away the underwriting templates. I don't know where they threw it, but they threw it away,' says Myron Picoult of Wasserstein Perella Securities Inc.

Expense problems occur because the insurance industry is "incredibly inefficient" and has inadequately addressed the issue of technology, he said.

Mr. Picoult said one "very distressing" development is calls he has received from underwriters who have either been let go or fear being let go and are seeking help in raising \$200 million in capital to fund a new insurance company so they can "go play elsewhere."

This is an industry that is "absolutely, unequivocally devoid of credibility," Mr. Picoult said. Most management decisions are based on self-preservation, he said. Compensation programs are adjusted so that management's compensation is unaffected by declining stock prices, he added.

In addition, there are frequent restatements of earnings reports because of factors such as restructuring or reserve adjustments. As a result, there is "no credibility to the numbers," said Mr. Picoult.

He also said he is "amazed" there have not been more shareholder suits filed against insurers over the reliability of reports.

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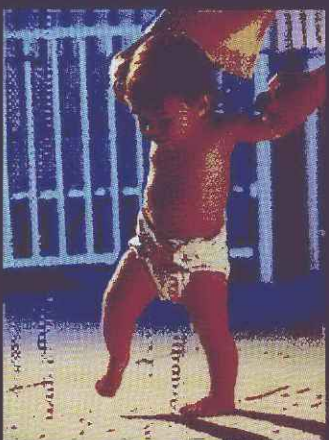
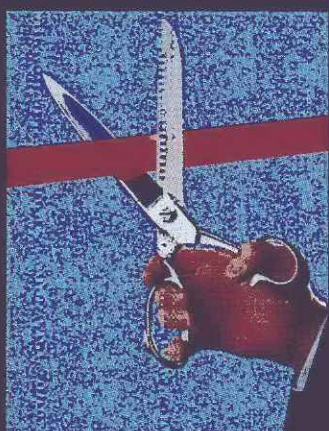
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External review preferable to courts

Expert physician panels are the best bet for resolving payer, provider conflicts

By Winifred S. Hayes

A courtroom is the last place most terminally ill patients would opt to spend their precious time.

Yet a growing number of gravely ill individuals find that their fight for survival draws them inevitably into emotional legal confrontations with reluctant health insurance companies. Denied coverage for treatment recommended by their physicians—treatment they believe is their last hope for life—these patients feel they must fight the system as well as the disease.

At the crux of these disputes are new technologies and therapies that hold out reasons for hope. For example, medications that directly target cancer cells could spare surrounding healthy tissue and avoid the devastating side-effects of traditional chemotherapy and radiation treatments. The problem is that most of these promising therapies are so new that very little data exist about their overall effectiveness in humans.

Who is best suited to decide whether an expensive new treatment is a warranted gamble or a dangerous exercise in futility? Should insurance companies—and ultimately all of society—bear the costs for heroic efforts to save each terminally ill patient? Will a focus on heroic efforts late in an illness shift resources away from education and prevention programs at earlier stages? Should patients who volunteer for experimental treatments be reimbursed in some way for their contributions to medical knowledge? When is it appropriate to tell a patient that medicine has nothing more to offer of a proven nature? Should families already under tremendous duress bear sole responsibility for the costs of experimental treatments for their loved ones?

These are difficult questions requiring unbiased appeal processes when disputes over health plan coverage occur. While many health insurance companies have created internal review processes, the perceived if not actual conflicts of interest have triggered a consumer backlash—a backlash that in recent years has spilled over into legislative reform. Today, 33 states and the District of Columbia require some kind of external review of patient appeals conducted by unbiased review boards or panels, and another eight states have bills pending. Lawmakers in several states have drafted legislation that would toughen existing laws substantially, or expand external review beyond the terminally ill to include all patients.

The outcome of this legislative flurry is a patchwork of laws with wide variations from state to state. Further complicating this already tremendously complicated picture is the fact that self-funded insurance plans, usually found at big companies that can spread health care risks over a large number of employees, are regulated by federal instead of state legislation. Add all of these ingredients together and you have a perfect formula for inequality. One can create scenarios in which patients feel compelled to flee a state in search of greater health care options in a more patient-friendly neighboring state.

Pressure is mounting for a federal Patients' Bill of Rights that would supersede regional disparities and encompass all forms of managed care, including fee-for-service, self-funded, HMO and PPO plans.

On Oct. 7, 1999, the House of Representatives passed H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999, following

heated debate and intense lobbying by the managed care industry, the American Medical Assn. and the plaintiffs' bar. The bill contains provisions requiring the availability of independent, external medical reviews for all insureds and enrollees denied coverage of medical items or services that are judged to be not medically necessary or appropriate or are experimental or investigational. The measure is currently being reviewed by a House/Senate conference committee that is attempting to reconcile it with a much narrower bill passed by the Senate last summer. If the House bill becomes the basis for compromise legislation and is signed into law by the president, the bill would preempt the Employee Retirement Income Security Act. It would permit overturns of coverage denials in situations where the medical service or item is *not* medically necessary, as defined by the health plan document or certificate of coverage. Furthermore, the relative importance or weight of scientific evidence in arriving at an external review opinion is diminished—physician reviewers may or may not consider available scientific evidence. Data considered in the review is at the reviewer's discretion. A successful compromise bill, negotiated

and ranges from a single reviewer to as many as seven reviewers, though the typical panel is made up of three physicians. Because early laws focused on terminally ill patients, many reviewers today are oncologists, some of whom are affiliated with major regional cancer centers. As the laws become broader in their scope, the composition of the review panels is changing to include experts on mental health, substance abuse and an array of other medical specialties.

Some states, like Vermont and New York, manage all stages of the appeal from gathering clinical documents to selecting an external review organization. Other states, like Arizona, allow health plans to select from a list of accredited or registered external review vendors. Ideally, vendors seek reviewers who are active clinicians with academic appointments at respected university medical centers.

Many of these physicians are clinical department heads or are responsible for a clinical program and/or a major research effort. With rare exceptions, they are board certified. After reviewing all relevant medical records and research reports, the panel reaches a "coverage" or "no coverage" decision. When reviewers are split, majority rules. If there is a tie, the decision goes in favor of the patient. The decision, which generally is made within seven to 10 days of the appeal, often is binding for the patient and the health plan.

This "evidence-based" process is where the real strength of external review is found. By reviewing all the relevant data on the effectiveness and safety of the proposed therapy and alternative therapies, the panel contributes immeasurably to finding the best treatment for each patient. Regional biases regarding certain kinds of treatments, or unconscious biases that may motivate physicians to recommend one therapy over another, are circumvented more consistently during external review.

Reviewers are trained to distinguish between medically unproven but appropriate treatment and that which is not appropriate. Cases involving terminally ill patients where standard therapy has failed or is likely to fail often fall in this category, especially when the proposed therapy is theoretically promising but unproven. Often in these cases, we will advise our clients—sometimes the state, sometimes the managed care organization—that extending coverage for the proposed technology to a specific patient

is the wisest course from a risk management, ethical, legal and/or public relations perspective. Or, the panel may opt for more conventional therapy that has a relatively good track record in preference to an experimental approach.

For example, a 48-year-old patient with advanced ovarian cancer recently sought treatment with an experimental drug—a monoclonal antibody—that had been used with some limited success in breast cancer only. In their decision to deny the appeal, the panelists noted the lack of clinical data for the drug's use with ovarian cancer and the availability of good alternative therapies.

In a second case, another of our accredited panels approved an experimental procedure for a 56-year-old man with a brain tumor who had undergone two unsuccessful surgeries for a fast-growing glioblastoma. The experimental procedure, called stereotaxis, involved a three-dimensional imaging technique to help surgeons more accurately locate and remove the tumor in a third surgery.

Reviewers also are trained to distinguish between medically necessary and strictly cosmetic procedures, as they demonstrated in a recent case involving breast reduction surgery for a woman

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State external case review status



GRAPHIC BY ADAM DOI

by the House and Senate, seems unlikely this legislative session.

Two of the original bills defined "medical necessity" as "a service or benefit that is consistent with generally accepted principles of professional medical practice." This ambiguous definition, which would replace health plan definitions of medical necessity, would become the standard for review. Its major shortcoming is that it fails to make reference to the need for scientific evidence supporting good clinical outcomes. This language may surface again in a House-Senate compromise.

Until a federal patient bill of rights is passed—and I predict it will become a major campaign issue in 2000—society needs to grapple with the profound ethical questions raised by the debate thus far over experimental treatments, medical necessity and external review. One of the most important roles for a consultant in medical technology and case review, such as myself, is to give people the definitions and facts they need to engage in such a debate.

As the first step in the external case review process, a panel is assembled that is made up of independent physicians who are experts in treating a specific disease. The size of the panel is determined by either the health plan or state law

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experiencing upper and lower back pain, neck pain and headaches unrelieved by medication. They granted the patient's request for coverage, citing numerous studies in peer-reviewed scientific and medical literature showing that such a procedure relieved pain in 60% to 96% of cases like hers.

In the long run, I believe external review has been a positive force that has improved treatment and spurred medical discoveries. I see it as a healthy way of addressing conflicts between payers and providers while sustaining the tenets of sound scientific inquiry. Ultimately, it is more reasonable to resolve disputes through external review than in a courtroom. I don't believe judges and juries are necessarily well equipped to sort through these issues.

That said, there are caveats. The danger exists that legislators, in their zeal to protect consumer interests, will get into areas they don't really understand and rewrite statutes that would set new ground rules for how plans are expected to make coverage decisions. The question has to be asked,

does society want to provide coverage for any treatment that anyone feels might be of benefit? The answer is a resounding "no," because even though the employer or government pays for these treatments, we as taxpayers get the final bill. Not only would unrestricted access to all treatments break the bank, but it could promote rapid dissemination of unproven technologies that are less effective than more-established treatment methods.

I am concerned about some of the new and pending statutes that are too broad in their coverage or limit time for expedited external review to three days or less. Unrestricted access to experimental treatments would take us back 100 years to an era when patent medicine salesmen made all kinds of unsubstantiated claims. Furthermore, if we permit unrestricted "off-label," untested uses of medications, we have taken away a major motivator companies have for doing costly clinical research required to determine a medication's effectiveness—or the effectiveness of a new device or procedure.

In striving to create a health care system for all, often it is necessary to strike a balance between

opposing needs. The primary goal is to assure that patients are treated effectively and humanely while upholding the values of society. Care must be available to everyone who needs it and not meted out only to those who can afford it. At the same time, treatment should contribute to scientific discovery, improve clinical outcomes and be cost effective. This is a tall order, to be sure, but one in which external review can play a central role, if well designed. The key is to base these crucial decisions on solid clinical and scientific evidence. **BI**



Winifred S. Hayes is founder and president of Hayes Inc. in Lansdale, Pa., which specializes in medical technology assessment and case review.

Prepare for litigation before it strikes

A strong response system can increase odds of favorable verdict

By James F. Dorion

Now, more than ever, the expenses associated with litigation are considered a cost of doing business. Even when you win, litigation is a drain on time, energy and money. As many business leaders realize, it can adversely affect both stock price and merger activity. Fortunately, the risks associated with litigation can be aggressively managed to minimize their effect on your bottom line.

Those who wish to favorably influence the outcome of litigation should be prepared before it begins. An initial step in this preparation is the assessment of claims facing your company and the identification of potential litigation. This will help to properly focus available resources. Your company's potential liability and the claimant's alleged damages should be investigated promptly. Favorable witnesses and/or evidence may not be available in-

Your response system should include a process for evaluating suits tendered to your company for defense by its business partners and customers.

definitely. A preliminary evaluation of each claim needs to be conducted by someone qualified to spot legal issues and estimate exposures. In addition, the potential to obtain contribution from any other parties also must be assessed.

There may be occasions when the facts that emerge during your investigation implicate your company alone. In such instances, when your liability is clear and the opposition's assessment of damages is reasonable, it is usually best to take advantage of any settlement opportunities. The cost to resolve such cases rarely diminishes with the passage of time.

It is crucial to establish an efficient response system for referring cases to counsel and providing notice to insurers. Such a system will help prevent having a default judgment entered against your company and will obviate battles with your insurer over the payment of "pre-tender" defense costs, which it may characterize as non-covered "voluntary" payments. Most insurance policies that provide for a defense require that notice of any suit be given immediately, "as soon as possible" or "as soon as practicable." In some states, prompt notice is a prerequisite for obtaining coverage. Most states,

however, require an insurer to prove that it has been prejudiced—that is, suffered irreparable harm—due to the policyholder's failure to give timely notice before it can deny coverage on this basis.

Your response system should include a process for evaluating suits tendered to your company for defense by its business partners and customers. As a business decision, you may choose to defend a lawsuit filed against your best customer if that suit involves your product, even if your company's liability appears questionable in the claim. Leaving this type of decision to the discretion of your insurer could result in damage to your multimillion-dollar customer relationship over a few \$10,000 to \$15,000 cases.

Special consideration should be given to lawsuits alleging any cumulative injury that may affect multiple policy periods. This type of lawsuit has the potential to trigger coverage under occurrence-based liability insurance policies having effective periods that have already expired. For example, if a plaintiff alleges that your company negligently polluted a site it occupied from 1979 to 1987, you could, in many states, look to the insurance policies that were in effect from 1979 onward to provide a defense to the suit if the terms and conditions of those policies so provide.

Some insurance programs give the policyholder the right to select its own attorney. Selecting defense counsel is an important decision that should not be made in haste or under pressure; these, however, are the prevailing circumstances when most lawyers are selected. For this reason, it is helpful to preselect counsel in jurisdictions where your company does business. An attempt should be made to develop a long-term relationship with particular lawyers, not necessarily firms.

Selection should be based on the lawyer who will actually be handling the case; watch out for the "bait-and-switch" maneuver. For example, you may have been attracted to a firm by a certain well-respected partner, only to discover that an extremely inexperienced associate will be handling your case under the partner's supervision. You don't want to be in the position of paying for on-the-job training. It should be noted that a passive client is not likely to get the best a firm has to offer.

A lawyer's or firm's familiarity with your business should be taken into consideration, but should not be the sole deciding factor. Selection is often best made on the basis of prior experience or referrals. If neither is available, you may wish to consult a reliable directory, such as "Best's Directory of Recommended Insurance Attorneys and Adjusters." Venue should also be taken into consideration. For exam-

ple, if your company has been sued in a small town, a well-respected local sole practitioner or small firm will often serve your interests better than would an out-of-town big firm. There is a lot to be said for "hometown" advantage in dealing with a given

Always choosing the least expensive firm may give your company a reputation as an easy mark, increasing the number of nuisance suits filed against it.

judge or potential jury pool.

Remember that firms with the lowest rates are not necessarily the least expensive in the long run. Although you may reduce the amount you spend on defense costs, you risk ultimately increasing the amount you pay to settle or otherwise resolve a lawsuit. Always choosing the least expensive firm may also give your company a reputation as an easy mark, increasing the number of nuisance suits filed against it. It has been said that the best lawyers are expensive, but the second-best lawyers are very expensive.

Once you have narrowed your list of potential candidates to two or three firms, you can ask each of them to run a conflicts check, and you should contact their references before making your final selection. You should communicate your litigation guidelines and reporting expectations at the outset of a suit, when your leverage as a client is greatest.

Firms should not claim competence in all things. The firm that did a sensational job defending against a severe auto claim may be totally ill-equipped to handle a wrongful-termination suit. Also, be wary of firms that have received negative press concerning malpractice suits or staff defections. Your case will not receive the attention it deserves if the firm is facing such distractions.

While seeking optimum performance from your local counsel, it is important to keep an eye on costs. This can be accomplished with the help of an outside litigation manager, through internal procedures and/or through legal bill auditors. Many people fear that lawyers will resist management, so they never try to manage costs.

Traditional hourly billing provides an incentive for inefficiency and delay. Overbilling isn't always the result of fraud; more often, it arises when a firm has been given free rein to bill as it pleases. There is

See Litigation on next page

INTERNATIONAL

Brown

Continued from previous page
pill," said Mary Francis, director general of the ABI in London.

"There is to be consultation on the proposition that claims provisions in insurers' accounts should be calculated for tax purposes after discounting for the effect of investment income. Claims reserving is not an exact science, and there are prudent rules for accounting and supervisory purposes," Ms. Francis said. "These should remain the basis for tax purposes. Any reduction will weaken the security of policyholders."

A Lloyd's spokesman said the full effect of the proposed changes

would not be known until after the consultation period, but he said the important issue for Lloyd's was whether Inland Revenue would tax monies set aside by members in the year they are reserved or the year they are released to pay claims, or are drawn down.

Ms. Francis noted that there was some good news to be found by insurers in Mr. Brown's budget. She cited the chancellor's announcement that there would be no change to the insurance premium tax, which currently stands at 5% for most classes of insurance business.

"This recognizes our case on the importance of insurance, especially for the less well off and startup

businesses," Ms. Francis said.

Mr. Brown also proposed expanding current U.K. tax benefits that apply to some life insurance sold to non-U.K. residents to ap-

Mary Francis noted that there was some good news to be found by insurers in Mr. Brown's budget.

ply to additional policy types. Currently, overseas life insurance businesses that sell pension policies, as well as some sophisticated

types of life insurance, are not taxed on either income or investment gains set aside to meet future benefits payments to policyholders.

But Mr. Brown said he had received feedback from companies that too few types of policies qualify for the tax break, and he said he would aim to relax the compliance requirements.

There will now be a period of consultation within the industry on Mr. Brown's proposals regarding overseas life insurance, but initial reactions were favorable.

"We are pleased (about Mr. Brown's proposals) because the definitions at the moment are tight, and it is very difficult for insurance companies to avail them-

selves of the benefit such as it is," said Vic Rance of the ABI's international department. "The government has said it will redefine the definitions for overseas life assurance business that can benefit from this treatment. This will enable insurers to do business with non-U.K. residents more easily than we can at the moment."

"The government has accepted our case for changes to the taxation rules for overseas life assurance business to facilitate cross-border sales from the U.K.," agreed Ms. Francis. "This will open up important business opportunities for our members, especially with the potentially huge savings and pensions markets developing in Europe." **BI**

Losses

Continued from previous page

Francoise des Societes d'Assurances, insured losses in France, which bore the brunt of the storms, will total about 30 billion French francs (\$4.41 billion). But the net costs to French insurers, after reinsurance recoveries, will not exceed 10 billion francs (\$1.47 billion), the federation noted.

As a result of the storm losses, French property/casualty insurers likely will sustain an underwriting loss of 3 billion to 4 billion francs (\$441 million to \$588 million) on their 1999 results, the first loss for several years, according to Paris-based FFSA.

The loss likely will increase French property insurance rates, a spokeswoman for the FFSA predicted.

Leading French reinsurer SCOR S.A. posted a 34% decline in net income to 98 million euros (\$98.7 million) for 1999, driven largely by poor operating results on property/casualty business. The company's property/casualty business posted an operating loss of 89 million euros (\$89.6 million) in 1999, due to the December windstorms that hit Northern Europe, among other disasters, compared with a profit of 48 million euros (\$57 million) in 1998.

Paris-based mutual insurer Mutuelle d'Assurances des Instituteurs de France, which provides personal insurance to teachers, this month announced a special premium

call of 350 million francs (\$60.9 million) on policyholders to cover losses from the storms. The mutual reported a loss of 374 million francs (\$65.1 million) for 1999. Before the storms, it had expected to make a profit in excess of 300 million francs (\$52.2 million).

MAIF received more than 240,000 storm-related claims, representing a loss before reinsurance of 2 billion francs (\$348 million). The mutual received reinsurance payments of 523 million francs (\$91 million) and used 500 million francs (\$87 million) of reserves it had set aside for natural disasters.

MAIF is a member of Gpt Entreprises Mutuelles Assurances, the French association of mutual insurers, which represents about 10% of French insurance business. GEMA Chairman Jacques Roche has warned that several of GEMA's members will be making premium calls this year as a result of the French storms.

Insurers and reinsurers in other European countries hit by the storms hope to absorb the storm losses and still make a profit.

In Switzerland, Swiss Re estimates that the European storms will cost it about 900 million Swiss francs (\$538.3 million), but the loss will be easily absorbed by the reinsurer, according to a company statement.

"A significant share of this amount is due to the extensive damage which occurred in France. The equalization reserves specifically set up for such large catastrophes will, however, ab-

sorb a major portion of the loss. Swiss Re has practically no exposure to these storms from retrocession markets," the company said in a statement.

Meanwhile, "strong financial markets and Swiss Re's active portfolio management, in addition to a good life result, should, nevertheless, result in earnings for 1999 which will be above the 1998 level," the group predicts.

German insurer Allianz A.G. Holding recently reported a 10% increase in profits for 1999 to 2.2 billion euros (\$2.1 billion), despite the December storms costing the group more than 260 million euros (\$250.7 million).

Munich Re announced earlier this year that, despite the winter storms costing the reinsurer up to 1 billion deutsche marks (\$493 million), it would pay shareholders an unchanged dividend.

"However, the exceptionally high claims costs in 1999 will probably mean that the group profit for the year will not reach the previous year's level," the reinsurer warned in a statement.

Fellow German reinsurance company Hannover Reinsurance A.G. announced that the losses from Lothar and Martin, together with the large number of other major loss events—including the hailstorm in Sydney, Australia; earthquakes in Turkey, Greece and Taiwan; and Hurricane Floyd and Typhoon Bart in Japan (see separate story)—will surpass the company's record gross loss account.

Nevertheless, "the double-digit profit increase planned for the 1999 financial year has not been jeopardized," Hannover Re announced earlier this year.

Hannover Re's share of the European storm loss will be "substantially in excess of 100 million euro (\$104 million) gross and roughly 40 million euro (\$41.6 million) net," the company stated. About half the loss derives from France and the remainder is largely attributable to Germany and, to a lesser extent, Switzerland.

Losses from the windstorms are not expected to breach an 80 million euro (\$83.2 million) loss threshold and trigger payment on the catastrophe bond issued by Halyard Re B.V. on behalf of Sorema S.A., according to Risk Management Solutions Ltd., a London-based subsidiary of California-based Risk Management Solutions Inc.

The \$17 million bond, issued on April 1, 1999, is a retrocessional structure based on losses to a designated set of contracts within Sorema's portfolio in both Japan and Europe, according to RMS, and it has an attachment point around 80 million euros. The bond was designed with assistance from a European windstorm model by RMS.

"Although the portfolio has a large concentration in France, Sorema has



PHOTO: UPI

In France, such as this spot near Normandy, many roofs were blown off by late December windstorms, which also hit Germany and Switzerland.

underwritten a broad portfolio across Europe. While the loss from Lothar in France has a return period of several hundred years and has blown through the reinsurance protection of all but one or two French insurers, in Germany, the loss has a return period of only a few years," as it was far less costly, said RMS Director Robert Muir-Wood. Loss return periods comprise the frequency and magnitude of a catastrophe loss in a particular area.

RMS' European windstorm model, first released in 1997, was also used in modeling risk from windstorm losses in Germany for the Gemini Re catastrophe bond option, issued on behalf of Allianz in 1998.

It was developed from the reconstruction of the complete windfields—the area where the wind strikes—of more than 400 windstorms and is calibrated against a catalog of windstorm track meteorology for more than 2,500 significant windstorms that have affected Western Europe since 1869, according to a statement from RMS.

"We are very pleased with how the model has performed with these unprecedented storms. Vulnerabilities for French building types, overall loss projections and loss return periods are looking very solid," said principal modeler Michael Drayton.

RMS, meanwhile, has set up research studies in France to learn more from the storms, said Mr. Muir-Wood.

Among the topics being studied are claims inflation caused by:

- The high cost of repair materials due to demand exceeding supply;
- The readiness of insurers to settle claims, and lack of resources to detect fraud, as they become overwhelmed by losses;
- And political pressure on insurers to pay up promptly and without questions.

One feature of the storms was that insurers had the option to argue that they constituted a single 72-hour

event, rather than two separate events with two separate retentions, for reinsurance recoveries, noted Mr. Muir-Wood.

Because most French insurers had exhausted their first-loss reinsurance capacity in Lothar, they chose to keep the storms separate and obtain reinstatement coverage for Martin, he said. If the French loss for Lothar had been only half the reinsurance limits, then most insurers would have argued that the two storms were a single event, Mr. Muir-Wood suggested.

Paul Nunn, manager of the London operations of Boston-based catastrophe modeling company Applied Insurance Research Inc., pointed out that there are "always lessons to be learned after such events."

But he said he was pleased how well his company's modeling products stood up, including its numerical weather prediction technology, which allows for the modeling of regional and global circulation patterns in three-dimensional space.

Speaking at a London conference last month, Swiss Re's Edouard Schmid, head of cat perils, noted that some functions of Swiss Re's European storm model would need to be modified as a result of the December storms.

Alex Gargolinski, group marketing director of London-based international loss adjusting company McLarens Toplis, pointed out that the losses in France could have been far greater had the storms been accompanied by heavy rainfall.

The main losses were external damage, particularly uplifted roofs, due to the high winds. Damage to contents, such as stock and machinery, was not huge due to the unusual lack of rain accompanying the storm, he said.

Commercial losses were mainly from shopping malls, industrial estates, vacation complexes and other modern light structures, Mr. Gargolinski said. **BI**

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INTERNATIONAL

Disasters

Continued from page 15

• Hurricane Floyd losses in the United States and the Bahamas, which Munich Re estimates cost insurers \$2.2 billion and Swiss Re estimates \$2.4 billion.

• U.S. tornadoes, which both companies estimate at \$1.5 billion.

• A Sydney, Australia, hailstorm that both put at \$1 billion. This storm is the costliest weather-related catastrophe in Australia's history, according to Munich Re.

• The Turkey earthquake, which Munich Re reports cost insurers \$1 billion, while Swiss Re sets the figure at \$2 billion.

• The Taiwan earthquake, which Munich Re estimates at \$850 million, while Swiss Re reports \$1 billion.

In terms of economic damages—which are totals of insured and uninsured losses—1999 was the second-worst year in terms of disasters after 1985, the year of the Kobe earthquake in Japan, the reinsurers agreed. In terms of economic damages, 1999's worst catastrophes were the landslides and flooding in Venezuela, the Taiwanese earthquake and the Turkish earthquake, with each generating total losses in excess of \$10 billion.

The worst 1999 disasters in terms of fatalities were: the landslides in Venezuela, with 20,000 dead by Munich Re's count and 50,000 dead by Swiss Re's count; the Turkish earthquake, with 19,000 dead according to Swiss Re and 20,000 dead according to Munich Re; and

the Orissa cyclone in India, with 15,000 dead by Swiss Re's count and 30,000 dead by Munich Re's.

Munich Re's Geoscience Research Group claims that its survey of 1999 disasters confirms an increase in the long-term loss trend. According to Munich Re, the number of loss events caused by natural hazards last year was 755, a figure that "far exceeds the previous record of 702 in 1998 and the long-term average of 600."

Meanwhile, 10 of the 1999 events reached "historical" dimensions, according to Munich Re.

"At the end of the millennium, therefore, there is no sign of any slowing, let alone reversal, of the long-term loss trends. If we compare the last 10 years of the 20th century with the 1960s, we will see that the number of great natural catastrophes increased by a factor of three, with economic losses—taking into account the effects of inflation—increasing by a factor of more than eight and insured losses by a factor of no less than 16," the Munich Re report notes.

"This acute increase in natural catastrophes represents a major challenge to the insurance industry, which is developing new financial tools in an endeavor to come to terms with the threatening loss potentials," including alternative risk transfer products, according to Munich Re.

Of the catastrophes registered by Munich Re throughout the world, windstorms were responsible for 80% of the insured losses, while earthquakes accounted for 10%; floods 6%; and other events, such

as forest fires, frost and heat waves, about 4%.

Swiss Re's report is in agreement that, "since 1970, the extent of natural and man-made catastrophes covered by sigma has increased."

According to the Swiss reinsurer, the bigger losses are due to higher population densities; more insured values in hazard-prone areas and a higher concentration of values in industrialized countries.

"Population growth and the increase in values in large conurbations and, in particular, land use in highly exposed regions" is the main factor in increased losses, Munich Re also noted.

Despite a number of extreme weather events, such as the European windstorms, the U.S. tornadoes and floods and landslides in Latin America and southeast Asia, "the increasingly distinct change in climate can in no way be made completely responsible for the constantly rising impact of natural catastrophes," according to Munich Re.

But climate change, with its related effects, including torrential rain, windstorms, heat waves and rising sea levels, together with a global increase in population and urban growth, will put many more areas of the world in danger, the German reinsurer predicts.

Swiss Reinsurance Co.'s sigma publication is available through its Web site, at www.swissre.com. Extracts from Munich Reinsurance Co.'s topics publication are available through Munich Re's Web site, at www.munichre.com.

Construction delays yield coverage fight

By PAULA WESTON

PERTH, Western Australia—An Australian mining company is turning to arbitration to resolve a \$90 million Australian (\$54.1 million) coverage dispute with underwriters at Lloyd's of London.

Stephen Dennis, group general manager of Perth-based mining company Anaconda Ltd., said that Lloyd's underwriters denied an extended liquidated damages claim related to construction delays at Anaconda's \$1.2 billion Australian (\$721.8 million) Murrin Murrin nickel mine in Western Australia.

Mr. Dennis said Anaconda bought an extended liquidated damages policy in 1997 providing \$150 million Australian (\$90.2 million) in limits from Lloyd's to cover problems related to the construction of the project, northwest of Kalgoorlie.

Anaconda had an agreement built into its contract with U.S.-based engineering group Fluor Daniel that Fluor Daniel would pay liquidated, or cash, compensation up to \$11 million Australian (\$6.7 million) for late construction. Anaconda then bought additional coverage, known as extended liquidated damages coverage, through a Lloyd's policy that would provide \$10 million Australian (\$6.1 million) for each month the project was late,

Mr. Dennis said.

"Because of some technical problems, construction was delayed by eight to nine months. We claimed \$90 million Australian from the syndicate, which attempted to avoid the policy on the basis of design changes in the plant, made two to three years ago," he said.

"In a complex metallurgical plant, there are thousands of design changes at any one time," Mr. Dennis said. "If underwriters can rely on these design changes to avoid liability, the policies really are worthless."

Mr. Dennis said that, in addition to Lloyd's, GIO Australia Ltd., now owned by Sydney-based AMP Ltd., was among 180 underwriters for this particular delay-related risk.

The arbitration, if successful, would set a precedent for extended liquidated damages because Anaconda's policy is the first of its kind. If the arbitration is unsuccessful, it is up to Mr. Dennis to decide whether to take the matter to court.

Lloyd's Australian representatives and GIO executives declined to comment on the case.

The policy was brokered by Heath Group Australasia Pty. Ltd., in Perth, Western Australia. Heath Group Western Australian Manager Bill Grierson was unavailable to identify either the syndicate or the lead reinsurer.

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Report

Continued from page 15

"The fact that intellectual property is difficult to quantify means that it is equally difficult to place a value on reduction of its worth as a result of an insurable event," said Mark Butterworth, chairman of AIRMIC.

"Factors such as competitor behavior, consumer reaction and poor management can affect the value of an organization's intellectual property," said Mr. Butterworth, who is risk manager for Prudential P.L.C. "However, these are not necessarily covered by traditional insurance products and require innovative solutions from the insurance industry."

Ian Harrison, an underwriter at the Lloyd's agency of Beazley Furlong Ltd., said that companies are beginning to realize that they must offer solutions to the problem of loss of intellectual property.

"There has been a sudden realization that there is a gap between liability and property coverage. Neither can adequately cover the damage to intangible assets or reputation," Mr. Harrison said. "Filling that gap is classic Lloyd's territory. Risk managers in the food and drink industry are turning to us for innovation."

Along with environmental issues and specific product-related

health and safety issues, a lack of coverage for accidental or deliberate product contamination was the second-largest area of concern, with 18% of respondents expressing worries about the adequacy of insurance coverage. In addition to the damage this can cause to a company's reputation,

or brand is most physically represented in recall."

The majority of respondents to the survey, 65%, said that the brand name was the most valuable asset contributing to a corporate image.

"The research findings of the food and drink survey concur

age/reputation, highlights the importance of intangible assets to these companies.

"This, together with the finding that risk managers are concerned about obtaining adequate cover for these risks, shows how knowledge and knowledge protection are at the forefront of risk management thinking in the industry," the report stated.

But the survey revealed that, despite the perceived worth of intellectual property and brands to food and drink companies, most companies in the industry do not attribute balance-sheet values to these assets unless they are involved in the purchase or sale of brands.

Only 39% of respondents said that their organizations gave values to intangible assets, and, among those, only 30% said that their companies had done so for more than five years.

Even some of the biggest names in the food and drink industry do not actively attribute balance-sheet values to these assets, according to the survey.

For example, at the end of 1998, Coca Cola's net assets were valued at \$19.1 billion—less than one-quarter of the \$83.8 billion estimate of the company's brand value by branding consultant Interbrand.

Despite the fact that the majority of respondents to the survey saw the brand name as the most

important factor contributing to corporate image, only 29% of respondents to the survey said that their companies would make attempts to place balance-sheet values on their intangible assets in the future, while 46% stated that they would not.

The report also revealed that concern about the safety of genetically modified foods is on the increase.

Recent media attention on genetically modified food scares in general has highlighted the potential influence of media coverage on consumer awareness, the report said.

A poll carried out by the research agency Mintel and cited in the Lloyd's survey revealed that the percentage of consumers concerned about genetically modified foods rose to 47% in April 1999, from 36% in August 1998. Several retailers in both the United States and the United Kingdom have removed genetically modified ingredients from their own brands in recent months.

"Such was the concern generated by the media that many companies removed GM foodstuffs from their products/shelves in an effort to reduce the damage to their image," the report said.

Copies of the report can be ordered from Andrew McKenzie, 44-207-327-5832; or andrew.mckenzie@lloyds.com.

'There has been a sudden realization that there is a gap between liability and property coverage. Neither can adequately cover the damage to intangible assets,' says Ian Harrison.

recall costs can be huge. But until recently, many companies did not purchase insurance to cover their product recall costs.

"Despite the damage associated with a recall, many companies either do not purchase cover or are not aware that such cover is available," according to the survey.

Mr. Harrison said that this situation is changing, however. "There is a growing demand for this kind of coverage. Organizations are beginning to recognize the value of their brands, be it on a balance sheet or not," he said. "This is particularly true of the food and drink industry, where damage to a corporate reputation

with the views of risk managers in other sectors. This sector makes up a large proportion of fast-moving consumer goods where the success of many products is heavily reliant upon the strength of the brand," said Robert Chase, special risks underwriter at Lloyd's agency Kiln.

The top-five assets forming corporate image, according to respondents, were: brand name, 65%; quality, 47%; product/product innovation, 35%; company image/reputation, 33%; and staff, 33%.

According to the report's authors, the prominence of brand, together with innovation and im-

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REQUEST FOR PROPOSALS

INVITATION TO BID

Sealed bids will be received by the Insurance Coverage Office - State Personnel, 655 S. Bay Road, Suite 201A, Dover, Delaware 19901, for **Excess Property Coverage** for the State, public schools and property of schools of higher education until 2:00 p.m., May 19, 2000, at which time they will be publicly opened.

Interested parties may inspect any and all bids after they are opened.

All bids submitted will be at net cost to the State of Delaware. Within the Request for Bid are the property schedules and other information which can be secured from the Insurance Coverage Office.

Interested agencies should provide a prioritized list of markets you wish to pursue by April 21, 2000.

The Insurance Coverage Office for the State of Delaware shall contact each agent with the approved markets for that agency to approach. The timing of the date stamp on the mail of facsimile shall determine the right of agent/broker to contact selected market/carriers. All agents/brokers shall be notified by phone within 5 days. Final submissions are due May 19, 2000.

Three copies of bid proposal should be submitted in a doubled sealed envelope clearly marked **EXCESS PROPERTY INSURANCE BID. DO NOT OPEN TILL MAY 19, 2000.**

The Insurance Coverage Office for the State of Delaware reserves the right to reject any and all bids. The Insurance will be awarded or all bids rejected by June 1, 2000.

Mailing Address:
Debra Lawhead
Insurance Coverage Office
655 S. Bay Road, Suite 201A
Dover, DE 19901
Phone: (302) 739-3651
Fax: (302) 739-5345

REQUEST FOR PROPOSALS

FIELD CLAIM INVESTIGATION SERVICES

The City of New York will receive proposals for field claim investigation services, in a procurement sponsored by the Office of the Comptroller. Detailed requirements are described in a Request for Proposals (RFP), which was released on Monday, March 20, 2000. A mandatory pre-proposal conference is scheduled for Wednesday, April 5, 2000. Firms interested in obtaining a copy of the RFP should contact:

Mr. Joseph Trapani, Chief
Bureau of Management & Accounting
Systems
Office of the Comptroller
1 Centre Street Room 1005,
New York, NY 10007
Attention: Ms. Vanessa Humphreys
(212) 669-8347 fax: (212) 669-8484

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- We would prefer an East-Coast presence, but are open to evaluating parties anywhere in the continental US. All interested parties may contact Tom Brown or Samir Dutt at 510 540-6776 for a confidential discussion.

REQUEST FOR PROPOSALS

Prescription Drug Program

The Nevada State Purchasing Division is issuing the following Request for Proposal:

Insurance Coverage for the Senior Prescription Drug Program (RFP 1148)
Proposals are due by 2:00pm, April 21, 2000.

For more information or to request a copy of the RFP, please contact:

Nevada State Purchasing Division
Services Procurement Section
755 N Roop Street, Suite 211
Carson City, NV 89701
(775) 684-8671 phone
(775) 687-1376 fax
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Results

Continued from page 2

a more disciplined pricing approach, "it was still too early to see the results on the bottom line," in insurers' 1999 results, said Michael Lewis, senior insurance analyst with Warburg Dillon Read in New York. "I'm hopeful that by the second half of the year we'll start seeing some improved earnings trends by some of the better underwriters," he said.

"It'll take a while for premiums to be earned and to see some improvement in the earnings," agreed Gary Ransom, senior vp at Hartford, Conn.-based Conning & Co.

Until then, he said, "we'll continue to get these mixed messages of prices going up, but earnings still being weak, and it's still not completely clear how the two lines will cross."

Matthew Coyle, a director at rating agency Standard & Poor's Corp. in New York, said this year's outlook remains negative "despite anecdotal evidence we're hearing from many of the large and regional insurance companies that pricing indeed is beginning to firm."

"It's not that we're disputing what we're hearing, but if you look at the industry factors that led to the initial underpricing of the original insurance risk, they still exist," said Mr. Coyle. There is simply too much capital chasing too few premium dollars, he said.

Michael Smith, an analyst with Bear, Stearns & Co. in New York, said, however, that there is evidence of more discipline in the market.

"Not only is competition dropping out of the market a little bit, but some of the weaker players are being shunned in the market so that... the worst thing for a risk manager to do is to put his risk management program in the hands of a defunct insurer," while the second worst is for a broker to do so, he said.

As a result, Mr. Smith said, "you've got a little more discipline being exerted by the customers and the inter-

mediaries as well as the underwriters."

Karen Horvath, vp at Oldwick, N.J.-based A.M. Best Co., said she anticipates a flight to quality, which to date has been more prevalent in the reinsurance sector, as insurance buyers become "a little more concerned about the financial integrity of their insurers."

Among the aggregate financial results for the 19 insurers surveyed by *Business Insurance* were:

- Net income decreased 1.4% in 1999 among the 17 insurers that report this information to \$9.66 billion. This compares with a 1.6% decline for the nine months ended Sept. 30, and a 0.9% improvement for all of 1998 by a comparable group of insurers.

- Net premiums written increased 2.2% among the 19 insurers surveyed to \$78.46 billion. For the nine-month period, premiums increased 5.7%, while they increased 2.4% in 1998.

- Underwriting losses deepened by 42.6%, growing to \$5.83 billion. This compares with a 42.9% increase in losses for the nine months and a 132.2% increase in the size of underwriting losses for all of 1998.

- The combined ratio for 1999 increased to 107.4% vs. 105.4% for 1998. Insurers reported a 106.4% combined for the nine-month period.

- Investment income increased by 2% to \$13.09 billion. It increased 1.7% for the nine-month period and declined by 3.2% in 1998.

- Policyholder surplus among the 18 insurers that reported this information declined by 1.2% to \$56.86 billion in 1999, while it increased 2.2% for the nine-month period and by 7% at year-end 1998.

Results were very disappointing, but not unexpected, said S&P's Mr. Coyle. Several companies—including CNA Financial Corp., Liberty Mutual Insurance Co. and Reliance Insurance Co.—"had a particularly bad year for 1999," he said, adding, "I think it's just a reflection of what's been happening to the industry over the last several years, and that's prin-

cipally been the rate deflation."

"Basically, it was a quarter of low expectations and the industry had a hard time meeting those expectations," said Mr. Lewis.

Factors influencing insurers' 1999 results included underpricing, rising loss cost trends and reserve deficiencies, he said. "These all had an impact on curtailing underwriting margins," Mr. Lewis said.

It was also a clean-up quarter, with insurers adding to their reserves, he said. In addition, losses from the European windstorms affected the results of a number of insurers and reinsurers, he added.

More reserve increases are expected this year, analysts say.

There will be more reserve increases in the first quarter, predicted Mr. Smith. By the middle of 1999, the U.S. property/casualty industry "very clearly had run out of room on the balance sheet to hide bad news," which is one reason there has been a proliferation of difficult earnings comparisons as well as some fairly substantial reserve increases, said Mr. Smith.

"They don't have any redundancies left there to absorb worsening experience," said Barbara Stewart, of Stewart Economics in Atlanta. "They're either going to have to reflect it in their reserves, or hold their breaths and hope something else will take them out of it. Things are getting very, very tight."

"I think reserves have clearly fallen over the past three years in our industry, mostly driven by workers comp and general liability," said Mr. Palczynski.

"Absolute adequacy is pretty elusive, but I think common sense says the cookie jar for a lot of companies is empty and some companies may very well be in trouble. So the companies that can afford to restore the balance sheet will," Mr. Palczynski said.

Although SAFECO has increased its reserves over the past couple of years, particularly in workers compensation, and feels comfortable that it is adequately reserved today, it is

concerned about inflation, said Mr. Yonker.

"We're going to be watching that closely and adjusting our reserves as we see fit," he said. "We currently feel we're about 5%-7% redundant in our reserves, but it's kind of a moving target."

Additional merger and acquisition activity is likely, though in recent months some of it has been slower than what most experts predicted. But as a sign of more activity to come, several analysts pointed to Citigroup's announcement last week that it will buy up publicly held shares of Travelers Property Casualty Corp.

CNA Financial Corp. last week also made a tender offer to acquire the remaining shares in CNA Surety Corp. it does not already hold.

"I've been a little bit surprised that I haven't seen more activity, particularly with the very low prices on the stocks right now," said Mr. Yonker.

He added, though, that Citigroup's announcement to buy the remainder of Travelers has the potential to create some momentum.

Hartford's Mr. Palczynski also pointed to the Citigroup announcement, saying "Clearly there's still lots of opportunity for consolidation in the industry."

Ken Zuckerberg, an analyst with Keefe, Bruyette & Woods in New York, said he believes that Travelers, along with Citigroup, "will be very active in M&A given their appetite for turnaround and distressed properties as well as the depressed prices among property/casualty stocks."

There are good buys out there in light of insurers' low stock valuations, added Mr. Zuckerberg. "We may actually see financial buyers looking to make acquisitions in the P&C business based on the compelling valuations," he said.

Mr. Smith agreed. "At the valuations the stocks have been trading I think there's some real potential for some outside buyers to come in," he said.

Less likely is consolidation among insurers, according to Mr. Smith. In-

surers in the past have used their stock as currency, but their shares are too cheap to do so right now, he said.

This is why Citigroup bought Travelers, Mr. Smith said. Citigroup's stock has twice the valuation of Travelers, so if Travelers is going to be a big consolidator, it's easier to use Citigroup's currency to make acquisitions "rather than its own."

Mr. Lewis said he expects more property/casualty insurers to buy each other. "It's been very, very slow so far in the year 2000, but I'm still a believer that this is a primary activity of the group, and I do think you will definitely see a pick-up," he said.

In addition to further consolidation activity, "I think you'll also see a lot of companies shedding what they consider to be non-core or underperforming lines of business," so they can focus on their most profitable lines of business, said Best's Ms. Horvath.

Analysts predict that commercial insurers' poor stock market performance will improve once better earnings become more imminent.

Insurer and reinsurer stocks were down 5.7% for the year through March 24, though they did improve by 6% for the week ended March 24, according to the BI Stock Index (see page 23).

"I think earnings visibility will be a key driver," said Mr. Zuckerberg, though he added he is not recommending many insurer stocks for purchase now "in the interest of conservatism."

"I believe that if the actions instituted by the more enlightened managements, coupled with their education in naive capacity, proves accurate, we should start to see a better operation environment" which will translate into higher stock market valuations, Mr. Lewis said.

"Wall Street doesn't necessarily have to see the earnings right now in order to be enthusiastic about the stocks," said Mr. Smith. An across-the-board improvement in premiums alone should accomplish this, he said.

Major property/casualty insurers' year-end 1999 results

Ranked by change in net income. All amounts in thousands of dollars.

Rank 1998	Corporate				Property/casualty operations								
	Net income 1999	Percent increase (decline) 1998-1999	Consolidated revenues 1999	Combined ratio 1999	Combined ratio 1998	Net premiums written 1999	Percent increase (decrease) 1998-1999	Pretax underwriting income (loss) 1999	Percent increase (decline) 1998-1999	Pretax investment income 1999	Percent increase (decrease) 1998-1999	Policyholders surplus 1999	Percent increase (decrease) 1998-1999
1 The St. Paul Cos. Inc.	834,434	833.9	7,569,036	108.1 ²	117.8 ²	5,111,817	(3.1)	(424,539)	51.8	1,255,923	(2.8)	5,500,000	17.0
2 Royal & SunAlliance USA ²	474,576	90.1	2,376,837	106.5	106.0	1,775,575	16.5	(124,820)	(31.1)	409,622	17.7	2,597,860	(12.2)
3 Ohio Casualty Corp.	114,141	34.4	1,900,080	112.8 ²	107.2 ²	1,586,897	10.4	(184,238)	(148.8)	181,078	9.9	899,759	(12.4)
4 American International Group	5,055,435	18.1	40,656,083	96.4	96.4	16,223,885	11.2	669,245	26.1	2,516,691	14.8	N/A	N/A
5 American Financial Group	141,400	13.7	3,334,500	102.0	102.8	2,263,300	(13.2)	(42,900)	43.6	339,800	(9.1)	1,664,200	(9.6)
6 RLI Corp.	31,451	11.4	225,756	91.2	88.2	227,624	56.2	17,134	2.1	26,015	8.7	293,069	(0.3)
7 Cincinnati Financial Corp.	254,723	5.5	2,128,223	100.4	104.2	1,680,812	7.9	(10,299)	84.0	207,640	1.8	2,851,774	(5.6)
8 Travelers P/C Corp.	1,276,200	(5.0)	10,571,800	103.1 ²	102.2 ²	8,213,100	1.4	(308,600)	(18.4)	2,088,900	(0.4)	7,655,700	8.1
9 Chubb Corp.	621,100	(12.1)	6,642,200	102.8	99.8	5,701,100 ²	3.6	(178,800)	(2,609.1)	821,000	9.6	3,288,400	18.7
10 Hartford Financial Services Group	862,000	(15.1)	13,528,000	103.5	103.7	6,707,000	(10.0)	(206,000)	20.5	883,000	(7.5)	6,898,000	(19.0)
11 SAFECO Corp.	252,200	(28.3)	6,866,200	108.4	102.6	4,483,800	5.3	(366,700)	(235.2)	462,300	(3.7)	2,727,700	(9.2)
12 Old Republic Int'l	226,839	(29.9)	2,102,199	112.2	99.6	854,557	(4.2)	(129,994)	(682.0)	182,511	(4.9)	1,344,023	(8.1)
13 Hartford Steam Boiler	72,800	(45.8)	606,200	94.4	89.6	366,700	4.0	21,300	(48.3)	64,100	(0.2)	428,700	(30.0)
14 Argonaut Insurance Co.	(22,431)	(127.1)	121,577	206.2	118.3	91,012	(19.6)	(80,722)	(259.6)	62,138	(11.7)	578,604	(12.0)
15 CNA Financial Corp.	(130,000)	(146.1)	16,400,000	121.2	116.3	9,070,000	(15.1)	(1,830,000)	(5.2)	1,620,000	(3.0)	8,590,000	12.7
16 Fremont General Corp.	(94,122)	(181.0)	975,733	128.7	96.2	897,633	57.0	(238,318)	(1,224.4)	149,808	(12.6)	562,879	(13.0)
17 Reliance Ins. Co. and subs.	(310,546)	(195.1)	3,153,256	124.3	102.1	2,560,409	5.0	(788,426)	(1,413.1)	286,420	(2.8)	1,244,003	(28.8)
-Kemper Insurance Cos.	N/A	N/A	3,225,023	110.6 ²	106.6 ²	2,424,431	(12.3)	(244,915) ²	(46.2)	270,308 ²	(22.4)	2,682,820	4.2
-Liberty Mutual Ins. Co. ²	N/A	N/A	N/A	116.8	114.0	8,222,781	26.2	(1,374,495)	(57.7)	1,258,946	11.2	7,045,853	0.3
Cumulative	\$9,660,200	(1.4%)	\$122,382,703	107.4%	105.4%	\$78,462,433	2.2%	(\$5,826,087)	(42.6%)	\$13,086,200	2.0%	\$56,853,344	(1.2%)

1 After dividends 2 Statutory
Source: BI survey

Leapfrog

Continued from page 1

capolis-based Buyers Health Care Action Group—found that while a lot of employers “talk” about value-based purchasing, few are doing anything concrete to effect it.

“One of the problems of employer quality purchasing initiatives is that they’re not focused, there’s no accountability,” observed Dr. Milstein.

“Leapfrog will bring focus and commonality to value purchasing, begin to hold purchasers accountable and apply a test to make sure they are doing it. It will be a kind of self-applied accreditation like ISO 9000 for U.S. manufacturers,” he explained. “We’ll take the same metaphor and ask, ‘Do you take quality into account in health care purchasing?’”

While all of the Leapfrog members already implement some form of value purchasing, “we can all learn to do more and to do it better,” said Mr. Bradley. “And by working together with other employers, we can increase the impact.”

To make sure that health plans don’t just pay lip service to employers’ demand for improvement in patient safety, the Leapfrog Group insists that providers with the best results are compensated accordingly “so the doctors and the hospitals—not the health plans—get the rewards,” Dr. Milstein said.

Besides recognizing and rewarding superior safety, the Leapfrog Group also seeks employers’ “voluntary” commitment to a set of value-based purchasing standards the group has been developing over the past two years, according to Ms. Delbanco.

Those standards will encourage and/or require health plans and their providers to:

- Computerize the entry of physician orders for prescriptions and other medical supplies or services.

Although computer software is readily available for prescription and other physician orders made in hospitals, only 30% of the nation’s hospitals have adopted it and fewer than 3% require doctors to use it, according to Dr. Milstein.

“Published research demonstrates that currently available systems can intercept 55% of serious prescription errors,” he said, referring to a 1998 article published in the *Journal of the American Medical Assn.*

- Use only board-certified staff in hospital intensive care units.

“When the physicians who staff the ICU are credentialed in critical care management, patients are less likely to die or get worse,” Ms. Delbanco explained.

- Use evidence-based hospital referrals so that patients are directed toward facilities that consistently yield the best outcomes, rather than ones that merely cost the least.

“Volume thresholds are known to produce better outcomes,” Ms. Delbanco pointed out.

“Our priority is to get as many purchasers as possible to put Leapfrog standards into their purchasing standards or, at the very least, push toward disclosure to create accountability through consumer awareness,” said Steve Wetzell, executive director of the Buyers Health Care Action Group, the Minnesota employer purchasing coalition. “We’ve got the money, so we control the incentives. That means we should be able to drive constructive change,” he said.

Even though Leapfrog has not yet formalized its quality standards, Denver-based U.S. West is already incorporating them into requests for proposal it sent out recently to health plans in the 14 states in which it does business, according to Dr. Paul Johnson, corporate medical director based in Englewood, Colo.

“We put words in our current initiatives that speak to the Leapfrog

principles,” he said.

For example, the RFPs for the 2001 plan year ask health plans to list the top 10 hospitals they use in terms of volume and to describe their plans for implementing computerized prescriptions, board-certified ICU staffing and evidence-based hospital referral at those facilities.

While U.S. West is not yet requiring their use, “we put it in as a heads up. Now we’re just gathering information. But we’ll be back later,” Dr. Johnson promised.

Another goal of Leapfrog is to improve patient education so that the actual users of the health care system can also serve as watchdogs.

“The efforts must be grounded in consumer activation,” Ms. Delbanco insisted. “We’ll work through employers to communicate with employees, arm them with information so that they are better educated and ‘safer’ patients” always on the lookout for medical errors, she said.

While the Leapfrog Group’s objectives are firm, the employers that adopt them will have flexibility over how and when they will implement them.

“We tried to make the rules flexible to adapt to each company’s corporate culture and market capabilities. It’s not a one-size-fits-all approach,” said Mr. Wetzell.

For example, requiring computerized prescription drug ordering may not be feasible in some markets, “but in other markets we can be more aggressive,” said Mr. Wetzell.

In some cases, employers may have to pay for some of these improvements through higher premiums, he said.

“At BHCAG, our care systems set their own budgets based on what they need to compete in the market. So they could build the cost of developing a computerized prescription drug infrastructure into their products’ cost,” Mr. Wetzell said.

“We’ve had a long history with

this. Back in 1992, we pushed for computerized records. But we need to give providers the discretion to make investments to improve patient safety,” he said.

Indeed, “one of my concerns is that many employers today are only buying based on cost,” said GM’s Mr. Bradley. “But it is our belief, and we’ve certainly seen it in manufacturing, that buying on quality can actually reduce cost” in the long run, he said.

“But there’s an even higher reason than cost—preventing mortality and serious injury,” he insisted.

U.S. West’s Dr. Johnson agreed: “When you’re aware of the problems, you have a moral or ethical responsibility to act on it as an employer.”

An HMO trade association appeared receptive to the Leapfrog Group’s aims, but said they will not come without some changes.

“These are reasonable things to ask hospitals to do, and they are the kinds of things health plans can include in credentialing, but the huge bulk of hospitals won’t meet these criteria,” said Dr. Charles Cutler, chief medical officer for the American Assn. of Health Plans in Washington. “So we’ve asked if they’re willing to live with a smaller group of hospitals in their networks,” he said.

In addition, because these improvements—particularly computerized order entry—will be expensive, the AAHP has also asked the Leapfrog Group if members are willing to pony up the cash to pay for them.

“Many health plans lost money last year and the year before, so they may not be able to provide these financial incentives,” he explained, adding that the hospitals themselves have been in even worse financial straits.

“We’ve got to get over this down-payment effect,” Dr. Cutler asserted. What was the Leapfrog Group’s reaction to the AAHP’s response?

“We’re still waiting,” he said. **BI**

But that has not been the case in Sikorsky’s experience, she said.

The national average for flexible work arrangements is 8% to 15% of your workforce and “that’s exactly what my numbers show,” Ms. Ellis said. Flex time is used by about 90% of Sikorsky’s workforce, she said.

Mr. Houghton said that it’s important to look at today’s workforce. When you do, he said, you will see that it is getting younger.

“The Gen-Xers and Gen-Yers have a very different attitude toward work and career. They’re very much into achieving, but they also want to have a killer life, not just a killer job,” he said.

“They do not understand rigid, structured, inflexible organizations,” Mr. Houghton said, “because that’s not the way they live their lives, that’s not the way they’ve gone to school. You’re talking about the ultimate multitaskers.”

To attract and retain the best talent, he said, employers really need to think more flexibly. **BI**

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Keith Crain
Chairman
9-29-99

Flex

Continued from page 3

“I remember one employee doing a hybrid of arrangements,” he said.

At Sikorsky, when an employee wants a flexible work arrangement, his or her proposal must explain, among other things, how business objectives will be met, how the arrangement will fit in with co-workers’ schedules and the ability to serve customers, and how the employee can be reached in an emergency.

“We have support tools, called ‘flex books,’ which ask about 15 to 16 questions of the employee, which, when answered, will be a comprehensive proposal for the employer. The supervisor has a corresponding book that he reads that gives him things to think about as he is evaluating the proposal,” Ms. Ellis said.

Both Mr. Houghton and Ms. Ellis agree that guidance from senior management, combined with training for flexible work arrangements, is key when implementing new policies.

In order for flex time to be successful in an organization, it’s critical that you have leadership and visible support from senior management, Mr. Houghton said.

With this strong guidance, “you will have eliminated two-thirds of the concerns that you’re going to hear from managers. Most managers are very comfortable with this, but they need to have that support from senior management,” Mr. Houghton said.

Ms. Ellis also emphasized the importance of leadership when starting training and a pilot program.

“You need a cross-section of different levels of employees; you also need some people involved who are not proponents of flex time arrangements. You need people who have influence

with their top management. They need to be highly thought of and need to have some kind of clout, so others will listen,” Ms. Ellis said.

She said that getting managers to accept the implementation of flexible work arrangements was as easy as letting them know “what’s in it for me.” For example, Sikorsky has found that its flex arrangements help improve employee morale, making managers’ jobs easier.

“The whole point here was culture change. If you look at flex work arrangements (only) as policies and programs, you’re going to miss,” Ms. Ellis said.

“You had to get to (management’s) belief patterns. There is the old work paradigm from the industrial age of time on a machine equals productivity, which equals money. We don’t work in the industrial age any more. We work in the information age, but we’re managing out of the industrial age. We’re managed by ‘if I can see you, then you’re working,’” Ms. Ellis said.

Understanding the need to balance flexible work arrangements with time in the workplace is also a key factor.

Mr. VanCleve of Hewitt Associates said he has observed that, in the past five years, “flex time has probably doubled in popularity.”

Even with their increased popularity, though, flexible work arrangements are not for everyone, he said.

Ms. Ellis said: “I think one of the biggest mistakes employers make when they start thinking about flexibility is that they start thinking that it’s all or nothing. So, say, for telecommuting, some managers worry that everyone will be out of the office 40 hours a week.”

But that’s not really the case, she stressed.

“Ninety-nine percent of our

telecommuters telecommute on a part-time basis. Say, perhaps a day or two or a couple hours a day,” Ms. Ellis said.

Mr. Houghton said that part-time flexible work arrangements seem to work best.

“You cannot work in a vacuum. I really don’t think that 100% working out of the office is the right thing to do—maybe three or four days a week, or it may be even more, but it takes a very disciplined person to be able to work remotely all of the time,” he said.

Trial periods of flexible work arrangement proposals are not uncommon, Mr. Houghton said.

In general, “any arrangement that you make should have some measures and milestones. Progress should be monitored, and trial periods are common,” Mr. Houghton said.

He said that, at the end of a typical trial period of perhaps 30 days, an employer might “adjust, change or eliminate” the flexible work arrangement.

“It’s always best to have something expire, because then you’re not taking something away,” Mr. Houghton said.

Management decisions about whether flex time will work should be determined on a case-by-case basis, Ms. Ellis said.

“If you have five financial analysts who want to work at home, each of their proposals will be different. Even if they all do the same job, they are all different people and they bring different skills to the job. Some of them may be very good self-starters; some of them may not,” she said.

“The supervisor can make an individual decision,” Ms. Ellis said.

One of management’s biggest fears, Ms. Ellis said, is that every employee will want flexible work arrangements.

U.S. buyers rally to Bermuda's aid

There's no sympathy among risk managers for the cause of U.S. insurers crying foul against Bermuda-based insurers for enjoying unfair tax advantages. Indeed, risk managers intend to defend Bermuda-based insurers against efforts to change U.S. tax law to close what the U.S. insurers say is a loophole that benefits the Bermuda-based companies.

Risk managers and other readers with long memories of the mid-1980s liability insurance crisis when they couldn't find coverage from any U.S.-based insurer wrote me in droves in response to my last commentary. They, too, see the irony in U.S. insurers attacking the Bermuda-based insurers they actually helped create by their unwillingness to insure U.S. businesses in the mid-1980s, as I pointed out at the end of my commentary.

"Your last sentence is truly telling. The industry, from top to bottom, shot itself in the foot on more than Fortune 500 companies in the mid-80s and it still whines about it," wrote one reader.

"Re: Last paragraph of your Commentary—how right you are!!!" wrote another reader.

"I especially liked the last paragraph. Some of the insurers certainly persist in 'sticking their heads in the sand,' whether it was 10 years ago or now. Then we have this bunch with their sour grapes. And folks wonder where integrity and quality disappeared to in the industry."

And risk managers aren't just writing me e-mails. They are preparing to defend the Bermuda-based companies in Congress.

"Hooray for your article! I was so burned up when I read of the attempt to get Congress to close the tax advantage for Bermuda-based companies," wrote one risk manager whose company "was one of the companies that was literally 'forced' to go to Bermuda in the '80's to secure decently priced D&O. And guess what? We found that it was an excellent market and we stayed. It behooves all of us to watch this situation and let our congressmen/women know our concerns."

Another risk manager wrote that he is working to organize risk managers "on opposing this nonsense."

Bermuda-based insurance companies not only have risk managers on their side, but also some very important public policy issues, as one tax attorney pointed out to me in his e-mail. "If the U.S. does this, it must face the consequences of having invented a new form of taxation that can be applied to the many foreign subsidiaries of U.S. companies, not just insurers, around the world. The U.S. has the largest number of foreign subsidiaries and many U.S. insurers reinsure all or most of their business back to the U.S. The foreign governments do not care whether the business is going to a tax haven; it has the same effect if it is going to the U.S."

The tax attorney further points out: "One of the results of this type of taxation becoming popular would be (i) less reinsurance back to the U.S.; (ii) a greater need for moving capital from the U.S. parent to its foreign insurance subsidiaries; and (iii) the investment income from this capital being subject to foreign taxation rather than U.S. taxation. I would also note that it could apply to the banking industry and many others, for example, the selling of loans by local offices back to the U.S."

Of the many notes from Bermuda I received, the one I liked best was from a supplier of services to the Bermuda insurance industry who wrote, "Thanks for writing about us. I think that if anyone asked the businesses that these Bermuda companies insure what they think of them, you would get a unanimous 'grateful,' particularly if they have sustained a loss and gotten millions of dollars in less time than it takes (insurance company name deleted) to clear a car insurance claim."

The reader also asked if the Chubb Atlantic that is doing business in Bermuda is related to the Chubb that is advocating the new U.S. tax on Bermuda-based companies. Indeed, it is.

Interestingly, Chubb Atlantic underwrites liability insurance from Bermuda, offering a wrap-around policy to cover punitive damages assessed in U.S. states that do not permit the insurance of punitive damages. I wonder how long it will take a U.S. insurer without a Bermuda-based subsidiary that can offer this coverage to lobby for a law against this product.

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



Kathryn J. McIntyre

Privacy

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act's express statutory protection of a consumer's "non-public personal information" means that any information collected through the private business operations of a financial firm be considered non-public information, even if some of that information could be found elsewhere publicly.

- Consumer "opt-out" procedures. The act requires that consumers be given a fair opportunity to opt out of having their non-public personal information shared with non-affiliated third parties.

While insurer trade groups generally prefer opt-out provisions, consumer-focused industry representatives argue such information should be protected unless consumers specifically "opt in" to permit sharing it. The NAIC helps fund the cost of consumer representatives' participation in NAIC activities.

- Clarifying the scope of federal privacy regulations. The proposed federal privacy regulations expressly include state insurance authorities in the list of regulators applying federal regulations, even though federal privacy regulations will not apply to insurance providers and state insurance regulators will have no role in enforcing federal rules.

Although Title V of the act does not impose specific deadlines on state insurance regulators, insurers and agents are subject to the financial services act regardless of whether they receive guidance from their domiciliary state.

So, state insurance regulators want to comment soon so federal rulemakers will consider their views before the May 12 deadline for adopting the final version of privacy regulations. Those regulations would then go into effect six months after the rule is promulgated, or

about Nov. 12.

State insurance commissioners face some special concerns in crafting their response to the proposed federal rules to enhance consumer privacy.

While state insurance regulators believe uniformity is the answer, state legislatures around the country are currently considering about 20 privacy-related bills "that might create diversity" in states' response to the federal inquiries, Ms. Sebelius said during an Industry Liaison Committee meeting held as part of the NAIC's recent spring meeting in Chicago.

To help prevent that potential diversity, state insurance regulators

Regulators may enlist the support of governors and legislators for a uniform state response, says Kathleen Sebelius.

may try to educate governors and legislators about the situation and enlist their support for a uniform state response. Essentially, regulators would encourage them not to pass new state-specific consumer privacy measures before federal regulators act, she said.

"The statutory requirements of (Gramm-Leach-Bliley) should be given a chance to become operational before additional state statutory requirements are imposed on insurers and financial institutions," said Michael Lovendusky, assistant general counsel for the American Insurance Assn. in Washington. The AIA—like several other insurer trade associations—contends "it is vital for all functional regulators, at both the state and federal level, to adopt uniform regulations," he said.

State insurance commissioners do need to be more active and vocal in addressing pending state privacy legislation, according to the Alliance of American Insurers in Downers Grove, Ill.

"Legislators and consumers all look to you for guidance on insurance-related issues and your silence on these issues has created a void quick to be filled by alarmists with their own political agenda, not to mention the sense that federal preemption/regulation is inevitable," Lenore Marema, vp of legal and regulatory affairs for the Alliance, said in a recent statement directed at regulators.

Given those concerns, state insurance regulators likely will welcome the National Conference of Insurance Legislators' stated support for a uniform approach to crafting consumer privacy rules.

"I think there is general appreciation of the fact that this is an area that lends itself to consistency," said Robert Mackin of Mackin & Co. in Albany, N.Y., who serves as executive director of NCOIL. Once federal consumer protection issues are resolved, some trade groups have urged that state legislatures use the NAIC Model Insurance Information and Privacy Protection Act as the basis for any further legislation.

Another concern NAIC leaders face is the fact that some state insurance regulators think that the current federal proposals establish too low a standard for consumer protections and need to be strengthened.

In addition, Ms. Sebelius said there is a great deal of concern about reconciling consumer privacy rules for financial services with pending rules for medical records privacy.

Suggestions about consumer protection guidelines should be faxed to the NAIC Privacy Working Group at 202-624-8579.

IRS

Continued from page 2
have different price tags. Unused credits can be taken as cash.

The key condition the IRS has attached to flex plans is that benefit elections—such as how much an employee will contribute to an FSA—must be made prior to the start of the plan year and that the decision is irrevocable for the rest of the year.

The IRS earlier said, however, that in certain situations employees could revoke benefit elections made prior to the start of the plan year. For example, if a spouse died during the middle of a year, an employee could move to single coverage from family coverage and reduce his or her pretax contributions.

The final and proposed regulations, though, considerably expand what are acceptable changes in status under which an employee could revoke or amend a prior benefit election.

"This is a pretty exhaustive list," said Rich Stover, a principal with Buck Consultants Inc. in Secaucus, N.J.

For example, under the final regulations, a strike or lockout would be considered a change in status allowing an employee to revoke a prior benefit election.

The final regulations also deal with situations in which employees covered by flexible benefit plans quit and resume employment.

If an employee quits and returns to work within 30 days, the employee—absent another status change—automatically would have his or her prior benefit election restored. However, if the employee returns to work more than 30 days after leaving, his or her employer could permit the employee

to keep his or her prior benefit election or make a new election.

The proposed regulations considerably expand what is a change in status when compared with the 1997 regulations.

Take the situation of a health plan that significantly increased premiums during the middle of a year. Under the 1997 regulations, such an increase would be considered a change in status only if the plan were fully insured.

By contrast, the proposed regulations would consider cost increases in self-funded plans to be changes in status as well, which would allow employees to change—prospectively—their pretax contributions to

'This is a pretty exhaustive list' of acceptable changes of status, says Rich Stover of the IRS regulations.

ward the premium.

Alternatively, if the cost of a traditional indemnity plan increased significantly, an employee could, for example, revoke his or her option to be in the indemnity plan and switch to a lower-cost health maintenance organization, if one were offered.

This expansion, though, only would apply to pretax contributions for health care premiums. It would not extend to the pretax contribution an employee earlier agreed to make to a flexible spending account.

The proposed regulations also address situations in which two working spouses are employed by different employers, whose health care

plans operate on different plan years.

One plan, for example, might operate on a calendar-year basis and require employees to make benefit decisions during an open enrollment season in November that take effect Jan. 1. The other plan might require employees to make benefit selections in May that take effect July 1.

Consider the situation if both employees had opted for single coverage. The employee in the July 1 plan then decides to opt for family coverage for the following plan year. The spouse in a calendar year plan would be able to make an election change in the midst of the plan year to drop single coverage.

"This is a very practical solution for working families in which spouses work for different employers with different plan years," said Andy Anderson, a consultant with Hewitt Associates L.L.C. in Lincolnshire, Ill.

The new proposed rules also would permit employees to revoke or amend pretax contributions to dependent care spending accounts if certain changes in status occurred.

During a plan year, for example, if an employee changed dependent care providers, the employee could make a new contribution election to the FSA to reflect the cost of the new provider.

In another example, an employee elects—prior to the start of a plan year—to make \$4,000 in pretax contributions to fund payments to his or her dependent care provider, who has agreed to provide services at an annual cost of \$4,000. During the year, though, the employee raises the provider's salary to \$4,500. The employee would be permitted to revoke his or her prior election to contribute \$4,000 to the dependent care FSA and would instead be allowed to contribute \$4,500. BI

PBGC

Continued from page 1

support the PBGC's insurance program through premiums they pay the agency. In 1974, when Congress created the PBGC to guarantee plan participants' basic, vested pension benefits, the annual premium was set at \$1 per plan participant.

Since the agency's creation, however, Congress on several occasions has had to raise premiums as losses from terminations of underfunded plans mounted and the PBGC's financial stability worsened. Today, the annual premium for fully funded plans is \$19 per participant, while an employer with a severely underfunded plan can pay as much as several hundred dollars for each person in its pension plan.

With a growing surplus, the PBGC's premiums—which, for fully funded plans, haven't been raised since 1991—should remain stable.

The rising surplus has led some business groups to call upon Congress to lower the agency's rates, a move Mr. Strauss said would be imprudent given the exposures the agency faces.

That \$7 billion surplus compares with an estimated \$17 billion to \$19 billion in unfunded obligations under pension plans maintained by financially weak companies—those with below investment grade bond ratings, he said.

Given the size of that exposure, "I don't think a \$7 billion surplus is out of line," Mr. Strauss said.

If PBGC premiums were to be cut now and the economy soured, leading once again to terminations of hugely underfunded plans, that financial cushion quickly erode and premiums would have to be raised, a scenario that Mr. Strauss said he does not want to see develop.

"My concern would be by making precipitous decisions now, you run the risk of having to raise premiums later when our premium payers are under a lot of (financial) pressure," he said.

The prudent course of action, he said, is to continue to take advantage of what has been a long run of near-perfect economic conditions to continue to build the PBGC's cushion.

The agency's growing surplus is the result of several factors, not the least of which is the sharp reduction—due to the strong economy—in terminations of underfunded plans.

Last year, for example, the PBGC reported \$224 million in claims—the gap between plan assets and liabilities—from completed and probable terminations of underfunded plans. The two largest claims came from the termination of a pension plan sponsored by Allegheny Health, Education and Research Foundation, which had \$23 million in unfunded benefits, and failed retailer, Caldor Corp., whose two plans had a total of \$10.5 million in unfunded benefits.

Those terminations pale in comparison to some of the blockbuster pension plan failures of the late 1980s and early 1990s. The termination and takeover by the PBGC of failed airliner Pan American World Airways' three pension plans—two in 1991 and one in 1992—alone resulted in a net loss of \$688 million incurred by the PBGC.

Higher interest rates also aided

'My concern is that very few new people are coming into the system,' says David Strauss of the PBGC.

the PBGC's financial results. The agency in 1999 used a somewhat higher interest rate assumption compared with 1998—reflecting market conditions—which has the effect of lowering the value of its liabilities.

While the PBGC's financial fortunes have vastly improved since a low point of 1993, when it faced a deficit of nearly \$3 billion, significant potential risks to the agency's insurance program and its premium payers remain.

Covered in the agency's insurance program are 184 companies with below investment grade bond ratings and whose pension plans are underfunded by between \$17 billion and \$19 billion, according to the PBGC.

Some of those companies with below investment grade bond ratings are in cyclical industries that are especially vulnerable to economic downturns.

For example, pension plans sponsored by steel companies with below investment grade bond ratings are underfunded by \$4.5 billion, while airline companies with below investment grade bond ratings account for another \$3.7 billion in un-

funded liabilities, the PBGC said.

Even as the PBGC's financial condition has never been better, its annual report details a continuing decline in the number of defined benefit plans.

In 1999 alone, employers terminated close to 2,000 fully or overfunded plans, while the agency took over 130 pension underfunded plans. That brought down to about 38,000 the number of defined benefit plans insured by the PBGC, compared with 112,000 plans in 1985.

The decline in defined benefit plans has been especially pronounced among small employers. Between 1985 and 1999, plans insured by the PBGC with fewer than 100 participants fell to 24,000 from 90,000, while covered plans with between 100 and 999 participants declined to about 11,000 from just over 19,000.

By contrast, the number of large plans—those with more than 10,000 participants—actually increased slightly between 1985 and 1999, though that probably is the result of a rise in the number of retirees and vested participants who have left a company, as well as corporate mergers, rather than new plans being created, the agency said.

The number of active participants in PBGC-insured plans actually fell to 22.6 million in 1996—the last year statistics are available—from 27.3 million in 1988.

Citing these and other figures, the PBGC's Mr. Strauss is an outspoken proponent of the need to revitalize the defined benefit system.

"My concern is that very few new people are coming into the system," Mr. Strauss said.

A consensus has emerged among benefit experts that more financial incentives are needed to encourage employers to offer defined benefit plans, while employers should be allowed to offer plans with more flexible designs and that government red tape needs to be cut, he said.

While the immediate prospects of Congress passing a defined benefit plan revitalization package incorporating those elements are not good, Mr. Strauss is optimistic about the long-term prospects of such a package.

"This is an issue Congress needs to address because there are large numbers of people in this country who are not prepared for retirement. In the short run, there may be some bumps in the road, but over the long run I am much more optimistic," he said.

B

Updates

Court to hear job bias cases

WASHINGTON—The U.S. Supreme Court last week heard arguments in an age discrimination case that could determine what evidence terminated employees must present to prove they were victims of age discrimination by an employer.

The case, *Roger Reeves vs. Sanderson Plumbing Products Inc.*, involves a 57-year-old supervisor at a Columbus, Miss.-based plumbing company who lost his job after 40 years of service (*BI*, Nov. 15, 1999). The company said that Roger Reeves was terminated because he failed to keep accurate time records. Mr. Reeves, noting that the company then filled his position with younger workers, sued his employer under the Age Discrimination in Employment Act, claiming he had been dismissed because of his age. A jury agreed, and the U.S. District Court for the Northern District of Mississippi awarded Mr. Reeves more than \$100,000.

Sanderson Plumbing appealed, and a panel of the 5th U.S. Circuit Court of Appeals reversed the lower court, holding that Mr. Reeves had not presented sufficient evidence of bias, despite showing that managers had made negative comments about his age. The appeals court was one of three to require the "pretext plus" standard, which places a higher burden on plaintiffs seeking to prove age discrimination cases than other circuits have called for. Mr. Reeves appealed the 5th Circuit's decision.

The high court also agreed last week to review another employment-related case. At issue in *Eastern Associated Coal Corp. vs. United Mine Workers of America* are the circumstances under which a court can overrule an arbitrator's decision to reinstate a worker who had tested positive for illegal drugs and who held a safety-sensitive job.

Meanwhile, in a case of interest to insurers, the high court heard oral arguments in *Hartford Underwriters Insurance Co. vs. Union Planters National Bank, successor to Magna Bank*. At issue in the case is whether an insurer that wrote workers compensation insurance for a business that was in bankruptcy proceedings can sue to collect unpaid premiums from another creditor that holds the bankrupt company's collateral.

RAA combined ratio 113.8%

WASHINGTON—The 32 U.S. property/casualty reinsurers surveyed by the Reinsurance Assn. of America posted a 113.8% combined ratio for 1999, compared with a 104.4% combined ratio reported by a comparable group a year ago.

The 113.8% combined ratio reflects an 81.5% loss ratio and a 32.3% expense ratio.

The reinsurers wrote premiums totaling \$21.21 billion for 1999, a 9.1% increase from the \$19.43 billion reported by a comparable group a year ago, according to the Washington-based trade association.

Canada reviewing health bill

OTTAWA—Canadian Prime Minister Jean Chretien has ordered the federal Health Ministry to examine an Alberta proposal that would allow private health care providers a larger role in the provincially controlled health care system.

The Health Ministry will report its findings in June, after the provincial Parliament is expected to approve the health care legislation. Bill 11 would allow certain medical procedures to be contracted out to government-approved private health care providers. The provincial government says the bill will help solve Alberta's shortage of health care services.

Opponents say it will lead to unequal treatment of patients. If the legislation is deemed to contravene federal laws, which provide for universal public health care in Canada, the province could be fined.

Mr. Chretien's announcement follows direct criticism of the controversial bill by Canadian Health Minister Allan Rock and the Canadian Union of Public Employees.

A report sponsored by CUPE and released earlier this month said the bill would breach federal requirements for "universality, accessibility and comprehensiveness."

The Canadian Department of Justice is reviewing the legislation.

Briefly noted

A federal judge has sentenced former insurance broker Richard Van Weir to 121 months in prison for diverting more than \$2 million in premiums from construction industry clients. A jury convicted Mr. Weir of conspiracy and mail fraud charges last October, finding that he pocketed audit premiums collected in a crane operators liability program rather than forwarding them to insurers (*BI*, Nov. 1, 1999). U.S. District Judge Jerry Buckmeyer also sentenced Mr. Weir to serve three years' supervised release and pay more than \$1 million in restitution. ... Up to 4,200 of the 13,000 workplaces identified as having the highest injury and illness rates may be targeted for comprehensive safety and health inspections in the next 10 months, the Occupational Safety and Health Administration announced late last week. OSHA identified the 13,000 sites with the highest lost-workday injury and illness rates based on employer-provided data from a 1998 survey of 80,000 worksites. "By targeting the high-hazard worksites, we're placing our resources where they are most needed," said OSHA Administrator Charles N. Jeffress in a statement. OSHA has notified employers identified as having high lost-workday rates. ... **Frontier Insurance Group Inc.** has deferred dividends on 6.25% convertible preferred securities issued by an affiliated trust, citing Frontier's need to improve liquidity. The securities allow Frontier to defer dividends for up to 20 consecutive quarters, the company said. ... Dr. Hubert Cameron Gibson III, the owner of New Beginnings Rehabilitation and Turning Point centers in Texas, was convicted last week by a federal court jury in Fort Worth, Texas, on one count of income tax evasion and nine counts of mail fraud related to workers compensation billings. The Texas Workers Compensation Insurance Fund said investigators estimated Dr. Gibson fraudulently billed insurers for as much as \$400,000 per month. ... Moody's Investors Service Inc. late last week confirmed its Baa2 insurance financial strength rating of **Reliance Group Holdings Inc.** with a negative outlook. Moody's cited uncertainty surrounding the recently announced sale of the insurer's most profitable unit, Reliance Surety.

Future

Continued from page 2

Today, an average of only about 2% of insurers' net revenues come through the Internet. But in 2005, about 16% of revenues will likely come through the Internet, the survey found.

And while the sale of insurance products over the Internet will be most concentrated in personal lines, corporate buyers also increasingly will be served through the Internet, Mr. Scheid said.

Currently, insurers use technology largely to reduce internal costs, but in the future, they increasingly will use it to gather information from policyholders and provide claims handling and other services, he said.

And in the future, claims handling is more likely to be outsourced to specialist claims organizations, Mr. Scheid said.

According to the survey, more than 40% of respondents see claims handling as a core competency today, but fewer than 30% of the executives think it will be a core competency of their companies in 2005.

Much of claims handling involves processing, which can be outsourced to a specialist, though insurers are likely to keep control of interactions with their policyholders, the survey said.

The changes that are likely to affect insurers will probably also have a significant impact on brokers, Mr. Scheid said.

Only 46% of the respondents in North America expect brokers to retain a role in large corporate insurance transactions. In Europe, 52% see a role for brokers; in Asia, the figure is 65%.

"Over the next five years, brokers' will have to become risk management service providers, or their role will shrink," Mr. Scheid predicted.

Technological developments will make it much easier for policyholders to receive pricing and other underwriting information directly from insurers, he said. In addition, as the insurance market continues to consolidate, there will be far fewer insurers to consider, Mr. Scheid noted.

These insurers, fewer in number but larger in size, will reap a greater proportion of their business from outside of their home markets in

five years, according to the survey.

Today, 36% of the respondents report that at least some of their revenues come from overseas. In five years, 54% expect to have international revenues, according to the survey.

International expansion is anticipated most among European insurers; 36% of those respondents said they expect more than 40% of their revenues to come from other countries in 2005. Among Latin American insurers, 27% said they expect to see that level of international business; for Asian insurers, the figure is 23%. Among North America insurers, though, only 7% responded that they expect to see such levels of international sales.

The low figure for North American insurers may be because the United States has a relatively high number of small insurers and because the large U.S. market can support many domestic insurers, the survey said.

Copies of "Property & Casualty: Mapping the Future" can be obtained through the Web site of the Economist Intelligence Unit, at www.eiu.com.

FTR FOR THE RECORD

Excerpts from BI's Daily Online Updates, March 20-24, 2000



PHOTO: REUTERS

The River Rouge plant exploded in 1999.

► **INSURERS SUE FORD** Five insurers of Dearborn, Mich.-based Rouge Industries Inc. have sued Ford Motor Co. to recover losses stemming from a February 1999 power plant explosion at a Ford and Rouge facility in Dearborn, Mich. In their \$25 million lawsuit filed in Wayne County Circuit Court, the insurers claimed Ford's negligence was responsible for the explosion that killed six workers and temporarily idled Rouge's steel-making operations at its mill within Ford's complex in Dearborn. The suit, which seeks recovery of all insurance costs related to the explosion, was filed by Essex Insurance Co., Lexington Insurance Co., Mount Hawley Insurance Co., Reliance Insurance Co. and Travelers Indemnity Co. of Illinois. Factory Mutual Insurance Co. filed a similar suit in U.S. District Court in Detroit, seeking \$134 million. Ford said the suits are without merit.

► **BLANCH MANAGEMENT CHANGES** Reinsurance broker E.W. Blanch Holdings Inc. announced the resignation of Rodman Fox, a member of Blanch's board and president and chief operating officer of its E.W. Blanch Co. unit. The duties of Mr. Fox, who last week was hired by rival Benfield Grieg Group P.L.C., will be assumed by Chris Walker, president and chief operating officer of E.W. Blanch Holdings and CEO of E.W. Blanch Co.; and by Kaj Ahlmann, vice chairman of E.W. Blanch Holdings. Blanch also said it expects its first-quarter earnings not only will fall short of those of a year earlier but also will be less than analysts' projections.

► **SEC PROBES FSA TRADES** The Securities and Exchange Commission is investigating

alleged insider trading of Financial Security Assurance Holdings Ltd. shares shortly before the financial guarantee insurer's announced takeover by European municipal lender Dexia Group. The SEC obtained a court order freezing brokerage accounts of "certain unknown purchasers" of 53,500 shares of FSA stock.

Regulators say unidentified buyers purchased the stock through five banks in Luxembourg and Israel during a two-and-a-half hour period March 9, using six U.S. stockbrokers. FSA announced later that day it was negotiating a possible sale. On March 14, Dexia announced that it would buy FSA for \$76 per share, or \$2.6 billion.



► **BRONCO II AWARD** Ford Motor Co. will appeal a multimillion-dollar compensatory award to a man injured while driving a Bronco II. An Alameda County, Calif., jury on March 14 awarded \$19 million to Richard Raimondi, 57, and \$13 million to his wife in a product liability suit stemming from a 1996 accident. Mr. Raimondi was left a quadriplegic after the Bronco II he was driving rolled over on a California highway. The jury, which did not award punitive damages, initially awarded \$38 million to Mr. Raimondi but assigned only 50% of the liability to Ford. In the accident, Mr. Raimondi was driving about 55 mph when he swerved to avoid debris and lost control of the vehicle. The Bronco II then hit another automobile and a median divider before rolling three times. A Ford spokeswoman said the automaker will appeal. The Bronco II is "a very safe, well-engineered vehicle" and the rollover was caused by Mr. Raimondi losing control and hitting another car, the Ford spokeswoman said.



► **HOLOCAUST DATA BATTLE** California Insurance Commissioner Chuck Quackenbush says Gerling Group A.G. has information the

state is seeking on Holocaust-era policies and called on the German insurer to make the information available to regulators. On March 10, Cologne-based Gerling sued the commissioner in U.S. District Court in Sacramento. Gerling's reinsurance and life insurance units are seeking injunctive relief from any fines and from the commissioner's demands for lists of policies that were issued during the Holocaust era. In other action, Munich, Germany-based Munich Reinsurance Co. requested last week, that a state Superior Court declare invalid a subpoena issued by the California department seeking Holocaust-era insurance records.



Mr. Quackenbush

► **SMOKERS CASE ENDING** Jurors will begin hearing closing arguments today in the so-called Engle smoking case in state court in Miami. Last July, the Florida jury ruled that the tobacco industry had produced a defective product (BI, July 12, 1999). In the current phase of the trial, they will determine how much the companies should pay the plaintiffs, who are Floridians with smoking-related illnesses and the estates of smokers who died. The court in September vacated its earlier ruling that damages in the case must be heard on a case-by-case basis. That leaves open the possibility of a single large award in the class-action lawsuit.

► **CNA TO BUY BACK SURETY UNIT** Looking to bolster its focus on commercial lines, CNA Financial Corp. is offering to acquire outstanding shares of CNA Surety Corp. that it does not already hold. Under the tender offer, announced last Monday, CNA subsidiary Continental Casualty Co. would offer \$13 in cash for each share of CNA Surety stock that it does not already own. CNA Surety closed Friday at \$13.94 per share. Continental Casualty and its affiliates currently hold about 62% of CNA Surety, which was spun off as a separately traded entity in 1997.

► **NEW E-BROKER FORMS** Arthur J. Gallagher & Co. is partnering with an e-commerce firm to launch an Internet-based insurance broker for small business. By the end of this year, BigCover.com will function as a full-service online broker, providing quotes, binding coverages, servicing clients and handling claims for all lines of property/casualty and group life and health insurance. Initially, Gallagher will own 45% of the new venture being developed in conjunction with Downers Grove, Ill.-based Digital Disrupters. BigCover.com will eventually be taken public to raise additional capital. Peter J. Durkalski, formerly CEO of Gallagher Bassett Services Inc., will serve as CEO of BigCover.com. Succeeding him at Gallagher Bassett will be Richard J. McKenna, currently executive vp of the unit.

► **BRIEFLY NOTED** The American Medical Assn. and the Pennsylvania Medical Society have petitioned the Antitrust Division of the U.S. Department of Justice to investigate alleged anti-competitive practices of two Pennsylvania-based Blues health plans. The physician groups allege that Independence Blue Cross in southeastern Pennsylvania, and Highmark Inc. in western Pennsylvania, have market dominance in Pennsylvania that they maintain by agreeing not to compete with each other. . . . Richard L. Huber, ousted last month as chairman and CEO of Aetna Inc., is leaving the company with a multimillion-dollar pay package. For 1999, Mr. Huber received a salary of \$1 million and a bonus of \$1.15 million, \$680,800 of which he took in cash and the remainder in Aetna stock, according to the company's latest proxy filing. Aetna will also pay him an additional 88 weeks of salary and bonus, the proxy says. At his 1999 bonus level, this amounts to another \$3.6 million. . . . The U.S. government last week agreed to pay \$508 million to settle a sexual discrimination lawsuit filed 23 years ago by 1,100 women who said they were unfairly denied jobs and promotions at the former U.S. Information Agency because of their gender. . . . Swiss Re New Markets Corp. elected Jeffrey Mack as a principal in charge of its industry solutions unit, which focuses on corporate risk financing. Mr. Mack previously held executive posts at Swiss Reinsurance Co. in the United States and Switzerland. BI

Find daily coverage of corporate risk, employee benefit and managed health care news at www.businessinsurance.com

BI Industry Stock Report MARCH 20, 2000, THROUGH MARCH 24, 2000

BROKERS

		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
Aon Corp.	NYS	30.63	18.36	-23.44	46.66	20.69	5178
Clark Bards Holdings	NDQ	15.00	9.59	4.35	21.00	11.63	154
E.W. Blanch Holdings Inc.	NYS	19.38	-65.09	-68.37	71.75	19.38	9003
Gallagher Arthur J. & Co.	NYS	30.50	0.00	-5.79	33.13	22.56	1082
Hibb, Rogal & Hamilton	NYS	27.19	0.69	-3.76	29.13	15.56	55
Kaye Group Inc.	NDQ	6.63	-5.36	-20.90	11.88	5.00	0
Marsh & McLennan	NYS	96.00	1.72	0.33	104.75	61.75	4118
Brown & Brown	NYS	39.00	5.76	1.79	40.63	29.31	66
BROKERS AVERAGE			-10.38	-16.12			

INSURERS/REINSURERS

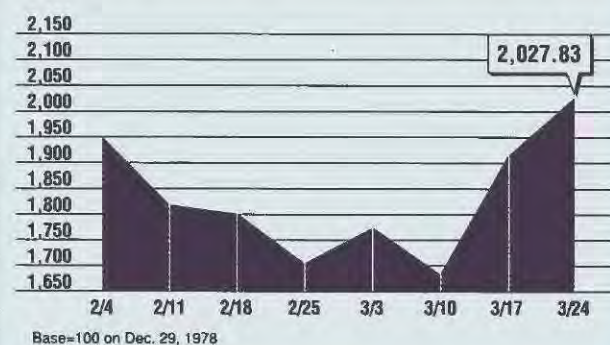
		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
ACE Ltd.	NYS	19.00	11.36	13.86	35.25	14.06	6203
Accel International Corp.	NDQ	0.88	16.67	-12.50	2.88	0.50	4
Acceptance Insurance Cos.	NYS	5.69	42.19	-1.09	17.06	2.75	959
AEGON N.V.	NYS	79.25	7.73	-17.02	104.00	63.00	654
Aetna Life & Casualty	NYS	57.00	5.56	2.13	99.88	38.50	4243
AFLAC Inc.	NYS	45.94	9.97	-2.65	56.75	33.56	4683
Allmerica Financial Corp.	NYS	48.75	8.33	-12.36	64.81	35.06	1418
Allstate Corp.	NYS	23.00	10.18	-4.42	40.75	17.19	18640
Ambac Financial Group	NYS	52.44	6.20	0.48	63.00	38.88	1872
American Financial Group	NYS	23.94	6.69	-9.24	38.38	18.38	390
American General	NYS	58.25	12.97	-23.23	82.19	45.63	4160
American Intl Group	NYS	107.63	10.53	-0.46	114.50	78.56	17500
American Safety Insurance	NYS	5.63	-7.22	-13.46	10.00	5.63	74
Argonaut Group	NDQ	19.94	0.00	0.31	27.94	16.88	295
AXA-UAP Group	NYS	71.00	9.97	0.00	73.63	53.75	592
Baldwin & Lyons Inc.	NDQ	17.75	3.65	-19.77	24.05	16.25	116
Berkley W.R. Corp.	NDQ	17.69	12.30	-15.27	29.13	14.00	528
Berkshire Hathaway Inc.	NYS	54800.00	6.82	-2.32	78600.00	40800.00	3
Capitol Transamerica Corp.	NAS	11.94	0.00	18.63	16.00	9.38	92
Chubb Corp.	NYS	59.69	12.09	5.99	76.38	43.25	4202
CIGNA Corp.	NYS	76.25	20.91	-5.35	98.63	60.75	6019
Cincinnati Financial Corp.	NYS	34.00	9.68	6.67	42.50	26.19	1526
Citigroup	NYS	60.56	6.02	8.75	61.81	38.30	67044
CNA Financial Corp.	NYS	31.31	9.87	-19.58	45.31	24.56	1268
CNA Surety	NYS	13.94	21.20	7.21	15.56	9.75	2268
EMC Insurance Group Inc.	NDQ	8.50	6.25	-6.85	13.38	7.63	293
ESG Re Limited	NDQ	4.25	6.25	-38.74	20.06	3.19	837
Enhance Financial Services	NYS	14.88	3.93	-8.46	24.75	10.75	514
Everest Reinsurance	NYS	29.25	5.88	31.09	35.88	20.50	663
Fremont General Corp.	NYS	6.81	7.92	-7.63	21.75	4.69	838
Frontier Insurance Group	NYS	1.50	-4.00	-56.36	17.25	1.13	2841
Gaisco Inc.	NYS	6.06	4.30	12.79	6.94	3.94	177

		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
Harleysville Group	NDQ	12.81	1.99	-10.09	21.38	11.63	104
HSB Group Inc.	NYS	25.94	9.50	-23.29	42.25	21.50	1010
HCC Insurance Holdings	NYS	13.88	6.22	5.21	25.13	9.00	421
ING Group N.V.	NYS	55.13	7.69	-9.63	63.94	46.81	683
IPC Holdings Ltd.	NDQ	13.38	9.18	-10.08	22.50	9.75	434
Harford Financial Services	NYS	43.19	20.59	-8.84	66.44	29.38	6127
LaSalle Re Holdings Ltd.	NYS	13.75	6.80	-16.67	19.88	10.88	181
Lincoln National	NYS	32.06	4.51	-19.84	57.50	22.63	4875
MAIC Holdings Inc.	NYS	20.00	2.89	-5.60	29.05	16.63	105
Market Corp.	NYS	131.75	3.33	-15.00	193.00	111.50	66
MBIA Insurance Group	NYS	50.19	5.80	-4.97	71.88	36.31	2117
Meadowbrook Insur. Group	NYS	6.06	2.79	-7.82	17.13	4.75	52
MMI Cos. Inc.	NYS	9.81	0.00	13.77	17.44	3.31	317
Mutual Risk Mgmt. Ltd.	NYS	15.69	4.15	-6.69	43.25	9.81	491
Navigators Group	NDQ	10.00	1.27	2.56	16.00	8.75	52
NYMag Inc.	NYS	12.38	-3.88	-6.16	19.50	12.00	114
Ohio Casualty Corp.	NDQ	13.94	16.15	-13.23	21.00	10.75	2072
Old Republic Int'l	NYS	12.50	5.82	-8.26	20.69	10.63	2503
Partner Re Ltd.	NYS	34.75	-1.07	7.13	43.63	28.38	561
Penn-America Group Inc.	NYS	8.63	7.81	11.29	11.44	6.63	81
PMA Capital Corporation	NDQ	17.75	-4.05	-10.69	21.13	16.00	81
Philadelphia Cons. Holding	NDQ	14.75	0.00	1.72	25.50	10.81	288
PXRE Corp.	NYS	14.25	-1.72	9.62	21.88	9.94	71
Reliance Group Holdings	NYS	3.58	1.79	-46.23	10.88	2.81	2381
ReliaStar Financial Corp.	NYS	32.63	6.97	-16.75	49.81	23.75	2264
RenaissanceRe Holdings Ltd.	NYS	37.88	0.50	-7.34	43.19	30.00	363
Risk Capital Holdings	NDQ	15.50	4.20	22.77	22.00	11.00	463
RLI Corp.	NYS	32.06	10.09	-5.70	38.81	26.25	105
St. Paul Cos.	NYS	29.50	10.80	-12.43	37.06	21.31	4494
SCOR	NYS	47.88	0.52	8.19	58.56	40.00	16
SAFECO Corp.	NDQ	24.38	17.47	-2.01	46.75	18.00	4042
SCPIE Holdings Inc.	NYS	30.31	-1.82	-5.64	36.94	23.69	NA
Seibels Bruce Group	NDQ	1.84	-1.67	5.36	6.25	1.47	72
Selective Ins. Group	NDQ	16.50	8.20	-4.00	22.50	14.63	192
Terra Nova Ins Co. Ltd.	NYS	22.75	3.41	-24.17	32.63	20.31	546
Tokio Marine & Fire	NDQ	49.50	-2.94	-16.28	67.00	45.00	130
Torchmark Corp.	NYS	23.88	6.41	-17.85	38.00	18.75	2306
Transatlantic Holdings	NYS	79.56	7.43	1.92	80.50	68.75	67
Travelers Property Casualty	NYS	41.13	21.85	20.07	41.88	27.69	15304
Trenwick Group Inc.	NYS	14.50	4.98	-14.39	32.00	12.00	155
Unico American Corp.	NDQ	5.75	1.10	-17.86	11.13	5.25	12
United Fire & Casualty	NDQ	19.00	3.75	-16.02	30.50	17.38	29
Unitrin	NDQ	38.50	12.41	2.33	42.38	30.50	642

HEALTH MAINTENANCE ORGANIZATIONS

		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
UNUM Corp.	NYS	14.13	1.35	-55.95	56.88	11.94	10368
Vesta Insurance Co.	NYS	6.00	1.05	54.84	7.88	3.38	520
XL Capital Ltd.	NYS	49.88	-3.86	-3.86	67.19	39.00	2724
Zenith National Ins.	NYS	20.44	-1.51	-0.91	26.69	18.75	82
INSURERS/REINSURERS AVERAGE			5.95	-5.66			
Foundation Health Systems Inc.	NYS	7.94	0.00	-20.13	20.06	6.25	1878
Humana Inc.	NYS	7.31	4.46	-10.69	19.50	5.88	1815
Oxford Health Plans	NDQ	14.56	3.10	14.78	24.25	9.75	4096
Pacificare Health Sys.	NDQ	47.75	1.73	-9.91	98.13	31.13	1723
Sierra Health Services	NYS	5.06	-7.95	-24.30	16.25	4.63	709
United HealthGroup	NYS	57.44	11.26	8.12	70.00	39.38	3777
Wellpoint Health Networks	NYS	64.75	3.08	-1.80	97.00	48.25	1098
HMOs AVERAGE			2.24	-6.27			
ALL COMPANIES AVERAGE			-0.73	-9.35			

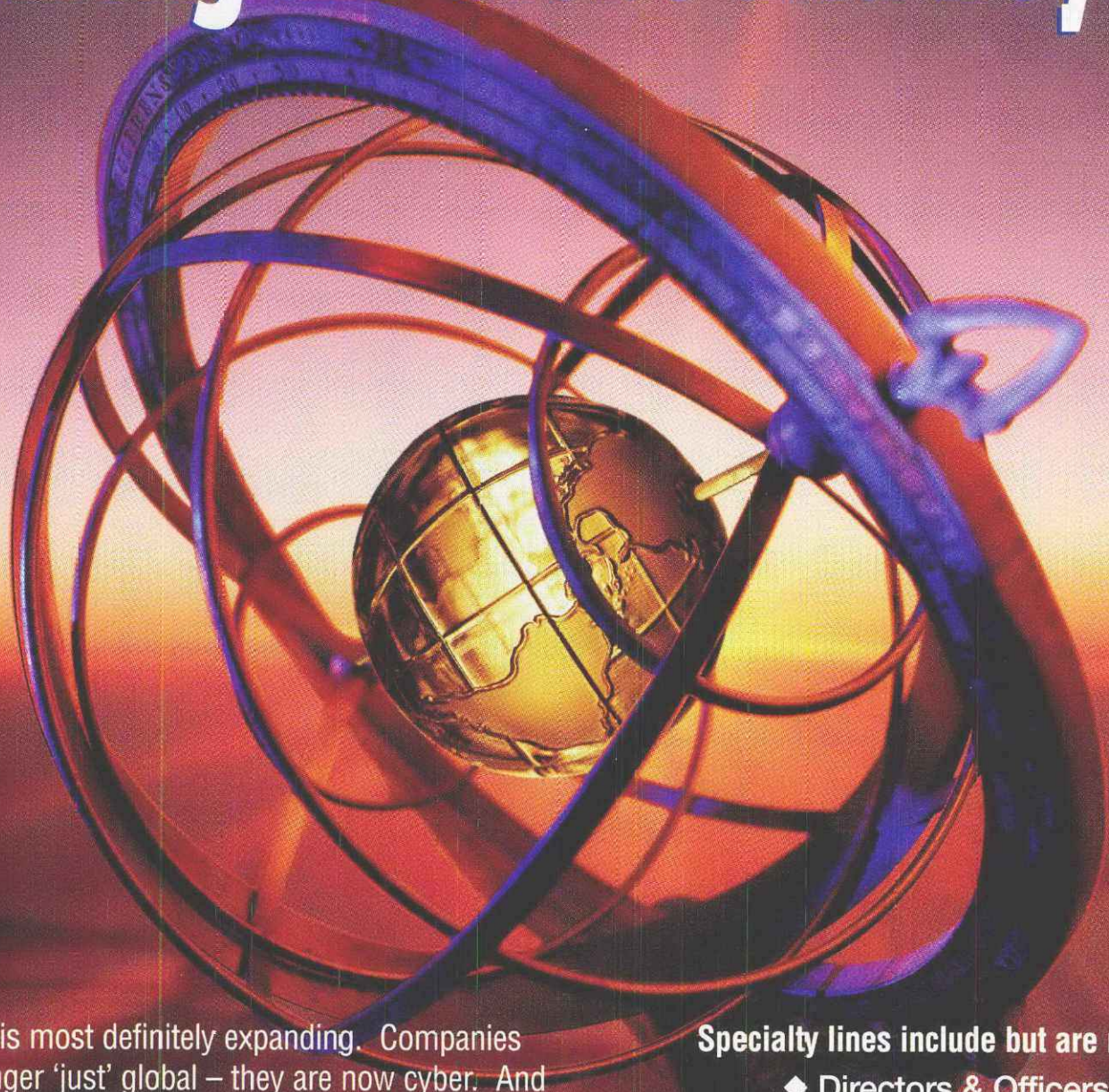
BI Insurance Index



Top advancing issues: Acceptance Insurance Cos., Travelers Property Casualty, CNA Surety. Leading decliners: E.W. Blanch Holdings Inc., Sierra Health Services, American Safety Insurance. Most active issue: Citigroup. The BI Index gained 7.2%; the Dow Jones 30 Industrials increased 4.9%; the S&P 500 went up 4.3%, and the NYSE Composite increased 3.1%. Average P/E: Brokers, 18.2; Insurers/reinsurers, 18.7; HMOs, 10.3.

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

Reliance National Spanning the Globe and Beyond



The World is most definitely expanding. Companies are no longer 'just' global – they are now cyber. And as this world continues to expand into new frontiers, businesses need an insurance carrier who can travel at technology's pace, even remain one step ahead.

At Reliance National, our product portfolio combined with our reach - both on earth and in cyberspace - does just that...offers client's coverage to safely navigate on earth and over the internet. With offices in the U.S., Canada, Latin America, Europe, Southeast Asia, Africa, and of course, Cyberspace...we allow our insureds to target whatever part of the international business world they desire.

When looking for a comprehensive commercial insurance product portfolio, come to Reliance National...domestic, international or cyber...we reach all the right places.

Reliance National products and programs underwritten by Reliance Insurance Company, Reliance National Indemnity Company, Reliance National Insurance Company, Reliance Insurance Company of Illinois, Reliance Universal Insurance Company, and/or United Pacific Insurance Company.

Specialty lines include but are not limited to:

- ◆ Directors & Officers Liability
- ◆ Risk Management
- ◆ Excess Liability
- ◆ Professional Liability
- ◆ Healthcare
- ◆ Integrated Benefits
- ◆ Ocean Marine
- ◆ Petrochemical/Energy
- ◆ Property
- ◆ Construction



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