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Critics Of MetLife Stock Conversion Heard In NY

Company defends plan at hearing

by C.A. Soule
Insurance Times

NEW YORK — MetLife's plan to demutualize favors Wall Street over small stakeholders, said a parade of policyholders Jan. 24 in a hearing before New York Superintendent of Insurance Neil D. Levin.

But the company asserted that its plan is "fair and equitable" and meets all the requirements of New York law.

Levin has until the middle of April to approve or deny the company's plan to convert from a mutual format to a publicly owned corporation that can sell shares of stock. By law he is required to approve the plan if it is not in violation of insurance laws or detrimental to the public, and providing the company has the capital and surplus deemed sufficient for future solvency.

The company said it is prepared to go ahead with an initial public offering of stock as early as the end of March, and that it would contemplate other capital-raising strategies as well.

It had revenues of $27.1 billion in 1998, up from $24.4 billion the year before. It had net earnings of $1.3 billion last year, up from $1.2 billion in 1997.

The company plans to become the subsidiary of a Delaware-based holding company called MetLife Inc. It would join the New York Stock Exchange under the listing "MET."

The first person to testify, Richard Norton, delivered a lecture peppered with observations drawn from the corporate history of MetLife and the views of its leaders over that time, including Haley Fiske, its leader in the early years of the last century.

"Fiske said in 1917 that MetLife is not merely an insurance company, it is a public institution," Norton said. "From the 1970s to today, those who have inherited the responsibility for a great institution have decided to ignore history."

But Robert Benmosche, MetLife's chairman, president, and CEO, in effect told Levin that the times are a-changin'. He said MetLife faces new challenges in the wake of a financial services modernization bill signed into law last year, which allows other types of financial services companies to compete on MetLife's turf by selling insurance.

"We face stiff competition from companies that have the flexibility to raise capital through the equities markets," Benmosche said. "It is very clear that the ability to operate as

a stock company amounts to a significant advantage when new business opportunities arise.

\ “We believe this creates a whole new surface of uncharted waters for our company,” he continued. “We do know that if we maintain a corporate structure of a mutual insurance company, that would preclude us from strategic options down the road.”

The company has hired the investment banks Goldman Sachs and Credit Suisse First Boston to underwrite the IPO.

Several said that the company’s decision to prohibit “subscription rights” for policyholders, their ability to purchase stock in the IPO, was unfair. Benmosche anticipated those arguments in his testimony.

“We felt very strongly that we were going to be giving 100 percent of the value of the company to our policyholders,” Benmosche said. “What we did not want is to have people speculating, and buying insurance not for financial need set forth in their own financial plan, but to speculate in hopes of getting stock in the company. We just thought it was inappropriate, and we wanted to make sure therefore that the policyholders bought insurance policies for their needs.”

Insurer Motivation

But other participants said that the company’s motivation was more self-serving than Benmosche confessed.

“The IPO of MONY is an example of how the IPO will be handled,” asserted Lance Gad, a MetLife policyholder. “It was virtually impossible for any policyholder who was not a huge producer of commission for Goldman to obtain shares at the $23.50 offering price. Policyholders had to buy them from Goldman’s best customers, in the aftermarket, at prices which approximated 25 percent more.

“Goldman Sachs is perhaps the most arrogant and difficult underwriter for anyone other than huge investors, largely institutions generating huge commissions for Goldman, to buy shares from,” Gad continued. “The right to buy shares at the IPO price first belongs to policyholders of Met, not to the best customers who pay the most in commissions to Goldman Sachs or Credit Suisse First Boston.”

That statement drew a burst of spontaneous applause from those attending the hearing.

But Benmosche argued in his statement that policyholders stood to profit in the transaction. “This represents a distribution to policyholders of tangible economic value they would not otherwise receive unless we demutualize,” he said.

Howard Silverstein, a Goldman Sachs partner, defended the decision to forgo subscription rights. “I think it was our joint view that having the subscription rights could adversely affect the offering,” he said. “It would have been hugely expensive to have undertaken subscription rights for that number of policyholders. It would have added complexity to the IPO and also cause a delay of at least several weeks in the timing of the subscription offering, so we believe a subscription rights plan

would adversely affect the initial public offering."
Gad attacked that attitude as a violation of the statute by which Levin must make his ruling. "Fairness and equity is required, it cannot be eliminated by what is quick and expedient," he said. "The fact that it would take a few more weeks is inconsequential."
In another cost-cutting measure, the company plans to hold the stock of all policyholders with less than 1,000 shares in an independently administered trust for one year. "The trust will create substantial savings for the company, which will be reflected in higher earnings for the company, which should be reflected in a higher IPO price," said Silverstein.
"The trust provides a very efficient and orderly mechanism for those shares if and when the policyholders decide to sell," he added. "We believe that will give investors the ideal comfort that the policyholder shares, as they are sold, will be sold in a manner that is not disruptive to the secondary trading markets."
Attorney Anita Kartalopoulous challenged the formation of the trust. "[The creation of the trust… denies [policyholders] the full use of their shares and denies them the opportunity to receive the fair value of their shares," Kartalopoulous argued, saying trust interests were not a type of compensation covered under New York law. "It operates as a de facto mutual holding company, even though the legislature decisively rejected the idea of the holding company in recent years. Those buying the public offering will have shares that are far superior than the shares given to MetLife's own shareholders, since several features of the trust keep those stockholders from receiving fair market value."
Gad described how the trust imposes unnecessary constraints on policyholders.
"Although IPO purchasers can sell right away upon initial trading, policyholders must wait one to two days, an eternity in stock trading, to sell shares," Gad said. "Even John Hancock, in its demutualization in Massachusetts, proposed to give policyholders being given cash the result of an up-to-20-percent 'pop' in the IPO price. Nothing like that is being done here. Any 'pop' in the IPO price will go to the customers of Goldman Sachs and Credit Suisse First Boston."
That "pop" has so far failed to materialize for Hancock. The stock opened at 17.25 and so far has peaked at 18 5/16 in a couple of weeks of trading, about 6 percent above its opening price. It closed at 17 on Feb. 7.

Other Demutualizations
MetLife's chief financial officer said that allusions between MetLife's demutualization and that of other companies are deceiving. "We realized that we faced a challenge that no other mutual life insurance company that has demutualized has faced to date," said Stewart G. Nagler, who is also vice chairman of the board. "We have over 11 million policyholders. If they all became shareholders, we would incur enormous logistical problems,

huge costs, to service that many shareholders. No other company in America comes even close to having that many shareholders." Nagler added that trust members would be able to buy and sell stock commission-free, a benefit they would not enjoy on the open market.

"We believe these arrangements will be beneficial and convenient for our policyholders, partly because many of them may not have brokerage accounts through which to hold stock," Nagler said.

An attorney said that the demutualization offered MetLife management the opportunity "to buy the company out from under policyholders on the cheap," and that they would benefit from future stock price increases. He claimed that a Merrill Lynch internal memo purported that insurance companies are consistently undervalued in demutualizations, due to anti-takeover provisions included in the plans.

"The problem with this plan is that it is structurally created to suppress the value that is actually given to the policyholders," said Paul Benton, a Missouri attorney who is representing three policyholders. "After one year, management will be entitled to give themselves stock options. Then after three to five years, the anti-takeover provisions will lapse, and the company will be put into play. At that point in time, you will have an auction. The company will be put up, and fair market value will be obtained at that point. But it will be obtained with management owning the company, with Wall Street owning the company."

Policyholders also accused MetLife of being unclear in its dealings with policyholders. Benton said that the demutualization mailings to policyholders were "oblique."

Policyholder Ralph Cabrinick said that in an effort to clear a problem with a life insurance policy, he "got nothing but 'gobbledygook'" from MetLife.

The company has also been trying to deal with the same problem that hounded Hancock's demutualization in Massachusetts – the company's inability to trace a number of holders of "industrial policies" sold to working class people years ago. While that issue amounted to little more than a public relations nuisance for Hancock, Kartalopoulous said that it created a potential problem for the company's "closed block" of walled off assets for future dividend payments.

"The large number, 600,000, of policyholders who have not been located creates only further uncertainty as to the adequacy of funding for the closed block, because of the likelihood that many of these are older industrial policies with particular problems of their own," Kartalopoulous said.

Kartalopoulous said that the closed block has other problems, claiming that its assets of $36 billion fall short by $3 billion. The company had total consolidated assets of $227.2 billion at the end of 1998.

Benmosche defended the company's record on "lost" policyholders. "The company has put in an enormous effort to begin to find policyholders of old industrial policies and we have had some success there," he said. "In fact, one has to keep in mind that

many of our policyholders were policyholders before Social Security was created. Therefore something as simple as a Social Security number did not exist."

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Proposed Mass. Aftermarket Parts Rider Sparks Controversy

Body shops blast two-tiered system as hurting consumers

by C.A. Soule
Insurance Times

BOSTON – An auto body shop representative told the Massachusetts insurance commissioner that he was "disgusted" by an insurance company proposal to allow drivers to purchase an insurance policy rider in order to guarantee the use of "original equipment manufactured" parts in vehicle repairs.

Commissioner Linda L. Ruthardt heard similar strong rhetoric from several members of the Massachusetts Auto Body Association, based in Hanover.

The use of generic "aftermarket" parts is mandated under Massachusetts law as a cost-containment tool. But the use of these parts, always controversial, has come under increasing scrutiny in the last six months, after an Illinois jury handed down a $1.1 billion judgment against State Farm Mutual Insurance Co. for the company's decision to use such parts. The company is appealing the case.

The Automobile Insurers of Massachusetts has recommended that an OEM endorsement be priced at 13 percent of the premium level for collision or limited collision coverage, and at 2 percent for comprehensive coverage.

Auto Body Industry

But the auto body industry says that the endorsement is putting the cart before the horse.

"For Massachusetts to approve a two-tiered system will only lend credibility and be perceived as tacit approval by the state, with respect to the use of these inferior parts," said Stephen Regan, executive vice president of MABA, addressing Ruthardt. "With most states and insurers moving away from using aftermarket parts, approval of this measure would be a dereliction of your responsibility to consumers of Massachusetts."

An auto insurance expert from Attorney General Thomas Reilly's office also expressed concerns about the proposed endorsement. "Insurers should provide sufficient information to policyholders to enable them to make informed decision to purchase or not to purchase the additional coverage," said Peter Leight, an assistant attorney general. "The coverage should be priced at a

level that reflects the real difference between the cost of OEM and aftermarket parts, a cost that should not be artificially inflated by the companies."

Leight added that future auto rate decisions should contain a formula to reflect the use of the endorsement, given an AIB prediction that the prices of OEM parts will rise 70 percent from current levels from the effects of the endorsement.

Leight recommended disclosure requirements in order to warn consumers that the new endorsement does not apply to glass or mechanical parts. He said insurers should also alert consumers that insurers already pay for OEM parts for newer cars; that the endorsement only applies when a part cannot be repaired; and that the higher cost of an OEM part could eat into a driver's Safe Driver Discount Plan bracket in a future year.

Auto body shop operators said that the proposed system of two options shifts too much of a burden to consumers.

Christopher Colo, president of the Massachusetts Auto Body Association, argued that "consumers will then be forced to choose between price or safety. The consumers of the Commonwealth will then be absorbing the liability instead of those in the liability business."

Ruthardt's State Rating Bureau is also assessing the filing on behalf of Massachusetts drivers, including the pricing of the rider and its impact on " safety among the motoring public," said Norma Brettell, SRB senior counsel.

Safety for those who repair autos was also a concern. An MABA vice president said that employees were routinely subjected to hazardous chemicals and materials while installing aftermarket parts. That typically is not the case with aftermarket parts, he said.

"This could create a situation where the state could be pursued in future class action lawsuits," she warned. "We have no way of protecting employees with regard to the use of aftermarket parts, and that should be a major consideration in your decision."

Insurance companies and agents were silent on the issue at the hearing, and this was noted by Brian Hickey, a legislative lobbyist for MABA.

"It is my personal belief that the insurance industry has not wanted to be associated with the issue of aftermarket parts for a very long time," said Hickey.

One industry source termed MABA's opposition from the vantage of price "bizarre," since they are able to earn a higher return when using OEM parts.

One insurance lobbyist acknowledged that the industry was still trying to reach agreement on the Massachusetts proposal. "There is not a broad industry consensus on whether an OEM endorsement is the way to go," said Gerald Zimmerman of the National Association of Independent Insurers.

Meanwhile, the Auto Damage Appraisers Licensing Board announced it will conduct a hearing March 21, in Marlborough, Mass., to assess the safety aspects of aftermarket parts. ADALB is under the direction of the insurance division.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Auto Claims Trends

Auto injury claim costs are rising and more lawsuits are being brought, even as auto accident frequency declines. For reports on two new studies from the Insurance Research Council, see pages 12SR and 13SR.
For a chart comparing bodily injury and property damage claim frequencies by state, turn to page 33SR.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Conn. Lawmakers Grapple With Ways To Lower Auto Rates

California experiment with lower limit policies attracts interest

by C.A. Soule
Insurance Times

HARTFORD – A committee of Connecticut House Republicans issued a report they said would help make auto insurance more affordable, then days later withdrew a provision for an auto insurance "choice" consumer option favored by insurers.
Even as the watered-down version was released, however, a different, bi-partisan committee explored whether auto insurance "territories" in Connecticut should be revamped or discarded in order to lower rates for urban residents.
The Commission on Auto Rate Savings, chaired by Republican Representatives Ruth Fahrbach and William Hamzy, has held five hearings since last November. The resulting recommendations are not accompanied by a cost plan, or strategy for implementation.
The CARS report originally recommended installing an auto choice plan, lowering liability limits, and prodding state agencies to provide more information to consumers.
The Republicans quickly yanked auto choice from their menu, however. They had recommended that Connecticut drivers be able to choose between a no-fault "personal injury protection" plan which would limit the amount a plaintiff could collect in the event of an accident, versus a "tort maintenance" plan which would not have had such restrictions.
The state currently has a tort plan in place.
CARS scolded the insurance department for providing detailed information on only 10 percent of insurers selling auto policies in Connecticut.
"DOI should also be required to include specific laws about

consumers' rights and the website itself should be redesigned to be more interactive to increase consumer usability," the report reads.

CARS also said that the department should increase the vigilance of its fraud unit, and that police should increase patrols in neighborhoods to thwart theft and vandalism.

"We don't agree that the department of insurance has fallen down on the job," said Suzanne Bump, a lobbyist with the American Insurance Association trade group. "This commissioner has made a point of making himself available at community meetings and other events. Are there other things that the department could explore doing? Maybe. But the department is expanding its fraud activity. If given greater resources, it would probably be a help."

The legislators quoted statistics from a consumer advocacy group, showing premium ranges for various demographic groups. According to Insure.com, a married 40 year-old pays a premium between $997 and $2,366, depending on underwriting criteria. An unmarried 18 year old male pays anywhere from $2,413 to $8,824, while two married 40 year-olds pay between $1,457 and $3,613.

Members of both caucuses hope to take a page from a new California law by allowing certain discount policies with reduced limits. Pilot programs in Los Angeles and San Francisco will lower liability limits by one third for bodily injury coverage and by 40 percent for property damage coverage. The new rules apply only for cars valued below $12,000. In Los Angeles, policyholders would pay $450 in annual premiums, while in San Francisco, they would pay $410. Drivers ages 19 to 26 would pay a 25 percent surcharge.

Connecticut currently has limits of $20,000 per person and $40,000 per accident for bodily injury liability; $10,000 for property damage liability; and $20,000 per person and $40,000 per accident for bodily injury liability involving an uninsured or underinsured vehicle.

A separate, bipartisan committee, motivated by reducing auto rates for urban residents, held a hearing Feb. 3 at which the star testifier was a no-show.

Legislators had requested a progress report from a researcher, Cheye Calvo, who is collecting data for an examination of Connecticut's use of territories in rating auto risk. Companies may charge higher rates in the state, depending on where policyholders garage their cars.

Legislators instead received a summary of the California law cited in the Republicans' report.

Sen. Louis C. DeLuca of Woodbury pounced on the California program, questioning whether the program was self-supporting or a subsidy program in camouflage.

AIA's Bump told InsuranceTimes that is the sticking point for insurance companies.

"The idea of doing something like the California system is being seized upon by [legislative] members," Bump said. "The idea is worthy of consideration. The primary caveat would have to be

that any mini-policy would be self-funded. We wouldn't want to create some kind of a subsidy system."

Broader public policy issues of fairness for insurers and consumers set off an exchange, pitting Rep. James A. Amann of Milford against city lawmakers Rep. Ernest E. Newton, II, of Bridgeport, Rep. Art Feltman of Hartford, and Sen. John Fonfara of Hartford.

"I wish we could throw away the stick, because we have beat this horse to death," Amann said. "People are complaining that they are getting penalized for living in the city in Connecticut. But the real penalty is for living in Connecticut period. That is what we get for being the state with the highest income and costs."

Annan emphasized that auto insurance was more expensive in Connecticut than elsewhere on account of a higher frequency of claims being filed. "You can't change the truth," he said. "If you don't reduce the number of claims, you cannot reduce the cost of insurance."

The other legislators were not persuaded by Amann's arguments, however. "I would hate to think that I have to pay a higher rate for something that has nothing to do with me except where I lived," said Newton. "A lot of people say that because of where I live, I am being penalized for the sins of those that came before me."

Amann shifted tack, and pointed out that qualifying factors, including geography, are factored into other types of insurance. "It is called risk," he said. "It is what makes the world go 'round. It is not there to penalize me if I do not get hit by a flood, it is there to protect me if I do get hit by a flood."

Sen. Fonfara made an analogy of the current committee's work to one that had looked at helping to provide heating fuel to poorer residents of the state. "These things come in different size boxes with different shapes," Fonfara said. "This is not an attempt to break the rules. This is an attempt to address a particular situation."

Insurance Times
February 15, 2000
Vol. XIX, No. 4

London's CGU To Divest Its U.S. Property/Casualty CGU

On Feb. 22 in London, the boards of CGU and Norwich Union announced an agreement to merge. CGU shareholders will retain their shares in CGU -- to be renamed CGNU -- and Norwich Union shareholders will receive 48 new CGNU shares for every 100 Norwich Union shares.

CGNU will be the UK's largest insurance group with strong positions in Europe and other international markets with worldwide premium income and retail investment sales of $42 billion.

CGU also announced that it will exit the U.S. property and casualty market through an orderly transfer of ownership of its U.S. property and casualty business.

Gowdy Reaction
Robert C. Gowdy, CGU's U.S. president and CEO, welcomed the moves. "This divestiture presents us the opportunity to align ourselves with shareholders who share our focus on the future of the U.S. marketplace," Gowdy said. "Our recent success in merging Commercial Union and General Accident has created a franchise with broad capabilities, financial strength and scale. We are unique with our singular focus on independent agents and brokers, and the customers they serve.
“Although it's been just two years since we announced the creation of CGU, we have established ourselves as a strong organization with much to offer new shareholders."
Robert A. Scott, group chief executive at CGU, explained that the board concluded that despite the scale and strength of its U.S. property and casualty operation and its attractive portfolio of businesses,” it will not be possible to reach the leading position without a substantial level of investment, particularly in view of the likely consolidation in a fragmented market. CGU has therefore decided to divest its U.S. property and casualty business."

Finding Shareholders
CGU will operate on the basis of "business as usual." The process of finding new shareholders has already begun, and is anticipated to be finalized promptly, subject to the usual approvals.
CGU Life Insurance Company of America, based in Boston, Massachusetts and with 1999 premium of $394M, will remain part of the CGNU group.
CGU, headquartered in Boston, operates in all 50 states and is supported through 44 offices and 13 regions, and represented through 6,400 independent agents and brokers. The 16th largest property/casualty insurer in the U.S., CGU has more than $4 Billion in written premiums and an A+ A.M. Best rating.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Two Mass. Benefit Consultants Merge

Northshore International Insurance Services, Inc. and Apex Management Group, Inc. are merging, forming a new company called NiiS/Apex Group Holdings, Inc., headquartered in Salem, Mass. The new company will offer insurers and employers claims management and auditing, actuarial and employee benefits consulting.
NiiS was founded in 1988, and Princeton, Mass.-based Apex was

launched in 1993.
The new company will include a consulting group, a management group, and a ventures group.
NiiS/Apex has 125 employees in ten offices, including London.
NiiS core clients include Lloyd’s syndicates, foreign and domestic insurers and reinsurers, self-insured entities, and municipalities.
Apex serves the insurance and reinsurance industries, health maintenance organizations, health plans, health systems, employers, and government entities.

Insurance Times

February 15, 2000
Vol. XIX, No. 4

Travelers Cuts NY Auto Insurance Office Staff

QUEENSBURY, N.Y. — Two years after a much-touted expansion, the area's Travelers Insurance office last week eliminated 48 jobs, or about 9 percent of its work force.
The job cuts are in assigned risk and nonstandard auto insurance, two high-risk categories for which demand has been declining, company spokesman Chris Hammond said from the company's central office in Hartford, Conn.
Assigned risk is a state-mandated program for drivers or cars that are considered risky. Nonstandard auto insurance is for drivers who don't qualify for regular insurance.
The company's last local layoff was in March 1994, when 40 employees were cut from a work force of 300.
Since then, more than 200 jobs had been added in phases. In February 1998, the local office created the non-standard auto insurance office, the same department that was slashed last week.

Insurance Times

February 15, 2000
Vol. XIX, No. 4

Mass. WC Deregulation Bill Expected Soon

BOSTON — Massachusetts workers compensation Insurers may soon have more freedom to price their product.
Rep. Peter Larkin, co-chair of the Commerce and Labor Committee, is reportedly ready to endorse a bill which would return some rate setting functions to carriers, according to sources. The insurance commissioner could retain overall control of pricing if competitive pressures did not serve to keep rates down.
Currently, companies are allowed to offer discounts off the insurance commissioner’s fixed rates, with approval from the Division of Insurance.

Insurance Times

February 15, 2000
Vol. XIX, No. 4

NY Grapples With Counties' Health Plan Costs

ALBANY, N.Y. — The state Legislature's top Republican has called for the state to pick up the extra costs facing counties from New York's expanded health plan for the poor approved in December. State Senate Majority Leader Joseph Bruno said his plan would save the state's 57 counties and New York City $340 million over the next three years. Bruno called it a property taxpayer relief proposal.

When the state adopted its Family Health Plus program in December, Bruno and Assembly Speaker Sheldon Silver, a Democrat, had lobbied for the state to pick up any extra cost that might be charged to the counties and New York City. They were rebuffed by Republican Gov. George Pataki.

Pataki aides has argued that the counties could cover the extra costs by dipping into their share of the national tobacco settlement and from their savings under Medicaid cost-containment provisions that were being extended in December as part of the health package. The counties had argued they wanted to use the tobacco money for other purposes.

Bruno said that he felt the extra costs for the state could be financed as part of the new state budget that is for the state fiscal year that begins April 1.

Insurance Times

February 15, 2000
Vol. XIX, No. 4

RI Governor Seeks Drunk Driving Curbs

PROVIDENCE, R.I. — Gov. Lincoln Almond has declared war on drunk driving with a new traffic safety legislative package that includes graduated penalties for drunk driving, stiffer breathalyzer refusal penalties and mandatory child restraints. His plan also calls for vehicle forfeiture by those convicted of driving intoxicated with a suspended license, higher fines for aggressive driving and enforcement of seat belt laws. The latter provision would allow police to stop motorists for not wearing a seat belt.

Insurance Times

February 15, 2000
Vol. XIX, No. 4

Conn. Ruling Requires Gay Couple Benefits

HARTFORD — An arbitrator's ruling Feb. 1 would require the state to offer health benefits to state employees in same-sex

relationships.
The ruling applies only to gay couples and does not affect employees in unmarried, opposite-sex ``domestic partner'' living arrangements. Arbitrator Roberta Golick estimated the cost to the state at $1.3 million to $1.5 million per year
It will take effect unless a two-thirds majority of one house of the Legislature determines that there is not enough money to pay the benefit. The Legislature began its session Feb. 9 and has 30 days to act.
State Comptroller Nancy Wyman said that the state is running an estimated budget surplus of more than $240 million.
``I don't think we'll have a vote to overturn this decision,'' said Senate Majority Leader George Jepsen, D-Stamford.
The state and the State Employees Bargaining Agent Coalition, which negotiates the pension and health benefits of about 43,000 employees, took the issue before a mediator last fall.
Gov. John G. Rowland's administration has opposed the proposal as too expensive and subject to abuse.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Mass. WC Study Lauds System's Post-Reform Stability

But insurers have eye on rising DIA expenses

by C.A. Soule
Insurance Times

BOSTON — A new data collection system being proposed by a state agency could drive up the cost of workers compensation in Massachusetts, according to insurers responding to a new comprehensive study of the system which concludes that the system operated soundly from 1994 to 1996 after reforms were enacted in 1991.
The study shows that while the costs of handling workers compensation claims ticked upward in Massachusetts throughout the middle of the decade, the overall marketplace exhibited beneficial stability.
The Workers Compensation Research Institute, based in Cambridge, Mass., focused the latest of its "CompScope" series of studies on Massachusetts. The reports are intended to provide a holistic view of workers compensation systems nationwide, and to provide policymakers with comparative data for future decisions.

'Should Not Tinker'
"This report portrays a system that is remarkably stable," said Don Baldini, a workers compensation expert for the Associated Industries of Massachusetts. "I don't think there is anything in there that suggests we should tinker with the system at this

point in time."

Insurance companies said that the dated nature of the information made its relevance to today's market sketchy, but they do think its increased expense figures should be noted in light of a push by the Department of Industrial Accidents (DIA) to beef up insurers' data collection requirements.

The WCRI report shows that benefit delivery expenses per indemnity claim, which include the cost of litigation and other claims handling expenses, rose from $401 to $799 from 1994 to 1996. WCRI said that the culprits were medical cost containment expenses and attorney fees, which grew at a 9 percent annual clip between 1994 and 1996.

DIA Battle

"That figure impresses us in the context of our ongoing tug-of-war with the Department of Industrial Accidents over data collection," said Suzanne Bump, a lobbyist with the American Insurance Association. "It underscores our contention that you can reach a point of diminishing returns in controlling medical costs, and should serve as a warning to DIA. There is no point subjecting every $200 emergency room visit to a utilization review."

DIA wants to compile a comprehensive database on workers compensation claims that it would call the Massachusetts Utilization Tracking and Trending System. According to DIA Commissioner James J. Campbell, the system has been pilot-tested, and the Attorney General is currently reviewing the program for its legality.

Campbell called criticism of MUTTS "penny wise and pound foolish," saying that Massachusetts already had one of the lowest ratios in the country when comparing medical costs to indemnity costs.

"Such a system would increase costs for employers, and would increase DIA's budget," said Bump. "Our contention is that there are already techniques out there in the medical community for capping costs. The Department of Industrial Accidents is not necessary in the establishment of medical treatment protocols."

'Bear Watching'

The WCRI report offers a snapshot of the workers compensation system, and does not delve into policy prescriptions. However, the organization said that the trends on costs "bear watching." The group also promised to provide updates as more data becomes available.

"For example, measures of the effectiveness of the workers compensation agency [DIA] and the dispute resolution process, as well as measures of workers' satisfaction, health and functioning, return to work, and earning recovery, should be reported," the study reads.

The report tracks data from 1994, when workers compensation reforms enacted three years earlier were fully implemented, to 1996. During that time, WCRI noted that workers compensation

costs in Massachusetts fell from $2.7 billion to $1.5 billion. Businesses have hailed the 1991 reforms as an incentive for them to do business in Massachusetts, but labor leaders complain that workers lost crucial benefits in the process.

Labor Agenda
Labor leaders want to restore workers compensation benefits to 66.7 percent of an injured worker's salary. Those benefits were reduced to 60 percent in 1991, in an attempt to provide employees with an incentive to return to work. Last spring, a parade of injured workers testified before the legislative Committee on Labor and Commerce that their claims checks were insufficient to cover basic living expenses.
AIA's Bump said that while medical costs appear to have stayed stable, worries remain for insurers.

Medical Fee Schedule
"It is easy to forget that not only does Massachusetts have a fee schedule that controls costs, but it has a low fee schedule," she said. "It is 74 percent the national average for medical costs. But the report doesn't reflect a recent problem with the schedule, which is surgeons taking advantage of their ability under the law to ask for higher fees, sometimes as much as five times the rate in the schedule."
As the WCRI report hit desks across the region, the new issue of Consumer Reports hit newsstands. The magazine, published by consumer advocate Ralph Nader's organization, included an article criticizing insurers for pocketing excessive profits from the sale of workers compensation insurance.
Insurers said that the article got it wrong. "Insurers may earn more profit some years, less profit in other years, but ultimately the price will be determined by the costs of the systems," said Nancy Schroeder of the National Association of Independent Insurers.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

NH Senate Passes 'Accountability' Act Governing Hmos

Patients could appeal medical decisions but not sue

by Gene Johnson
Associated Press

CONCORD, N.H. — The state Senate passed legislation to make health maintenance organizations more accountable for the decisions they make.
Lawmakers called the measure long-overdue and said it would go a long way to protecting New Hampshire residents from HMOs that try

to cut costs by denying needed care.
``Many of us campaigned on the issue of making HMOs accountable for the decisions that are made,'' Sen. Rick Trombly, D-Boscawen, said Thursday. ``It's a good consumer bill, and one that should have been law a long time ago.''

External Appeals Board
The so-called HMO Accountability Act would let patients appeal to an external board when health maintenance organizations refuse to cover medical care costing more than $400.
Under the bill, HMO medical directors also would have to be doctors, and they could lose their medical licenses in cases of misconduct.
Patients would not be able to sue medical directors over their decisions to deny care. Lawmakers said they were trying to hold HMOs accountable without creating a rush of lawsuits that would drive up the price of medical insurance.
The Senate passed the bill overwhelmingly, and House Speaker Donna Sytek, R-Salem, said the House will almost certainly send it to Gov. Jeanne Shaheen next week. A similar measure, which allowed patients to sue medical directors, failed in the House by one vote last year.
Shaheen, who proposed last year's legislation, addressed the Senate after the vote to thank members for passing the bill.
``New Hampshire residents deserve to know who is making decisions about their health care,'' Shaheen said later in a written statement. ``They deserve to have an outside review when their HMOs deny them health care.''
Shaheen also addressed the issue during her State of the State address , saying a healthy workforce is essential to competing in the ``new economy.''

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Panel Backs $100 Million NJ HMO Bailout Plan

by Ralph Siegel

TRENTON, N.J. — An Assembly committee has approved a $100 million package to reimburse hospitals and doctors who are still owed money from the bankruptcy of the state's largest HMO last year.
The committee vote got the ball moving on the controversial bailout package endorsed by Gov. Christie Whitman in her annual budget address. The state budget would provide $50 million, and another $50 million would be assessed against insurance companies.

Insurer Opposition

However, the central opponents to the measure, the Association of Health Plans, representing insurers, said the hearing finally gave them an opportunity to spotlight the defects of the proposal that has been on the back burner for a year.
``We didn't lose today,'' said association president Paul Langevin. ``Clearly, we gained recognition of how many unanswered questions there are and how much needs to be done before any part of $100 million is spent.''
The Assembly Banking and Insurance Committee approved the measure 5-1. Whitman was gratified that Democrats were willing to support her proposal.
Whitman said the payment was essential to reward hospitals and doctors that provided care to members of HIP Health Plan of New Jersey despite the risk that they might not be paid because of the HMO's financial problems.
The money would pay bills left behind by HIP, formerly the state's largest HMO with 165,000 members, which began failing in 1998 and went bankrupt last spring. Money is also due for unpaid bills left by the bankruptcy of the small American Preferred Provider Plan.
Physicians and lobbyists for the state's hospitals said although the amount of money will not cover all the costs, it reduces the debt. Irv Ratner, president of the New Jersey Medical Society, which lobbies for doctors, said $150 million is owed but that his group supports the partial payment.
Peter Lillo of the New Jersey Hospital Association said the payment is essential as new reports show New Jersey hospitals facing an ever-tougher financial pinch.
The Star-Ledger of Newark reported that Saint Peter's University Hospital in New Brunswick is owed $4.1 million, Robert Wood Johnson University Hospital in New Brunswick is owed $7.5 million, and St. Joseph's Medical Center in Paterson is owed $5.6 million.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

NH Insurers Seek Reversal Of ‘Double Dipping’ Ruling

by Penny Williams
Insurance Times

CONCORD, N.H. — Insurance companies are rallying behind a bill designed to prohibit injured workers from "double dipping" — collecting benefits under uninsured motorist coverage as well as workers compensation.
The bill, proposed by the National Association of Independent Insurers (NAII), addresses only the workers compensation issue raised by the September,1999 New Hampshire Supreme Court decision in Gorman v. National Grange. That decision allowed injured

workers to collect under their own uninsured motorist coverage if they were injured at work due to a motor vehicle accident even while collecting workers compensation benefits.
The Gorman decision stated that "the statute preserves an employee's right to pursue her contractual claim against her uninsured motorist carrier and 'does not upset the fundamental quid pro quo upon which the Workers Compensation Law is based.'" Insurers hope to reverse this decision which they argue undermines the exclusivity of the state's workers compensation remedy for injured employees.

Court Ruling
"The Supreme Court decision in Gorman threatens the exclusive remedy provision that is the bedrock of the workers compensation system. It also has the effect of exposing uninsured motorist coverage to claims and risk for which no premium has been collected," according to NAII Associate Counsel Gerald Zimmerman.
NAII's bill was sponsored by Reps. Robert Clegg (R-District 23) and Keith Herman (R - District 13).
The bill states that an employee waives his or her rights of action against an employer's liability insurer, and the employer's uninsured motor vehicle insurer for the purposes of the workers compensation law.
Zimmerman testified before the House Committee on Labor, Industrial and Rehabilitative Services last week, telling lawmakers that HB 1241 will prevent market problems while still allowing employees to recover damages arising from third-party negligence.
"The bill protects not only the employer and its insurer, but also employees," the NAII lobbyist said. "Workers are entitled to collect if they are injured due to negligence, and they are entitled to workers compensation coverage. But they are not entitled to collect on a personal auto policy simply because it is there. This bill is designed to clarify what was muddled in the Gorman decision."
The state's other industry trade associations are also supporting the legislation.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Federal Financial Privacy Rules Proposed

by Marcy Gordon
Associated Press

WASHINGTON, D.C. — Federal regulators are proposing new rules spelling out how consumers' personal data will be protected as banks, investment firms and insurance companies merge to create one-stop financial supermarkets.

The first sets of rules were put forward Thursday by the Federal Reserve and a Treasury Department division. They will make it tougher for financial companies to share even seemingly innocuous information, such as customers' names, addresses and telephone numbers, with outside marketing firms.

The regulators take the view that such basic information is ``nonpublic'' information when it is taken from sources such as customer lists _ even if the names and addresses also are available from a telephone book.

As ``nonpublic'' information, the names and addresses — as well as more personal financial data such as account balances — cannot be shared with outside telemarketers if customers expressly ask their banks, brokerages or insurance companies not to do so.

Still, the onus is on consumers. They must ask, in a letter or standard form, financial companies with whom they do business not to share or sell their data.

Furthermore, under a financial overhaul law enacted in November, banks, brokerages and insurers that join together under the same corporate roof are entitled to share customers' personal financial data with each other. In that case, customers do not have the right to block such sharing.

Consumer groups and privacy advocates have said the new law's privacy protections fall short.

Frank Torres, legislative counsel for Consumers Union, said the new rules proposed by the regulators ``have a broad definition of what kind of information ... (is) covered by privacy requirements, which is encouraging.''

``However, we do have some concerns,'' he added. ``It's unfortunate that these rules are constrained by the financial services law passed last year.''

Catherine Pulley, a spokeswoman for the American Bankers Association, said the group will ``look more closely at these regulations.''

Some bankers privately objected to the new rules, saying they took an overly broad interpretation of privacy protection.

Fed Chairman Alan Greenspan, who won Senate confirmation Thursday for a fourth term, expressed approval of the new privacy rules at an open meeting at which he and the other central bank governors voted to propose them for 60 days of public comment.

``So far, so good,'' Greenspan told the Fed staff attorneys, who had drafted the rules and negotiated with other federal agencies to make the regulations consistent for different financial industries and sectors.

The Fed is among a group of agencies that have been drafting privacy rules for the industries and sectors they regulate, because of the legislation enacted in November that swept away Depression-era barriers and allowed banks, investment firms and insurance companies to get into each other's businesses.

The other agencies include the Securities and Exchange Commission; the Office of the Comptroller of the Currency, the Treasury Department division that regulates national banks; the Office of Thrift Supervision and the National Credit Union

Administration.
The Federal Trade Commission is writing the rules for insurance companies and agents and a panoply of other businesses outside of banks and securities firms _ including travel agencies, mortgage companies, tax preparation services, check-cashing outlets, credit bureaus and department stores that issue credit cards.
The agencies have been working under a tight deadline. Under the new law, final regulations must take effect by November.
The Comptroller's office also published its rules Feb. 3, and the other agencies are expected to follow in the next few weeks.
``This is a very important advance in privacy protections for consumers,'' Julie Williams, the agency's chief counsel, said in a telephone interview. ``This is a winning situation for consumers and potentially a new competitive (feature) for banks'' that offer strong privacy protections.
Under the rules, financial companies will have to disclose their privacy policies to customers at least once a year.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Senate Gets Bill To Reinstate Installment Sales Method

WASHINGTON, D.C. — The Independent Insurance Agents of America (IIAA) lauded Sen. Conrad Burns (R-Mont.) for leading congressional efforts to repeal a ban on the use of a popular agency sales method.
Burns has offered S. 2005, simply titled “a bill to repeal the modification of the installment sales method.” Joining Burns to cosponsor the new bill were Senate Majority Whip Don Nickles (R-Okla.), and Sens. Wayne Allard (R-Colo.), Rod Grams (R-Minn.) and Pat Roberts (R-Kan.).
The Burns bill would overturn a recently enacted provision that prohibits the use of the installment sales method by accrual-basis taxpayers. The installment sales ban was enacted as part of the Ticket to Work and Work Incentives Improvement Act (Public Law 106-170) that was approved by Congress and signed into law by President Clinton in December.
S. 2005 has been referred to the Senate Finance Committee.

Small Business Issue
IIAA has joined other small business groups to call on both the House and Senate to act quickly to overturn the ban, claiming it is having a dampening effect on the sales of thousands of small businesses. Bill cosponsor Nickles is a member of the Senate Finance Committee.
“The repeal of the installment sales ban is the top tax issue for independent insurance agents and IIAA in this session of Congress, bar none,” says IIAA President William M. Houston, CPCU, ARM, branch manager of the Denver office of the Reidman

Insurance Corporation. “This is an issue that is negatively impacting the sales and values of not only independent insurance agencies, but hundreds of thousands of small businesses across the country.”
One small business group estimates that most of the 200,000 small business sales expected to occur this year would be adversely impacted by the installment sales ban. For small business owners seeking to sell, the ban is driving the sales price of their business down by five percent to 20 percent.

Larger Corporation Targets
Opponents of the provision charge that the installment sales method ban has badly missed its target — the sales of larger corporate entities or parts of a corporation.
“The installment sales ban was originally intended to target the sales of larger corporations, but it is having a much harsher impact on small businesses, such as independent insurance agencies,” says IIAA Executive Vice President Robert A. Rusbuldt. “IIAA member agencies that are being affected by the ban are not major, national corporations. Rather, they are community-based and family-run businesses that are providing coverage to Main Street America businesses and millions of families and homeowners.”
The installment sales method is used in a significant number of small business sales. In some sectors of the economy, installment sales may be used in as many as nine of 10 transactions. For sellers the installment method enables them to be more flexible in structuring the sale and to get a higher price for the business. For buyers, it allows them to purchase a business that normally would not qualify for bank financing.
A companion bill is to be introduced in the House of Representatives very soon by Rep. Wally Herger (R-Calif.), a senior member of the House Ways and Means Committee, that chamber’s tax-writing panel.
In addition to working with lawmakers on Capitol Hill, IIAA has joined with the National Federation of Independent Business, Small Business Legislative Council and numerous other organizations to fight the ban.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Northeast Lawmakers Unite Over Drug Prices

Northeast lawmakers keen on reducing the spiraling cost of prescription drugs plan to compare notes again last week on how they might collectively address the politically popular idea. And this time, their ranks are growing.
A December meeting in Vermont on the subject drew representatives of four states. A session last week in Boston was expected to

draw legislators from all six New England states, as well as New York.
The rationale is to use the resources and clout of all the states' legislatures to make a difference in what consumers pay for their life-sustaining drugs.
``The goal is to use our imaginations to figure out how we can work together to achieve fair pharmaceutical prices,'' said Vermont Senate President Pro Tem Peter Shumlin, D-Windham.
``Really, this will be the meeting where we try to become more specific about how we can help each other.''
Prescription prices are a big issue in New England and nationally. A seven-state congressional study in 1998 concluded that of the 10 best-selling brand-name drugs, older Americans paying for their own prescriptions pay more than double the price paid by big insurance companies, HMOs and others that a get a deal from the industry.
A separate congressional study conducted at the request of Rep. Bernard Sanders, I-Vt., found that of the 10 most widely used drugs by seniors, Americans pay 81 percent more than Canadians.
``Paying for the increasing cost of prescriptions is one of the biggest problems seniors face,'' said Connecticut Sen. Edith Prague, D-Columbia.
She said she would like to see more people eligible for a Connecticut program that helps low-income senior citizens pay for prescription drugs. Several of the states have such programs.
Maine Senate Majority Leader Chellie Pingree, D-North Haven, was to talk at the summit about a bill she sponsored that would bar pharmaceutical companies from charging more for drugs in Maine than they do in Canada.
``It's probably one of our biggest constituent issues,'' she said. ``They choose between filling up their oil tanks or buying food or cutting back on their medications.''

More Effective United
Pingree and other legislative leaders believe they would be more effective with a united approach.
``If you have a region that's really pushing for something, I do believe that the influence of all the congressional delegations from the eight or six states versus the one state is that much greater,'' said Vermont Senate Health and Welfare Committee Chairwoman Helen Riehle, R-Chittenden.
So representatives of Vermont, Maine, New Hampshire and Massachusetts met in Vermont in December, divvying up responsibilities for researching a variety of solutions. Rhode Island, Connecticut and New York will join them to discuss regulating prices; establishing a regionwide purchasing pool; educating consumers, pharmacists and physicians about prescribing and using drugs; using their retirement portfolios' ownership of pharmaceutical industry stocks to demand changes; and taking pharmaceutical industry would simply stop selling in a particular state that regulated prices on its own or would sue states that regulated. But that's no reason not to try, several said.

``At least we will have tried to do something that has been rising in importance from Montauk to Buffalo,'' said Jerry McLaughlin, an aide to New York Sen. John Marchi, R-Staten Island. ``Senator Marchi does not wish to duck an important issue because of a court fight.''

Insurance Times
February 15, 2000
Vol. XIX, No. 4

IIAA, ACLI Form State Lobbying Council

by C.A. Soule
Insurance Times

The Independent Insurance Agents of America and The American Council of Life Insurers announced they would collaborate on lobbying state lawmakers on issues important to life insurance companies and life agents by forming a new coalition called The Life Council.

The Life Council forms an unusual partnership between representatives of property/casualty agents and life insurance companies, parties who do not always see eye-to-eye on state matters.

"We have entered an era where strategic alliances and coalitions will be needed to advance agent and life insurer issues," the organizations said in a joint written statement. "Clearly no two organizations will agree 100 percent of the time, but our staffs are identifying issues and states where we have mutual interests and goals."

The groups said the effort recognizes that property/casualty agents are increasingly selling life products.

Warren Ruppar, executive director of the Connecticut affiliate of IIAA, said that the move underscores the increasing convergence of life and property and casualty agents. "A coalition is good for whatever is the issue of the day," Ruppar said. "The great thing about a coalition is that you can agree to disagree when that is appropriate."

Future One Model

"My feeling is that this will work somewhat similar to the "Future One" effort from some years ago, where property and casualty agents would sit down with company representatives to explore whether they were on the same wavelength," said Frank A. Mancini, executive vice president of the Massachusetts Association of Insurance Agents. "In Washington, one of the first things groups do to advance issues is coalition building. From a political standpoint, it doesn't make much difference who your bedfellows are."

Parties declined to comment on how the new council would affect the activities of the National Association of Insurance and

Financial Advisers, which traditionally has represented life agents.
“We already cooperate with NAIFA,” said Herb Perone , a spokesman for ACLI. “The reason the Life Council is being started to begin with is that the senior leadership of the two groups have longstanding personal relationships.”
IIAA represents 300,000 agents nationwide, while ACLI has more than 400 member companies.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Bill Would Hike Vermont Limits

MONTPELIER— Vermont drivers could see annual auto insurance policy increases of as much as 48 percent if the state legislature approves a bill to increase minimum auto coverages, insurance representatives warned at a hearing last week.
Senate bill S.308 proposes to increase the private passenger auto financial responsibility limits in the state. Limits for bodily injury and uninsured/underinsured motorist would increase from $25,000 and $50,000 to $100,000 and $300,000.
According to the National Association of Independent Insurers, a policyholder with liability limits of 25/50 BI and 50/100 UM/UIM would see an annual rate increase of between $58 to $84, or about 28 percent a year.
Insureds with other companies could see hikes of $29 to $67, or 46 to 48 percent. Drivers with limits lower than 100/300 living in Rutland Count would see the lowest increases, while those in Caledonia, Essex, Franklin, Grand Isle and Orleans Counties would see the highest increases, NAII warned. p

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Editorial Opinion Budget Finale

While candidates talk of tax breaks, President Clinton has insurers talking about the tax increases which he buried in his latest and final budget proposal.
Estimates by the American Council of Life Insurers put the total of new taxes on the life industry alone at $12.9 billion.
Carroll Campbell, Jr. , president and CEO of the ACLI, announced life insurers' opposition to the Clinton Administration's proposals to tax life and annuity products at a time when savings and retirement planning should be encouraged.
"Throughout his administration, President Clinton has repeatedly urged Americans to take personal responsibility for their own retirements by taking advantage of private sector retirement

security and financial protection products. Seeking new taxes that will make those products less affordable runs counter to that message," Campbell said.

The $12.9 billion in proposed life insurance industry taxes account for a whopping 27 percent of the total $47 billion in new individual and corporate income taxes in the administration's proposal.

"People need life insurance products — such as pensions, annuities, 401(k)s, life and disability income insurance and long-term care plans — to provide financial protection during their working lives, to accumulate and manage assets for retirement, and to create their own private safety nets at a time when government entitlement programs are increasingly strained," Campbell said.

Campbell says the life insurance industry already pays its fair share in taxes. Research by Coopers & Lybrand indicates that for the 10 years ending in 1995, the life insurance industry paid corporate income taxes at a rate of about 32 percent - significantly exceeding the average rate of 25 percent paid by other industries.

America's demographic realities demand a policy of establishing tax incentives to encourage working Americans to take advantage of private sector solutions. Surely, the nation's budget surplus allows for this.

Life insurers are not the only ones gearing up once again to fend off Clinton tax proposals.

Property/casualty insurers also are concerned over parts of the final Clinton budget, notably the proposals to raise taxes on certain investments, eliminate the tax deduction for punitive damages and to reinstate Superfund corporate taxes.

The Administration again seeks to raise from 15 to 25 percent the tax insurers pay on a portion of exempt interest earned from municipal bond investments and certain dividend income. These bonds are used to help local and state governments improve infrastructure and build schools. Borrowing costs for local and state governments would rise and insurers would be less inclined to buy as many municipal bonds if this change were enacted.

Clinton again seeks to deny a tax deduction for punitive damages. "The Administration assumes that punitive damages are generally covered by insurance, which as a general rule, they are not," said Allan Stein, AIA assistant general counsel.

This proposal would drive up the cost of settlements, which would ultimately increase the cost of insurance.

Also, the Administration has again proposed to reinstate Superfund excise taxes and the corporate environmental tax, which it has done every since 1995. Insurers only support reinstatement of these taxes as part of comprehensive Superfund reform and "only if revenues from those taxes are used for cleaning up toxic waste sites, and not to find other programs," adds Stein.

Insurers are also opposing a Clinton tax on the purchase of structured settlements

“After losing those battles year after year, you’d think the Administration would get the message by now that these ideas are dead-on-arrival,” said Melissa Shelk, assistant vice president for the American Insurance Association.
Apparently, although Clinton hasn’t gotten the message, Congress has and will again thanks to the efforts on the insurance lobby in Washington.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

DCAP Buys Out Joint Venture Partners

EAST MEADOW, N.Y., — DCAP Group, Inc. has acquired the interests of its joint venture partners in 13 DCAP retail insurance stores, in exchange for approximately 850,000 shares of common stock. DCAP Group now wholly owns 17 storefront locations, which are in addition to the remaining 8 joint venture locations and 40 DCAP franchise stores.
The acquisitions are part of the company's plan to phase-out joint ventures in the DCAP system and concentrate on company-owned and franchise stores. Company-owned stores will operate as a model for the franchisees.
"We are rolling up our joint venture stores to prepare for continued expansion of our franchising system, which has been growing at an unprecedented rate. Our company stores will offer a full complement of insurance products and value-added services, providing a prototype for the franchises," said Kevin Lang, DCAP President.
DCAP is a chain of independent retail insurance stores in the Northeast, with 65 locations. DCAP sells vehicle, homeowner, business and life insurance products from 26 different companies to nearly 100,000 retail insurance customers in New York City, Long Island, Westchester County and New Jersey.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Chubb Engagement Ring Program Closes Gaps

WARREN, N.J. — Chubb has launched a new engagement ring program which it says addresses a growing market need at a time when jewelry purchases are soaring.
Current estimates of art, collectibles and jewelry sales levels are exceeding those of the mid-1980s. Expensive engagement and wedding rings may not be insured properly under standard property insurance policies.
Chubb will write any engagement ring, anytime, anywhere for its full agreed value. Typically, no appraisal is required as long

as the agreed value is less than $50,000.
By not requiring appraisals and providing agents with consumer brochures and other marketing materials, Chubb makes the program easy and efficient for agents to sell and consumers to purchase.
In addition to generating additional revenue for agents, the program allows agents to establish relationships with new customers. In the past, young couples without homeowners or other property insurance frequently found it difficult to get their engagement ring insured.
Other key Chubb engagement ring program features include:
· Coverage can be written on a monoline basis. No other business or
jewelry coverage with Chubb is required.
· The coverage can be written in the name of either fiancée.
· No minimum value on the ring.
· Loose stones qualify as long as they are set within a reasonable
time.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Florida Homeowners JUAS Depopulate

TALLAHASSEE, Fla. —Two of Florida's state-created insurance pools that are designed to provide homeowners with coverage they can't get from private insurers were cut by more than half after three companies took over some 82,000 policies.
The policy removals were announced by the Florida Residential Property and Casualty Joint Underwriting Association.
Both the JUA and the Florida Windstorm Underwriting Association grew dramatically after Hurricane Andrew hit South Florida in 1992.
Qualsure Insurance Corp., which is based in Sarasota, removed 40,456 policies from the windstorm pool and 40,000 policies from the JUA.
American Superior Insurance Co. of Miami received 1,300 policies from the JUA and Professional Protective Insurance Co. of Winter Park received 800.
The transfers dropped the JUA to about 67,000 policies — the first time it has dropped below 100,000 since it began writing policies in March 1993. The JUA peaked at nearly 937,000 policies with a $98 billion exposure in the fall of 1996. The JUA now has about $12 billion in exposure.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Allstate Exiting Japan's Auto Market

NORTHBROOK, Ill. — The Allstate Corp. announced it is closing its Japanese auto insurance operation.
The decision was based on Allstate's recent assessment of its overall business strategy. In making its decision, the company is committed to continuing serving its current Japanese customers as it moves out of the marketplace.
Allstate continues to believe there is long term opportunity in the Japanese market. However, as a result of reviewing its overall business strategy, the company believes it is prudent to focus its resources on other growth initiatives.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Allstate Names First NJ Auto Agent In 25 Years

Also signs with 6 independent agents

BRIDGEWATER, N.J. — Citing dramatic changes in the New Jersey auto insurance marketplace due to implementation of auto insurance reform, Allstate New Jersey Insurance Co. (ANJ) last week announced the appointment of Patricia Egberts, the company's first new exclusive agent in over 25 years.
The property and casualty insurer also recently took steps to begin offering its auto and property products through select New Jersey independent agents.

Milestone
"The appointment of our first agent since 1974 is a milestone for our company and New Jersey consumers," said Richard C. Crist, Jr., president of Allstate New Jersey, one of the largest insurers in New Jersey.
"The auto insurance reform laws have fostered a marketplace where healthy competition is growing, consumer rates are falling, and the cost of doing business appears to be stabilizing. The appointment demonstrates Allstate's belief that legislators passed comprehensive auto reform laws and regulators are skillfully implementing the reform. It also shows our optimism that the judiciary will hold fast to the legislative intent of reducing pain and suffering lawsuits for non-serious and non-permanent injuries."
The new Allstate agency will be located at 436 Mantua Avenue in Woodbury Heights and run by Egberts, a 12-year veteran of the insurance industry.
Allstate New Jersey has 136 additional agency locations throughout the Garden State and plans to hire several agents by year's end.

Six Independent Agencies
Since December 1999, Allstate New Jersey has also appointed six independent agencies to tap into New Jersey's $800 million property and casualty independent agency market. This is in keeping with Allstate's multi-channel strategy.
"The expansion of our distribution system offers consumers in the Garden State more opportunities to do business with Allstate New Jersey," said Crist. "However, we are going to grow very strategically, only adding agents and other distribution channels if the market continues to support competitive growth. Ultimately, our expansion is dependent on the continued success of New Jersey's historic auto reform."

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Earthquake Predictions Remain Uncertain

SAN FRANCISCO -- In spite of significant research to better estimate the likelihood of earthquakes throughout the U.S., there is still much disagreement regarding earthquake prediction, panelists told the Casualty Actuarial Society annual meeting recently.
However, recent improvements in technology may make earthquake predictions far more accurate.

Below Average Activity
While there have been numerous catastrophic earthquakes throughout the world this year, overall the earth's seismic activity has been below average said panel moderator Ronald Kozlowski, consulting actuary for Tillinghast - Towers Perrin. "There are thousands of earthquakes a year - typically 13 are of a magnitude 7.0 or higher," he said. "So far there have been 12 earthquakes of that magnitude in 1999, unfortunately many of them have occurred in highly populated areas."
The 1989 Loma Prieta earthquake that measured 7.1 on the Richter Scale and affected the San Francisco Bay Area has been a major source of information on seismic activity for scientists. "The Loma Prieta earthquake was a stepping stone in the study of earthquakes," said Michael Blanpied, associate chief scientist for scientific programs, Earthquake Hazards Team for the U.S. Geological Survey, "In the 10 years since Loma Prieta a lot of understanding has been accumulated."

70% Chance
A working group on California earthquake probabilities, comprised of 70 scientists, recently found that there is 70 percent chance of an earthquake of magnitude 6.7 or higher occurring between 2000-2030 in the San Francisco Bay Area, he said. This area is made up of numerous faults, including the San Andreas, Rogers

Creek/Hayward, San Gregoria, Calaveras, Concord/Green Valley, Mt. Diablo and Greenville faults, which add up to widespread risk in an area that is heavily populated.
The key to predicting future earthquakes is the study of past earthquakes. "The 1906 San Francisco earthquake was of such large magnitude that it reduced stress and greatly reduced the chances of other earthquakes in the Bay Area," said Blanpied. Data on past earthquakes in Northern California showed that seismic activity was high before the 1906 earthquake and greatly reduced after the earthquake.
Blanpied noted that the principal sources of uncertainty in earthquake prediction are differences in opinions of scientists, the quality of data, and the inherent variability and randomness of seismic activity. However, with time and further study, these uncertainties should decrease, he said.
While California is believed to be at the greatest risk of earthquakes, there are faults in other areas of the United States that pose danger.

Most Powerful
"The most powerful earthquake in the continental U.S. is thought to have occurred in the central United States," said Dr. Seth Stein of the Department of Geological Sciences. Data suggests that in the 1800's three earthquakes of magnitude 9.0 occurred in New Madrid, Missouri. Study of the New Madrid area is especially important because an earthquake in the midwest could be much more catastrophic than an earthquake of the same size in California. "You could feel a magnitude 5.0 earthquake that occurs in the New Madrid area in Boston," said Stein, "energy from seismic activity moves faster in the mid-west."
He noted that the Global Positioning System (GPS) is a new research tool that scientists are using to detect fault movement. GPS uses precise satellite broadcasts to determine the slippage of faults. Scientists have found that movement on the New Madrid fault system may actually be slowing or shutting down.
"Seismic hazard at New Madrid is hard to assess because so little is known about past activity in that area, however, the latest data shows that the risk has been highly overestimated," said Dr. Stein.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Euro, Internet Said To Allow More P/C Insurers To Expand To Global Arena

Why have U.S. insurers been slow to enter European market?

NEW YORK — The Euro and the Internet are instrumental in creating a level playing field which will allow European and U.S.

property/casualty insurance companies to expand their market base to the global arena, Dr. Henning Schulte-Noelle, chairman of Allianz, AG told the Property/Casualty Insurance Joint Industry Forum, held here.

Schulte-Noelle heralded the Euro as one of the driving factors behind European companies' push toward globalization. "The Euro will increasingly allow European companies to achieve some of the economies of scale from which the United States, with it's universally valued dollar, has benefited in the past," he said.

Schulte-Noelle questioned why the U.S. insurance industry has been slow to enter the European insurance marketplace. "A lot of major European insurers have made major investments in this country (U.S.)...in comparison, the U.S. has been more reluctant to develop activities on the other side of the Atlantic."

U.S. insurance companies may become more attracted to the European markets when individual European countries' legal, economic and social policies converge. Schulte-Noelle also views the convergence as one of the final obstacles to strengthening the Euro and Europe's role in the worldwide business arena.

Looking at emerging markets in Asia, Central and Eastern Europe and South America, Schulte-Noelle noted that the European and U.S. insurance industries have a responsibility to support the World Trade Organization's initiatives to open up these markets. "Not only is this in the interest of the insurance industry, but also in the interest of the people in these regions," he said.

Schulte-Noelle noted that most personal and commercial lines products offered by European and U.S. insurance companies will remain local for the foreseeable future, while some business lines such as reinsurance, alternative risk transfer solutions and international investor insurance have the potential to become truly global. He acknowledged that travel insurance, credit insurance and marine/transport insurance also have global market potential.

Whether their goal is to grow their market overseas or at home, insurance companies must reevaluate their marketing strategies, according to Schulte-Noelle. He suggested using a marketing approach that takes the lifecycles into account and offers tailored products for different age groups.

"Insurance companies could increase their growth rate by developing full capabilities to solve problems for their customers," he said. "But more individual needs and changing customer behavior will force more differentiated and sophisticated distribution channel strategies."

One of those distribution channels is the Internet. "In transaction-related businesses with simple commodities and where the processes are easy to automate, the Internet is a viable independent distribution channel," he said.

Schulte-Noelle added that the Internet will allow the insurance industry to increase productivity and improve efficiency because people and information are now accessible all day, everywhere. He said customers can be serviced better, policies can be assigned faster, risk can be assessed more easily and products

can be tested more efficiently.
"The Internet will change the insurance business more fundamentally than all other past innovations because it links us as citizens of the world," Schulte-Noelle The Internet and the Euro provide European and U.S. insurance companies with tools to grow globally, he concluded.
To effectively utilize these tools, Schulte-Noelle advised insurance companies to keep focused on the basic question of "...which customer group wants to be addresses through which kind of distribution channel concerning what kind of product." predicted.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

BancOne, Nationwide Team On Annuity

COLUMBUS, Ohio — Banc One Insurance Group and Nationwide Financial have teamed to issue and underwrite the largest proprietary variable annuity sold through financial institutions. The One Investor Annuity reached $1 billion in assets in 1999, making it the largest variable annuity of its kind.
To cement that relationship, Nationwide Financial has created a service team dedicated to providing Banc One Insurance Group customized service on sales of proprietary annuities underwritten by Nationwide.
In 1999, more than $600 million of The One Investor Annuity and The OnePlus Annuity were sold through Bank One banking centers by team leaders and licensed bankers.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Amex Settles $215 Million Class Action

NEW YORK (AP) — American Express Co. disclosed a $215 million settlement of claims last week that it misled people into buying insurance products without fully disclosing fees. But the company managed to report a 15 percent profit in the fourth quarter that met Wall Street projections.
American Express, which did not admit any wrongdoing, said the preliminary settlement of three class-action lawsuits covered 2 million people who bought annuity products from the company starting in 1985.
The company said its settlement of three class-action lawsuits, related to sales of insurance and annuity products, will mostly be covered by money previously reserved. But American Express said it had set aside an additional $74 million, before taxes, during the fourth quarter to cover the deal. The agreement

settles claims against the company dating back to 1985, American Express said.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Prudential Of Canada Sells To RBC

TORONTO — RBC Insurance is acquiring the individual life insurance and annuity business of the Prudential of America Life Insurance Co. (Canada), known as PruCan, and a 15 per cent interest in PPI Partners, a provider of insurance and related financial products to high net worth Canadians.
Through the agreement, which is subject to regulatory approval, RBC Insurance will assume responsibility for about 17,000 PruCan life insurance policies and annuities in Canada. The insurance policies and annuities are held by individual clients in the affluent segment of the life insurance market.
`This agreement gives us the opportunity to develop and distribute insurance products that serve the growing segment of high net worth households in Canada,` says Jim Westlake, president and CEO of RBC Insurance, the insurance operations of Royal Bank Financial Group.
PruCan was established in 1990 as a joint venture between the Prudential Insurance Co. of America and PPI Partners. The operations have about 115 employees based in Toronto and generated about $130 million in individual life and annuity premiums in 1999.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Nominees For Business Ethics Award Sought

BRYN MAWR, Pa. — The Society of Financial Service Professionals is seeking nominees for the seventh annual American Business Ethics Award (ABEA). Entry forms are available from national headquarters and from local chapters throughout the country.
The ABEA honors companies that exemplify high standards of ethical behavior in their everyday business conduct and in response to specific crises or challenges. The award was established in 1994.
The deadline for 2000 ABEA entries is March 15, 2000.
Awards will be presented in three categories: public companies, private companies, and small businesses (companies with 100 employees or fewer). Insurance companies, brokerages and agencies are not eligible to participate. An independent panel of experts drawn from business, academia, public service, media, consulting, and the ethics community will judge entries.

Past ABEA recipients include: Bell Atlantic, Walker Information, Wright Water Engineers, Lockheed Martin Corporation, PricewaterhouseCoopers, Fenimore Asset Management, Weyerhaeuser Co., Western Extralite Co., Delta Sand & Gravel Co., Starbucks Coffee Co., Texas Instruments, Levi Strauss, Merck & Co., H.B. Fuller, Guardsmark, Rich Products, and Hanna Andersson.
For more information,call 88-243-2258 or visit the Society's Web site at www.financialpro.org.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Americans Saving More Towards Their Retirement Security

Many confused about Social Security

Seventy percent of Americans are now saving for retirement — up from 68 percent in 1998 — and a growing percentage are attempting to determine how much they will need to accumulate, according to the results of the Employee Benefit Research Institute's (EBRI) ninth annual Retirement Confidence Survey (RCS).
But the survey indicates there are still major hurdles—including widespread confusion about Social Security—facing the retirement security of many Americans.
The survey results, reported in the December EBRI Issue Brief, show that employers play a major role in ensuring retirement adequacy, by providing workers with retirement benefits and financial education. Forty percent of all workers responding to the survey said they expect that funds provided by their employer will be a major source of retirement income, and 46 percent of workers expect that money they contribute to a retirement plan at work will be a major source.

Role of Employers
"The role of employers is crucial," said EBRI President Dallas Salisbury. "Retirement plans and educational materials offered by employers are cited by many workers as a major motivator for beginning or resuming saving for retirement, or changing their contributions."
In addition, the RCS provides evidence that education can have a significant impact on savings behavior. "If retirement income security is viewed as a long-term challenge, education must be the central focus of any efforts designed to meet this challenge," said Don Blandin, president of the American Savings Education Council and a co-sponsor of the survey:
The RCS tracks Americans' retirement planning and saving behavior and their confidence regarding various aspects of their retirement. It also categorizes workers and retirees into distinct groups based on their individual views on retirement, retirement planning, and saving. For the second year, the RCS

also reported public opinion in three minority groups: African-Americans, Hispanic-Americans, and Asian-Americans. EBRI is a private, nonprofit, nonpartisan public policy research organization based in Washington, DC.

Among the survey's key findings:

* Seventy-one percent of workers are confident that they will have enough money for a comfortable retirement, and majorities are also confident about having enough money for basic expenses, about their financial preparations for retirement, about having enough money to support themselves in retirement no matter how long they live, and about having enough money for medical expenses. But most of those who are confident are somewhat confident rather than very confident—that is, they should have enough money if everything goes just right.
* But many people may be falsely confident: While 70 percent of Americans are saving for retirement and 49 percent have calculated how much they need to accumulate, 30 percent have not begun to save, and 51 percent have never tried to determine how much money they will need.
* The RCS includes a Retirement Readiness Rating (R3), which is designed to indicate how well individual workers are preparing for retirement. Based on the results of this scale, 8 percent of American workers appear to be doing a very good job of preparing for retirement, 31 percent appear to be doing a good job, 32 percent appear to be doing an adequate job, 19 percent appear to be doing a poor job, and 10 percent a very poor job.
* A lot of Americans are confused about their Social Security benefits. For example, 59 percent of workers expect to be eligible for full Social Security benefits sooner than they actually will be, and an additional 19 percent admit they do not know when they will be eligible.
* What motivates Americans to save for retirement? Not being able to count on Social Security, seeing people not prepare and struggle in retirement, and realizing that time is running out to prepare were most frequently cited. The availability of a retirement plan at work and earning enough money to be able to save are also powerful motivators.
* Among the minority groups surveyed, Asian-Americans expressed the most the most confidence that they will have enough money to live comfortably throughout their retirement years (31 percent were very confident, 46 percent somewhat confident). Twenty-four percent of African-Americans were confident, and 42 percent were somewhat confident; 19 percent of Hispanic-Americans were very confident and 36 percent were somewhat confident.

The RCS is sponsored by the Employee Benefit Research Institute, the American Savings Education Council (ASEC), and Mathew Greenwald & Associates.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Hancock Stock Misses Opening Day Surge

by Tom Kirchofer
Associated Press

BOSTON (AP) —After 138 years of ownership by its policy holders, John Hancock debuted on the New York Stock Exchange on January 26, initially trading moderately higher.

Initially, 102 million shares of the insurance company were priced at $17 a share, raising $1.73 billion. Shares opened at $17.75, but had slipped to $17.371/2 in late morning trading.

With such a large number of shares available, analysts weren't expecting it to match the opening-day surges experienced by some other initial public offerings with only a few million shares available.

Still, some experts say John Hancock Financial Services Inc.'s stock could experience a slow but steady increase.

``The Hancock brand name is probably second to none in the insurance business. It's probably a good long-term investment,'' said Adam Levy, a financial services analyst at Invesco Funds Group in Denver. ``But as far as desire for IPOs, right now it's just not as sexy.''

Stock watchers say John Hancock's IPO will also be dampened by a variety of factors, including last year's increases in interest rates, which hurt many insurance stocks.

``Their timing is horrible,'' said Irv DeGraw, research director of WorldFinanceNet.com, a Sarasota, Fla.-based provider of financial information.

But given Hancock's size, reputation and longevity, DeGraw expected the stock to look like that of an established blue-chip corporation, rather than a headline-grabbing Internet IPO.

``It's going to be a very solid offering. It's going to price as expected and then it's going to immediately begin behaving like a standard seasoned stock, not an IPO,'' he said. ``If you want to get rich quick, this is not the one to do it with. If you want to get poor quick, this is also not the one to do it with.''

Along with the 102 million shares in the IPO, an additional 229.7 million shares will be distributed to policy holders, who are the current owners of the company. Most of the money generated from the IPO is expected to be used to pay policy holders who are not eligible for stock or decide they don't want it.

The deal culminates John Hancock's transition from a mutual company to a stock company, which is owned by stockholders. The company has said it wants to go public to remain competitive in the consolidating financial services industry.

Worried Watcher

David Menlow, president of IPOfinancial.com, a Millburn, N.J.-based IPO newsletter publisher, wasn't convinced Hancock would become a Wall Street success.

He worried about a declining rate of increase in premiums, as

well as a decline in profits. Hancock’s net income for the first nine months of 1999 was $409.1 million, down from $443.6 million in the same period of 1998.
``I think it’s going to languish. They’re going to have to show some fundamental changes in how they are perceived financially,’’ Menlow said.
The Boston-based company is trading under the symbol JHF on the NYSE.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Senior Advocates Hope For Clinton And Republican Compromise On Drug Plan

by Alice Ann Love
Associated Press

WASHINGTON (AP)— With President Clinton and majority Republicans in Congress offering competing plans to improve prescription drug coverage for senior citizens, a compromise bill has a shot this year, albeit a long one.
``There will be a very active debate this year on the issue and whether or not something actually gets enacted depends on how engaged the public gets,'' said John Rother, director of public policy for AARP, the largest organization of older adults.
Political conditions are not ideal for compromise as the political parties try to emphasize their differences before this fall's elections. Yet larger-than-expected budget surpluses have given Republicans some maneuvering room to consider new spending as lawmakers look for accomplishments to tout on the campaign trail.
Democratic pollster Mark Mellman said even younger voters sympathize with older adults' worries about high drug costs.
``The concern is certainly greater among senior citizens, but it's a concern that really does permeate the electorate,'' Mellman said.
Clinton wants to add drug coverage to Medicare as an option for all Americans age 65 and older, who would pay about $24 a month for a limited benefit.
``In good conscience, we cannot let another year pass without extending to all seniors the lifeline of affordable prescription drugs,'' Clinton said in his State of the Union address.
Under his plan, the government would contract with the pharmaceutical benefit managers many private health plans use. They negotiate bulk discounts with drug companies and allow consumers to use prescription cards at pharmacies or order by mail.
Republicans say Clinton's approach would waste government dollars replacing the private drug coverage that about two-thirds of

senior citizens already have — from former employers, HMOs or supplemental insurance know as Medigap.
GOP leaders have promised alternative legislation soon.
``We're working on a responsible plan to make sure senior citizens have access to affordable prescription drugs,'' House Speaker Dennis Hastert announced. ``We don't want to jeopardize the good coverage that already exists.''
Hastert said the GOP would focus on helping those who now lack access to or cannot afford private options.
One possibility is a tax credit. A second is a federal block grant to support state programs — already existing in some places — that help low-income senior citizens pay for drugs.
Meanwhile, in the Republican rebuttal to Clinton's speech, Sen. Bill Frist, R-Tenn., said Senate GOP leaders want quick action on legislation that would add prescription drug coverage to Medicare as part of a major overhaul of the program.

Republican Plan
Under that plan, the government would give Medicare beneficiaries a limited contribution toward the purchase of approved private health plans , a setup similar to federal employees' health benefits. The plans would be required to offer prescription coverage.
Although a few moderate Democrats support this approach, party leaders have attacked it as voucher system and the administration has raised concerns it could result in the shift of rising Medicare costs to the elderly.
As lawmakers try to find some common ground, lobbying is expected to be intense.
AARP has not endorsed any proposal so far. But the group would prefer drug coverage made available to all senior citizens through Medicare and considers ideas such as tax credits an incomplete solution.
Allied with Republicans are drug and insurance companies that fear government controls and say senior citizens should be empowered to use private options.
The Pharmaceutical Research and Manufacturers of America recently pledged to ease off attacks on Clinton's plan. The group still opposes it and is financing an ambitious campaign, including new television ads in which the now famous gray-haired bowler ``Flo'' promotes ``bipartisan solutions,'' like the one Senate GOP leaders favor.
The Health Insurance Association of America said the tax credits and state block grants were ``the best approach in the near-term.''
On Clinton's side are prominent consumer groups, including Ralph Nader's Public Citizen and the Consumer's Union, which publishes Consumers Report.

Insurance Times
February 15, 2000

Vol. XIX, No. 4

Average D&O Award Rises As Pricing Continues To Decline

Observers expect adverse loss ratios and shrinking profit margins if these current trends continue

The average size of a shareholder directors & officers (D&O) liability claim award rose to $8.67 million, the highest ever, but overall pricing still declined for D&O liability insurance for the fourth consecutive year, according to the 1999 Directors and Officers (D&O) Liability Survey, an annual study completed by Tillinghast - Towers Perrin.

High-tech and biotech companies with recent initial public offerings (IPOs) ran against the overall downward trend, with some posting substantial premium increases.

Very Competitive

"This market remains very competitive, with reinsurance and primary insurance capacity growing and policy language generally less restrictive," said Mark Larsen, a Tillinghast - Towers Perrin consultant and the survey's author. "While premiums decreased an average of 7 percent for comparable coverage, shareholder D&O claim costs rose $1.51 million to $8.67 million, with the average indemnity payment for closed shareholder claims -- excluding those closed with no payment -- up from $7.16 million in last year's survey.

"The trend is similar for D&O claims from employees, which reported an average cost of $306,000 versus $287,000 in the prior survey," added Larsen. "Shareholder and employee claim cost trends are crucial since these are by far the most frequent sources of D&O claims, with shareholder claims most common for publicly traded companies and employee claims most frequent for private companies and nonprofit organizations.

Liability Tail

"If these trends continue, we could soon see adverse loss ratios and shrinking insurer profit margins," noted Larsen. "And despite the dearth of Year 2000 (Y2K) claims to date, this type of liability has several more years to its tail and could result in significant losses for D&O insurers. For companies seeking coverage, the financial strength and reputation of D&O insurers will definitely be factors."

According to U.S. survey respondents, employee claimants most frequently cited discrimination in employment as an issue; such claims accounted for 27 percent of all D&O claims reported. For shareholder claimants, issues related to financial disclosure were most common and accounted for more than 7 percent of all claims.

The current survey was endorsed by the Research Committee of the Risk and Insurance Management Society (RIMS) and had over 1,400 responses.

Fifty-six percent of the 1,325 U. S. participants were publicly traded companies, and slightly more than half had experienced merger, acquisition or divestiture activity in the last five years. Median asset size was approximately $150 million.
The report is available by calling (312) 609-9347, via fax at (312) 609-9393 or e-mail at mazem@towers.com.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Employee Benefits & Managed Care

Met:Life acquires BMA's workplace business
NEW YORK— MetLife has reached agreement to acquire the Group Workplace Benefits Division of the Business Men's Assurance Co. (BMA), a Kansas City, Missouri based insurer that is a subsidiary of Assicurazioni Generali, Italy's largest insurer.
Under the agreement, MetLife will acquire $100 million of group life and long and short term disability premiums, which is marketed primarily to small and mid-sized businesses. MetLife plans to maintain the division's current operations based in Kansas City and 17 field offices across the country.
This transaction, which is subject to approval by the New York Insurance Department, will increase MetLife's small group business by 35 percent and increase its small group sales force by 40 percent. MetLife will also benefit geographically as the company will gain regional offices in cities where it is not currently present.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

NJ Blues Offering Alternative Medicine Benefit

NEWARK, N.J.— Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) is now offering an alternative medicine program with discounts to members on such services as acupuncture, massage therapy, nutritional counseling, and yoga instruction, as well as vitamins and related products.
Horizon Alternative Therapies will be part of Horizon BCBSNJ's growing value-added discount programs available to all members of the company's health plans. The program is designed to help complement traditional health care.
Horizon BCBSNJ members can access the program by making appointments directly with any alternative therapy provider in the program's extensive statewide network. To locate a provider in their area, members can call 877-940-0944 toll free.
Members receive a 20 percent discount off providers' regular fee for alternative therapy services and 10 percent off products distributed by providers.

As part of the program, members also receive through Vitamins.com discounts of 15 to-50 percent off national retail store prices on vitamins, supplements, minerals, natural cosmetics, books and health-related publications. There is also an additional 10 percent discount on Vitamins. com items through the Alternative Therapies program.
Members can place vitamin orders by contacting Vitamin com at 800-741-8273 or by visiting the company's web site at http://www.vitamins.com. Free same-day shipping is offered on all orders.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Humana Sells Its Workers Comp Unit

LOUISVILLE, Ky. — Humana Inc. has reached a definitive agreement to sell its workers compensation services unit, Workers Compensation Services (Humana WCS) through a management buyout. Terms of the transaction were not disclosed.
Humana WCS, to be renamed at the close of the transaction, will be headquartered in Longwood, Florida under the leadership of Gene Roberts, who has led Humana's workers compensation product business since its inception in 1993. The new company will continue to service existing customers and contracts held by Humana WCS.
James Murray, Humana senior vice president and chief financial officer, said the sale of Humana WCS allows Humana to focus on its core business of health insurance.
"This sale, combined with the earlier announcement of our sale of the PCA P&C workers compensation insurance company, totally removes us from the workers' compensation market, which was a non-core business for us," said Murray. "As we move forward in 2000, this strategic move will give Humana the ability to concentrate on our goal of improved profitability in the health insurance market."
Humana Workers Compensation Services serves over 18,000 business customers in 17 southeastern and midwestern states.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Conn. Campaigns To Boost Children's Health

HAMDEN, Conn. — A new public service campaign has been launched to get more children enrolled in the free or low-cost HUSKY health plan.
The radio announcements will be accompanied by pamphlets to be given to children at school and to parents who enroll their

children in school lunch programs.
The Census Bureau will distribute information about the plan to people who will work as census-takers this year.
HUSKY enrollment has not met projections. About 90,000 children without insurance may be eligible for the plan but have not applied, U.S. Rep. Rosa DeLauro said Friday in announcing the awareness campaign.
HUSKY, which stands for Healthcare for Uninsured Kids and Youth, is federally funded. Depending on a family's income the health coverage is free or available at a small premium with some co-payments.

Insurance Times

February 15, 2000
Vol. XIX, No. 4

Small Business Seen Key To Uninsured Fix

Rising percentage in job-based health plans

A rising percentage of nonelderly Americans are covered by employment-based health insurance, despite rising health care costs in 1998, according to a new report by the nonpartisan Employee Benefit Research Institute (EBRI).
The percentage of Americans under 65 covered by employers' plans increased to 64.9 percent in 1998, from 63.5 percent in 1993.
The EBRI report also found that the percentage of Americans who are uninsured may have stopped growing, while the number of uninsured—currently 44 million—increased very slightly between 1997 and 1998.

Job-Based Increase
The report attributes the increase in employment-based health coverage among nonelderly Americans between 1994 and 1998 to higher rate of coverage among children. Increased worker coverage during 1997-1988 may be explained by a decline in self-employed workers and an increase in workers at large employers, EBRI found.
"These data point to the importance of health care reform measures that would help small employers offer affordable insurance to their workers," said EBRI President Dallas Salisbury. "Since a large portion of uninsured workers are employed in firms with fewer than 100 employees, this is an critical sector for policymakers to focus on."
Among the report's findings:
* In 1998, 194.7 million nonelderly Americans—81.6 percent—had some form of health insurance. More than 64 percent had it through an employment-based health plan; 6.5 percent purchased it on their own; and 14.3 percent were covered by public programs, mostly through Medicaid (10.4 percent). "Nonelderly" Americans are those under age 65.

* Between 1994 and 1998, the percentage of children (ages 0-17) covered by an employment-based health plan increased from 58.1 percent to 60.2 percent. For adults (ages 18-64), it increased from 66.1 percent to 66.9 percent.
* In 1998, 18.4 percent of the nonelderly population was uninsured (43.9 million people), compared with 14.8 percent in 1987. This percentage has generally been increasing since at least 1987, although the percentage in 1998 was statistically insignificant from that in 1997 (18.3 percent). The increase in the uninsured prior to 1993 can be attributed to the erosion of employment-based health insurance. However, since 1993, the percentage covered by an employment-based health plan has increased from 63.5 to 64.9 percent.
* Adults started to realize gains in employment-based health insurance between 1997 and 1998, when the percentage of working adults with employment-based coverage increased from 72.2 to 72.8 percent, despite the apparent return of health care cost inflation in 1998.
* The decline in public sources of health insurance would mostly explain the recent increase in the uninsured. For example, between 1994 and 1998 the percentage of nonelderly Americans covered by CHAMPUS/CHAMPVA declined from 3.8 to 2.9 percent, in large part due to downsizing in the military. Similarly, between 1993 and 1998, the percentage of nonelderly Americans covered by Medicaid declined from 12.7 percent to 10.4 percent as people left welfare.

Insurance Times

February 15, 2000
Vol. XIX, No. 4

Employers Seek Ways To Fight High Health Costs

With a booming economy and an increasingly tight labor market, many employers are looking for ways to battle rising health care costs., reports the annual 1999 Employer Survey on Managed Care conducted by Deloitte & Touche LLP and Business & Health Magazine.
The survey reveals that employers are finding ways other than increasing employees' contributions to skirt the high cost of health care.
These include the exploration of purchasing options, redesigning plans, joining purchasing groups, instituting pharmaceutical cost controls, and contracting with lower cost carriers.

Prescription Drugs
With nearly a third of employers identifying prescription drug costs as a primary cost driver, nearly 90 percent have instituted some form of pharmaceutical cost controls and nearly 15 percent are considering joining or forming drug purchasing coalitions. More than half (56 percent) of employers are targeting chronic

illnesses or diseases for management. The most commonly targeted conditions are: diabetes, high-risk pregnancy, heart disease, asthma, and cancer.

Nearly 80 percent entirely or partially outsource the administration of their health and welfare programs and many indicated that they would add or expand outsourcing services in the future.

—Less than half of respondents are offering health care plans to retirees under the age of 65 and only 39 percent offer coverage to post-65 retirees.

—Surprisingly, only 31 percent of employers have performance standard in place with their health plans and only 16 percent are monitoring quality of care indicators.

According to the survey, costs are up an average of nine percent with similar increases predicated across all plan types for 2000 and 2001. During 1998, total annual medical costs averaged $3,871 per employee and included: $415 for pharmacy benefits; $101 for mental health coverage; $80 for vision; and $394 for dental.

Why are employers against a wall on price?

"There are a number of convergent reasons for these significant price hikes after years of moderate increase," explains Eileen Raney a principal with the firm's Human Capital Advisory Services practice and national director of its Integrated Health Group. "Consolidation in the industry has stifled the competitive market to a degree, prescription drug costs have risen dramatically, and pent-up cost increases in the managed care market are finally being felt — increases primarily driven by consumer demands for greater access to care."

Tight Labor Market

The tight labor market has put pressure on employers to divert the expense to anywhere but the employees. Instead of passing on costs to employees, the majority of employers are relying on plan design changes to control cost.

They're also exploring their purchase options with an increasing number considering joining purchasing coalitions.

Although many employers monitor patient satisfaction, surprisingly, only a small percentage are focusing on qualitative factors like plan performance and quality of care. "Right now only a third of employers have plan performance standards in place and only a fraction monitor quality of care indicators," said Raney. "In this market, when you've reached a wall in terms of negotiating price, it is incumbent upon employers to push plans on quality and performance issues."

Pharmaceutical costs are clearly at the forefront of the current cost crisis. A third of respondents identified prescription drug costs as having the greatest impact on their plan costs.

Respondents spent an average of $415 per employee on pharmacy benefits last year. This accounted for nearly 12 percent of their health care spending per employee and was more than what they spent on vision, mental health, or dental coverage.

"People are living longer, new and better drugs are being

developed, and consumers are responding to direct-to-consumer advertising and access to on-line information, all of which translates into increased utilization," noted Barbara Adachi, survey director and a principal with Deloitte & Touche. "What employers and the health care community have to force themselves to do is to look beyond the initial shock of these costs and focus on outcomes — will these drugs ultimately lead to healthier populations and less costly care overall?"

Preventive care and disease management are also key issues in the cost debate. More than half (56 percent) of employers are currently targeting chronic illnesses or diseases for management. The most commonly targeted conditions are: diabetes, high-risk pregnancy, heart disease, asthma, and cancer.

Employers and health care plans are more open to non-traditional forms of care. Nearly all (95 percent) of employers currently offer chiropractic treatment and 29 percent offer acupuncture. Over 60 percent of employers believe that employees will be more heavily involved in their own health care in the future.

"Xerox recently indicated that they are considering moving to a voucher system where employees would be individually responsible for purchasing their own health insurance," commented Adachi. "This may not be far away and will have a significant impact on the industry."

There are other ways employers are looking to trim costs. They are turning to partial or full outsourcing to offset some of the administrative costs associated with their health and welfare plans. Nearly 80 percent entirely or partially outsource the administration of their health and welfare programs and many indicated that they would add or expand outsourcing services in the future.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Employers Playing Larger Role In Employees' Retirement Planning

Hewittt survey identifies trends in 401(k)s and retirement options

New research by global management consulting firm Hewitt Associates indicates that U.S. employers are boosting their 401(k) plan offerings and providing more investment education to help employees manage their retirement savings.

According to Hewitt's 1999 survey of 491 employers nationwide with a combined total of 3.3 million participants and $295 billion in assets, employers are offering more investment options than ever before. Nearly twice as many employer-sponsored plans (42 percent) offer 10 or more investment options today than in 1997 (23 percent). On average, plans offer 11 investment options, up from an average of eight options in 1997.

“Clearly, employers recognize that a well-designed plan is critical for employees to prepare for a secure retirement,” says Scott Peterson, defined contribution practice leader, Hewitt Associates. “By offering more investment options, employers are enabling employees to diversify, which is essential for retirement investments.”

The level of employer matches also is on the rise, with 19 percent of employers that offer matches providing a dollar per dollar match, up 5 percent since 1997. The most common type of match is 50 cents per dollar, reported by 32 percent of employers offering matches. In total, 92 percent of employers match before-tax employee contributions.

Enhanced Education Efforts

As a result of more choices and opportunities for employees to build their 401(k) savings, Hewitt’s research shows that employers have enhanced their investment education efforts. The majority of employers surveyed (86 percent) provide investment education for employees, up significantly from 59 percent in 1997.

Of those that provide investment education, 61 percent of employers maintain an on-going communication campaign aimed at educating employees about 401(k) plan investing. Many employers are also considering providing employees with access to investment advice. Nearly half (47 percent) of employers plan to offer outside investment advisory services within the next 12 months or will consider it in the future.

“As employers offer more options in 401(k) plans, it is crucial that they also increase their efforts to help employees make the most of this benefit,” says Peterson. “Understanding how decisions made today affect their finances tomorrow is imperative if employees hope to have a stable financial future.”

Other Findings

Other key findings from Hewitt’s 1999 401(k) Trends and Experience survey are:

- On average, 78 percent of eligible employees participate in their employer-sponsored 401(k) plan.
- Forty-one percent of employer plans surveyed serve as their employees’ primary retirement income plan.
- In addition to 401(k) plans, employers surveyed offer other retirement programs, such as defined benefit pension plans (65 percent), other deferred profit sharing or savings plans (18 percent) and stock option plans (14 percent).
- Sixty-two percent of employers use the Internet as a medium for employee investment education, more than three times as many plans (20 percent) in 1997. Of those using the Internet, 92 percent report it is either very effective or somewhat effective in communicating investment concepts.
- The most common maximum employee contribution rate is 15 percent, allowed by 41 percent of employers surveyed.
- Two-thirds (66 percent) of surveyed employers report that

employees contribute between 5 and 8 percent of pay to the 401(k) plan.
- When selecting investment options for the plan, 88 percent of employers surveyed indicated that investment performance was the most important factor, followed by investment fees (60 percent) and employee communication (29 percent).
- Ninety-two percent of employer-sponsored plans offer a loan provision.
Hewitt Associates LLC is a global management consulting firm specializing in human resource solutions.

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Trial Of Prominent NY Infertility Doctor Charged With Insurance Fraud Underway

NEW YORK (AP) — A prosecutor says a prominent doctor lied to insurance companies to force them to pay for infertility treatments, but his lawyer describes his client as the victim.
``There was no fraud, you will see,'' defense attorney Theodore D. Wells said during opening statements Jan. 27 in the case against Dr. Niels Lauersen.
Lauersen, an obstetrician and gynecologist, and Dr. Magda Binion, an anesthesiologist, are being tried on charges of conspiracy, health care fraud and mail fraud in connection with an alleged 10-year scheme to falsely bill fertility surgeries that were not covered by insurance as gynecological surgeries which were.
Assistant U.S. Attorney Christine Chung told jurors Lauersen was a thief as she outlined her case in U.S. District Court in Manhattan.
``Ripping somebody off. That's what the evidence is going to show these doctors did. They stole millions of dollars by telling lies year after year after year,'' she said.
Wells portrayed his 63-year-old client as a hero to patients struggling to have a child.
He acknowledged Lauersen often didn't bill insurers for laboratory work that matched sperm and eggs before inserting the combination into women.
But he said the doctor was nearly always able to bill the insurance company accurately for treatment of the underlying physical problems preventing pregnancies.
Lauersen, the author of ``It's Your Body,'' has appeared frequently on television and in publications as an expert on fertility matters, which make up about 10 percent of his practice.

Started in 1987
Chung said the conspiracy started in 1987 as Lauersen falsely charged insurance companies $7,500 at least 500 times, collecting

at least $2.2 million.
``He decided he was going to lie and defraud and cheat the insurance companies,'' Chung said. ``For every patient he had — rich, poor or somewhere in between _—this is what he did.''
She said he alleged on forms that women were bleeding or in pain, requiring surgical procedures.
``There was no bleeding. There was no pain. There was no problem. The women were there because they were trying to have a baby,'' Chung said.
Wells said prosecutors were relying on ``false accusations and distortions of the truth.''
The lawyer said his client also was sloppy with paperwork because he was overworked.
``He had to use some standard forms and some of his paperwork is screwed up. But that does not make him a criminal,'' he said.

Insurance Times
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Vol. XIX, No. 4

Auto Injury Costs Outpacing Property Damage Costs

Connecticut, New Hampshire, West Virginia, and Massachusetts had cost indices that doubled or nearly doubled over the six years, 1987 to 1993

The cost of claims for bodily injuries in automobile crashes is growing more than two and a half times faster than the cost of property damage claims, a study by the Insurance Research Council reveals.

The cost of injuries per insured car in the United States increased at an average annual rate of 7.4%, while property damage costs rose only 2.7% per year in the six-year period of 1987 to 1993.

Countrywide, the injury cost per insured car increased 54%, from $138 to $212 between 1987 and 1993. In sharp contrast, average property damage costs rose only 17%, from $54 in 1987 to $63 in 1993.

The growth in injury costs closely tracks the findings of earlier IRC studies which showed that even though auto accident rates have declined in recent years, American consumers are far more likely to claim auto crash injuries and involve attorneys than in the past.

"The new findings are especially significant," according to Terrie Troxel, IRC's executive director, "because the actual increases in paid losses are what drive up automobile insurance rates."

The study shows that in terms of both average value and rate of growth, the cost of auto injuries varies dramatically by state.

For example, in 1993, the average cost of injury claim payments per insured car ranged from a high of $504 in New Jersey all the

way down to $75 in North Dakota.

This is the first study of its kind to use an Injury Cost Index, which allows for meaningful comparisons between states by removing the effects that population, vehicle density, and cost of living differences have on overall injury and property damage costs. The countrywide injury cost index in 1993 was 3.36. That means that $336 in injury claim costs were paid for every $100 in property damage claim costs in 1993.

Even when injury costs are indexed, there are wide variations among states. For example, among states with fault-based compensation systems in 1993, Delaware's injury cost index was 5.24, while Nebraska's was 1.99. In no-fault states, Hawaii had the highest injury-to-damage cost index of 5.73, while Kansas had the lowest at 1.81.

Countrywide, the injury cost index increased 31% between 1987 and 1993, up from 2.57 to 3.36, with 26 states experiencing growth above the national average. Connecticut, New Hampshire, West Virginia, and Massachusetts had cost indices that doubled or nearly doubled over the six years. Only Montana and Idaho had decreases, while eight states (Mississippi, Illinois, Georgia, North Dakota, Kansas, Louisiana, Pennsylvania and Oregon) had growth rates below 10%.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

Auto Accident Frequency Drops But More Injury Lawsuits Follow

Accident and injury rates, as well as claim costs, vary among states, with Mass. reporting the highest property damage and bodily injury frequencies

MALVERN, Pa.—There has been a dramatic drop in the frequency of auto accidents over the past two decades. In spite of that, however, people are now more likely to claim injuries as a result of auto accidents.

Auto accidents, as measured by property damage claims, decreased 17 percent from 1980 to 1998. They dropped from 4.94 per 100 insured cars in 1980 to 4.09 in 1998.

During the same period, bodily injury claims resulting from those accidents soared 33 percent, going from 0.88 per 100 insured cars in 1980 to 1.17 in 1998. The injury rate, however, has recently shown signs of improvement. After peaking at 1.22 in 1995, it declined in 1996, 1997, and 1998.

These findings are contained in a new Insurance Research Council (IRC) study, Trends in Auto Injury Claims, that documents changes in auto accident and injury rates every year from 1980 through 1998, for the nation as a whole, each state, and territories within states. The study also examines claim costs for the country and each state from 1987 through 1997.

"The good news is that we are seeing improvement in accident frequencies as a result of a variety of safety measures, such as safer designs of cars and roadways and active campaigns against drinking and driving," said Elizabeth A. Sprinkel, senior vice president of the IRC. "However, the increased propensity of people to claim injuries remains a serious concern, although the recent improvement is encouraging."

The study also found that accident and injury rates, as well as claim costs, varied broadly among and within the states. Massachusetts had the highest accident frequency in 1998 at 7.06 property damage claims per 100 insured cars, compared with Wyoming which had the lowest rate of 3.05. Massachusetts also had the highest bodily injury claim frequency at 2.29 per 100 insured cars compared with North Dakota's 0.20 rate.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

LICONY honors Mannion, Flanagan; The Hartfod appoints Hudson; Bozzo joins Kemper; Providence Mutual's Centrella scores highest; ProMutual names Cantrell

LICONY

John Mannion was named "executive of the decade" by the Life Insurance Council of New York.

Mannion is chairman of Unity Mutual Life Insurance Co., headquartered in Syracuse. He was given a crystal eagle in recognition of his service to the life insurance industry, at LICONY's annual dinner in New York Feb. 16.

LICONY also recognized Peter J. Flanagan for his 25 years as LICONY's first president, and the organization awarded Harry Phillips III its "William J. Flynn Community Service Award."

The Hartford

Calvin Hudson was appointed group senior vice president and director of property and casualty claims of The Hartford Financial Services Corp., succeeding Paul Schwartzott, who is retiring April 1.

Hudson was previously senior vice president of commercial lines claims. He joined The Hartford in 1973, and has held positions in claims, management consulting, and field operations.

Kemper

Nicholas Bozzo has been named vice president for Kemper's Financial Insurance Solutions division in New York City. Nicholas will manage the New York underwriting region, which includes New York City and Long Island, and also establish a global center in New York City for non-traditional underwriting on behalf of Financial Insurance Solutions

To support him in this effort, Bozzo has assembled a team of industry veterans consisting of Tim Braun, David Kahn and Ed

Talarico. The three join as assistant vice presidents and will be located at One World Trade Center, 36th Floor, New York, N.Y.
Most recently, Bozzo was vice president and worldwide D&O product manager for The Chubb Corp. Prior to that, he served as vice president of underwriting for Chubb Atlantic Indemnity Limited in Bermuda.

Providence Mutual
Cheryl A. Centrella won an “Award for Academic Excellence in the Associate in Insurance Services” program of the Insurance Institute of America, awarded annually to an individual who earns the highest grade averages for the national essay examinations administered by IIA.
Centrella is an underwriting assistant for Providence Mutual Fire Insurance Co., based in Warwick, R.I. She received $250 and a commemorative plaque.

ProMutual
Cynthia Cantrell was named a claim representative at ProMutual Group, a medical malpractice insurer based in Boston.
Most recently, Cantrell was a senior technical specialist for Travelers Insurance Co.

IRMG
Michael Douglas was named vice president of IRMG, a risk management and captive management firm based in Metro Park, N.J.
Douglas was previously vice president of reinsurance for Marsh in Bermuda.

Insurance Times
February 15, 2000
Vol. XIX, No. 4

P/C Leaders See Internet Posing Major Challenge

NEW YORK — Leaders of the property and casualty insurance industry believe that the Internet will pose a significant challenge to traditional distribution systems over the next five years, according to a poll conducted by the Insurance Information Institute (I.I.I.) at its fourth annual Property/Casualty Insurance Joint Industry Forum, held here.
Sixty-nine percent of survey respondents said that they expect insurance marketing on the Internet to increase. Although e-commerce for insurance is presently limited largely to providing information, 64 percent of survey participants said their companies plan to use the Internet as a distribution channel by year-end.
"The rapid adoption of the Internet as a distribution channel reflects the insurance industry's determination to meet the challenges and opportunities of the 21st century head-on," said Robert Hartwig, vice president and chief economist with the

I.I.I. "Internet-based technologies can complement existing distribution channels such as agent networks and call centers by offering increased product flexibility and more contact with the customer while also reducing costs."

With the passage of the Financial Services Modernization Act of 1999, almost all respondents said there would be more strategic and marketing alliances between banks and property/casualty insurers, further expanding the distribution field. However, only 39 percent of participants felt there would be a surge in mergers and acquisitions activity between banks and property/casualty insurers in 2000.

Seventy-nine percent of the respondents said that they expected the insurance industry to be less profitable, as measured by the combined ratio, a percentage of each premium dollar a property/casualty insurer spends on claims and expenses. The combined ratio for 1999 is estimated at 106.4.

Broken down by lines of insurance, 87 percent of respondents expect auto insurance to deteriorate in profitability in 2000. Sixty percent also predict lower profitability in homeowners insurance.

Finally, more consolidation among insurers and reinsurers can be expected in 2000, according to 90 percent of the survey participants.

Forum participants included more than 350 representatives from property and casualty insurance and reinsurance companies and organizations. Of these, roughly 40 percent responded to the survey.

Insurance Times

February 15, 2000
Vol. XIX, No. 4

NY Democratic Assembly Passes HMO Bills Including Right To Sue; Bills Move To Senate

ALBANY, N.Y. (AP) — The state Assembly approved a package of bills last week that the chamber's controlling Democrats said would restore accountability to the treatments health maintenance organizations provide their patients in New York.

Assembly Speaker Sheldon Silver said the measures are needed to redress what he called the growing imbalance between HMOs' protection of their bottom lines and New Yorkers' right to proper health coverage.

The centerpiece of the package is a bill allowing people to sue health maintenance organizations if they deny coverage they should be offering or provide inadequate care, Silver said. Doctors and other health care professionals can currently be sued, but since HMOs do not practice medicine directly, they cannot be brought as parties in such actions.

``These corporations know that when they act contrary to the patients' best interests, they know that they cannot be held

responsible,'' Assemblyman Richard Gottfried, a Democrat who chairs the Assembly's health committee, said. ``New Yorkers are suffering as a result and it's wrong.''

The Assembly's package would also require the state Insurance Department to hold hearings whenever HMOs seek rate increases of more than 5 percent and for more detailed external review of cases where HMOs deny treatment for customers with permanently disabling or degenerative medical conditions.

Most of the bills have passed the Assembly before but died in the Republican-controlled Senate.

The New York Health Plan Association, which represents 30 managed care health plans, said the Assembly bills would add to the cost of HMO coverage throughout the state if they became law, and make insurance unaffordable for tens of thousands of New Yorkers.

State laws already include extensive protections for health consumers, Health Plan Association President Paul Macielak said. ``This effort to pile on will only add new and duplicative layers of bureaucracy that will make it more difficult for consumers to navigate the health care system,'' Macielak said.

Silver denied that the Assembly bills would add to health care costs. If they cost anything extra, the speaker said, it should come from the profits of the HMOs' shareholders.