

Insurance Times: ISO WARNING: Record P/C Downturn Ahead If Trends Continue

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Underlying trends are worse than reported financial results show

If imbalances between growth in premiums, losses and expenses continue at recent rates, property/casualty insurers' underwriting results will be even worse than in record-poor 1984, an industry leader has warned.

An extrapolation of third-quarter 1999 growth rates in premiums, losses and expenses by Insurance Services Office (ISO) actuaries shows the industry's combined ratio would increase from last year's 107.5 to 111.7 in the year 2000, and to 136.2 in the year 2005 - almost 20 points worse than the industry's all-time worst combined ratio of 118.0 in 1984, said Frank J. Coyne, president and chief operating officer of ISO.

If Recent Trends Continue

Coyne emphasized the figures were not forecasts, but are "what-if numbers that illustrate the consequences if recent trends continue."

The combined ratio is a basic measure of insurers' underwriting performance that shows the percentage of each premium dollar that goes to claims and expenses. A combined ratio of 100 or more is an underwriting loss.

Speaking at the Pacific Insurance & Surety Conference here, Coyne indicated that underlying trends are worse than reported financial results show.

"Since the mid-1990s, growth in reported losses has been depressed by declines in catastrophe losses, and in environmental and asbestos losses on old business, as well as by deterioration in loss-reserve adequacy" said Coyne.

Losses Outpace Premiums

When ISO adjusted results by normalizing catastrophe losses, eliminating environmental losses and asbestos losses on past policies, and restating calendar-year losses as if insurers had maintained reserve adequacy, ISO found that loss growth actually outpaced premium growth from 1995 to 1999, in stark contradiction to reported results, said Coyne. "For the past two years, even reported losses have been rising faster than premium," he said, adding: "Last year, reported losses and lost-adjustment expenses grew more than twice as fast as the 2-percent growth in earned premium for all lines."

"The combined ratio sums up the tale on underwriting results and expense performance," said Coyne. "In the '70s, the industry made an underwriting profit in five years out of ten. But in the two decades since the 1970s, the industry has not once posted an annual underwriting profit."

Deterioration hit many lines of business. ISO's president noted that in 1999 combined ratios worsened severely in general liability, commercial multi-peril and workers compensation. For workers compensation, that key measure of profitability

deteriorated nearly 13 points in the last two years to 113.5 at year-end 1999, despite widely enacted reforms and health-cost containment.

Investment Income Decline

While underwriting deteriorated, "investment income hasn't helped much either," observed Coyne. He noted that investment income has declined for the past two years in a row - two of four years in the 1990s with such declines. Those were the only years among the past 40 that investment income fell.

He cited declining bond yields and fierce competition that decimated premium growth and left the industry with little new cash to invest. ISO estimates that the industry's 1999 operating cash flow at \$13.7 billion hit its lowest level since 1984 - the bottom of the worst underwriting cycle in history.

Return on Net Worth

Bringing together investment results and underwriting performance, the industry's GAAP return on net worth was 6.8 percent last year, down from 8.5 percent in 1998. Adjusted for catastrophes, environmental losses and deterioration in reserve adequacy, the industry's 1999 return on net worth was just 6.3 percent.

"Now you can earn 6.3 percent risk-free on a ten-year Treasury note," observed Coyne.

While some analysts cite agent surveys that show rates on renewals are firming, it may be too early to conclude that the pricing tide has turned, cautioned ISO's president. Other agent surveys found that rates on renewals for all major commercial lines except commercial auto declined in both 1998 and 1999, with workers compensation and commercial multi-peril dropping the most, said Coyne.

Will Overcome

Despite bad news on the state of the property/casualty industry, Coyne said he is confident industry leaders can - and will - overcome present challenges.

"We've been through what seemed to be the worst of times before and survived," said Coyne. "Now, we see signs that astute industry leaders are innovating in all aspects of the business to respond to current conditions - by embracing technology, by serving the customer, and by delivering on credible value propositions."

Coyne urged insurance executives to "execute the fundamentals of solid underwriting - careful risk identification, thorough risk evaluation, cost-based pricing and excellence in claims handling." These fundamentals, said Coyne, "will determine whether you win or lose."

Despite revolutionary changes in the nature of the insurance business, "the battle-tested rules still apply. Over the long-term, you can't generate profits if you ignore the fundamentals," said Coyne. "Consider costs when you price your products."

Insurance Times: Critics Capture Mass. WC Forum To Ask If Workers Are Being Treated Fairly

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Workers comp industry urged to track 'outcomes' for workers

by C.A. Soule
InsuranceTimes

A report on cost trends in the Massachusetts workers compensation system was greeted with ambivalence, as panelists and participants at a conference urged policymakers to develop studies that would track "outcomes" for workers.

The Workers Compensation Research Institute, based in Cambridge, held a conference last month to present its "CompScope" report on the Massachusetts workers compensation system. WCRI researcher Carol Telles, the report's author, said that the study was intended to establish a "baseline" for comparing Massachusetts figures historically and with other states, and to identify "emerging opportunities" in workers compensation.

The study showed that administrative expenses associated with certain aspects of the system are on the rise. But some in attendance hijacked the proceeding to raise the question of whether the system was fair to injured workers.

"How the system treats individual workers is probably a dimension that is not reflected in the cold data of this report," said state Sen. Stephen Lynch, co-chairman of the legislative Commerce and Labor committee. "I understand our goal here, and it is a wonderful goal, to create an accurate monitoring system for the workers compensation on a state-to-state comparative basis. But it does need to include the human side of this, the other dimension, which is how the worker is being treated."

Old Data

Insurance industry representatives also quibbled with the report's efficacy, saying that the data was old and failed to capture recent trends.

But they added that CompScope serves a valuable purpose, and that its limited scope should not detract from its usefulness to policymakers.

"CompScope is a more objective, data-driven program," said Paul Mattera, an executive with Liberty Mutual Co., and a WCRI board member. "But I think it can be supplemented. Perhaps working with the WCRI or otherwise, those attitudes can be acquired, and they can be added to the public policy debate and decision making."

New Study

Richard A. Victor, executive director of WCRI, said that he would speak with stakeholders to try to ascertain how concerns could be addressed in a new study.

Commissioner James Campbell noted that his Department of Industrial Accidents is already participating in a limited study with a small group of other states, examining the "worker outcomes" alluded to by Lynch.

Perhaps the day's strongest criticism emanated from a likely

source, organized labor. "Pretty much every other industry in the world looks at the evaluation of services provided and satisfaction for customers," said Robert Haynes, president of the Massachusetts chapter of the AFL-CIO, a labor group. "This might be the only industry in the world that does not take into account satisfaction of the people that are actually using the services." Critics of the study said that the information was only of marginal use, since it examined 1994 to 1996. They said that the Massachusetts system today has changed greatly.

"Legislators in the early part of the 90's were really flying blind," said Liberty Mutual's Mattera. "[The report] may not be perfect, but it tells us a heck of a lot more than we ever knew before. Big system changes are not being called for. But what I do hear stakeholders say, is that there are smaller, targeted reforms that need to take place, corrections if you will." He said that today in Texas and California, efforts are underway to reform aspects of the workers compensation systems, but that in Massachusetts, most of the needed reforms were handled ably by the 1991 reform law.

Much Healthier

"In 1991, it was fairly well understood that the [Massachusetts] system was too litigious; that there was an enormous backlog of cases; that medical costs were too high compared to the national average; that disability 'durations' were too long; and that time to first payment was too slow," Mattera said, adding that today's climate was healthier on these points.

Other panelists included Suzanne Bump, a workers compensation expert for the American Insurance Association, and Sandra Mitchell, an executive with Gillette Co., one of the largest employers in Massachusetts.

Bump, the AIA representative, said that other problems have fires have popped up that need to be extinguished.

Doctors' Advantage

"There is a phenomenon where doctors are taking advantage of a provision in the statute that allowed them to negotiate for rates that are higher than the fee schedule," Bump said. "We are now anecdotally hearing that this is becoming a much more common phenomenon, particularly with regard to surgical procedures. Insurers are telling me that they on a routine basis demand for service up to and beyond five times the fee that is set in the schedule. That is not just a factor in the cost of those services but it is also a factor in the benefit delivery services, because controllers are having to negotiate, and that is time consuming process."

"One area where doctors can't negotiate is for higher fees," Bump said. "They can't do so with Harvard Pilgrim, and they can't do so with Blue Cross. So to the extent that they can get more out of workers compensation, they are attempting to do so."

Bump Warning

Bump stressed that insurers could only absorb so many costs before the system entered a state of disequilibrium.

"Some people think if a little medical cost containment is good, then a lot must be even better," she said. "And the report states correctly that utilization review features and treatment

guidelines have helped keep our costs low. It has also been documented that 'there is a cost to contain medical costs.' I think something that this report underscores is that you can reach a point of diminishing returns."

Insurance Times: NY-Area Life Groups Gather Under One Umbrella To Face Challenges
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Consolidated management promises more services

by C.A. Soule
InsuranceTimes

NEW YORK - They pack them in like sardines into two windowless classrooms across the street from the New York Public Library. That is just fine with David A. Dreifuss.

The executive vice president and chief executive officer of the Alliance of Insurance & Financial Professionals keeps his business card printer on retainer, as he works to bring more trade organizations under his tent. It is five and counting now, and he hopes to announce a sixth real soon, although he would not identify the new organization.

"There has been an ongoing, huge consolidation in the trade groups," Dreifuss said. "But I am not sure that too many have thought of transforming into a regional multi-management organization, like what we are building toward."

In so doing, Dreifuss is anticipating a boom in financial services from the passage of federal legislation in Washington that removes boundaries that prevented insurers, banks, and securities firms from operating on each others turf. He currently administers the New York City Association of Insurance and Financial Advisors; the New York Chapter Society of Financial Service Professionals; the Connecticut chapter of the National Association of Insurance and Financial Advisors; the New York Center for Financial Studies; and the General Agents and Managers of Greater New York.

While some national trade groups have adopted cosmetic changes to acknowledge the new landscape opening before them, Dreifuss hopes to build a dominant umbrella organization that will offer continuing education and other services for the widest gamut of financial professionals possible.

Dozen Organizations

"We will represent a dozen organizations in the next two to three years," Dreifuss said. "This is a great opportunity to benefit our members collectively."

His groups currently have 6,000 members, of which about 80 percent are life and health brokers, Dreifuss estimated. But the Queens native envisions bankers, accountants, and even estate-practice lawyers finding their way to his organizations.

"There is a sense that competition is becoming more intense," Dreifuss said. "But the more sophisticated producers view

everything as an opportunity.

If LIMRA (Life Insurance Marketing and Research Association) statistics are true, then there is more than enough business for everybody."

Dreifuss said that more of his time these days is spent meeting with the budding insurance units of banks and brokers. He acknowledged that some life insurance producers would find a changed world before them sooner than they might have thought.

"With the Financial Services Modernization Act, marginal producers may disappear," Dreifuss said. "A certain percentage of business will go retail, and a certain percentage will go right here," he said, pointing to his computer monitor.

But the advent of online sales may have a reinforcing effect as well for the smaller life agent or financial planner, he added.

Information Overload

"It is an interesting phenomenon that we are seeing, the phenomenon of information overload," Dreifuss said. "People are almost having a knee-jerk reaction in the opposite direction.

The more they are exposed to information, the more they want a trusted advisor, a relationship that lasts for years and years, someone who is there when they hit a bump in the road."

Just as clients long for that relationship, Dreifuss hopes to foster a similar connection between his organizations and their members throughout New York and Connecticut, especially in the area of continuing education, a point he repeatedly emphasized.

"Consumers will be far more educated and informed, and that is going to require far greater sophistication on the part of people who sit down with them," Dreifuss said. "People are getting frustrated with dialing a 1-800 number, enduring a 32 minute wait, only to get a customer service representative who will has no name, only a number."

Positive Relations

Dreifuss said that no distribution system can deliver positive public relations for companies better than agents.

"If you are my MetLife advisor for the last decade, then I love Met," he explained. "I don't know the company from a hole in the wall, but nevertheless, I love Met."

Dreifuss said that he believes, in general, that relationships between metropolitan New York agents and their companies are good.

"Companies constantly go through the process of reevaluating themselves," he said. "Those with the correct business plan clearly will not throw out the baby with the bath water. They will go with alternate distribution systems that complement the agency system, not those that replace it."

Good Shape

Likewise, relationships between agents and their customers are in good shape, Dreifuss asserted, notwithstanding some of the turmoil in recent years in life insurance sales. Companies paid huge penalties to avoid prosecution on charges of fraudulent sales practices called "churning," whereby life insurance agents were given incentives to encourage customers to trade in their old policies for newer ones, allowing companies to reap greater premiums over the life of the policies.

"That can happen in any industry," Dreifuss said. "When an agent goes awry, there is a branding that goes on across the board. That is where a trade organization can come along, and say, 'Hey, let's not forget about what the other 98 percent of these people are doing.'"

Dreifuss and his staff are now in overdrive, preparing for NYCALU's "Sales Congress" on April 12, which he calls "the marquis event for a local trade association in this country." In the meantime, they will keep packing them in across the street from the library, educating an ever-widening array of financial services professionals. Dreifuss says that he does not worry that his organization could see its focus blurred by trying to be too many things to too many people. "We are trying to grow into this correctly," he said.

Nevertheless, the organization's Internet site is under reconstruction for a month, a long time for members not to have online access to information about the organization, and perhaps a sign of growing pains.

Insurance Times: Big 'I' Logo May Be Casualty Of Upcoming Branding Campaign
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IIAA President-Elect Hofmann addresses IIANH

by Penny Williams
InsuranceTimes

MANCHESTER, N.H. - As independent agents step up their branding activity, the Big "I" logo of the Independent Insurance Agents of America (IIAA) may end up going the way of the Shawmut Bank Indian.

William Hofmann, the Massachusetts agent who is president-elect of the IIAA, suggested that the familiar logo with the eagle and big I may not survive IIAA's branding efforts, which he called "the key" to the future of independent agents.

"Branding is something we all have to come to, because we need to drive the insurance consumer into doing business with independent agents," Hofmann said.

Hofmann said the Big I hasn't decided what, if anything, it is going to do about its present logo. But a recent survey of consumers indicated that almost half thought the logo had something to do with the U.S. Postal Service.

"Name brands are important to clients," he noted. "This branding is an issue that is something that is absolutely critical and how we handle it going forward is critical. There will be changes."

In addition to highlighting IIAA's branding efforts as a key to the future of independent agents, Hofmann used the occasion of his speech before the Independent Insurance Agents of New Hampshire (IIANH) to again call for consolidation of trade associations. New Hampshire is one of the states which still has both an IIAA and a PIA affiliate.

Urges Association Merger

He urged those who hold membership in both PIANH and IIANH to work to bring about a merger of the two state associations.

"We've got to get all the agents on the same page," Hofmann told the IIANH Mid-Year meeting attendees. "We've got to have just one agents' association. It's absolutely ridiculous to have PIA and Big I competing against each other. I am a firm believer we should get all intermediaries, those of us who sell insurance, on the same page - the life people and the property casualty people. We should not be competing in a trade association for your money, for your educational experience and so forth. It's something I think we've got to look at."

"One of the messages I really want to deliver to you today is that you've got to be flexible, you've got to be ready for change," Hofmann continued.

Customize

He noted that a recent survey suggested that consumers find price important but that they want to be able to customize their policies and not be treated in "cookie cutter" fashion.

"The little agent is alive and well," he maintained.

He advised that independent agents must set themselves apart from direct writers and suggested that having employees earn professional designations is one way for an agency to to distinguish itself.

Agents must keep up with automation in order to be able to afford to stay in business. He told the group IIAA has helped to develop a new standardized computer language tool called XML, which will replace SEMCI (single entry multiple company interface) -- which never really happened. Using this new tool, agents can enter client information once on a single XML form and multiple companies will be able to access and use the information. It allows for uploading and downloading of information. IVANS will be using XML and XML recognizes ACORD forms.

Hofmann also stressed the need to bring young people into the agency business.

"They are the lifeblood of our industry -- its future. We need to bring young people into our business and give them a piece of the pie."

He pointed out that agents now have more to worry about than direct writers for competition.

Banks as Competitors

"Don't underestimate the banks as competitors," he warned.

Noting that IIAA's own thrift operation, InsurBanc, is still several months way from being granted a charter and years away from being available to agents in all states, he urged agents to make arrangements that made sense for them with banks in their area.

While these are "exciting times" in the business with new competition, new products and new technologies, Hofmann said agents must get back to the basics of selling to succeed in order to continue winning back market share.

"Too many of us have sat too long. We've got to get back into the business of selling. We can not be order takers; we've been order takers too long. That's why the direct writers and the direct

response companies were able to jump in there."
Agents' share has increased the past two years but Hofmann says the fight is far from over.
"We've got to keep it going and that means you've got to go out and ask for the business and not wait for someone to come knocking at your door."

Insurance Times: HMO Reform Signing Marks Win For NH Gov. Shaheen
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by Gene Johnson
Associated Press

CONCORD, N.H. - Gov. Jeanne Shaheen has signed a compromise version of the HMO Accountability Act into law, accomplishing one of her major policy goals.

The law holds medical directors more accountable for their decisions and establishes a review board that to which patients can appeal when refused care.

Shaheen was flanked by dozens of supporters as she signed the bill, including a Bow family denied coverage for a chronically ill son.

Lisa Serard said her 13-year-old son, Benjamin, has diabetes and Chron's disease, which blocks digestion. Healthsource refused to cover his \$36,000-a-year treatment until the governor's office stepped in.

"We've all heard too many stories like Lisa's," Shaheen said. "People should not have to seek intervention from the governor's office to get the health care their insurer has promised them." Anyone denied coverage costing more than \$400 will be able to appeal to an independent panel of medical experts, which will have the power to overturn the decision. The law also requires the medical directors of health maintenance organizations to be licensed New Hampshire doctors.

If the medical directors show serious or repeated negligence in denying care, they could lose their licenses and their jobs.

In Effect in 6 Months

The law, which takes effect in six months, offers other provisions to protect consumers: HMOs no longer can fire medical directors who recommend that patients receive coverage for certain care or offer financial incentives to deny care.

HMOs now must tell a patient when they have financial partnerships with medical providers. Shaheen said that will let patients know whether there was a monetary reason when they were referred to one specialist over another.

They also must release the names and credentials of medical directors.

Tough Fight

The accountability act faced a tough fight in the Legislature before it reached Shaheen's desk. Opponents said the wording of the original version could have been interpreted to mean patients

had the right to sue medical directors, even though federal law forbids it.

While Shaheen supports the right of patients to sue medical directors, that's not what she was trying to accomplish, said her legal counsel, Judy Reardon.

``We could not come up with a way to get around the federal law,'' Reardon said.

The House Commerce Committee ironed out a compromise last summer by saying specifically in the bill that medical directors could not be sued. It passed in the House and Senate last month.

The Serards said they hope what they went through will make things easier for others.

``This is so exciting, Mrs. Serard said. ``Everything I dreamed would happen has happened.

Insurance Times: Mass. Seeks More Oversight Of Hmos
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BOSTON - A bill filed by Gov. Paul Cellucci would give the state's insurance commissioner more oversight of nonprofit HMOs, including the ability to conduct more frequent financial inspections.

Under the plan, the commissioner would be required to examine the state's HMOs every two years - the same rate that for-profit companies are inspected. The legislation would also give the commissioner the right to obtain information about an HMO's financial status at any time.

Cellucci's bill also calls for health maintenance organizations to meet tougher financial standards, including maintaining a minimum net worth of \$1.5 million. The minimum rate would be increased as an HMO attracted more members.

Judy Glasser, a spokeswoman for the Massachusetts Hospital Association, called the bill a first step, but said lawmakers should also move to ensure that HMOs pay their bills more frequently.

Glasser said a survey of hospital members found millions dollars in overdue bills from HMOs. Her organization supports a ``prompt payment bill'' that would require HMOs to pay their bills within 45 days.

Insurance Times: NJ Self-Employed Can Elect WC Benefits
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TRENTON - New Jersey self-employed persons or partners of any partnership begin operating under new workers compensation rules beginning April 13.

For corporations, partnerships, limited liability corporations or limited liability partnerships, the law has been amended to permit proprietors and partners to elect to be eligible for workers compensation benefits.

"Up until now, self-employed individuals and partners could not be covered under their own workers compensation policies," explains Charles S. Stults, a member of the workers compensation task force of the Independent Insurance Agents of New Jersey (IIANJ). "This was due to the concept that one could not be both 'master and servant' as regards the employer/employee relationship."

But now self-employed persons can elect to be deemed employees as long as they are "actively performing services on behalf of the business."

A proprietorship or partnership without a workers compensation policy can buy one with an effective date of April 13, 2000 or later and be included for benefits subject to premium payment. Business with current workers compensation policies must wait until their renewal date to make the election as employee.

Insurance Times: NY Med Mal Association To Be Dissolved
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NEW YORK - New York officials are readying to dissolve the state's Medical Malpractice Insurance Association, which handles hard-to-place health care practitioners and facilities in need of medical malpractice coverage.

The Insurance Department has scheduled a hearing for March 29 in New York City to review its own proposed plan and others submitted by interested parties for both dissolving the plan and equitably distributing its remaining policies among existing insurers.

The department is required to approve a dissolution plan by April 30 and a distribution plan by July 1. The latter will be the subject of its own public hearing at a later date.

Insurance Times: Insurers Blast Conn. WC Benefits Measure
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Hartford - Insurers in Connecticut are blasting a proposed "discretionary benefits" workers compensation bill which they say is unfair to workers and employers, and would cause financial headaches for insurers.

The "discretionary benefits" bill (HB 5161) gives the the state's workers compensation commissioners discretion to grant extra benefits to some injured workers, but there are no objective eligibility standards.

The lobbyist for the American Insurance Association could find little good to say about the measure.

"The lack of any basis for determining which injured workers will receive additional benefits is unfair to all parties to the system," said Suzanne Bump, American Insurance Association assistant vice president, northeast region. "For injured workers, a grant of benefits will depend entirely upon which

Commissioner considers their request. For insurers, the lack of certainty as to the potential payout to an injured worker makes it impossible to properly set reserves in workers compensation cases. For employers, the cost of workers compensation premiums, which recently came under control after years of turmoil, is sure to escalate."

AIA also warned that proponents of the bill are telling half-truths when they say this bill is modeled on the workers compensation systems in Florida and Texas. "Unlike Connecticut, which bases workers compensation payments on a subjective wage loss system, both Texas and Florida have adopted an objective impairment system to define and pay permanent partial disability benefits," said Bump.

Insurance Times: How Serious Are Region's Health Care Troubles?
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Forum discusses wisdom of free market in health care

by Tom Kirchofer
Associated Press

BOSTON - Against a backdrop of spiraling prescription costs and a lingering population of people who don't have health insurance, lawmakers and policy experts tried to come to grips with just how serious New England's health care troubles are, and toss around some ways to improve the system.

Among the topics of discussion at a recent forum: the appropriateness of letting the free market determine the availability of a commodity so vital as health care, and ways to extend health care access to more people.

"It was a 20th-century disgrace that so many Americans found the quality of their health determined by the quantity of their wealth," Sen. Edward M. Kennedy, D-Mass., said as he described his proposal to use federal subsidies to bring coverage to the uninsured.

Record Number Uninsured

Kennedy said the number of uninsured Americans rose to a record 44 million last year, and will continue to rise this year, although he noted that lack of insurance coverage is not as severe in New England as in other parts of the country.

Kennedy said that while he would ideally like to create a plan that would guarantee health coverage for all Americans, his current proposal - which will likely be introduced to Congress in the spring - is not so comprehensive, designed instead to win the necessary support of Republicans.

The conference was organized by Blue Cross and Blue Shield of Massachusetts, Brandeis University and the New England Council, an organization of businesses, public and private organizations that promotes economic growth.

Deep Crisis

Many of those who attended were not as willing as Kennedy to make compromises, and they also described the current health system as one in the midst of a deep crisis.

``The fundamental problem with our health care system is a lack of universal coverage,'' said Robert Restuccia, executive director of Health Care for All, which advocates for health care consumers.

U.S. Rep. John Tierney, a Salem Democrat, echoed the sentiment, and said he would file a bill seeking federal grants that would allow up to 10 states to develop universal coverage systems. He also said government regulators and policy makers shouldn't be afraid to get involved in the health care industry. He said some politicians have a philosophical ``slavery to the unrestrained free-market mantra.''

But Thomas Finneran, speaker of the Massachusetts House of Representatives, said that while the state's health care system has its problems, it's still one of the best in the world. He defended the current free-market system against advocates of a single-payer system, saying it has provided five of six Bay Staters with some form of health care coverage. He also urged the policy makers not to ``pander'' to voters by calling for an overhaul of what he said is a system that generally functions well.

``I would argue for a restrained and balanced approach'' to health care reform he said. ``But some would argue for jettisoning this system that provides excellence.''

Panelists also discussed ways to help senior citizens pay the high costs of prescription drugs.

Kennedy supported coverage by Medicare of prescription drugs, while Finneran backed a plan in which prescription drug purchasers in the six New England states and New York would band together to get bulk discounts.

Nancy Turnbull, a professor of health policy and management at the Harvard School of Public Health, proposed mandating that all Medicare recipients pay for prescription drug coverage. She said such a move would spread costs among a wide group of people, and greatly lower the high costs currently paid by people who have to buy supplemental coverage.

``We have mandatory auto insurance and the banks make us buy homeowners insurance, she said. ``The time has come for mandatory health insurance.

Insurance Times: NH Lags In '97 HMO Reform Regulations
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CONCORD, N.H. (AP) - The state has a new law to hold health maintenance organizations more accountable. But in the meantime, its last attempt to regulate HMOs is languishing.

In 1997, the Legislature passed a law to limit waiting times for appointments, give patients more choice and access to specialists, and make sure care is available even in the most rural parts of the state.

The law took effect in 1998, but still has no teeth. That's

because the state Insurance Department has not finished writing necessary regulations, Assistant Insurance Commissioner Monica Ciolfi said.

The regulations will spell out how short waiting times for appointments should be, for example, and how much access there should be to doctors in rural areas.

``It's primarily because there's been such a huge amount going on in the health care area,'' Ciolfi said. ``But it's something we need to do. There's really no excuse for it.''

A series of big transactions have kept the department busy: Cigna bought Healthsource, Blue Cross Blue Shield of New Hampshire bought Matthew Thornton Health Plan, Anthem Inc. bought Blue Cross, and Tufts Health Plan of New England closed and is being liquidated by the department.

``These were just huge things that were unforeseen, unforeseeable,'' Ciolfi said.

Ciolfi said draft rules should be ready to send to a legislative review committee within a few weeks.

Ciolfi said the new HMO law, enacted last week, is clear enough to enforce even though the department is unlikely to have rules prepared and approved before it takes effect Sept. 3.

Insurance Times: Aetna Balks At Reparations Over Slave Policies
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A New York attorney whose great-great-grandmother was a slave in South Carolina says businesses that profited from slavery should be made to pay.

Daedria Farmer-Paellman, who spoke with The State newspaper of Columbia, said Aetna Inc. was first on a long list of businesses including textile, banking and steel firms - that she'll target for apologies and reparations.

Sold in 1850s

Aetna, the nation's largest health insurer, apologized earlier this month for selling policies in the 1850s that reimbursed slave owners for financial losses when their slaves died. The Hartford, Conn.-based company's public apology was prompted by an inquiry from Farmer-Paellman.

Farmer-Paellman wants Aetna to donate \$1 billion to set up a foundation benefitting minority education and businesses. She said other businesses that benefitted from slavery also should contribute to the foundation.

Aetna spokeswoman Joyce Oberdorf said her company would balk at paying reparations, noting slavery was not illegal when the policies were issued. ``It's unclear whether we ever made a dime on that,'' she said.

``Aetna has long acknowledged that for several years shortly after its founding in 1853 that the company may have insured the lives of slaves,'' said Aetna spokesman Fred Laberge. ``We express our deep regret over any participation at all in this deplorable practice.''

Aetna records show the company wrote no more than a dozen such

policies to slave owners.

Tom Baker, director of the Insurance Law Center at the University of Connecticut School of Law, said it was a common practice to guarantee slaves, including insuring them as cargo on ocean voyages.

``It's never very pleasant to think about with 20th century eyes, but Aetna wasn't unique in that regard,'' Baker said. ``When you had a slave economy, it infected many facets of economic life.'' Several German companies paid reparations to Holocaust victims for their use of Jewish forced labor during World War II, and European insurance companies have been sued by relatives of Holocaust victims for failing to pay life insurance claims. The pursuit of private American companies for slavery reparations is rare, but Farmer-Paellman said she planned to meet with a group experienced at seeking Holocaust reparations.

Ira Berlin, a University of Maryland history professor who specializes in slavery, said efforts like Farmer-Paellman's are forcing businesses to consider their past. ``This can be a very a troubling question.''

It's a question more businesses may have to answer, said Randall Robinson author of ``The Debt: What America Owes to Blacks'' and president of TransAfrica Forum, a think tank specializing in African, Caribbean and African-American issues.

Robinson said he expects to see legal action taken against companies in the future. ``From the reparations side of this, this is the first salvo.

Insurance Times: Insurers Allege Fraud In \$60 Million Lawsuit Against NY Physicians

March 28, 2000, Vol. XIX No. 7

Charge doctors sold use of their medical licenses

NEW YORK - In an unusual cooperative effort, four major insurance companies filed a \$60 million lawsuit against a group of New York physicians who allegedly sold the use of their names and medical licenses to chiropractors and lay people.

``These doctors were not out to heal, they were out to steal,'' said Vince Coyne, corporate special investigations unit manager for Progressive Auto Insurance. Other insurance companies behind the lawsuit - and the four-year investigation which preceded it - are Allstate, GEICO and New York Central Mutual.

10 Defendants

The civil complaint filed in state Supreme Court in Manhattan charges 109 defendants with perpetrating what it calls ``massive fraud'' against insurance companies, the state of New York and thousands of consumers the companies allege were treated by chiropractors and lay people posing as medical doctors.

Officials from the insurance companies said their investigation was continuing and that a criminal lawsuit would likely ensue.

``We have to look into these medical companies and see. ... We are looking into the possibility of a criminal lawsuit,'' said

Charles DeRienzo, director of the Insurance Fraud Bureau of the state's Insurance Department.

The insurance companies allege in their civil lawsuit that six doctors in the New York area sold the use of their names and licenses for about \$4,000 a year to chiropractors and lay people for the purpose of forming 40 phony medical professional corporations.

The lawsuit identifies the six doctors as: Alan Cohen, Swapnadip Lahiri, Robban Sica, George Battaile, Robert Mallela and John Grauerholz, with Cohen identified as the principal perpetrator with 29 of the phony professional corporations linked to his name. The lawsuit said Battaile's license has been revoked; the others were licensed to practice in New York state.

The fake medical corporations were used as fronts for the improper billing of patients and the fraudulent billing of insurance companies, the lawsuit alleges. Instead of charging insurance companies about \$30 for a visit with a chiropractor, for example, the lawsuit alleges that the medical professional corporation would charge about \$100, pretending that the patient had in fact been treated by a medical doctor.

Medical Corporation

It is against New York state law for anyone other than a licensed medical doctor to own a medical professional corporation.

The insurance companies are trying to recoup about \$60 million in damages from these allegedly fraudulent corporations, physicians and the real owners of the sham companies.

A man who answered the phone at Bay Medical Health Care and Diagnostic in Brooklyn, one of the allegedly fraudulent corporations named in the lawsuit, said, ``I am unaware of any lawsuit.'' Calls to some other corporations listed were not returned.

The insurance companies said that several of the doctors allegedly involved had a history of disciplinary measures and that some of the professional corporations employed medical doctors who were on state-imposed probation and whose licenses were subsequently revoked.

Insurance Times: Agents Claim OSHA Ergonomic Rules Undermine Workers Comp **March 28, 2000, Vol. XIX No. 7**

WASHINGTON, D.C. - Independent agents oppose ergonomics standards offered by the Occupational Safety and Health Administration (OSHA) because they fear they could trump the state-based workers compensation system and because of the uncertainty of their compliance costs, says the Independent Insurance Agents of America (IIAA).

The IIAA position came in written comments submitted to the federal agency on the proposed ergonomics standards offered last fall.

In its comments, IIAA focused on the displacement of the state-based workers compensation system and the costs of compliance. IIAA President-Elect William F. Hofmann III, who testified on

Capitol Hill, noted that the current workers compensation system has worked well for both employers and employees. "There is no need to reinvent this successful program merely to provide federal regulators a toe-hold into an area long regulated by the states," said Hofmann.

"IIAA is greatly troubled that OSHA's proposed medical care and wage placement requirements directly overlap existing state-based systems and present a significant and unwarranted intrusion into what has heretofore been a successful social insurance program," noted IIAA in its written comments.

Exceeds Authority

IIAA claimed that this rule exceeds OSHA's authority.

"OSHA has gone far beyond its statutory mandate of injury prevention and moved into the realm of injury compensation," IIAA claimed.

The agents' association also charged that the standards could lead workers to file claims for injuries not resulting from workplace tasks.

"Under the OSHA proposal, claims could and likely will be filed alleging injury due to multiple causes not exclusive to the workplace, yet employers will undoubtedly bear the cost and burden of these new claims."

IIAA questioned OSHA's \$4.2 billion estimate of employer costs to implement the ergonomic standard, citing evidence that the actual costs could be as much as 10 times that and arguing that doubts about costs is reason enough to delay implementation.

Finally, IIAA urged OSHA to wait for the results of a NAS study on repetitive stress injuries. This study was mandated in legislation approved by Congress and signed by President Clinton in 1998. NAS is to report back to Congress by January 2001.

Insurance Times: Life Insurers Urge Congress To Pass ERISA Modernization Act

March 28, 2000, Vol. XIX No. 7

Washington, D.C. - The American Council of Life Insurers (ACLI) urged Congress to modernize the Employee Retirement Income Security Act, the federal pension law governing private employee benefit plans.

Reforms are needed to address changes in the nation's retirement system and developments in the financial markets, said Ken Cohen, senior vice president and deputy general counsel of Massachusetts Mutual Life Insurance Co., who testified on the ACLI's behalf before the House Education and the Workforce Subcommittee on Employer-Employee Relations.

"Although ERISA has been largely successful at protecting plan benefits, certain aspects of the regulatory structure have impeded innovation and imposed significant costs on plan sponsors as well as those who provide services and investment products to plans," Cohen said.

"In many cases, these costs are passed through and directly borne by plan participants and beneficiaries. Other costs are borne

indirectly in the form of lower benefits than those that would otherwise be offered, fewer investment options or, for many Americans, a lack of pension coverage altogether," Cohen said. Since ERISA was enacted in 1974, there has been a shift in the retirement plan market away from defined benefit plans, which guarantee a specific lifetime income for plan participants in retirement, toward defined contribution plans, such as the popular 401(k)-type plans where plan participants bear the investment risks.

The shift has heightened the importance of investor education. Cohen encouraged the House panel to restructure ERISA so that plan sponsors can more easily and inexpensively deliver investment education services to plan participants.

Also, during the last 25 years, the financial services industry has consolidated, exacerbating problems for insurers and other pension plan providers posed by ERISA's prohibitions against dealings with affiliated third parties, such as banks, mutual funds and brokerages. The prohibited transaction rules have served to reduce investment choices, while at the same time making pension plan management more costly, the ACLI argued. ERISA reform will be a "difficult, although enormously important," said Cohen, and modernization should "create a regulatory structure that maximizes the potential of our retirement system and our financial markets."

Insurance Times: Commercial Lines Deregulation Advanced By Conn. Panel
March 28, 2000, Vol. XIX No. 7

HARTFORD - The Connecticut Insurance and Real Estate Committee has approved a bill that would simplify commercial lines rate and form filing. The bill (SB 549) now goes to full Senate.

Insurance agents, who oppose the measure, succeeded in killing a similar bill last year.

Meanwhile, insurers have been the chief advocates of easing the reins on commercial lines rates and forms.

The current bill makes companies with aggregate premiums in excess of \$25,000 or more a year eligible for deregulated forms and pricing. Eligible risks must also employ a full time risk manager or use a licensed agent; employ more than 25 people; and have a net worth in excess of \$25 million

Agents have argued that the bill is unnecessary and, if there is to be one, that the threshold must be higher to protect small businesses that can't fend for themselves in a deregulated market.

Insurers, on the other hand, think deregulation is needed to keep business from fleeing U.S. markets and they argue that the bill's parameters are just fine.

"This bill provides a reasonable plan for lessening the regulatory burdens on insurance products needed by large commercial businesses in Connecticut," said John Cucci, vice president of the Northeast region for the Alliance of American Insurers, which helped shape the bill's language.

Under present law, as an insured's needs change, insurance

companies must file new and/or revised rates and forms with the Connecticut Insurance Department. Therefore, the benefits of a new or enhanced product aren't available to the sophisticated consumer immediately, according to Cucci, who adds that often this delay causes business to leave the state and the country. According to data from Sedgwick Inc., a brokerage and consulting company, Cucci noted that 48 percent of commercial insurance business representing about \$128 billion has fled the U.S. insurance industry and is now in the alternative and foreign markets. This loss represents a sizeable portion of money no longer available to insurers in Connecticut and countrywide. "The economic effect is magnified when one considers the diminished tax payments to the state, as well as increased potential unemployment or lost future employment opportunities in the insurance industry," Cucci added.

Insurance Times: Conn. Urgd To Resist Changes In WC Statute
March 28, 2000, Vol. XIX No. 7

HARTFORD - Insurance agents in Connecticut are also worried that legislators may water down recent workers compensation reforms, and are urging the Labor and Public Employees Committee to oppose several laws that agents feel would do so.

"Since the 1993 workers compensation reforms were passed, workers compensation premiums have dramatically decreased," said David LaManna, president of the Professional Independent Insurance Agents of Connecticut. "This has played a significant role in improving the Connecticut business environment and retaining and attracting more employers into our state."

One potential law, SB 66, would increase workers compensation benefits from 75 percent to 80 percent of average weekly earnings. "We do not see the need to increase benefits," LaManna said. "The current formula has proved fair to both injured employees and their employers throughout the state."

HB 5161 would repeal one of the reforms by removing the cap on discretionary awards, and giving the workers compensation commissioner greater latitude in awarding extra wage differential benefits. "This change in existing law will negatively impact Connecticut's business owners by increasing the overall costs associated with the workers compensation system," LaManna said. The Independent Insurance Agents of Connecticut also opposes the laws.

Insurance Times: 'Double Dip' Prevention Among Bills Favored In NH
March 28, 2000, Vol. XIX No. 7

CONCORD, N.H. - A bill designed to prevent employees from collecting both workers compensation and uninsured motorist coverage is on the fast track for passage by the New Hampshire legislature. Bills on insurance consumer rights and policy limits disclosure appear to be dead for this session. The "double collection" bill, H.B. 1241, was referred back to the House Labor Committee with a 4 to 0 vote from the subcommittee that was studying it, according to Gerald L.

Zimmerman, associate counsel for the National Association of Independent Insurers (NAII), which drafted the measure. It is scheduled for discussion this week by the full Labor Committee, which usually adopts the subcommittee vote.

The bill was created to overturn a 1999 New Hampshire Supreme Court decision in *Gorman v. National Grange*, in which the court ruled that an employee could collect both workers compensation and uninsured motorist coverage. The original case involved a worker injured in a truck on the job who collected workers comp benefits and later filed a claim under the uninsured motorist provisions of her auto insurance.

"H.B. 1241 clarifies the ambiguity arising from this decision by stating that employees waive their rights of action against an employer's liability insurer, the employer's uninsured motor vehicle and their own uninsured motorist coverage under the workers' comp law," Zimmerman said. "The bill also clarifies the definition of a third party for purposes of the workers' comp law."

Two other insurance-related bills have been referred to an interim study group, and are considered dead this legislative session. These are H.B. 1428, the "Insurance Consumer's Bill of Rights," and H.B. 1398, which would require the disclosure of policy limits by insurers.

The House will appoint representatives to study these bills in late summer or early fall, Zimmerman said.

Insurance Times: Insurers Urge NJ Retain Auto Insurance Medical Protocols
March 28, 2000, Vol. XIX No. 7

TRENTON - The state's new auto insurance medical protocols must be given a chance to work, the American Insurance Association argued in a letter to New Jersey Senate Commerce Committee Chairman Gerald Cardinale, who held a recent public meeting on the issue.

John A. Andryszak, AIA assistant vice president, wrote that when the legislature enacted the Auto Insurance Cost Reduction Act of 1998 (AICRA), legislators recognized that a primary cause of the continuing increase in the cost of auto insurance was the overutilization of personal injury protection (PIP) medical expense benefits for the purpose of gaining standing to file pain and suffering lawsuits, rather than to treat injuries.

"AICRA's centerpiece is the elimination of unnecessary medical treatment and testing in order to decrease PIP benefit costs," he said.

Pursuant to AICRA, the Department of Banking and Insurance (DOBI) promulgated regulations establishing medical protocols in early 1999. The protocols require that medical providers demonstrate and document the medical necessity of the treatment they provide for auto accident injuries.

"These protocols are critical to achieving cost savings for drivers while providing good medical care for injured auto accident victims," Andryszak said. "Limiting and regulating diagnostic tests and treatment is an essential element of a successful effort to reduce unnecessary costs and fraud in the auto insurance system."

In early 1999, a group of health care providers and trial lawyers challenged the authority of the Insurance Commissioner to promulgate the medical protocols. The case went all the way to the Supreme Court of New Jersey, which upheld the DOBI's adoption of the medical protocols and diagnostic tests under AICRA.

"The primary purpose of both AICRA and the medical protocols is to ensure that auto accident victims receive the necessary care they deserve. In addition, the law and the regulations are also designed to prevent fraudulent insurance claims that lead to higher insurance costs for everybody.

"We urge the legislature to give the new regulations a chance to work before they revisit this issue again," he added.

Insurance Times: Opinion Exchange: Conning & Co. Sure Knows How To Irk Independent Insurance Agents By Publishing Reports That Either Forecast Agents' Demise Or Label Them Obstacles To Progress
March 28, 2000, Vol. XIX No. 7

The research group's latest report, Internet Insurance Distribution: Here we .com...ready or not, purports to analyze the drivers and obstacles of Internet distribution.

The Conning study criticizes insurers for not having effective Internet strategies. It found that only one percent of insurance company sites offer interactive customer service or online sales and only seven percent offer online quotes. This is not a good situation, the analysts maintain.

Also, the Internet's potential for selling products that have differential pricing or features is also not being exploited by insurers. With very few exceptions, insurers' current online offerings are the same as their off-the-shelf products.

The study maintains that the biggest obstacles in using the Internet for distribution are insurer concerns about creating channel conflict with their agents and apprehension about being judged solely on price.

"Few companies are currently pursuing this channel effectively. They either fear it as a potential source of channel conflict or underutilize the technology by employing it solely as a marketing tool," said Mark Trencher, vice president at Conning and author of the study.

"The Internet has made everything a commodity. Customers will look to purchase insurance online because they want to do it cheaply and quickly. Forming a relationship is secondary," said Trencher. "But as the Internet market grows, companies whose web strategy does not include the ability to close sales online may be wasting a great opportunity and may lose business to those sites that do have a closing capability."

The notion that agents may be an obstacle to their insurers' success has never gone over well with independent agents, who rightfully see themselves as keys to their companies' success. So a response to Conning was in order...and a good one was issued by the the Professional Insurance Agents of New York, New Jersey, Connecticut and New Hampshire.

PIA's Executive Director Kenneth Bessette pointed out how smart

companies are not using the Internet to bypass their agents, as Conning suggests they must do, but as a way to include them in their future web sales.

"With insurance, the best type of partnership on the Internet is one where the insurance company, agent and consumer are in the same relationship," Bessette said. "We're seeing many company Web sites heading in this direction, where consumers can get connected to their insurance agents via the company Web site." PIA also took exception to Conning's insistence that insurance -- like "everything" -- is a commodity.

"There has been a growing sentiment that personal lines insurance products are 'cookie-cutter' commodities, but this trend does a disservice to the buyer," continued Bessette. "Insurance policies are actually complex contracts involving many different options which, depending on the choices made, can either protect people thoroughly or leave holes in their protection. These choices need to be explained and reviewed with consumers in the context of their overall financial picture, in order for consumers to make informed cost/benefit choices.

"Bad decisions are made by Internet purchasers every day, and often the results are immediately evident. But bad decisions made by online insurance shoppers don't become evident until there is a loss."

Conning assumes there is something wrong with not wanting to be judged on price alone when selling insurance.

Conning apparently also sees no wisdom in insurers' listening to their existing distribution force or including agents in their Internet strategies.

Conning prefers to blame "channel conflict" for insurers' reluctance to utilize the Internet as fully as Conning believes must be done.

PIA's response reminds us that there are indeed other considerations. Insurers and agents are equally concerned with what is best for their customers.

Insurance Times: Insurers, Agents Keys To NY's New Uninsured Motorist ID System

March 28, 2000, Vol. XIX No. 7

ALBANY, N.Y. - The state Department of Motor Vehicles plans to crack down on uninsured motorists with the help of bar-coded insurance cards, a new vehicle registration database, and lots of help from insurers and agents.

The new cards - designed to fight the growing problem of counterfeits - will give police departments the option of using a hand-held computer scanner during traffic stops to make sure a driver's insurance is still in effect, officials said.

The DMV will match records with insurance companies to make sure the names and vehicle identification numbers for vehicle registrations and insurance cards are identical. The state then will require insurance companies to issue new bar-coded insurance cards.

``This is going to be an encrypted bar code. We're working on the

finished product right now," DMV spokesman Ken Brown said. Insurance companies will have nine-months to comply and the policy may go into effect early next year, Brown said.

'Substantial Resources'

Dana Hogan, a spokesman for State Farm Mutual Automobile Insurance Co., said the new system will require "substantial human and financial resources" from insurance companies.

"We believe the concept is a good one," he said. "As is the case with any new technology, there's always going to be concern about challenges and glitches. Until the program begins, we don't know what those challenges or glitches will be, or if they will exist at all."

Meanwhile, the state will begin compiling a new database of registered vehicles next month through expanded reporting requirements called the "insurance information and enforcement system."

With the new database, the DMV can suspend the vehicle registration of a motorist immediately if it learns insurance was terminated and is not notified of new coverage within 14 days. That 14-day window will narrow to seven next year, officials said.

Insurance companies are currently required to report only automobile insurance terminations to the DMV. Officials said the new database will save time required to track down motorists for new proof of insurance.

Recognizing that insurance agents will play a central role in the new program, the Professional Insurance Agents of New York sponsored briefing seminars on the new IIES and the related changes in ID cards.

"The information on the IIES systems is so vital to an agency's operations, our board voted to sponsor briefings for members across the state," noted PIANY President Robert Franzese.

Director of Consumer Protection and Auto Business Regulation Ernest Kitchen and IIES Project Director Craig Holbrook told PIANY board members that insurance companies are preparing to load their policyholder data into the IIES database between April 3 and June 1. Some insurers are enlisting their agents' help in gathering information they lack in their systems.

When the information has been loaded, the DMV will seek to match insurers' records with its own registrations. Insureds for whom no match is found will be identified as potentially uninsured and notified by the DMV. This will be the second phase in which agents will be involved, helping policyholders confirm coverage. Companies that fail to comply with the IIES requirement could eventually find themselves stripped of their DMV code and unable to issue ID cards. The DMV is also revising the way in which ID cards will be issued, to prevent fraudulent cards.

Estimates by state and industry officials put the number of uninsured motorists in New York as high as 800,000.

Insurance Times: Harvard Pilgrim Rehab Plan Promises All Debts Will Be Paid

March 28, 2000, Vol. XIX No. 7

If approved by courts, doctors and hospitals in Mass. and Rhode Island will be paid in full; other creditors will be paid with surplus notes

BOSTON - The rehabilitation plan for Harvard Pilgrim Health Care promises that the troubled HMO will pay all of its debts incurred not only in Massachusetts, but also those in Rhode Island, which HPHC exited last October.

Massachusetts Insurance Commissioner Linda Ruthardt and Attorney General Tom Reilly filed the plan with Massachusetts Supreme Judicial Court for its approval on March 20 and expressed confidence in the HMO's business recovery plan. Last month, Reilly and Ruthardt determined that HPHC did not have to be sold or liquidated but could be kept in business given signs that its own turnaround plan was working.

The rehabilitation plan was also signed by Tom Schumpert, director of the Rhode Island Department of Business Regulation and liquidator of HPHC in that state, and must be approved by Rhode Island's high court as well.

HPHC was placed into receivership in January, after company officials told Ruthardt it had lost about \$177 million in 1999. In the rehabilitation plan, however, Reilly and Ruthardt told the court the plan's losses were closer to \$226 million.

"This plan accomplishes our primary goals of protecting the interests of the patients and health care providers," said Attorney General Reilly. "Harvard Pilgrim has a good business plan and our proposal to the court will allow the company management team to put that plan to work. We will continue to watch out for the members and providers as Harvard Pilgrim moves toward restored financial health."

Uninterrupted Care

"Health care will continue uninterrupted to over one million members and payment made in full to all providers of health care services," said Commissioner Ruthardt. "We believe we have found a way to keep Harvard Pilgrim operating with little or no disruption to its members. "

She noted that under this plan, health care providers will not be allowed to terminate a relationship with Harvard Pilgrim because of the receivership.

If the plan is approved by the courts, HPHC will be released from temporary receivership and placed under the administrative supervision of the commissioner for at least 24 months.

Other Creditors

While doctors and hospitals will be paid first, other creditors, including computer consultants, landlords and former employees who are owed close to \$5.4 million, will be paid in surplus notes to be paid over 10 years at 9.5 percent interest. These payments must be approved by Ruthardt.

This creditor payment arrangement is one of two steps taken to address the health plan's biggest problem: a lack of capital to support it during its recovery. The other step involves an accounting change concerning HPHC's real estate holdings. Since the beginning of the year, HPHC has seen improved cash

flow, bringing in more than \$200 million, which has helped it keep up with debts and claims.

Net Worth

However, its net worth has plummeted to a negative \$100 million, according to officials. In addition to paying lowest category creditors with 10-year surplus notes, HPHC will be permitted to carry some of its real estate holdings at market value for statutory accounting purposes. These two steps are designed to boost HPHC's statutory net worth by about \$237 million to approximately \$137 million.

Rhode Island officials were pleased they were able to work with officials in neighboring Massachusetts to come to terms on the debts HPHC left behind in their state.

Tom Schumpert, director of the state Department of Business Regulation, estimates the insurer owed Rhode Island health care providers \$52 million. About \$17 million already has been paid from premiums collected from Harvard Pilgrim subscribers between the time the insurer went into receivership in Rhode Island and shut down its operations there at the end of December, Schumpert said.

Massachusetts hospitals have said they are owed more than \$300 million by Harvard Pilgrim.

The plan sets aside a total of \$14.5 million to pay Rhode Island doctors and hospitals right away. Of that, \$5 million was to be released last week, and the remaining \$9.5 million was to be paid after the Massachusetts and Rhode Island courts approve the plan. "With this agreement..., Rhode Island providers will be paid in full. That means 100 cents on the dollar. That's an accomplishment we can all be very proud of because no one ever thought we would see this day," said Rhode Island Gov. Lincoln Almond.

Ruthardt and Reilly also decided that HPHC needs a new board of directors. Under the plan, Ruthardt will appoint new directors. The board will be required to provide the attorney general with 60 days notice before engaging in any merger or acquisition; any reduction in service areas or lines of business; any changes in provider network or member contracting; and any material changes in benefits.

The plan includes a request for a permanent injunction enjoining any persons doing business with HPHC from terminating their relationship for cause on the basis of HPHC's financial condition. In addition, the injunction seeks that all claims against HPHC regarding general unsecured obligations and HEFA loan obligations be directed to the court and that any judgments be made in surplus notes. These would include payments on bond debt.

Payment of HPHC's outstanding loan obligations under a 1998 agreement with the Massachusetts Health and Education Facilities Authority (HEFA) and Citizens Bank would be subject to the prior approval of the commissioner.

The Massachusetts court will hear arguments on the plan April 27. A public hearing will be held before the court date.

Insurance Times: Travelers Weighs Backing Hartford Baseball
March 28, 2000, Vol. XIX No. 7

HARTFORD - Travelers Insurance is considering being a major player in the city of Hartford's press for a minor league baseball team.

Mayor Michael P. Peters has been approaching local corporation in his bid to bring minor league baseball to the city by helping finance a \$15 million reconstruction of Dillon Stadium.

A spokesman for the Travelers said the insurer is giving serious consideration to investing in a Hartford ballpark.

"We are in discussions, and we are looking at it very favorably at this point," Keith Anderson, the Travelers spokesman said.

Anderson would not discuss how much Travelers might pay or loan for the project. But Peters said if Travelers signs on, the project would have about \$12 million of the roughly \$15 million it would need to rebuild Dillon Stadium.

The Massachusetts Mad Dogs, a minor league team that plays in Lynn, Mass., has said it wants to move to Hartford.

The city council has already approved \$1 million for the project, while the owner of the Mad Dogs, Jonathan Fleisig, is offering \$2 million up front and about \$4 million in lease fees to help finance a proposed 5,000-seat ballpark.

Insurance Times: AMS's TowerStreet Offers Internet Hosted Service
March 28, 2000, Vol. XIX No. 7

TowerStreet, an AMS Holding Group start-up, has unveiled a prototype for an online personal lines point-of-sale service, the first in a family of service that will provide an integrated insurance information and software service hosted on the Internet.

The Internet service integrates comparative quoting/policy rating, underwriting report delivery, reference information, proposals, Acord forms and electronic submission. TowerStreet plans a beta test of the personal lines service this month. It offers quoting for automobile, homeowners and dwelling fire. The service is hosted on the Internet so that agents and companies can have everything they need, without the costs and efforts required to manage a data center, according to Jim Rogers, TowerStreet product development manager. TowerStreet handles all upgrading of technology, maintaining data and enhancing applications. There will be no need for new software releases or updates; TowerStreet is a complete, turnkey automation service.

Insurance Times: Environmental Risk Of Golf Courses Covered
March 28, 2000, Vol. XIX No. 7

Environmental Risk Managers, Inc. (ERMI) is offering a pollution insurance program for golf courses, called PAR (pollution and remediation). According to ERMI's Chris Bunbury, "this program is accomplishing what no one else has been able to."

The PAR program offers broad coverage, on admitted paper, with minimum premiums starting at \$1,500.

Coverage includes, on-site and off-site pollution clean up along with third party bodily injury and property damage. "Most programs only offer herbicide and pesticide coverage on a sudden and accidental basis and their premium reflects the limited coverage," Bunbury said. The PAR program definition of a pollutant is any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals and waste materials, on a sudden and gradual basis. The PAR program can be broadened to insure underground storage tanks for an additional premium.

The PAR program is being offered on a stand alone basis to complement existing standard insurance golf course programs. "We are not trying to reinvent a product that other insurance carriers have been offering for years," Bunbury said. "With the PAR program we are giving agents the ability to separate themselves away from the competition." The PAR program is available to any retail insurance agent.

Contact Bunbury at Environmental Risk Managers, Inc., P.O. Box 1127, Leland, MI, 49654. Phone: 231-256-2122, fax: 231-256-2123 or Email: jcbunbury@aol.com.

Insurance Times: Truckerscoop.Com, Arthur Gallagher Join Forces
March 28, 2000, Vol. XIX No. 7

Celadon Group, Inc. of Indianapolis announced that its TruckersCo-op.com subsidiary, a business-to-business cost savings Web site for the trucking and the private fleet industries, has signed a supplier agreement with Arthur J. Gallagher & Co. to provide insurance products and services for TruckersCo-op.com. Currently, more than 25,000 member trucks have enrolled in TruckersCo-op.com, officials maintain.

TruckersCo-op.com is a fully interactive site offering significant cost savings for member truck owners, online network enrollments and a dedicated Yahoo! Club site.

"Trucking and transportation is one of our most important market niches and we are committed to serving that niche effectively. Our participation in this effort demonstrates that commitment," said J. Patrick Gallagher, Jr., Gallagher's president and chief executive officer.

Insurance Times: Program For Scrap Recyclers Introduced
March 28, 2000, Vol. XIX No. 7

An environmental insurance program designed especially for scrap

recyclers was recently introduced by ECS Underwriting, an XL Capital company and a leading provider of environmental insurance to business and industry worldwide. The program was designed with the cooperation of the Institute of Scrap Recycling Industries, Inc. (ISRI) and is exclusively available to its members.

"Environmental exposures can have a significant impact on the financial stability of any business," said Joseph Catanese, assistant vice president of ECS Underwriting's Environmental Facilities Business Unit. "To protect ISRI members, ECS Underwriting has designed an affordable environmental insurance program that is flexible enough to allow members to individualize their coverage to best meet their risk management needs."

ISRI members will have a choice of five coverage modules. Available coverages include third party loss, first party loss, products pollution liability, non-owned disposal site liability and contingent transportation liability. Additional information about the program is available on the ECS website: www.ecsinc.com/evf.

Insurance Times: Lloyd's, Facing Major Lawsuit In England, Wins One In Canada
March 28, 2000, Vol. XIX No. 7

Canadian names ordered to honor debts to insurer

by Bruce Stanley
Associated Press

LONDON - Lloyd's of London, faced with a potentially crippling lawsuit at home, recently won a victory in a related case in Canada.

A Canadian judge has ruled in favor of Lloyd's in its effort to collect \$32 million from dissatisfied Canadian investors, the company said.

The 88 Canadian investors had refused to pay, accusing Lloyd's of acting fraudulently for not informing them of the full extent of losses that Lloyd's faced in the 1980s.

Losing Years

Lloyd's lost \$12.8 billion from 1988 to 1992, causing financial ruin for many investors, known as ``Names,' ' and driving about 30 investors to kill themselves.

The Canadians were not among more than 230 Names who filed a lawsuit seeking damages of up to \$237 million, now being heard in London's Commercial Court, but they did make similar allegations of fraud.

In Canada, Justice Katherine Swinton issued a judgment in the Ontario Superior Court of Justice requiring five of the Canadian Names to honor their debts to Lloyd's.

An additional 83 Canadian Names said they would abide by the judge's decision.

``While attention is now being focused on the London court case, it's important to note that Lloyd's is still making significant

progress in its debt enforcement activity around the world," said Philip Holden, head of Lloyd's Financial Recovery operations.

London Lawsuit

The London lawsuit alleges that Lloyd's concealed \$6.3 billion in claims arising from asbestos-related illnesses in the United States while reserving a tiny fraction of that amount to pay for them. The Names say Lloyd's executives hid the liabilities while they launched a worldwide drive to recruit thousands of new investors to help absorb the potential losses. Opening arguments in the case began March 13.

"This is an institution you could not trust," said Simon Goldblatt, lead lawyer for the investors who accuse Lloyd's of massive fraud.

The case filed by more than 230 Names - including 24 Americans - is being heard by Justice Peter Cresswell at London's Commercial Court.

Their lawsuit, which seeks damages of up to \$237 million, poses a potentially mortal threat to Lloyd's.

The suit could irreparably blacken the reputation Lloyd's has nurtured over its 312-year existence as one of the world's premier insurance markets. Worse still, a successful suit could open the floodgates to claims of fraud from others.

Goldblatt accused 33 senior Lloyd's executives of complicity in the alleged cover-up.

Lloyd's, whose coat of arms carries the motto "Fidentia" - Latin for "Utmost Good Faith" - denies any suggestion of fraud.

"These allegations are a rerun of what this dissident group of Names has been saying in public on and off for over 10 years and has failed to substantiate," Lloyd's chairman May Taylor said in a statement. "I do not believe their case has any substance at all, and Lloyd's is very confident of winning."

Lloyd's, which is a self-regulating market of insurance syndicates rather than a company in its own right, noted that the government's Serious Fraud Office reviewed these allegations in 1992 but decided not to take further action.

Private Individuals

Lloyd's relies on more than 30,000 Names - mostly private individuals - who provide the money for underwriting insurance. In successful syndicates, they earn annual returns; in troubled syndicates, they can lose all of their investment and be liable for a share of the overall loss.

For Tom Poole, a Cambridge lawyer who became a Name in 1982, claims due to asbestos-related illnesses cost him more than \$4 million - and his marriage.

"My wife just couldn't stand the pressure any longer and got out and took as much as she could with her, which just increased the strain," he said in an interview. "Those who have been decimated by Lloyd's must strive to continue resisting the complete erosion of their morale by the architects of their financial disaster."

Asbestos Claims

Asbestos-related insurance claims in the United States began to mount in the 1970s and 1980s. It was then, claimants in the

lawsuit allege, that Lloyd's began to recruit large numbers of new investors.

Lloyd's made it easier for them to join by changing its rules to let new Names pledge their homes as collateral for policies they underwrote and for which they were personally liable.

At the same time, syndicates that were heavily exposed to claims by victims of asbestosis and lung cancer caused by asbestos fibers had to ``stretch credibility to the limit'' to appear solvent, Goldblatt argued.

They juggled their books, and some even broke with Lloyd's normal practice and refused to reserve against such claims so as to avoid showing a loss, he alleged. Those that did reserve against asbestos-related liabilities put aside a total of just \$32 million, or 0.5 percent of Lloyd's total exposure to these claims, he added.

``Names ... were being told to rely both globally and at the syndicate level on figures that told one story and meant another,'' Goldblatt said.

Political Ramifications

The accusations may have political ramifications. Lloyd's is immune to lawsuits, except in cases of proven fraud, thanks to the Lloyd's Act passed by Parliament in 1982.

However, Goldblatt suggested that Lloyd's executives withheld crucial information about its beleaguered finances from members of Parliament's House of Commons, who hotly debated the bill before making it law.

Insurance Times: Notebook Computer Owners Rated As High Risks **March 28, 2000, Vol. XIX No. 7**

For notebook computer users, their convenience also includes a high risk of damage or loss, according to a new insurance industry study.

Safeware, The Insurance Agency, Inc. based in Columbus, Ohio, reported that an analysis of personal computer damage claims for the past three years shows a steep rise in reports of losses from accidents, thefts and other damage among notebook owners.

88% of Total PC Claims

In 1999, claims by notebook owners accounted for 88 percent of total claims, compared to 53 percent in 1997. Annual losses in dollars from notebook PC claims also rose more than 11 percent over the three years to nearly \$1.75 million 1999. All personal computer claims in 1999 totaled approximately \$1.9 million. Safeware's annual loss statistics are projected from actual reported claims by the company's national client base. The company, which is a member of Assurant Group, says it is the largest insurer of personal computers in the country.

Accidents -- for example, damage caused by dropping a PC -- accounted for about 52 percent of all notebook losses in 1999, up 3 percentage points from 1998. The next highest category was theft, with 29 percent of claims. Power surges, lightning,

transit, water and other causes accounted for the remaining 16 percent.

"An increasing number of schools and students are purchasing notebook PCs to support everyday learning," said Don Strejeck, president of Safeware. "With more and more students carrying personal computers back and forth to class in their book bags, accidents are inevitable," he said.

Study Highlights

Other highlights of the 1999 Safeware Loss Study:

Accidental damage accounted for 49 percent of all reported losses, a 6 percent increase from 1998

Power surges are the No. 1 source of claims among desktop PCs, accounting for 30 percent in 1999. Accidents ranked second, with 27 percent.

Strejeck said that students, home PC users and businesses are becoming increasingly aware of the potential risks associated with PC use and the costs to repair or replace equipment. Yet, he said, millions of computer owners never think about insuring their investment until it is too late.

Another reason to purchase special coverage for a personal computer is that most standard home and business policies exclude accidental damage -- the number one cause of loss -- and limit coverage for thefts and power surges.

Since 1982, Safeware company has issued coverage for more than \$1.6 billion in computer hardware, media and software. Call 800-800-1492 or visit the company's website at www.safeware.com.

Insurance Times: Insurers Spend Big, Win Big, In California Right-To-Sue Referenda Battle **March 28, 2000, Vol. XIX No. 7**

Defeat of laws is defeat for Democratic Gov. Gray Davis

SAN FRANCISCO - Insurers and business groups put two right-to-sue measures on the ballot and then devoted \$50 million to persuade Californians to vote ``no'' on them, outspending their opponents 10-1 in their successful campaign.

With 85 percent of the precincts counted, 68 percent of voters rejected Proposition 30, repealing legislation that would have allowed accident victims to sue the rival insurance company for bad faith in cases where legitimate claims were delayed or resolved unfairly.

The insurers also got their wish with 71 percent of the vote against a companion measure, Proposition 31, which targeted another right-to-sue law.

"It's clear that people overwhelmingly understood their insurance rates would go up under these measures and that they would get nothing for it," said Allan Zaremborg, president of the California State Chamber of Commerce.

``If an insurance company had been faced with a punitive damage lawsuit of millions of dollars for defending a policyholder, they

would have been quicker to accede to a higher settlement, and our numbers showed that would increase premiums by 15 percent'' he said.

But supporters of the two laws, which were signed last year by Democratic Gov. Gray Davis, a longtime political ally of the trial lawyers, called them ``fair and reasonable protections for consumers.''

``The insurance companies, with their \$50 million in campaign money, certainly succeeded in confusing people with their lies,'' said spokeswoman Kelly Hayes-Raitt.

Proposition 30 targeted a law allowing accident victims to file bad-faith lawsuits against the at-fault parties' insurers, and Proposition 31 addressed a law letting either side seek binding arbitration in claims of \$50,000 or less.

Triple Damages

Bad-faith judgments, which may entail triple damages and typically are higher than settlements in other civil actions, have been at the core of a dispute for years between lawyers and insurers. Both sides have identified it as their top political priority. Lawyers want the bad-faith rule; insurers don't. Trial lawyers say the bad-faith lawsuits would protect consumers from insurance companies that low-ball claims, and that consumers need legal leverage when they confront well-heeled insurers in court.

Blocked Laws

But insurers, who qualified the two measures for the ballot in hopes of getting them voted down and thereby blocking the laws Davis signed, said the bad-faith doctrine provided bigger fees for lawyers but does little for consumers. They said the increased costs of litigation get passed on to consumers as higher premiums.

The right to file such lawsuits is known as the Royal Globe doctrine, after the legal rule the state Supreme Court established in 1979. Royal Globe was the name of the insurance company involved in the precedent-setting case, in which a woman slipped and fell at a Butte County market.

The high court threw out the bad-faith rule in 1988.

Moments after Davis signed the legislation last year, the business-insurance coalition began a major television campaign to successfully qualify the two referendums for the ballot. They then began an equally pervasive media blitz to campaign against both measures.

\$50 Million Raised

The opponents, bankrolled mostly by major insurance companies, raised some \$50 million to defeat the measures.

Supporters, including lawyers, retirees and consumer groups, raised about \$5 million.

A referendum, unlike an initiative, asks voters whether an existing law should be kept on the books. The laws signed by Davis were put on hold pending the outcome of the election.

Insurance Times: Allfinanz Promises Swift Life Underwriting For Banks
March 28, 2000, Vol. XIX No. 7

NEW YORK - Allfinanz Inc. has introduced a new Web-enabled software solution that it claims allows branch managers to walk customers through the entire buying process, including underwriting and presentation of contract, in under 25 minutes.

"With the recent passage of the Financial Services Modernization Act (also known as HR10), banks are in the enviable position to market life products directly to their customers, and Allfinanz helps them do that in an easy-to-use, cost-effective way," says Jim Maher, CEO of Allfinanz Inc.

With Allfinanz E-Business, underwriting is handled electronically while the customer is still in the bank branch. If the process results in a "Yes" decision with no further need for consideration, the policy can go into effect the moment the customer pays the first premium. Cases that result in a "No" decision are either declined, postponed or referred for additional consideration. The entire process, from premium estimate to in-effect policy, takes less than 25 minutes and can be performed by a manager or sales representative with minimal training. More importantly, this streamlining helps prevent the exodus of customers which occurs in about 75 percent of cases, notes Jim Maher, Allfinanz CEO.

With little variation, the Allfinanz sales process is adaptable for the independent agent's office, carriers' call centers or even a customer's own desktop or laptop computer. Banks will soon be able to use the software to offer multiple carriers' life products.

Allfinanz Inc. (www.Allfinanzinc.com) has offices in New York, Massachusetts and Dublin, Ireland.

Insurance Times: Lincoln National Claims Allfinanz Infringes Patent
March 28, 2000, Vol. XIX No. 7

FORT WAYNE, Ind.-- Lincoln National Risk Management, Inc. (LNRM), the technology affiliate of Lincoln Re, has filed a lawsuit here in U.S. District Court against three related parties: FMS House, FMS and Allfinanz, Inc., with offices in Massachusetts, New York and Ireland. The lawsuit claims FMS/Allfinanz -- by making, using, offering to sell and selling its suite of software systems and components -- infringes upon LNRM's risk assessment patent. The LNRM patent, "Method and Apparatus for Evaluating a Potentially Insurable Risk," was issued Dec. 4, 1990, as U.S. Patent No. 4,975,840. The patent covers, among other things, LNRM's knowledge-based automated life insurance underwriting software products, i.e., the Lincoln Underwriting System and the LincUs suite of underwriting system products. The petition seeks a declaration from the court that the risk assessment patent is being infringed, monetary damages, and an injunction against continued infringement.

"Lincoln Re was granted this patent because we were the first to recognize the power of technology in delivering mortality risk management knowledge and tools to our customers. Our ability to

do this through software using our own intellectual property is key to our success. That is how we are able to contribute to our clients' success," said Lawrence T. Rowland, president and CEO of Lincoln Re.

Insurance Times: Life Insurers Urge Normalized Trade With China
March 28, 2000, Vol. XIX No. 7

Life Insurance Executives Urge PNTR Enactment This Year; Will Meet With White House and Congressional Leaders Thursday
Washington, D.C. (March 8, 2000) - The American Council of Life Insurers (ACLI) hailed President Clinton's push for permanent normalized trade relations (PNTR) for China. The ACLI also praised Senate Majority Leader Trent Lott for promising to move quickly on China PNTR legislation the administration sent to Capitol Hill.

"The administration delivered the right message today," said ACLI President and CEO Carroll A. Campbell, after President Clinton's speech advocating China PNTR at the Johns Hopkins School of Advanced International Studies here in Washington.

Twenty-five life insurance company CEOs went to Washington for high-level meetings at the White House and on Capitol Hill to press for China PNTR and retirement security legislation - notably pension reform and an "above-the-line" federal tax deduction for the purchase of private long-term care insurance. More than 20 ACLI member companies have representative offices in China and have been working for years for a liberalized Chinese market. Congressional approval of PNTR would secure the benefits of China's WTO trade agreement for U.S. businesses, and China's insurance and pension markets could be open to the U.S. as early as 2003.

While China has one of the highest rates of individual savings in Asia, the Chinese are underinsured, spending less on all insurance than 28 of the U.S. states. In fact, China spends less on life insurance than its smaller and poorer neighbor, India.

"Both U.S. and Chinese businesses and consumers can gain enormous benefits through open and competitive trade relations," Campbell said. "We urge Congress to enact, at the earliest possible date, legislation to provide China with PNTR."

Insurance Times: Metlife Puts 24% Of Shares Up For Sale In IPO
March 28, 2000, Vol. XIX No. 7

Offer scaled back somewhat from original plans

NEW YORK (AP) - MetLife Inc., the nation's second-largest life insurer, filed March 9 for an initial public offering of 179 million shares, or 24 percent of the company, which is converting to a public company from one owned by policyholders.

The shares were expected to price between \$13 and \$15 each, raising up to \$2.7 billion, the company said in a filing with the

Securities and Exchange Commission.

The offering was scaled back from the company's original plans. In November, MetLife estimated it would raise \$6 billion by selling 255 million shares for \$14 to \$24 each.

That would have made it the largest domestic IPO ever, surpassing the \$5.47 billion raised this month by United Parcel Service. But insurance stocks, along with other ``Old Economy'' blue chips have come upon hard times in the intervening months, prompting the company to make a more modest offering.

Private Placement

The New York-based insurer could raise an additional \$1.1 billion through a private placement of 73,000 shares with Credit Suisse First Boston and Banco Santander Central Hispano SA, who together could hold up to a 9.8 percent equity stake, according to the filing.

MetLife also filed to sell up to \$1 billion in convertible securities.

At the time of the offering, MetLife issued 493.5 million shares, or a majority 66.2 percent interest, to a policyholders trust to be held on behalf of approximately nine million eligible policyholders. After the IPO, there were to be 745 million shares outstanding.

MetLife is one of a string of large insurance companies that has either completed or is planning an IPO. Others include the John Hancock Mutual Life Insurance Co., Mutual of New York and Prudential Insurance Co., the nation's largest life insurer. One reason insurance companies are going public is to create a currency - publicly traded stock - that can be used for acquisitions. Recent federal legislation allows the companies to partner with banks and investment firms to offer numerous investment products insurers had previously been banned from selling.

Insurance Times: Mass. High Court Hears Ethics Cases Involving Lobbyists March 28, 2000, Vol. XIX No. 7

BOSTON (AP) - It was three free golf outings and two dinners more than five years ago and Rep. Angelo Scaccia's been paying for them ever since.

Last week he took his case to the state's highest court to fight for his reputation and the \$3,000 he paid in ethics fines for accepting gratuities from insurance and tobacco industry lobbyists.

Scaccia, D-Boston, was fined in 1996 in part for an Amelia Island, Fla., trip partly financed by the insurance industry. The commission found evidence that showed Scaccia, House chair of the Taxation Committee, sponsored bills and held hearings after the outings that favored the insurance industry.

Scaccia's lawyer argued that the commission failed to show any link between the dinner, golf and any legislative action he took as a result.

``They simply said he held hearings before he had played golf,``

said lawyer Morris M. Goldings after arguing Scaccia's case before the Supreme Judicial Court. ``He held some hearings afterwards. That's his job, what is he supposed to do, not be a legislator?''

Ethics Commission lawyer Judy Levenson said the commission determined it did not need to find specific connections between Scaccia's golf matches and his work. But she said Scaccia not only held hearings, but sponsored several bills on behalf of the industry.

Scaccia's air fare and hotel accommodations at the conference were paid for with his campaign funds, Levenson said.

``If he had paid for his own golf we wouldn't be here?'' asked Supreme Judicial Court Justice John M. Greaney.

Scaccia's actions were part of a larger investigation into lobbyist activities that came in the wake of a spotlight series by The Boston Globe.

The SJC took Scaccia's case under advisement after hearing the case and was expected to rule in about four months.

Scaccia, who was in the courtroom for the arguments, declined to comment.

Along with Scaccia's case, the SJC heard a similar argument by the Life Insurance Association of Massachusetts Inc.

The industry organization in 1997 was fined \$13,500 for providing meals and golf to lawmakers on nine occasions from 1989 to 1993.

A lawyer for LIAM asked that an Ethics Commission finding be thrown out or be reconsidered in light of a U.S. Supreme Court decision bolstering its contention that the Ethics Commission was ``overbroad'' in its interpretation of the law.

The cases were being closely watched by activists and lobbyists.

``These two cases indicate just how far lobbyists and some legislators will go to preserve the old boy network and perks that they now share with each other,'' said Ken White, executive director for Common Cause of Massachusetts.

``It's true the ethics law needs reform, but these cases demonstrate that the laws need to be strengthened, not weakened,'' White said.

Benjamin Fierro III, a private lobbyist on Beacon Hill for 19 years, who also listened to the Ethics Commission arguments, disagreed.

``These twin cases are not about defending the right of lobbyists to buy a meal for a legislator,'' he said. ``This case was about the state Ethics Commission following the law and treating everyone, including lobbyists and legislators fairly and reasonably.

Insurance Times: Milliman & Robertson Study Ordinary Life Expenses: A Benchmark
March 28, 2000, Vol. XIX No. 7

by Bradley M. Smith, FSA, and
Susan L. Hunt, FSA

Expense Management is an essential ingredient in a life insurance

company's ability to offer competitive products and generate an adequate return to investors. For several years, Milliman & Robertson, Inc. has produced an annual study of life insurance industry expenses to estimate overhead expense for the ordinary life line of business.

This investigation analyzes the level of home office expenses a company incurs in its ordinary life business. Although it includes home office acquisition (issue and underwriting) expense, variable policy maintenance expense and home office overhead expense, it excludes commission and agency-related expense. It does include marketing and developmental expenses incurred in the home office, since an important consideration in expense management is how much can a company afford to spend continuously for these items.

321 Life Companies Studied

For the purpose of this study, the ordinary life insurance industry in the United States was represented by 321 companies. The companies selected for the study accounted for approximately 88% of the total ordinary life face amount issued in the United States in 1998. Expense results were calculated for the industry as a whole (represented by the 321 companies) as well as for various segments of the industry (i.e., mutual/stock companies, large/small companies, career agency/brokerage companies). We developed formulas we believe reflect typical variable acquisition and maintenance expenses. These formulas were based on functional expense studies and the expense of various underwriting techniques.

Underwriting procedures vary by face amount and issue age from company to company, so this formula is necessarily an estimate. Nonetheless, it reflects typical underwriting expenses incurred by companies that issue fully underwritten business and expect a mortality level consistent with those in the annual Society of Actuaries mortality study of the ordinary life line of business. Using information available from statutory financial statements as well as the unit expense factors developed for these studies, variable expense for policy issue and maintenance was imputed for each company. Overhead expense was defined as the excess of General Insurance Expense over the imputed variable expense. Table 1 presents the overall results of this year's study.

Five Year Period

Results are calculated for a five-year period using data from calendar years 1994 through 1998. The results are expressed as a percentage of direct ordinary life premium income (excluding single premium). Therefore, a company with a large amount of assumed business will have an expense percentage higher than appropriate because no expense is being defrayed by policies assumed through reinsurance.

The weighted average result is the ratio of the total fixed overhead expense to the total direct premium income (excluding single premium) for the ordinary life line of business for all companies included in the study.

The arithmetic mean is the average of the results for all the companies included in the study, with no weight given for company size.

Expense per policy was calculated as the total ordinary life

overhead expense divided by the average number of ordinary life premium-paying policies in force during the year. The ratio to variable expense is the ratio of overhead expense to direct variable expense (i.e., acquisition and maintenance expense).

The quartile breakdowns provide additional insight into the distribution of results. Approximately 25 percent of the companies studied had overhead expenses in excess of 17% of premium, approximately 50 percent had overhead expenses in excess of 11% of premium, and 25 percent of the companies studied had overhead expenses less than 5% of premium.

Companies by Size

Figure 1 shows the results from 1994 through 1998 for company groups based on size. Large companies are defined as companies with more than \$100 million in ordinary life premium, medium companies as those with between \$25 and \$100 million in ordinary life premium, and small companies as those with less than \$25 million in premium. In past studies, the overhead expense ratio was inversely related to the size of the company (i.e., the smaller the company the larger the overhead percent). However, an upward trend for large companies and downward trend for medium companies caused the relationship to reverse in 1995. Currently, the three groups appear to be converging on a point close to the flattened level of the large company group.

Although the overall weighted average results indicate an increasing trend, when the results are analyzed by company size, only the large companies exhibit this trend. This fact, especially when considered with the arithmetic mean - which is not increasing - tends to suggest that increasing expenses among the large companies are influencing the trend for the group as a whole. However, the increasing median indicates that more companies have increasing ratios than decreasing.

In Figure 2, the results for stock companies are compared with the results for mutual companies. In general, ordinary life overhead expense is a smaller percentage of ordinary life premiums for stock companies than for mutual companies. This relationship holds true when differences in distribution systems and costs associated with these distribution systems are considered. It also holds true when company size is considered. A company in business over the long haul must issue policies that yield a reasonable return to investors and that compete for policyholders' attention. To compete for capital and market share, companies must have unitized expenses that compare favorably with those of its competition. The overhead expense results calculated in this study provide a benchmark for a company to use in evaluating its own position within the industry or some subset of the industry. A company with expenses consistently higher than average may find it difficult to offer profitable products at a competitive price. A company able to reduce its overhead expense levels should have a competitive edge.

The complete study is described in more detail in a report available from the authors in the Dallas office of Milliman and Robertson at (214) 891-7300. The complete report contains more information about the methodology of the study as well as more detailed results.

Authors Smith and Hunt are consulting actuaries with Milliman & Robertson in the Dallas office.

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Overhead Expenses Ordinary Life Insurance
1994-1998 All Companies

	1994	1995	1996	1997	1998
Weighted Average	9.5%	10.1%	10.4%	10.8%	10.9%
Arithmetic Mean	12.3%	11.9%	10.9%	11.1%	11.2%
Median	9.8%	10.2%	10.7%	10.8%	11.3%
Expense per Policy	\$48	\$52	\$52	\$56	\$55
Ratio to Variable Expense	169%	185%	191%	199%	200%
Number of Companies	321	321	321	321	321

Expenses measured include home office acquisition (issue and underwriting) expense, variable policy maintenance expense and home office overhead expense. Commission and agency-related expenses are excluded.

Milliman & Robertson

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Insurance Times: City Of Hartford Anticipates Aetna Split
March 28, 2000, Vol. XIX No. 7

City and state officials hope proposed break-up of insurer will keep business and jobs in Hartford

HARTFORD (AP) -The decision to split Aetna Inc. into separate companies drew a favorable reaction from city officials, who hope the breakup would keep business activity in Hartford, and from doctors, who hope to mend fences with the nation's largest health insurer.

Hartford, which has seen a number of major insurance players move away or consumed in mergers, is relieved by Aetna's promise to keep a significant presence in the city.

``It sounds a lot better than what I was hearing a week and a half ago,'' said Hartford Mayor Michael Peters, who had met with Aetna's new chairman and chief executive William H. Donaldson after Aetna received a \$10 billion buyout offer.

Peters said he would seek a meeting with Donaldson soon about the headquarters issue.

``Having a corporate headquarters here is very important,'' Peters said.

Gov. Rowland

Gov. John G. Rowland said Hartford would have an edge in remaining a headquarters for one or both of the new companies because of the large base of employees and talent in the Hartford area.

``It makes a lot of sense to be located in Hartford,'' Rowland said.

But even if Hartford does lose a headquarters, Rowland said the strategic split is still ``great, great news'' because the new

companies, as yet unnamed, would retain a major presence in the city.

Some doctors are focusing on Aetna's promised ``comprehensive review'' of the way it runs its health business which could help ease the tensions between insurers and physicians.

``They sure have a lot of road to cover,'' said Dr. Donald D. Timmerman, president-elect of the Connecticut State Medical Society. ``But it really is time to form a partnership with physicians and ease the animosity and bickering.''

Timmerman said Aetna must change its attitude toward doctors and allow physicians to use their medical and patient knowledge to properly administer treatment, rather than getting in the middle. The buyout offer that was rejected earlier this month came from Dutch financial services conglomerate ING and California health insurer Wellpoint Health Networks.

Insurance Times: CAR ERP Distribution Upheld By Appeals Court
March 28, 2000, Vol. XIX No. 7

BOSTON - Trust Insurance Co. of Taunton, Mass. lost its challenge to the appointment of two of its exclusive representative producers when the Massachusetts Appeals Court upheld a Superior Court ruling earlier this month.

Trust, a personal lines insurer now in receivership, lost its argument that Massachusetts Commissioner of Insurance Linda Ruthardt was wrong when she neglected to consider other servicing carriers' subjective motivations in terminating their ERPs. CAR's Rules of Operation require that a servicing carrier have ERP exposures proportionate to its total share of the insurance market. Companies with a share of the ERP market smaller than their market share undersubscribed companies are the first to receive additional ERP assignments from CAR.

On March 31, 1993, CAR notified Trust, an undersubscribed company, that it would be assigned several new ERPs, including the Marietta M. Paquette Insurance Agency, Inc., in Lowell, (which was formerly owned by Mario Espinosa), and Allan R. Zagami, doing business as New Main Street Insurance Agency, in Worcester.

Trust argued that Safety Insurance Co. of Boston should have been assigned Paquette and that Commerce Insurance Co. of Webster should have been assigned Zagami.

"Trust argues that Paquette should have been assigned to Safety as an ERP because Paquette purchased a book of business that Safety previously serviced. Under CAR rule 14(A)(2)(e), when an agent or broker which has an ERP appointment to a servicing carrier sells its book of business to an agent or broker who lacks a relationship with a servicing carrier, the appointment inures to the purchaser.

Trust maintained that Safety took advantage of Espinosa's sale of its book of business to terminate Espinosa's ERP appointment and free itself from an unprofitable relationship.

Trust contended that Ruthardt ignored Safety's motivations in terminating Espinosa as an ERP. However, even Trust acknowledged

that Espinosa failed to remit premiums, failed to cooperate with Safety and CAR during audits and investigations, and violated premium collection standards - conduct that constitutes grounds for termination under CAR's rules. Trust also admitted that Safety terminated Espinosa before the sale to Paquette, leaving no servicing carrier relationship that would attach to Paquette. The trial judge ruled that CAR rules governing the termination of ERPs do not refer to the subjective motivation of the servicing carrier, and that the commissioner properly concluded that Safety terminated the agency status of Espinosa in accordance with CAR's rules.

Noting that CAR rules set forth an objective list of standards for ERP termination, Judge Kass agreed, writing that " the commissioner's decision, that a servicing carrier's subjective motivation in proceeding with the termination of an ERP is immaterial under the CAR rules, is based upon a correct interpretation of CAR's rules."

The situation was similar regarding Zagami. Trust argued that Commerce terminated New Main to rid itself of unprofitable business and that this termination was ineffective because Commerce continued to service New Main's book of business through its subsidiary, NMS Liquidation Co. Trust maintained that NMS Liquidation acted as an ERP with Commerce as its servicing carrier, a relationship that continued until Zagami purchased NMS Liquidation's business.

While Commerce continued to service New Main's book of business in hopes of recouping some of its financial losses, Commerce previously had terminated New Main as an ERP because of embezzlement by its former principal.

The Appeals Court agreed with the Superior Court, finding that NMS Liquidator was never an ERP under CAR rules.

"Regarding both Paquette and Zagami, Trust confuses books of business with the insurance agents and brokers who service those books of business. Only agents and brokers can be ERPs; only agents and brokers can be terminated as ERPs. The CAR rules governing ERP termination concern only acts or omissions by the agents or brokers, and do not refer to any quality of the business that those agents or brokers service. Whether a servicing carrier in terminating an ERP considers the profitability of that ERP's business is immaterial to determining the propriety of the termination," Judge Kass wrote.

"Essentially, Trust urges us to examine whether the servicing carrier's reason for terminating an ERP was a pretext. In personnel employment and criminal law contexts, courts do look at pretext because a showing of pretext unmaskes the apparent legitimate explanation of the adverse hiring decision, search, or arrest. That sort of inquiry does not generally apply to the termination of essentially contractual arrangements conformably with the rules governing those arrangements. The commissioner and the Superior Court judge were correct in declining to read CAR's rules as considering the subjective motivations behind ERP terminations for causes set out in those rules."

Insurance Times: Agents, Insurers Assess Banks' Ability To Compete
March 28, 2000, Vol. XIX No. 7

With the recent repeal of the Glass-Steagall Act, the doors are open for banks to enter the insurance industry. How will this new development affect agents/brokers and insurance companies? Will banks be successful in their bid to claim a piece of the insurance industry pie?

An article in the Winter, 1999, edition of the CPCU Journal addressed these questions, and revealed the somewhat surprising results of a survey of banks, agents and brokers, and insurance companies, regarding their opinions on banks in insurance.

"Ready or Not, Here They Come: Banks in the Property and Casualty Insurance Marketplace," by Gary G. Butler, CPCU, MBA, and Jason N. Mostofsky, MBA, both of Employers Re, also includes the results of a consumer survey on the topic.

The survey reveals a trend of vulnerability that agents and brokers feel toward the potential involvement of banks in the insurance industry. The authors state that agents and brokers, "responded that they feel banks' involvement in the insurance markets will have an overall negative effect on the insurance industry as a whole, with the greatest negative impact on the agent/broker segment specifically. Banks perceive a new revenue opportunity and agents/brokers see a threat to their current revenue stream."

Surprisingly, the survey shows that insurance companies did not appear to feel quite as threatened as the agent/broker. However, all three groups surveyed (banks, agents and brokers, and insurance agents) agree that banks will be successful, or at least have meaningful impact in the marketplace. Each group indicated a belief that:

banks have a greater competitive advantage over agents/brokers than insurance companies.

banks will become major competitors for both agents/broker and insurance companies, but more so for agents/brokers.

the full participation of banks in insurance will have a less positive effect on agents/brokers than insurance companies.

Small Agents

The survey also revealed that small agents are most concerned about banks' involvement in the insurance industry, and that they are less optimistic than the industry as a whole, should banks become involved in insurance. The authors point out that small agent/brokers likely feel more threatened because they may not have the resources to handle complex insurance needs, and tend to focus on simpler products that require less technical knowledge. These are the same products that will be easier for banks to duplicate.

Banks Not Confident

According to the authors, in 1975 banks controlled 68% of the assets in the financial industry, while today they only control 22%. The need for banks to generate additional revenue is a direct result of loss of market share, and one of the main reasons that banks have become interested in entering the insurance marketplace.

However, the survey also shows that banks do not have a high level of confidence about entering the insurance marketplace. In fact, the authors state, "Throughout the survey, banks continually grade themselves and their abilities at a much lower level than did both insurance companies and insurance agents and brokers. That lack of confidence may be due to their lack of insurance knowledge."

The impact that banks will have on the industry depend on four distinct factors: distribution, branding, products, and technology.

Banks will offer an alternative distribution channel that previously did not exist. The traditional channels of insurance distribution included three channels: independent agent/broker, captive agent, or directly by the insurance company. The authors point out that, "Now, simultaneously two new and significant means of distribution are being developed: banks (through branches and direct marketing), and on the internet. While both of these types of distribution will still fall within the three primary distribution methods, they represent significant change to how insurance products will be distributed."

Since additional distribution channels create more confusion for the intended customer, branding will be an increasingly important factor. The authors state, "For products distributed in a channel other than by an agent/broker, branding becomes critical. A successful sale becomes unlikely in a competitive environment with no advocate (agent/broker) and no track record (brand)."

The greatest opportunity for banks to sell insurance appears to be in the personal lines property/casualty arena. Since automobiles and homes are often financed through a bank, banks may seize the opportunity to cross-sell the insurance needed to protect the new asset. Patrick J. Gallagher, Jr., president and chief executive officer of Arthur J. Gallagher, predicts that personal lines are "the first things that go the bank route." Few predict that banks will enter the complicated commercial lines arena soon.

While bank technology is not as well developed as its distribution and branding, many think it is only a "matter of time" before banks are able to direct their sophisticated databases that collect information on spending habits and savings to match up customers with insurance products.

In order for banks to be competitive in the insurance industry, the authors state that the agency approach offers some key advantages. Agents/brokers can help banks attain a level of technical knowledge. Joint ventures between banks and insurance agencies, or individual agents, may be a low cost way for banks to gain access to the agencies' markets. Finally, the authors point out that it is, "critical that bankers include an insurance company in joint venture negotiations to line up a primary "go-to" market, and to make sure the market understands the targeted program."

Based on the survey, the authors conclude that insurance companies have little to worry about in the near future. Banks are very reluctant to take any underwriting risk, even as an owner of an insurance company subsidiary. Therefore, regardless of the level of success banks have in entering the insurance

marketplace, premiums will continue to flow through insurance companies. The authors state that the largest opportunities for insurance companies are in two areas: competing or partnering with banks in the insurance realm; or competing or partnering with banks in the banking realm.

Many insurance companies have already applied for thrift charters. Thrifts are an attractive option, because they allow the insurance company to perform most banking functions, but without the same restrictions as banks. By using thrifts, insurance companies can create their own consumer banking base and consequently, a fully integrated system of distribution and financial products which the banks cannot match.

Consumers

"The ultimate fate of all successes and/or failures lies in the hands of consumers," the authors write. "Consumers will play the critical role in determining success of the insurance agents/brokers, insurance companies and banks in this newly created insurance marketplace."

Agents/brokers concern may be overstated since 79.2% of consumers surveyed use agents/brokers to buy some, if not all, of their insurance, and 47.1% indicated that agent representation is an important feature in insurance buying decisions.

The authors state that the high level of knowledge and expertise that agents/brokers possess will likely allow them to sustain a large portion of the insurance market in the years to come.

"Agents/brokers will always be needed to provide this highly personal and professional level of service to customers who need representation for difficult or unusual risks and exposures, and for clients who appreciate working with a knowledgeable agent/broker who will continually upgrade the clients' policies to appropriately cover changing needs."

Insurance Times: Personal Lines: Bank CEO Finnegan succeeds Wintermute at Lumber Insurance; Tangney heads Mutual Fire Association; Dolan joins Fred C. Church; Fallon joins Allied American
March 28, 2000, Vol. XIX No. 7

Lumber Insurance Companies

Neal F. Finnegan has been elected president, chief executive officer and a director of Lumber Insurance Companies of Framingham, Mass. Finnegan, formerly chairman and CEO of the U.S. Trust Co., succeeds Jack Wintermute, who retired in January. Finnegan comes to the Lumber Insurance Companies after a career with Shawmut Bank and U.S. Trust, which recently merged with Citizens Bank.

Lumber Insurance Companies, rated A- (Excellent) by A.M. Best, and provides coverage to the lumber industry through Lumber Mutual, North American Lumber and the Minnesota-domiciled Forest Products Insurance Agency. Lumber also sells commercial lines to New England small businesses through its Seaco subsidiary. Lumber Insurance Cos. has also named W. Keith Kloza as vice president and controller. Most recently, Kloza worked with Arkwright Mutual Insurance Co. (FM Global) as assistant vice

president and manager of financial analysis.

Mutual Fire

Insurance Association

Joseph G. Tangney has been named president and chief executive officer of the Mutual Fire Insurance Association, a 120-year old loss control and engineering service group for New England mutual insurance companies. In addition to providing loss control and engineering services, the association also manages several reinsurance pools and administers several employee benefit programs for member companies.

Fred C. Church

Robert C. Dolan has joined the commercial sale staff of Fred C. Church, Inc. of Lowell, Mass. Prior to joining Fred C. Church, Dolan was vice president of commercial lending at Family Bank.

Mony Group

Steven G. Orluck, who heads The Mony Group's alternative distribution efforts, has been promoted to senior vice president for the New York financial services firm. Orluck will continue to direct strategy for complementary distribution channels, which focus on specific target markets such as purchasers of corporate and bank-owned life insurance.

Maine Mutual Fire

Maine Mutual Fire Insurance Co. of Presque Isle, Maine, has promoted Stacy Shaw to programmer analyst and Ruthann B. Weeks to senior casualty claims examiner.

Allied American

Natick, Mass.-based Allied American Insurance, the largest independent insurance agency in New England, has appointed a new commercial lines sales manager. John Fallon, formerly with Liberty Mutual Insurance Co., will be responsible for the business insurance sales staffs of Allied American Insurance and its wholly-owned affiliate, Carlin Insurance.

Hartford Life

Hartford Life, Inc., of Simsbury, Conn., the nation's third largest life insurance group, announced three promotions and the hiring of a new vice president of market and product development within its Employee Benefit Division.

Kim Johnson is the new vice president of market and product development., She most recently served as vice president and chief actuary at UnumProvident Corp. Her role will be to provide more focus to the division's product development, to leverage products across all markets, and to aggressively develop new market opportunities and alternative distribution systems.

Dong H. Ahn, is vice president and director of employee market underwriting. He will oversee underwriting, pricing and service of all products sold in the employer market. Ahn joined Hartford Life in 1995.

Peter A. Cook, vice president and director of employer market sales, now oversees a sales force that provides a broad spectrum of products to the employer market, including group life and disability, critical illness and travel accident.

Bob Neil, who formerly headed the group specialist risks sales operation, now is director of employer market national accounts.

Urban Insurance Partners Foundation

Suzanne Reade, a former CNA executive, has been named president of the Urban Insurance Partners Foundation. The nonprofit foundation was founded by insurance companies to address urban insurance issues.

Among the Indianapolis-based organization's supporters are Nationwide, Liberty Mutual, Allstate, Farm Bureau Mutual, Farmer Insurance, General Reinsurance, the American Insurance Association and the National Association of Mutual Insurance Companies.

Beacon Mutual

Beacon Mutual Insurance Co., W. Warwick, Rhode Island, has named Michael D. Lynch as vice president of legal services. In his new position, Lynch will establish a staff counsel office to manage legal services provided to Beacon and its policyholders. Lynch brings 16 years of experience in workers compensation law at Hoggins, Cavanagh & Cooney, where he had been a partner since 1992.

MetLife Financial Services

Jim Gartin, director of industry professional development programs for MetLife Financial Services, was recently honored with the 1999 Ernest E. Cragg Award by the Life Underwriters Training Council (LUTC). The award recognizes the unique and extraordinary accomplishments of LUTC's most dedicated supporters during the previous years.

HSB Group

HSB group, Inc., Hartford, Conn., announced that Richard H. Booth has been elected chairman of the board. Booth, a member of HSB Group's board of directors since 1996, succeeds Gordon W. Kreh, who retired on Jan. 1, 2000.

Penn Mutual Life

The Penn Mutual Life Insurance Co. has named Louis P. DiCerbo general agent of its New York City-based agency, the winner of its 1999 National Chairman's Award.

The award is presented each year to the top general agent who demonstrates excellence in field sales management. This is the twelfth time DiCerbo has won the award. His agency, Professional Compensation Planners, is the largest Penn Mutual agency in the country.

Crum & Forster

Crum & Forster of Morristown, N.J., announced that Don Spence has been appointed to the newly-created position of director of e-commerce. He was a regional vice president in Philadelphia.

USI Insurance Services

USI Insurance Services Corp., Glastonbury, Conn., the country's fifth largest commercial insurance and financial services brokerage, has announced the appointment of Douglas J. Rubinstein

a president of one of its subsidiaries, USI Consulting Group. Rubinstein succeeds Brian D. Whitney. USI Consulting is comprised of nine regional offices offering employee benefit consulting and total benefit outsourcing to middle market employers. It has offices in Massachusetts, New Hampshire, New Jersey, New York, Maine, Tennessee and California.

Delta Dental

Susan C. Morris has been named vice president for communications and public policy for Delta Dental Plans Association, the Oak Brook, Illinois-based national network of independently-operated dental plans.

Insurance Times: Mass. Hearing On Policy Rider Fuels Auto Parts Debate March 28, 2000, Vol. XIX No. 7

MARLBORO, Mass. - Auto body repair shop owners are trying to reestablish the carmakers' monopoly that existed before the introduction of competitive repair parts by claiming that generic replacement parts are unsafe, insurers charged at a recent public hearing.

"Body shops get paid a commission based on the price of the repair part they put on a car," said Gerald L. Zimmerman, associate counsel for the National Association of Independent Insurers (NAII). "Before the introduction of competitive repair parts in the early '80s, OEM part markup was as high as 800 percent. Today, they still cost about 60 percent more than competitive parts. Preserving the carmakers' 'silent monopoly' on replacement parts serves only the interest of body shops, not consumers."

The issue of competitive repair parts and their safety was debated March 21 at Assabey Valley High in Marlboro. Speakers included Stephen Oesch from the Insurance Institute for Highway Safety, whose studies show generic auto parts to be safe, and Jack Gillis from Certified Auto Parts Association (CAPA), whose organization certifies generic parts.

Massachusetts Insurance Commissioner Linda Ruthardt asked an obscure state agency, the Auto Damage Appraiser Licensing Board, to review the issue of original manufacturers (or brand name) equipment parts vs. after market or generic parts.

Policy Rider

The state's auto insurance industry's has proposed to offer a policy rider, priced at about \$37, for insureds who want only brand name parts used in their cars' repairs. Massachusetts now requires insurers to use lower-priced generic parts or rebuilt original parts unless a brand name part is available at lower price or the auto being repaired has less than 15,000 miles on it. Ruthardt has asked the appraisers' board, whose members represent auto body shop owners and insurers, to make a recommendation to her regarding the issue.

The Massachusetts Auto Body Association opposes the use of generic parts and the policy rider proposed by Massachusetts

insurers because its members claim that generic parts are unsafe, of inferior quality, and often do not fit well.

Last year, in a hearing in the Transportation Committee on a competitive parts bill, Evangelos Papageorg, a former officer of the Massachusetts Auto Body Association (MABA), went so far as to testify that competitive parts were responsible for "killing, injuring or maiming" people.

"The safety argument simply doesn't hold water, and has been disproved time after time over the years," Zimmerman said. "Most recently, the Insurance Institute for Highway Safety (IIHS) conducted crash tests of hoods. Not surprisingly, IIHS determined that who manufactured the part had absolutely no effect on its performance."

Higher Prices

CAPA's Gillis told the hearing that auto body repair shops make more money on higher-priced brand name parts. Repair shops had been using the generic parts for years, but only began complaining in 1980s when insurers refused to continue paying the higher brand name prices for them, Gillis maintained.

Gillis said that competition from generic parts makers is needed to hold down the costs of auto repairs, otherwise "the person who's going to pay is the consumer."

The argument has been fueled in part by last year's class-action lawsuit verdict against State Farm, in which a jury in downstate Illinois determined that the insurer should pay almost \$1.2 billion in damages for using competitive parts.

"The sad fact is, drivers may soon feel the impact of the State Farm verdict in their pocketbooks," Zimmerman said.

"Because it is no longer allowed to quote generic crash parts on auto repair estimates, State Farm's parts costs were \$4.8 million more than expected in the first full month since it suspended competitive parts use. This may be good news for body shop operators, but it doesn't bode well for consumers, who will end up paying higher premiums across the board if other insurers follow State Farm's lead and stop using competitive parts."