Insurance Times: Commissioner Reider Rides Off Respected Conn.Regulator Exits After 5 Years To Enter Teaching
May 9, 2000, Vol. XIX No. 10

by Mark Hollmer
InsuranceTimes

George M. Reider Jr. never imagined that the insurance business would bring him to China. But after more than 35 years, it finally did.
Reider, Connecticut's commissioner of insurance, traveled there in January as a technical advisor to the U.S. Commerce Department. He briefly visited the Great Wall of China, but spent most of his time in conferences and meetings with Chinese officials, offering advice on how to develop insurance regulation.
Reider said the trip was crucial to the insurance industry both here and around the world.
"China has a tremendous potential economically ... as you see the economy growing, (it) develops a strong need for insurance, and when you have insurance you have to have solid regulation of insurance," he said.
The journey is just one highlight in Reider's five-year career as commissioner of insurance.
And now Reider, 59, is leaving that career and his $107,162-a year post behind on May 5, to take some time off and possibly teach college in the fall. He took on the position after 31 years with Aetna.
The commissioner said it's simply time for him to move on.
"Five years is a significant period of time to be in the public sector," he said. "I look forward at my point in life to (taking) the summer off ... the first
summer vacation since I've had since I went to work at age 14."
Reider, a married father of four sons and grandfather to five children, leaves behind an industry that credits him with making the state a more hospitable place in which to do business.

Industry Praise
"Under his leadership, the Connecticut Department of Insurance has helped to turn the state into a friendlier place for insurers to do business, which benefits consumers by offering more choice," said Jay Jackson, a previous state commissioner and the Connecticut attorney for the National Association of Independent Insurers.
Jackson points out that the department under Reider's tenure reduced the residual auto insurance market from 65,000 policies to less than 5,000.
In fact, Reider points to a number of changes for the better, such as the additional 207 companies now licensed to operate in the state.
"The best medicine is competition," Reider said.
More competition in the auto insurance market has also led to reduced rates over the last several years, he said.
Before Reider came on board, the department faced a backlog of about 100 companies waiting for licensing - some delayed nearly four years. He credits Gov. John Rowland and the Legislature with giving his office more resources to help catch up on backlog. The department has added 40 new positions over the last five years to improve consumer services, he said, and also strengthen its capacity for "financial overview" of companies.
Reider said he's pleased with his office's new continuing education program, which requires insurance producers to update their education every two years to maintain their licenses.
And he's happy that the state survived its National Association of Insurance Commissioners (NAIC) reaccreditation process last January and received "one of

the highest scores in the country ... a very intensive review."
He said the job was sometimes frustrating because there are "times you know you're making absolutely the right decision and yet you know you can still be criticized."
But for the most part, Reider said, he's enjoyed his work.
"It's a very rewarding experience to be able to help ... and protect consumers the Connecticut (Insurance Department) does that job very well."
Reider began his insurance career in 1963, as a claims representative for Aetna. He moved up to claims manager, general manager and then vice president of underwriting for personal lines.
He retired from Aetna in July 1994, as vice president of claims, around the time Gov. Rowland was elected. Soon after, Rowland asked Reider if he'd consider being nominated as the state's next insurance commissioner. Reider initially committed to a four-year term but then stayed after taking on additional responsibilities after being elected an officer of the National Association of Insurance Commissioners. He became president last year.
Deputy Insurance Commissioner William Gilligan was expected to serve as acting commissioner.
Rowland is considering three candidates to replace Reider, according to a spokesperson.

Insurance Times: Agencies Safe From Bank Inroads: Peoples Heritage CEO Says Banks Can't Beat Local Agents On Service
May 9, 2000, Vol. XIX No. 10

by Penny Williams
InsuranceTimes

PORTLAND - Small insurance agencies have less to fear from banks selling insurance than do large direct response and direct writer insurers, says a bank executive who should know.
Peoples Heritage Financial Corp. President and CEO William J. Ryan, whose bank acquired several prominent New England agencies during the past few years, recently told a Maine insurance group that his bank's insurance operations are not a threat to local insurance agencies as long agents can provide better customer service.

No Inroads Made
"I've got to tell you," Ryan told the Maine Chartered Property Casualty Underwriters (CPCU) "we've not had any ability to make inroads into the agencies that are run by local people. There's still a service component to the insurance business where people want to deal with somebody face-to-face. We haven't been able to, and don't want to, break into that.
"You operate on good service and we can't compete with that," the chief executive officer told agents in attendance. "We are certainly a threat for GEICO, State Farm and Allstate, companies that tend to do business in a more global way or do it not with a local agent.

Ryan maintained that New Englanders still value service more than consumers in other states and because of this he expects that small insurance agencies and small banks will always be around.
"I don't see them going away. However, I'm not so sure how much they can grow in the next couple of years since our state isn't growing from a population

standpoint. But I certainly don't see them at risk for going away. If anything, I see the small local bank and the small local insurance agency getting together because of social issues," he said.
Peoples itself has grown to become the largest bank in Maine and New Hampshire, third largest in New England and 24th largest nationally.
Along the way to becoming one of Maine's chief companies, Peoples Heritage purchased Morse Payson & Noyes Insurance Agency in Portland, followed by Catalano Insurance Agency in Methuen Mass. and A.D. Davis Agency in North Conway, N.H. These three insurance agencies write annual premium of more than $160 million.

Further Expansion

And Ryan's not finished expanding. On April 24, Peoples received final regulatory approval to buy Vermont-based Banknorth Group, Inc., a deal valued at about $580 million. This will give Peoples 300 branches in six states and more than $18.5 billion in total assets.
He' not through making inroads into insurance, either.
"We expect to expand the business by buying more insurance agencies probably more in Connecticut, Vermont and upper New York State," he said. "We'll continue to grow that business over the next couple of years because it has been so successful so far. And no doubt we will grow the banking business, too. We plan to become a $30 billion dollar bank over the next few years."
Peoples bought into insurance to make up for the revenues it was losing as its deposit customers migrated to mutual fund companies and loan customers went to non-bank companies. Ryan considers the insurance side successful even though it doesn't have the return on investment that traditional banking products do.
"The insurance business is the best alternative even though the return isn't as high as banking products," he said. "It's a tougher business environment today. We compete with mutual fund companies for our deposit customers and with the Money Store for loan customers.
"What we had that we could make money on was our customers," he said. Peoples has a customer base of about one million.
"The bank decided, 'Let's get into those other businesses and we've done it in a big way,'" he added.
Peoples has seen good growth in both homeowners and automobile insurance; slower growth in commercial lines; little or no growth in life insurance, and no impact on employee benefits as yet Ryan said.
"I still think the employee benefits insurance piece has the potential to be one of the bigger pieces but we haven't even touched the tip of the iceberg there yet," he said.

Different Cultures

The biggest difference Ryan sees between banking and insurance is the culture. He observed that banks move very slowly when making change. "It has been a matter of getting the insurance people to adjust to the slowness of the bank to make the changes we have to make," he observed. "I think the agencies are thrilled with all the potential customers the bank brings, but we have to move very carefully to ensure that we follow the very strict and structured regulations regarding how this pool of people can be used."
Peoples Heritage hasn't always been flying high as it is today. It wasn't too long ago that it teetered on the edge of bankruptcy.
"Today's success," Ryan said, "is all because of those people back in the early '90s who stayed with the company and worked us through these problems. They believed in the company, they saw its potential.
"This is a great turn-around story. It is a great turn-around story for Maine, which has seen six of the eight top companies leave the state in the last 18 months."

Small Companies

While the departure of the large companies isn't necessarily good for Maine, Ryan said it isn't all bad either. He believes there will be an influx of small companies coming to Maine because of the good workforce and the quality of life. It will take five to 10 years, he said, but the small companies will offset the loss of the big companies.

"It will be a dilemma for us for a short period of time, but I think it is positive long term," he observed.

He predicts that the Maine economy will continue to grow at a rate of one to two percent annually - not the growth seen in neighboring New Hampshire with its rate of five to six percent or that of Massachusetts at four percent.

The nation's economic growth "is pretty much guaranteed for the next two to three years," according to Ryan, who maintained that this economy has been tested by the Clinton administration, the war in Bosnia and the oil crisis and has survived all the tests.

"Can it stay this good, this high much longer?" he asked. "No. What goes up must come down. There is a cycle to this.

"However, the message I want to leave you," he told the CPCU group, "is that at the end of the day, I think you will be happy you're here in Maine. I think the economy will continue to grow, not as much as you'd like it to grow, but it will continue to grow. There will be some steps along the way, but I think the global economy probably won't be as big a factor here."

Insurance Times: Pet Project

May 9, 2000, Vol. XIX No. 10

Is 22 too young to start your own pet insurance company?
Charles Gaudet II -
a 22-year-old New Hampshire entrepreneur fresh out of
college - doesn't believe so and he's
got backers who agree.

Insurance Times: Industry Must Change To Win War For Talent

May 9, 2000, Vol. XIX No. 10

by Mark Hollmer
InsuranceTimes

War isn't pretty.

But war is what Constantine Iordanou sees when he looks at today's smoldering-hot job market - the battle between companies to snare qualified employees.

"We are in a war for talent," says Iordanou, president and chief executive officer of Zurich U.S., the domestic arm of the global multi-line insurer and financial company.

"The world doesn't have enough skilled people to go around today. Human capital is replacing monetary capital (in its significance) and if you have it, you win .... You need the right people and you need to engage them."

Iordanou spoke about the current shortage of skilled labor and how to fight it during the annual Connecticut Insurance Day, held April 20 at the Farmington

Marriott. He elaborated further in a subsequent phone interview with Insurance Times.
Iordanou said the shortage of qualified labor in high-technology and financial jobs has become a global problem.
Germany has a shortage of 75,000 high-tech employees, and Spain and France are experience similar numbers, he said. In China, officials have identified a need of 1.4 million more employees with MBAs over the next decade.
The labor shortfall threatens everyone, he said, including the insurance industry.
"We need to attract people and get better at utilizing talent," he said.
To win the war of recruiting qualified talent, companies must attract employees from different industries "and make our world comfortable for them," he said.
"The winners will attract and retain and allow that capacity to go on."
Iordanou urges insurance and financial companies to recruit from "unconventional areas" to maximize their ability to sell products on the Internet or face-to-face.
"We need to be able to bring people in from the banking industry from consumer products-types of companies" and other areas, he said.
But the traditionally conservative insurance and financial industries must loosen up more than they have, he said, in the search for long-term employees.
"If you want to get the best possible talent for information/technologies, a company better have a flexible dress code and environment.
"We've created flexibility at Zurich ... we allow people to work at different times of the day as a matter of routine ... we allow people to dress more liberally ... (with) business-casual attire every single day.
"These are changes of behavior in an industry (that) ... would be considered unacceptable in the past."
And there's great hope for the future, Iordanou said, maintaining that the intermingling of the banking, investment and insurance industries will help to make insurance more attractive to a diverse crop of employees.
But companies that stay the traditional route will have problems.
"You probably will not attract the best and brightest ... you can't afford to compete with other industries that are paying a lot better (if) the populations doesn't view it as a very attractive job.
"Some of the companies are going to be left behind."
Iordanou also spoke about the Internet and the rise of capital ownership, phenomena that have created a "truly unprecedented democratization of equity ownership."
The industry can be a winner within this new economy "if we're willing to transform ourselves."
Zurich has done just that over the last five years, he said, by getting into the capital funds market. Now, the company has become one of the largest asset fund managers in the nation.
Zurich U.S. is a member of the Zurich Financial Services Group, which has offices in 60 countries, reaches more than 30 million customers and has 68,000 employees.

Insurance Times: You don't have to be a rocket scientist to be the CEO of a major company, but Constantine "Dinos" Iordanou is.
May 9, 2000, Vol. XIX No. 10

Iordanou, 50, -- chief executive officer of Zurich U.S. -- holds a degree in

aerospace engineering from New York University. Fresh out of college, he worked for Pratt & Whitney in Hartford as a trainee, with an engineering group designing a 747 jet engine.
Six months later, Iordanou - a native of Nicosia, Cyprus -- left it all behind. "I didn't like the engineering profession as much as I thought I would like it," he explained during a recent phone interview. "I thought there was too much competition within the engineering ranks ... and I would have had difficulty getting top clearance because I was foreign-born."
Iordanou looked to the insurance industry for his professional future in 1977. He joined AIG as a management trainee and stayed with the company until 1987, leaving as senior vice president in charge of casualty for domestic brokerage. After that, he was president of Berkshire Hathaway Group's commercial casualty division. Iordanou joined the Zurich-American Insurance Group in 1992, serving as president of the company's specialty business division. He moved up the ranks to chief operating officer and then chief executive officer of the company's American division.
So why did Iordanou choose insurance?
"I wanted to be in the financial services sector," he said. "AIG was the first company that gave me an offer and I accepted, and the rest is history."
The change is something Iordanou has embraced ever since.
The married father of three daughters jokes that his wife says "my job comes first, the kids come second and she comes third."
"I love what I'm doing," he said. "I'm doing it almost 24 hours a day. I try to have a little bit of balance in between (but) ... the job is in my mind at all times."
Iordanou said he carries a beeper and asks his senior managers to do the same, to keep communication lines open 24-hours a day. The practice isn't as brutal as it sounds, Iordanou insists. It "actually improves the ability to balance" one's life, he said.
In the end, Iordanou said he views his management team as a collaborative effort. Everyone, he said, is working together for a common goal: "for us to be as innovative as Cisco is in revolutionizing the way we do business by using all available tools technology is bringing to us."
He promises to work "relentlessly" over the next five years to achieve that goal.
Mark Hollmer

Insurance Times: Network Not Working?

May 9, 2000, Vol. XIX No. 10

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Insurance Times: W.R. Berkley Envisions Future With Agents, High Tech And Acadia

May 9, 2000, Vol. XIX No. 10

by Penny Williams
InsuranceTimes

S. PORTLAND - Imagine a future where Agency Management Systems (AMS) and other insurance technology vendors do not exist and some insurers pay only 3.5 percent commission.

W.R. Berkley envisions such a future, even as one of his own companies struggles to stay alive in the present.

Berkley, chief executive officer of the corporation that bears his name and that is parent to Maine's Acadia Insurance Co., had a two-pronged message for the Maine Insurance Agents Association (MIAA) meeting here recently. He sought to reassure agents that his company and Acadia are committed to the agency system and to success in New England and Maine, while also emphasizing how technology is quickly changing the industry.

Berkley's speech came on the heels of across-the-board price increases averaging 10 percent and a reorganization at Acadia which saw the company's founding management team, Richard Sawyer, chairman, and Rick Cote, president, replaced on an interim basis by Robert Cole. The moves are part of Berkley's strategy to return to profitability. For 1999, Berkley reported an operating loss of $23.3 million and a net loss of $37.1 million-- financial woes to which Acadia contributed.

"We're not going away. We don't have plans of closing down anything; we don't have plans to close Acadia down. One of the main reasons for the changes we've made is because we have a commitment here and we think that commitment will be even greater because we see much greater opportunities as the market tightens and others withdraw," Berkley told Maine agents.

"We've invested $100 million and lost half of that in the seven years building Acadia," he said. But Berkley insisted that Acadia is in the region for the long haul and is committed to the independent agency system.

Sharing his take on the industry and its future, Berkley told the group that success will be predicated on agency and company utilization of technology to eliminate redundancies and to reduce cost.

"Technology is where we have to go," the CEO declared.

"Technology provides the data and the facts. It shows us the numbers that reflect what is going on in our business. These things all require change on our part and on your part," he said.

He stressed that agencies and companies must eliminate duplication. It makes no sense for agents and companies to both keep copies of the same files, he noted. Agents should have access to all the information their companies have when they need and want it and customers should be kept informed on a real-time basis of what is happening with a claim or a policy, he maintained.

Also, agents must be empowered to obtain actual quotes directly from their

insurers' systems, a development which could render agency systems like AMS obsolete, he added.
Eliminating redundancies and cutting costs will have other effects.
"It means more uniformity of products. You're not going to have quite so many tailor-made things and when you do get them, they will be more expensive because it requires more work," Berkley maintained.
Berkley also envisions a future with Internet insurance companies doing everything electronically, using nothing but independent adjusters and having no loss control. These companies will offer 3.5 percent commission and have an expense ratio estimated at no more than 15 percent. "They are going to be able to cut price and price at some point means something," Berkley warned.
A 15 percent expense ratio is half that of Acadia's, he noted. "We don't have to have a 15 percent loss ratio, but we can't have a 30-plus percent loss ratio," he said. "This vision isn't tomorrow; this vision is three years down the road. But it is going to happen."

Insurance Times: Mass. Adopts Mental Illness Parity Law

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BOSTON - The state will require expanded insurance coverage for mentally ill patients thanks to new legislation Gov. Paul Cellucci signed into law on May 2.
The so-called mental health parity legislation ends insurance limits on many biologically-based illnesses. It also expands outpatient visits for non-biologically based mental illnesses and improves coverage for children with mental health disorders.
The new law will become effective next January 1, and kick in for small group and nongroup health insurance plans a year later.
Under the existing law, patients with mental health disorders are covered by a standard insurance policy for 60 days of inpatient treatment and $500 (eight sessions) for out-patient visits.
But now, coverage will be required without discrimination for biologically-based illnesses including: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, and affective disorders.
Any scientifically-recognized, biologically-based mental disorder appearing in the Diagnostic and Statistical Manual (DSM0 of the American Psychiatric Association is also covered, if also approved by the commissioner of the department of mental health. Mental health benefits for rape victims are also included. Other highlights of the new law:
Patients with non-biologically based mental disorders will have a right to 24 outpatient visits and 60 days of inpatient treatment a year.
Insurers must also cover children under age19 who have any mental, behavioral or emotional disorder covered in the DSM that "substantially" limits how a child functions and interactions socially.
Coverage limits for alcoholism and substance abuse-treatment are lifted if it coincides with treatment for mental disorders.
Consent standards for disclosure of information are now similar to standards used for other medical conditions.

Mass. countersignature repeal advances
BOSTON - A bill that would repeal the countersignature requirement in Massachusetts made it through the state Senate on April 27.

The bill - HB 4883 now returns to the House, which already approved the measure in November. Officials must make sure both approved versions are in synch regarding an unrelated technical amendment.
The measure will likely be enacted, according to the Alliance of American Insurers, which has pursued countersignature reform in the state.
"Eliminating situations in which a resident insurance agent's signature is required on an insurance contract to make it binding facilitates sales of insurance across state lines ... encouraging insurer competition and lowering costs," said Rey Becker, Alliance vice president of property/casualty.
Wyoming became the first state this year to pass countersignature reform, and Alabama is also considering similar legislation, according to the Alliance. Georgia, Louisiana, Nebraska, South Carolina and Utah passed reforms last year. Kentucky, Iowa and Pennsylvania repealed their countersignature laws in 1998.

Conn. BI costs rising faster than nationally
Farmington, Conn. - Sharply rising bodily injury liability frequency is the driving factor in Connecticut auto insurance rates, David Snyder, AIA assistant general counsel told an audience at the Connecticut Insurance Day panel on Automobile Rates and Politics.
"Most of the auto insurance premium dollar goes for liability costs. Of that most is for bodily injury (BI) liability that in Connecticut is not performing well in terms of comparative costs and cost increases," said Snyder.
Since 1993, when Connecticut repealed its no-fault law, the frequency of bodily injury liability claims per 100 cars has risen from 1.04 to 1.60. That is an increase of more than 50% during a time when the national trend was the reverse, a 10% decrease nationally. The BI frequency is highest in Connecticut's urban territories, Hartford - 4.18, New Haven - 3.53, Bridgeport - 3.51. Over the longer haul from 1986,
Connecticut BI claims frequency has increased 135%, while the countrywide increase in these claims is just 12%. This increased claim frequency has driven up the average loss cost per insured car by 80% since 1986, compared to a 45.5% national average. This results in a Connecticut policyholder paying nearly twice the national average for BI liability coverage, $201 versus $104.
Snyder said the increased BI costs differ sharply from all other coverages in Connecticut, which have increased much less rapidly than the countrywide average.
To lower these costs, Snyder said that Connecticut policymakers should look at improving highway safety, improving the graduated licensing laws for young drivers and consider a no-fault or choice program to eliminate nuisance and minor injury lawsuits. All of his recommendations are policy choices that AIA has recommended across the nation.

Insurance Times: Mass. WC Chief Defends Enforcement Record After Report: State Auditor Claims Millions In Fines Uncollected
May 9, 2000, Vol. XIX No. 10

by Mark Hollmer
InsuranceTimes

BOSTON - Hundreds of Massachusetts employers are operating without workers compensation insurance because of a lack of oversight by the state Department of Industrial Accidents, according to a recent state report.

And State Auditor Joe DeNucci, who released the report on April 24, said the inconsistency puts an unfair burden on employers who do pay for insurance.
``Law-abiding employers who carry the required coverage for their employees are placed at a competitive disadvantage because they are forced to pay higher premiums to compensate for those employers who don't follow the law,'' DeNucci said.
DIA Commissioner James Campbell insists his office is doing its job -- contrary to DeNucci's conclusions.
"All fines are under collection," he said. "The difference of opinion is the interpretation of the law."
The audit report contains some highly critical conclusions about how the DIA collects fines and enforces workers compensation laws.
According to the audit, many employers have been allowed to remain open after being cited for not having workers compensation insurance, and the DIA has lagged in collecting fines from violators.
Among the audit's conclusions:
The DIA was forced to reissue 82 stop orders to employers that should have been closed already during one six-month period.
In 1998 the DIA had to write off over $2.1 million in uncollected debt.
During a four-year period, DIA failed to assess or collect fines totaling $22.2 million, DeNucci said.
DeNucci also criticized the current DIA policy of computing the $100-a- day fine up to the day that a violating business buys its insurance. He said state law calls for businesses that do not have workers compensation insurance to be fined $100 per day and given stop work orders until the required coverage is obtained and the fine is paid in full.
But Campbell said his office "does not believe it was the intent of the legislature" to close down a business that way.
Campbell said his office has "effectively closed 20,000 businesses" since he became commissioner eight years ago, and allowed them to open and pay their fines over time.
But if he followed DeNucci's interpretation of the law, Campbell said he'd be affecting "innocent employees" and causing damage to the economy.
"We would have affected the economy in the state if we would have been closing all of these businesses," he said.
Campbell disagrees with DeNucci's calculation of a $22.2 million shortfall in the assessment or collection of fines; he said the number "is more like $4 million and half of that has been collected and the other half is under collection."

Downplays Significance

He also downplays the significance of having to reissue 82 work stop orders to employers that should have been closed. The DIA revisits cited businesses every 60 days, he said, to make sure they've closed. If they remain open, the DIA issues another closure notice "as required by law."
Campbell also points out that the DIA is an administrative agency rather than one that can enforce workers compensation closings, and so the courts must step in on the enforcement end.
He also said the DIA record since he became commissioner eight years ago proves the office is doing a good job.
The agency was handling about 30 stop work orders a year, Campbell said, before he took the commissioner's job in 1992. That number is now up to 3,000 per year, he said.
Fine collections have also increased, Campbell said. The DIA collected $28,000 in fines in 1992. That number jumped to $655,000 in 1999, he said.
"We feel our program is working."
DeNucci did note some positive things about the DIA, including the agency's

progress in cutting case backlog and reducing the time it takes to process workers' compensation claims. The agency also hired a collection agency, he said.
But stricter controls are needed, DeNucci said, so the agency can collect all of the money it's owed.
"It's the Commonwealth's responsibility to make sure that the burden is shared by all employers in an equitable manner," he said.

Insurance Times: Police Help In NJ Crackdown On Uninsured Motorists

May 9, 2000, Vol. XIX No. 10

TRENTON, N.J. (AP) - Police across New Jersey are getting new tools in the battle against auto accident fraud and uninsured drivers, problems that add to already hefty insurance rates for honest motorists.
The state Office of Insurance Fraud Prosecutor last week sent every New Jersey police department and county prosecutor's office a training video, wallet cards listing classic ``M.O.'s'' and other printed material to help officers spot staged accidents and forged insurance cards.
Those crimes ``can cost citizens of New Jersey plenty,'' State Insurance Fraud Prosecutor Edward M. Neafsey tells officers during the training video.

10% Without Insurance
Neafsey also notes an estimated 10 percent of New Jersey motorists - or 400,000 people - drive without insurance.
``This number affects everyone who legitimately pays for auto insurance,'' he said. ``I'm asking for your help in catching potential insurance violators.''
The 11-minute video depicts a state trooper who, after pulling over a female motorist for speeding, has a police dispatcher call the insurance company on her insurance card and learns it is a fake. The woman admits she bought the phony card for $50 from an acquaintance in a bar.
In a second segment, after previously planning the scenario, one driver has rear-ended another and passengers in both vehicles complain of injuries despite minor vehicle damage. They all tell a trooper that they will see their own doctors rather than getting checked immediately.
Neafsey advises officers in such situations to question people separately to catch discrepancies in their stories, get identification from everyone involved and do a thorough investigation.
``Local police officers stand on the front line in detecting many types of insurance fraud,'' Neafsey says. ``Their actions can strongly impact the quality of ensuing investigations.''

In recent years, insurance companies have detected a number of large rings operating in different parts of the state that staged accidents to collect settlements.

Last October, for example, Allstate Insurance Co. filed a lawsuit in Camden County against participants in a 172-person ring that allegedly staged more than 100 fraudulent crashes over two years. The same day, the company sued 89 people in Morris County it accused of participating in staged accidents in Perth Amboy.

In another case, Allstate last July sued 67 doctors, businesses and individuals accused of participating in a huge insurance fraud ring that cost the company

more than $14 million.

Such rings typically use ``runners'' paid $400 to $800 to stage auto accidents and fake neck and back injuries. Chiropractic clinics in the ring then bill several insurance companies for the same treatment or file false claims for treatment that never occurred.

Along with tips about how to interview accident participants, printed materials in the antifraud kits tell officers to note whenever damage is minor or nonexistent, when the injuries victims claim aren't consistent with the area of the impact, whether the vehicles have prior damage or are old, and whether they think the accident looks staged.

The kit also points out common mistakes on forged insurance cards and includes a 30-page list of insurance companies, their subsidiaries and contact numbers so dispatchers can verify that coverage is current.

``Working together with local police departments can be an important tool in the statewide effort to combat insurance fraud,'' said Attorney General John J. Farmer Jr. ``The more resources we can provide in this fight, the better chances we have of making a real difference.''

On the Net: NJ site to report or learn about insurance fraud:
http://www.njinsurancefraud.org

Insurance Times: Florida Charges Racial Bias In Burial Insurance Sales: Blacks Paid More Than Whites, Agency Charges
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TALLAHASSEE, Fla. - State insurance regulators have uncovered evidence that thousands of African-American policyholders in Florida are paying more than whites for the same insurance coverage and have filed an order accusing one of the nation's major life insurers of continuing the racially discriminatory practice.
Florida State Treasurer and Insurance Commissioner Bill Nelson filed a cease-and- desist order directing American General Life and Accident Insurance Co. to stop collecting higher premiums from African Americans based solely on their race.
The complaint also orders the Nashville, Tennessee-based insurer to take "corrective action" that could include refunds of the racially discriminatory portion of premiums paid by affected policyholders. Details of a corrective action plan must be given to regulators by the company within 20 days.

Ongoing Investigation
The complaint is the first to come from an ongoing investigation launched last year by the insurance commissioner's office into the sale of industrial life, or so-called burial insurance -- a small-value policy sold largely to minority and low-income consumers. Most insurance companies say they don't sell such policies anymore. But in the past, some insurers charged different rates based on race. Such pricing was generally abandoned on new sales in the 1960s, but some companies never eliminated or reduced the higher premiums charged to African Americans who purchased policies prior to the change, Nelson said.
With American General alone, he said, there may be as many as 97,500 existing

policies in Florida that were sold on a discriminatory basis. Many of these originally were sold by three companies later acquired by American General. Some of the African Americans involved now have paid up policies, but thousands of others still are paying premiums that range from 7-percent to 33-percent above what whites were charged.

"By continuing to collect the higher premiums a company is perpetuating racial discrimination," Nelson said. "That's why I'm serving American General with legal notice that there must be swift and full corrective action."

In recent weeks, Department of Insurance lawyers have been in talks with American General aimed at finding ways of correcting racial and other inequities associated with industrial life insurance.

More Than Value

Besides the race issue, Nelson said, many policyholders have paid more in premiums than the actual policies are worth. For example, a Tallahassee woman's aging mother has paid $3,000 into one burial policy that will provide just $500 when she dies.

Other issues include the sale of multiple policies to consumers who stood to benefit more from a single, regular life insurance policy, and about $700,000 a year in Florida death benefits that go unpaid in part because the insurer says it lost track of policyholders.

Although the talks stalled, Nelson said he's still hopeful American General will agree to do what is in the best interest of policyholders, whose average age is 59. The company has 20 days from receipt of Nelson's complaint to respond.

Meantime, the insurance department's investigation into American General and four other insurers is continuing.

Evidence of continuing discriminatory premium collections surfaced in response to subpoenas issued by Nelson last October. Among the records sought from five insurers, including American General, were any policies having different premium schedules based upon the race of the insured, and all documents identifying the steps taken to remedy any such discriminatory activity.

Five Insurers

The five insurers hold much of the $900 million worth of 1.2 million burial insurance policies currently in force in Florida. Besides American General, the subpoenas seeking records that date back to 1959 went to United Insurance Company of America, Capital Security Life Insurance Co., Liberty National Life Insurance Co. and Life Insurance Company of Georgia.

The probe follows efforts to ban industrial life insurance sales in the state failed the past two years.

American General issued a statement decrying the practice and vowing to work "hard to resolve this issue equitably and responsibly."

Insurance Times: Premier HMO Auto Discount Awaits Further Rate Hearings

May 9, 2000, Vol. XIX No. 10

by Mark Hollmer
InsuranceTimes

Premier Insurance of Worcester is seeking a 15 percent discount for customers who purchase the company's proposed managed care endorsement with their auto insurance policy.

The discount would affect Premier policyholders' personal injury protection and

medical payment premiums on their auto policies. Standard personal injury protection covers up to $8,000 in medical services, wage loss and related services.
Company representatives presented their proposed discount at a Division of Insurance rate hearing held on April 18.
Next, the state attorney general's office and the state rating bureau have the chance to file their recommended discount for the endorsement, which could be lower or higher than Premier's number.
Those filings are due by early June, and then another rate hearing should be held a few weeks later, said Susan Scott, general counsel for Premier.
The recent Premier hearing is the latest step in an ongoing saga that dates back to January 1996.
Back then, Premier requested a managed care endorsement which Commissioner Linda Ruthardt approved without a hearing.
But the Massachusetts Academy of Trial Attorneys sued on two counts. MATA argued the endorsement interfered with the no -fault statute established by the legislature, and that Ruthardt had no right to do so. The organization also claimed the endorsement approval violated public policy because it was granted without a public hearing, according to MATA counsel Frank Corso.
Ruthardt suspended her approval of the measure in response to the suit, and her office has held hearings ever since.

Use Own HMO

Premier's filing would give policyholders the 15 percent discount on personal injury protection and medical payments coverage as long as they buy the endorsement under which they agree to use their own HMO carrier to handle auto-related injuries. If they don't have an HMO, they agree to use a Preferred Provider Organization approved by the Division of Insurance.
The filing is different than the one Premier originally submitted in 1996. That version gave the same discount to policy owners if they bought the endorsement, but customers would have been mandated to use a specific PPO contracted with Premier.
Premier revised its endorsement based on an unrelated Supreme Judicial Court decision last year involving personal injury protection coverage. The decision requires auto insurance policyholders to use their HMOs for personal injury medical needs costing more than $2,000.

Insurance Times: Federal Report: Safety Engineers Voice Views Over Ergonomics Standards

May 9, 2000, Vol. XIX No. 10

ASSE urges OSHA to develop a reasonable standard but leave the social issues and workers comp reengineering to existing federal and state laws and regulations

WASHINGTON - At a Congressional hearing recently, a representative of the American Society of Safety Engineers (ASSE) said the single incident trigger and its interference with established state workers compensation systems are just some of the components included in the Occupational Safety and Health Administration's (OSHA) proposed ergonomics standard that are of major concern.
"We believe there needs to be an ergonomic standard," John Cheffer, CSP, and Chair of the ASSE Governmental Affairs Committee testified at the House Small Business Committee's Subcommittee on Regulatory Reform and Paperwork Reduction

hearing on OSHA's proposed ergonomics standard and its impact on small business. "However, ASSE is concerned that the flaws in the proposed rule and its complexity with respect to small business entity compliance may result in the rejection of the entire standard."

Not only did Cheffer express a need for an ergonomic standard, but outlined several major concerns that must be addressed before moving forward with the OSHA proposal. And sparked by the possibility that the current negative debates being waged countrywide on this issue could result in the standard being totally rejected, noted that the ASSE has provided OSHA with a counter proposal, based on input from its 33,000 safety professional members, which offers a more reasonable and user friendly approach to the control of workplace musculoskeletal disorders and ergonomic exposures than the current OSHA proposal.

Small Business Concerns

"With respect to small business issues, a key question involves the cost and complexity of performing an ergonomic analysis, "Cheffer testified. "OSHA has provided insufficient information to enable the small business owner or operator to understand the ergonomics issue and the proposed standard, or to determine what actions must be taken in order to identify and correct ergonomic hazards. ASSE is at a loss to see how a small business employer without specialized training will be able to use the standard to prevent work- related musculoskeletal disorders (WMSDs)."

The proposed OSHA ergonomics standard would require employers in manual handling and manufacturing operations to implement ergonomics programs in their workplaces. However, the provisions of the standard could be triggered in any workplace (agriculture, maritime operations and construction industries are not included in the proposed rule) so long as one musculoskeletal disorder (MSD) is reported. MSD's are associated with repeated trauma, including carpal tunnel syndrome and other conditions that result from repetitive motions. They are also known as cumulative trauma disorders.

Cutting- Edge Programs

"Many of ASSE's members, who work for all types of industries, have developed and implemented cutting edge ergonomic safety programs that have led to significant decreases in the number of workplace MSDs," Cheffer continued.

The ASSE is urging OSHA to develop a more reasonable standard which enhances occupational safety and health, and leave the issue of payment for rehabilitation, social issues and workers compensation reengineering to the existing federal and state laws and regulations governing these areas. "We have concerns about the apparent social engineering agenda contained in the current OSHA proposal which overshadows the prevention aspects of the standard," Cheffer said.

The ASSE also believes that the 'one case' trigger called for in the standard is poor policy because many ergonomic problems arise off-the-job and in the absence of a clear triggering incident, getting at the root cause is extremely problematic. If the cause is not in the workplace, trying to fix the workplace will not reduce or eliminate injuries.

The ASSE urges OSHA to promulgate this as a safety standard, not as a health standard as they are proposing to do and believe that ergonomic injuries should not be treated in a different manner than other workplace injuries.

"Most ergonomic problems cannot be corrected through low-tech solutions such as having an employee stand on a box, or propping up a computer monitor with a phonebook as OSHA has suggested," Cheffer testified.

ASSE 's 33,000 members manage, supervise and consult on safety, health and environmental issues in industry, insurance, government and education nationally and globally.

Insurance Times: IIAA Optimistic States Will Beat NARAB Deadline With Reforms

May 9, 2000, Vol. XIX No. 10

WASHINGTON - It is unlikely that the National Association of Registered Agents and Brokers (NARAB) proposal will ever come into existence, Independent Insurance Agents of America (IIAA) spokesman Ronald A. Smith, CPCU, told a Senate hearing last week.

The Senate Banking Committee's Securities Subcommittee was hearing public testimony from IIAA and other industry groups about the impact NARAB is having on reform of state-based agent licensing.

"IIAA is optimistic that the states will achieve the level of reform required by Congress and implement a licensing system that is in fact better than that offered by the NARAB provisions," testified Smith, president of Smith, Sawyer & Smith, Inc. in Rochester, Ind. and an IIAA past president.

"NARAB offers the promise that effective licensing reform-implemented either by the states or through the creation of NARAB-may finally be imminent. IIAA prefers that these reforms come from the states and is doing its best to see that state licensing reciprocity is enacted by a majority of the states."

The IIAA spokesman told the senators that the association is a staunch supporter of state insurance regulation but is mindful that there is room for improvement in the current state-based regulatory system, particularly in the area of state licensing of insurance agents.

"There are some very real problems with the current multi-state licensing process. As agents and brokers obtain growing numbers of nonresident licenses, our members increasingly struggle to stay on top of the required paperwork and clear the logistical and bureaucratic hurdles that are in place today," said Smith.

The NARAB provision was included in the Financial Services Modernization Act (also called the Gramm-Leach-Bliley [GLB] Act) that was enacted last November. The provision requires the creation of the insurance agent-licensing clearinghouse if 29 states-do not enact licensing reciprocity by Nov. 12, 2002.

In IIAA's estimation, the National Association of Insurance Commissioners (NAIC) and individual state insurance departments have begun to respond to Congress's NARAB message and are making progress toward heading off the proposed agency's creation.

Most notably, the NAIC recently approved a new agent licensing model law-the Producer Licensing Model Act-that will serve as the starting point for agent licensing reform in every state and will promote uniformity and reciprocity in the licensing arena.

"The NAIC model contains provisions that allow a state to become NARAB-compliant by establishing the requisite level of reciprocity," described Smith. "While it is not a perfect proposal, the model act makes great strides in the effort to enhance, improve and streamline the agent licensing process, particularly in the area of nonresident licensing."

States have 31 months -- or just two legislative session-- to enact licensing reciprocity or uniformity,noted the IIAA spokesman.

Despite possible obstacles, IIAA believes the states are up to the challenge and will take the steps necessary to forestall establishment of this new federally created entity.

Insurance Times: "Oracle Of Omaha' Buffet Faces General Re, GEICO Downturns

May 9, 2000, Vol. XIX No. 10

by Joe Ruff
Associated Press

OMAHA, Neb. - Billionaire Warren Buffett was be able to tell shareholders in person last weekend what he already has said in print: his company had its worst year ever and he blames himself for the performance.

Last weekend's annual meeting of shareholders in Berkshire Hathaway was expected to attract 12,000 investors and followers of Buffett, one of the world's richest men, who has made the gatherings a circus-like event.

Companies in which Berkshire has holdings lay out their wares, including Dairy Queen, Coca-Cola, See's candy and Dexter shoes. Stockholders, some of whom have attended for decades, come to meet old friends and listen to Buffett crack jokes and talk about investment strategies.

In Berkshire Hathaway's annual report released in March, Buffett - known as ``the Oracle of Omaha'' - said 1999 was his company's worst in its 35-year history.

``Even Inspector Clouseau could find last year's guilty party: your chairman,'' Buffett said.

Facing shareholders, Buffett probably will lay it on the line again, said Andrew Kilpatrick, a stockbroker from Birmingham, Ala., who wrote ``Of Permanent Value, The Story of Warren Buffett.''

Shareholders will be understanding, Kilpatrick said, because people who stick with Buffett know he picks good investments and stays with them.

``I bet he walks out to a standing ovation and then gets some tough questions,'' Kilpatrick said.

Buffet Will Work Through

Longtime shareholder and retired stockbroker Bob Soener of Omaha said Buffett's investments helped him put seven children through private school and college. He believes Buffett will work through the tough year.

``The cream always goes to the top,'' Soener said.

Buffett has some climbing to do. Berkshire's earnings dropped 42 percent in 1999, to $1.6 billion from $2.8 billion the year before. Berkshire's stock, the most expensive on the New York Stock Exchange, fell 20 percent last year.

At the same time, the stock market soared, including a 19.5 percent increase in Standard & Poor's 500.

Berkshire Hathaway's Class A stock gave up early gains and closed down $100 at $59,300 a share Friday on the New York Stock Exchange. While that's almost 25 percent below the 52-week high of $78,600, it also is 45 percent above its 52-week low of $40,800.

Berkshire's main business -insurance - struggled, particularly because of losses in one of the largest reinsurers in the world, General Re Corp. Huge payouts on claims from earthquakes and storms contributed to an $897 million underwriting loss.

GEICO's Profits

Auto insurer GEICO's underwriting profit also fell last year and probably will be weak again in 2000, although GEICO's investment in marketing is paying off, Buffett said in his annual report.

Buffett is warning stockholders that his company will not outperform the stock

market as dramatically as it has in the past. Prices are higher for businesses and stocks, Buffett said, and Berkshire is so huge that if it makes a new investment it would have to be among a limited number of big businesses to have any major impact on Berkshire's fortunes.

General Re is raising its rates, Buffett said, and barring any new catastrophe, its underwriting losses should fall considerably. However, Buffett said, General Re probably will have an unsatisfactory year in 2000.

Some core investments for Berkshire, like Coca-Cola, did not perform as they have in the past, Kilpatrick said, and General Re suffered through extraordinary claims, including earthquakes in Turkey and Taiwan and winter storms in Europe.

Kilpatrick said he believes General Re will recover and provide the investment money that Buffett wants. As Buffett warned, it will not happen overnight, he said.

``It's still a big ship and it will be a slow turn,'' Kilpatrick said.

Insurance Times: Opinion Exchange: Editorial Opinion Blame Game

May 9, 2000, Vol. XIX No. 10

Rural residents pay a higher percentage of their income for their health insurance than their city cousins, yet they are less likely to blame insurance companies for recent increases in health premiums.

While there is little consensus on preferred reforms for the health care system, there is wide consensus that consumers should have more choice among health insurance plans.

Those were among the key findings of a survey commissioned by Communicating for Agriculture & the Self-Employed (CA) and conducted by Strategic Research Group of Minneapolis. CA is a national non-profit association that provides benefits and services for more than 100,000 independent businesses and their families.

Some 900 urban, suburban and rural households across the USA were randomly surveyed.

"The survey results would appear to confirm there is a sharp divergence of opinion on how to best improve health care access and keep costs affordable. We are a long, long way from a national solution on who and what is to blame and how to fix it," said Wayne Nelson, President of CA.

"However, there appears to be strong belief in the need for choice and a range of health insurance options available to consumers. And there is wide support for the idea of using tax credits to help those who can't afford health insurance, a concept now gaining more favor in Washington."

The survey found:

Seventy one percent of respondents said their health insurance premiums had recently increased, and 14 percent said they had recently dropped their health insurance because of higher costs.

But survey respondents differed on whom they blame for the cost increases and on what solutions they would favor to reform health insurance.

When asked who is most to blame for rising health care costs, suburban and urban respondents tended to blame insurance companies most, while rural residents blamed doctors and hospitals for increasing costs.

Rural residents were more likely to pay for their own health insurance, and paid a greater percent of their income to get it. Suburban residents, while claiming the highest income of the three groups, also claimed to pay the least amount of their household income for health insurance.

Only 11% of Democrats thought government rules and regulations were driving up health care costs, compared to 15% of Republicans, and -- surprisingly -- 26% of Independents.
Overall, 89% of respondents, almost equally among all groups, favor of giving consumers more choice choosing the type of health plans they can buy, including plans that would reduce the level of coverage to make them less costly.
Seventy three percent of respondents said they support giving tax credits for people who can't afford insurance to address the rising level of Americans without health insurance protection.
Rural residents were the strongest critics of a plan to replace the current health care delivery system with a government-run plan, like in Canada. Republicans also opposed this concept. Democrats and suburbanites were most likely to favor this plan, as were women.
There is little awareness of the health care proposals of the Presidential candidates, with 85 percent overall saying they did not know enough about them to have an opinion, and 9 percent admitting they didn't know the candidates had health care proposals. The results were virtually the same among Republicans, Democrats and independents.

"Some of the results were surprising," observed Jeff Smedsrud, of Strategic Research Group. "We did not anticipate the insurance companies to be viewed as the culprit. In reality, the companies pass rising medical costs, such as high prescription drug costs, and many of them have been losing money recently. But consumers do not see it as such. This should serve as a wake-up call for the insurance side of the health care industry. Unless they begin to effectively tell their side of the story, they face the likelihood of greater scrutiny by the American people, Congress and regulators. Insurance companies have faced greater regulation over the past 10 years, and analysts now point out it has not lowered costs for consumers. It has raised costs and contributed to the rising number of uninsured. "
"The results tell us several things, said Nelson. "First of all, when Congress considers reforms it is clear that 'one-size-doesn't-fit-all'. The impact of rising health care costs hit people in different locations in unique ways. Congress should especially consider that if you live in a rural area you are more likely to pay for your health insurance, and may be more likely to pay a greater percentage of your household income for your health premiums.
"Second, it suggests that there is overwhelming support to give consumers themselves greater say in how they design and pay for their health insurance plans. In this Internet-age of individual empowerment, consumers believe they can choose for themselves, and they don't want 'Big Brother' to pick their health plans for them.
"And last, it reminds us that the growing number of uninsured Americans is a direct result of the rising costs of health care. Access to health insurance may still be a problem for some, but the major reason more and more Americans are uninsured is that they cannot afford the coverage. And the costs increase are not entirely caused by the insurance industry -- the causes are often the very factors -- rising drug costs and greater government intervention -- that consumers are not eager to blame."

Insurance Times: Study: Men More Likely Than Women To Be Hurt On The Job
May 9, 2000, Vol. XIX No. 10

A new study by the National Council on Compensation Insurance, Inc. (NCCI)

concludes that men-particularly unmarried men-are more likely than women to be seriously hurt on the job.
Female workers, on the other hand, file more carpal tunnel, mental stress, and workplace violence and assault claims with their workers compensation insurers.
The study, titled "Gender in Workers Compensation Claims," is based on scientific analysis of NCCI's Detailed Claim Information (DCI) database-a massive collection of individual claim information reported on workers compensation injuries by insurers throughout the nation. Additional data was provided through the Current Population Survey (CPS) published by the United States Department of Labor.

Major Findings
Among the study's findings:
Fully two-thirds of all lost-time claims in workers compensation systems are filed by male workers
While male workers file more claims, female workers file more carpal tunnel (67.5%), mental stress (63.1%), and occupational disease and cumulative injury claims (over 50%)
Females file more workplace violence and assault claims
Women are less likely to be involved in on-the-job motor vehicle accidents (23.6%)
Males-particularly single males-are significantly more likely to suffer traumatic, permanent and fatal injuries
Older workers who are injured at work are more likely to be female
The study further concludes that the gender composition of a particular workplace contributes to injury rates. For example, the risks of on-the-job injury to women are significantly lower in female-dominated occupations. Injury rates for women working in male-dominated professions increase, however, but still remain below the rate of injuries to men in the same environment.
"As the leading workers compensation information company in the nation, we feel it is important for states and employers to have an understanding of who is being hurt and how," said NCCI president and CEO Bill Schrempf. "Understanding the nature and composition of workplace injuries may lead to better workplace safety and accident prevention methods-a win-win development for the workers compensation industry, for employers and for employees alike."

Insurance Times: Human Resource Managers Play Role In Managing Workers Comp
May 9, 2000, Vol. XIX No. 10

WC consultant Brook stresses importance of educating human resources managers who are battling tight job market of the implications of hiring the 'wrong' employees

by Mark Hollmer
InsuranceTimes

The red-hot job market may be the sign of a booming economy but the shortage of qualified employees is indirectly increasing workers compensation costs, an industry expert said recently.
"Companies are ... forced to hire people that five years ago they wouldn't even

consider for a job," said Bonnie Brook, co-founder and president of Stephenson & Brook of Marblehead.

'Shouldn't be Working'

As a result, Brook said, those employees are fueling an increase in workers compensation claims - because their bosses are lowering standards and "hiring people that shouldn't reasonably be working."

Brook's company works nationally to help client companies control their workers compensation costs. She spoke about the issue on April 25, during the Mutual Underwriters Association of New England dinner in Dedham, Mass.

Working with a company's human resources manager is a major step toward establishing better loss control over workers compensation claims, Brook said.

A human resources manager must individually consider the cost benefits of every potential employee in detail, she said, even though the greater drive may be to fill a vacant position at all costs.

"Yes, you have to keep the shift running and the store open, but if workers compensation is up 100 percent, it doesn't make sense" to hire someone with a larger insurance risk, she said.

In addition, Brook said, employers and their human resources managers should create a stable, long-term environment to reduce turnover.

Companies with lower wages and benefits and corresponding high turnover, she said, naturally experience higher workers compensation claims. She added that those claims often include fraud cases, such as when a person is able to return to work but does not.

Stable Workforce

By contrast, an organization with a stable workforce usually deals with a lower rate of claims, Brook said, "particularly where fraud is involved."

Meanwhile, as employers deal with rising workers compensation costs, Brook sees experience modifications beginning to climb as market conditions harden.

In general, Brook said both business owners and brokers need more education detailing the workers compensation insurance process.

"The lack of education is still a large factor in (not) being able to keep risk down and exposure down," she said.

Learn How

As a result, Brook said, many employers don't know how to manage open claims, loss runs or their experience modifications.

In the end, it is in the employer's best interest to learn how workers compensation insurance actually functions, Brook said.

"There is financial motivation for every piece of workers compensation, and if (employers) don't learn how to manage it, they are the ones who will be losing," she said.

Brook's firm has been able to reduce clients' workers compensation costs by 50 percent. Stephenson & Brook works with both employers and insurance brokers.

Insurance Times: Government Survey Reveals What Workers Lose Days At Work Due To Illness Or Injury And Why

May 9, 2000, Vol. XIX No. 10

A total of 1.7 million injuries and illnesses that required recuperation away from work beyond the day of the incident were reported in private industry workplaces during 1998, according to a survey by the Bureau of Labor Statistics,

U. S. Department of Labor. The total number of these cases has declined in each year since 1992. In contrast, the number of injuries and illnesses reported with only restricted work activity rather than days away recuperating has increased during this same time period by nearly 70 percent, to over 1,000,000 cases in 1998.

Since 1993, truck drivers have experienced the largest number of injuries and illnesses with time away from work.

The survey shows that more than 4 out of 10 injuries and illnesses resulting in time away from work in 1998 were sprains or strains, most often involving the back. The number of sprains or strains cases declined by nearly 26 percent from 1992 to 1998, which was about the same as the decline for all cases. However in 1998, the overall decline in the number of injuries was not observed in cuts and lacerations, which increased from 1997 by 3 percent.

Insurance Times: Worker Traits: Following Are Some Highlights Of The 1998 Findings For Various Worker Traits

May 9, 2000, Vol. XIX No. 10

Following are some highlights of the 1998 findings for various worker traits:

Men accounted for two out of three of the 1.7 million cases, a proportion somewhat higher than their share (59 percent) of the hours worked by all private wage and salary workers.

Workers aged 24 and under accounted for 15 percent of the cases and 14 percent of the total hours worked by all private wage and salary workers. Workers aged 25 to 44 accounted for 56 percent of the cases and 55 percent of the hours worked. Workers aged 45 and older accounted for 27 percent of the cases and 30 percent of the hours worked.

Operators, fabricators, and laborers led all other occupational groups, accounting for 42 percent of the case total. This group includes truck drivers; laborers, nonconstruction; construction laborers; assemblers; welders and cutters; and stock handlers and baggers. Together, these six occupations accounted for 371,000 injuries and illnesses with time away from work.

Almost 6 out of 10 workers had at least a year of service with their employer when they sustained their injury or illness. Indeed, over a fourth had over 5 years of service, suggesting that many experienced workers incur lost worktime injuries.

Insurance Times: Disabling Condition

May 9, 2000, Vol. XIX No. 10

Case characteristics help identify the disabling condition resulting from the lost worktime case and how the event or exposure occurred.

Sprain and strain was, by far, the leading nature of injury and illness in every major industry division, ranging from 34 percent in agriculture, forestry, and fishing to 51 percent in services.

The trunk, including the back, was the body part most affected by disabling work incidents in every major industry division, except for agriculture, forestry, and fishing. Most other injuries and illnesses were to upper or lower extremities.

Overexertion while maneuvering objects and contact with objects and equipment led all other disabling events or exposures, cited in about 15 to 40 percent of the cases in every major industry division.

No one source of injury or illness stood out, although the following three had roughly 15 percent each of the case total: floors and other surfaces, worker motion or position, and containers

Insurance Times: FUTURE WORK: Changes In Work Bring New Risks
May 9, 2000, Vol. XIX No. 10

Regardless of the industry, occupation, or business, new technologies can create new problems as well as new solutions. Mechanization of coal mining, for example, brought higher levels of respirable dust, creating greater potential for cases of silicosis and black lung disease but fewer injuries from accidents such as mine collapses. Increased use of diesel-powered equipment in underground mines can mitigate some safety problems associated with using electric equipment but poses a host of other health questions deserving examination. Increased mechanization also increases a miners potential for work-related hearing loss.

Workers in other settings experience analogous problems. Closed office buildings and modern cooling and ventilation systems allow for comfortable working conditions but they also contribute to indoor air quality problems ranging from Legionnaires disease to illness caused by second-hand tobacco smoke. Computer-chip manufacturing may expose workers to many exotic chemicals whose long-term impact on workers is not yet known. These are but two examples of the health and safety issues needing attention by employers, workers, and government as work environments change and new technologies emerge.

Workplace fatalities have plummeted in this century. In some cases, specific occupational diseases such as byssinosis (brown lung disease) in the cotton textile industry have been virtually eliminated. Young workers are also safer than ever before. Cooperation among workers, employers, insurers, unions, and government has been a critical element in many of the successes in workplace protection. But challenges remain.

Each year sees more than 6,000 fatalities, over 6 million new injuries or diagnoses of occupational illness, and tens of thousands of deaths from occupational diseases. While new technologies can give rise to new hazards, they can also help identify problems and provide solutions.

Technology has already provided the workplace safety and health effort with

tools that could not have been imagined 100, 50, or even 10 years ago. Future challenges may be more complex than those confronted in the past, requiring creative approaches and vigorous effort. There is no doubt that workplaces can be made safer and more healthful for workers in all industries if we meet the considerable challenge of fostering workplace cultures that view safety and health as important.

Insurance Times: Societal Problems

May 9, 2000, Vol. XIX No. 10

One million workers suffer violent assaults each year, according to Department of Justice statistics. In a single year, the workplace total included 615,000 simple assaults, 264,000 aggravated assaults, 79,000 robberies, and more than 51,000 rapes and sexual assaults - a level of violence that greatly exceeds that of other countries. Robberies and other crimes are a primary motive for workplace homicide, accounting for 79 percent of the approximately 1,000 violent workplace deaths which take place yearly. Sales workers, taxi drivers, and law enforcement officers are particularly at risk. About 70 law enforcement officers are killed each year in the line of duty. A much greater share of women than men are victims of workplace homicide.

While violent crimes are decreasing in the late 1990s, the overall level of workplace violence is still high, and it will not disappear in the near future. Workers and employers will continue to seek effective protective measures. The Department of Labor has published guidelines on workplace violence for healthcare and social service workers and recommendations for the prevention of violence in late-night retail establishments. These recommendations adapt the generic safety program approach to these occupations and workplaces. The Department encourages employers to include workplace violence in their ongoing safety and health program efforts.

Motor vehicle accidents also claim the lives of a large number of workers. These accidents are the leading source of work-related fatalities, accounting for 24 percent of all workplace fatalities in 1998. However, employers can implement seatbelt-use policies and offer training in safe driving techniques to help mitigate this problem.

Employers who have control over vehicles at a worksite can also implement effective traffic control, maintain vehicles in safe operating condition, and ensure that warning signals, such as backup alarms, are fully functional. Road construction companies can install barriers and work with local law enforcement officials to encourage enforcement of speed limits in work areas.

From the U.S Department of Labor FutureWork Report

Insurance Times: Musculoskeletal Disorders

May 9, 2000, Vol. XIX No. 10

The U. S. Department of Labor defines a musculoskeletal disorder as an injury or disorder of the muscles, tendons, ligaments, joints, cartilage, and spinal discs.

Nearly 593,000 musculoskeletal disorders were reported, accounting for more than one out of three of the injuries and illnesses involving recuperation away from work.

Manufacturing and services industries each account for 26 percent of musculoskeletal disorders, followed by retail trade with 15 percent.

Three occupations -- nursing aides, orderlies, and attendants; truck drivers; and laborers, non-construction -- together account for one out of five musculoskeletal disorders. Injury and illness severity.

Insurance Times: Lost Work Days

May 9, 2000, Vol. XIX No. 10

The median number of lost workdays for all cases was 5 days in 1998, with a fourth of the cases resulting in 21 days or more away from work. The survey also found the following patterns:

Among major disabling injuries and illnesses, median days away from work were highest for carpal tunnel syndrome (24 days), fractures (19 days), and amputations (18 days).

Repetitive motion, such as grasping tools, scanning groceries, and typing, resulted in the longest absences from work among the leading events and exposures - a median of 15 days.

Truck drivers had the highest median days away from work (10 days), followed by electricians, plumbers and pipe fitters, and public transportation attendants (each with 8 days). Injuries to the wrist and knee resulted in the longest absences from work - a median of 11 and 10 days, respectively.

Insurance Times: Conn. Legislative Session Ends With Mixed Insurance Results

May 9, 2000, Vol. XIX No. 10

Measures addressing flood insurance requirements of lenders and Social Security offsets for auto benefits pass but commercial deregulation, others go nowhere

by Mark Hollmer
InsuranceTimes

HARTFORD - The final days of the Connecticut legislative session last week produced mix results for the insurance industry, according to state lobbyists. While there were some successes -- like changes in underwriting guidelines --

some saw the session as an excuse to keep things unchanged during an election year.

'Little Happened'

"Relatively little happened in this session ... (there were) a number of bills that never really went anywhere," said Gerald Zimmerman, associate counsel with the National Association of Independent Insurers.

Others saw success in the bills the Legislature did not pass.

"There were several (bills) in the workers compensation area, including (bills regarding) medical records, privacy standards for bill payment ... and other benefits bills which were all killed and this will keep the system in balance," said Suzanne Bump, assistant vice president of state affairs with the American Insurance.

"Likewise," she said, "there were auto industry-related matters that did not advance and so those are wins for the industry."

Gov. John G. Rowland either signed or was expected to sign a number of insurance-related bills, but commercial lines deregulation didn't make it through the Legislature. The industry is pushing for the change nationwide, but the move is controversial in Connecticut where companies support the measure but agents oppose it.

"That bill was not killed but it was a bill that we had sponsored. The prognosis didn't look good and we didn't want to subject it to further amendments, (so) we did not push the bill beyond the Insurance Committee," Bump said.

Warren Ruppar, executive vice president of the Independent Insurance Agents of Connecticut, said the association was glad the commercial lines deregulation bill did not move forward. The IIAC, he said, "had difficulty agreeing with the need for deregulation of commercial rates and forms at the level the legislation was proposing.

Other States

"We've looked at other states that passed deregulation laws and have not seen direct changes in the marketplace," he said.

Bump said she was particularly upset about House Bill 5144. It will keep insurance companies from reducing plaintiff claims under uninsured and under-insured motorist coverage by whatever Social Security disability or other federal benefits a plaintiff gets. At press time, Rowland was expected to sign the bill into law.

"It's more costly to drivers," she said.

On the other hand, Ruppar said he was happy about at least one new piece of legislation - a bill to assist home owners regarding flood insurance..

According to Ruppar, the new law prohibits the lender from requiring flood, fire or extended coverage insurance, or any combination of the three to equal the amount of a mortgage. The cost has to be the replacement cost value instead, he said.

"It's better for consumers."

Zimmerman said he was hoping the Legislature would have approved a bill dealing with self-audit privilege (The bill did not make it through.) It would have allowed insurance companies to police themselves and correct problems they find without the risk of being sued.

Major Bills' Status

The Legislative session had until midnight on May 3 to finish its business. Here's a rundown of some of the major insurance industry bills and their status as of press time.

S.B. 549 -- Commercial Lines Deregulation. Dead after being voted to the Senate Appropriations Committee.

S.B. 579 - Low-cost insurance. Would have created a pilot program for limited,

low-cost insurance for low-income uninsured residents in New Haven, Hartford, Bridgeport and Waterbury. Dead after the Senate Appropriations Committee voted it down.
H.B. 5144. - End of Social Security offset. Eliminates the offset for Social Security benefits in auto accident cases. Approved by the Legislature and awaiting Rowland's signature.
H.B. 5125. - Underwriting reform. Speeds up the Insurance Department's approval process for underwriting guidelines for auto liability and homeowners policies. Rowland signed the bill.
S.B. 484 - Noncompete agreements. Would have restricted how much non-compete agreements could be enforced. Legislators defeated the measure in Committee.
S.B. 444. -- Amendment to the Connecticut Unfair Insurance Practices Act. Authorizes the commissioner to order restitution of any money proven to have been obtained by someone who violated the act. Approved by the Legislature and awaiting Rowland's signature.
S.B. 445. - Flood insurance. Stops lenders from requiring a mortgage customer to buy flood insurance, including flood insurance or extended coverage higher than that replacement valued of the home. Rowland was expected to sign. Both the IIAC and PIACT supported the bill.
S.B. 321 - Banks. Would have allowed the Banks committee to study the need for new laws regarding financial modernization and privacy. Defeated in the Legislative Management Committee.
S.B. 64 - Workers Comp. Intended to speed up the conclusion of workers compensation claims. Was still on the House calendar as of May 3.
H.B. 5859 - Licensing. Licensed insurance producers serving in public office who don't sell insurance will be exempt from continuing education requirements. Awaiting Rowland's signature.

Insurance Times: State Farm Surcharges NJ Homes With Oil Tanks

May 9, 2000, Vol. XIX No. 10

State Farm Insurance Co., New Jersey's largest provider of homeowners insurance, has hit policy owners who have fuel-oil tanks on their property with a surcharge.
The Bloomington, Ill.-based insurance company may be the first insurer in New Jersey to impose a $28 surcharge to offset some of the costs related to claims and cleanup costs from leaky tanks, the company said.
State Farm paid $5.5 million in tank-related claims between 1996 and 1998, company spokeswoman Bonita Vanderkooi told the Asbury Park Press of Neptune.
``Although we do not know exactly how many policyholders this will affect, we have about 400,000 homeowner policies in New Jersey, and of that, about 30 percent'' will likely see the increase in their bill, Vanderkooi said.
Previously, State Farm required homeowners only to provide inspection certifications for their tanks.
Allstate Insurance, which has 200,000 homeowners insurance policies in New Jersey, also began requiring the certifications last month.
About two-fifths of the more than 8,000 known contaminated sites in the state were linked to leaks, spills or overflowing underground oil tanks, according to the state Department of Environmental Protection.

Insurance Times: Swett & Crawford Expands Foodborne Illness Program

May 9, 2000, Vol. XIX No. 10

Swett & Crawford has beefed up its Foodborne Illness Program, which features specialized coverage to protect restaurants from the potentially catastrophic exposures posed by outbreaks of foodborne illness. Rather than providing only general liability, the program focuses on exposures to loss of profits, continuing expenses and extra expense.

The FBI Program now has higher limits and enhancements to include coverages for extortion, product recall, and work place violence, according to Mike Hamby, branch manager of the Seattle office of Swett & Crawford.

Swett & Crawford has also partnered with a food safety and environmental hygiene company to offer policy holders with multiple locations a free, optional inspection of their operations to ensure that they comply with government regulations and with the company's own safety and hygiene standards.

In addition to the new limits and coverages, the FBI Program covers loss of income as a result of any media announcement of an actual or alleged foodborne illness; ongoing operating expenses including rent, payroll and debt service; advertising and promotional expenses to restore business after an outbreak. Call 877 877-5324 for information.

Insurance Times: Hartford Launches E-Bill For Workers Comp

May 9, 2000, Vol. XIX No. 10

Billing for workers compensation services just got faster and easier for medical providers with The Hartford's introduction of an Internet processing and payment system that handles bills and supporting medical documentation in a single electronic file.

Until now, electronic processing of workers compensation invoices involved manual processing of the bill and supporting documentation necessary to make payment decisions. A new technology platform employed by The Hartford allows such materials to be electronically attached to the bill on a secure Internet site, reducing the need for manual input of billing data, requests for information and manual transfer of backup documentation needed for a payment to be processed.

The technology gives the medical providers immediate access to The Hartford to inquire about bills or to correspond with the company's case managers. Medical providers need only a computer and Internet access to connect to The Hartford. Once the bills and attachments are downloaded into the billing system, the software automatically scans the invoice to ensure that all necessary information is entered before it is submitted. The invoice is then viewed online by the insurer's bill examiner processed for payment.

The processing system, eBillPro, was developed by Corporate Systems and is powered by the eStellarNet portal developed by StellarNet, Inc.

Insurance Times: Conning Unveils WC Market Research

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The MarketStance Division of Hartford-based Conning & Co. has released MarketStanceWC, a CD-ROM based product that gives insurers ability to analyze the workers compensation marketplace simultaneously by NCCI (National Council on Compensation Insurance) class codes and traditional SIC business classifications.

This analysis tool should help carriers position themselves in a market that may be headed for some stormy weather. Conning expects the workers compensation market to be roiled by a combination of factors: inadequate pricing, worsening loss ratios, increased claims costs and stressed reserves. To make matters worse, workers compensation premiums are anticipated to grow only modestly over the next few years.

MarketStanceWC provides premium estimates by size of account, geographic location and class of business in addition to historical and forecast growth rates for employees, payroll and number of accounts. Visit the website at marketstance.com.

Insurance Times: Business Happy With Commercial Policies, Agents And Insurers: But Survey Finds Lower Satisfaction With Pricing

May 9, 2000, Vol. XIX No. 10

More than half of firms with sales of between $5 million and $100 million are very satisfied with insurers' understanding of their needs and the coverage they offered to meet those needs, according to a recent business survey by the Insurance Research Council (IRC) of Malvern, Pa.

Fifty-six percent of respondents said they are very satisfied with the coverage insurers offered to meet their needs. Another 30 percent said they are satisfied with the coverage offered to them. Only two percent are very dissatisfied with the insurance offered to them.

Satisfaction with agents, brokers, and current insurers is also high with these same firms. More than three-quarters (76 percent) of respondents indicate great satisfaction with their agents or brokers. Sixty-eight percent report they are very satisfied with their current insurers. Only about a third (36 percent) of the respondents, however, are very satisfied with commercial insurance companies overall.

Although 73 percent of the respondents are very satisfied with their current insurance coverage, only 39 percent are very satisfied with the price. Therefore, it is not surprising that companies with sales between $5 million and $100 million indicate the price of insurance is the most common issue prompting them to change from one insurer to another. More than seven out of ten (73 percent) of those who changed insurers in the last five years name securing a lower premium as the reason.

Only nine percent give lack of satisfaction with the service they have received as the reason they have switched insurers.

In addition, 69 percent of those who will definitely or probably change insurers in the next two years plan to do so to lower premiums, while just 12 percent plan to change because they are not satisfied with the service they have received.

" For commercial insurers, the good news is that, overall, firms are satisfied with their current insurers," said Elizabeth A. Sprinkel, senior vice president who heads the IRC. "Ultimately, however, lower premiums are enough for some of

these firms to change insurers."
The results contained in IRC's recently released report, Business Attitude Monitor 2000, are based on a survey conducted by Roper Starch Worldwide. The survey focused on firms with annual sales of between $5 million and $100 million.

Insurance Times: Unsafe At Any Altitude?: Airline Flight Attendants Seek OSHA Protections

May 9, 2000, Vol. XIX No. 10

Faulty beverage carts,
toxic cabin air, over-sized
carry-ons among
airline hazards

WASHINGTON - A survey conducted by the Association of Flight Attendants of injury and illness logs at 11 U.S. airlines showed that out of 31,024 flight attendants, 10 percent reported an injury that required medical attention beyond first aid or caused them to lose time from work in 1998.
"Flight attendants need OSHA protections," said Patricia Friend, president of the Association of Flight Attendants. "We work hard and deserve the same protections that other American workers enjoy."

BLS Statistics

Data from the Bureau of Labor Statistics (BLS), confirms that aviation is a dangerous industry, Friend maintained.
The Bureau of Labor Statistics reports there were about 1.2 million workers employed in the "transportation by air" category in 1998, and the industry- wide rate of recordable injuries and illnesses was higher (14.5%) than in construction (8.8%), agriculture (7.9%), or mining (4.9%).
Flight attendants suffer injuries related to operating poorly designed food and beverage carts, slipping on galley floors, handling or being struck by heavy carry-on baggage, falling on icy walkways, and sustaining cuts and burns from galley equipment and oven racks.
They are concerned about radiation exposure, particularly this year when solar storms are expected to reach a peak, and possible exposure to HIV and hepatitis since flight attendants must provide in-flight emergency medical treatment including mouth-to-mouth resuscitation and assistance during childbirth.
Most American workers are protected by standards set by the Occupational Safety and Health Administration flight attendants are specifically excluded from OSHA coverage.
The FAA, which regulates aviation safety, has largely ignored the occupational safety and health issues of the predominantly female flight attendant workforce, charges the association.
Flight attendants at airports in Atlanta, Seattle, Los Angeles, and Chicago planned to leaflet passengers about the dangers they face in the airplane cabin and hold a protest in Washington, D.C. outside the FAA's headquarters.

SAN DIEGO -- Pricing and reserving for newly emerging risks and contract structures poses unique challenges for actuaries who must deal with the absence of historical insurance data and develop appropriate models.
Edward D. Dew, Tillinghast-Towers Perrin, observed that with traditional ratemaking, actuaries gather historic insurance data, such as claim information by accident or underwriting year, and ultimately develop trended loss costs and

a final rate. The rate may also require regulatory approval.
"The biggest difference between traditional and emerging risks is the lack of historical insurance data," said Dew. "There is a lot of information to analyze, but it's just not arranged in a typical format."
As a result, he said, the actuary typically would end up "modeling the process that may occur during the policy period." Such computer models will produce a distribution of potential outcomes.

Usually Multi-Year Deals

He also pointed out that emerging risks ratemaking usually involves multi-year deals, require some form of loss funding and face fewer regulatory hurdles than traditional risks.
"Key rating components include a loss distribution component that reflects premium features, loss and expense expenditures and timing risk and a capital allocation component," he said. In addition, the rate must include target rates on key ratios to reflect the return on capital and premium as well as ratios of expected estimate to worst case.
He cited as an example of an emerging risk, a hydroelectric power plant operator who wants to buy a five-year policy to provide coverage for financial loss due to low rainfall. The plant is under contract to provide power through its own plant or by buying power on the open market. The utility also desires a policy with annual premium payments and a return premium feature for low loss levels.
In this case, Dew said the actuary would need to develop a cascade model for the weather exposure, including information on past precipitation levels, the utility's reservoir levels, the price of producing electricity, the cost of purchasing power on the open market, variable and fixed operating costs and, finally, profit and loss.
Using this information, a cash flow chart by quarter for the five year contract term would be produced to include collected premium, paid losses, underwriting results, capital contributions of the insurers cash levels and investment income.
Another type of emerging risk involves insuring income from lease payments, said Dew. In this case, a manufacturer wants to insure the income stream from payments of leased equipment under a multi-year policy. Losses could result from the lease payment being less than expected due to lessee default, extended downtime of equipment, reduction in market lease rates or higher than expected costs from equipment refurbishing, marketing and other transaction costs.

Lease Payments

"Loss modeling of lease payments is very complex," he explained. "Each individual equipment lease contract must be modeled from inception through expiration or default. Then, you must model the process of subsequent leases for each item of equipment."
The model must incorporate all the economic factors affecting the manufacturer and the lessees, such as inflation, interest rates and the creditworthiness of lessees, according to Dew. "Learn about other fields to model the process," he advised. "But don't try to become an expert. Know when to seek advice."
Dew also cautioned against over-reliance on the models. "Don't become married to the model and don't create a 'black box' that can't be explained."
Lawrence A. Berger, Swiss Re New Markets, outlined the pricing challenges created by the new integrated risk management products which add capital market hedges to traditional reinsurance products. "The idea behind integrated risk management is that a company should be managing the total risk it faces," said Berger.
Such products protect against equity market declines, interest rate increases, foreign exchange losses and corporate bond defaults, he said.
"The client gets more reinsurance protection when investment results are poor,"

said Berger. He observed that integrated features can be added to any type of reinsurance program.

Capital Markets Exposure

Pricing a transaction that combines traditional insurance and capital markets exposures requires understanding that insurance companies and capital markets take different approaches.

"But both incorporate expected losses and a risk load," said Berger. Actuarial pricing techniques are used for insurance risks, he said. This involves calculating expected loss and a separate risk load and then using probability distributions based on historical data and projections of future loss experience. However, capital market risks use risk neutral pricing techniques, according to Berger. These techniques use a probability distribution which is inferred from market prices. The probability distribution is "arbitrage free" because it is consistent with market prices.

"If you sell something that isn't consistent, you will be arbitraged," he said. "If you are high, they will sell you short and buy low. If you are low, they will buy from you and sell high."

One approach to pricing integrated products where the insurance risk is combined with capital market risks involved applying Monte Carlo methods to simulate a probability distribution on the integrated product, said Berger. The price can then be determined by using "actuarial probabilities for insurance exposures and risk neutral probabilities for capital markets exposures," he said.

Insurance Times: GE Site Includes Insurance And Banking

May 9, 2000, Vol. XIX No. 10

STAMFORD, Conn. - Two months after launching an Internet site for personal finances, General Electric Co. has signed on with CompuBank to expand the site to include full-serving banking.

GE Financial Network, www.gefn.com, came online in February specifically targeting consumers.

The site initially included information on annuities, auto and life insurance, loans and mutual funds. The Web site also provided for consumers to set up a savings account or apply for a credit card and obtain immediate approval online.

``By adding banking to our existing breadth of offerings, GEFN continues to give consumers the best financial products and services to meet all of their financial needs,'' said Bill Goings, senior vice president of e-Business.

With this announced alliance with CompuBank, GEFN consumers will be able to establish checking, savings and money market accounts, write checks and access funds through automated teller machines, GE said.

In addition, consumers can arrange direct-deposits and electronic fund transfers, re-order checks online and take advantage of services such as domestic wire service and bill paying features.

CompuBank also offers Certificates of Deposit and Visa check cards.

Jackson National Life continues growth

LANSING, Mich. - President and CEO of Jackson National Life Insurance Co. Robert Saltzman has overseen an aggressive business strategy which has nearly doubled JNL's profits in five years, to $466 million in 1999. Now JNL is adding

to that growth.
Jackson National's subsidiary, Jackson Federal Bank (JFB) recently announced its intended purchase of Highland Bancorp, Inc. for $120 million in cash. Highland Bancorp is the holding company for Highland Federal Bank, which operates seven retail branches in Southern California and is headquartered in Burbank, California. Subsequent to the acquisition, Highland Federal Bank will be merged with JFB and the branches of Highland Federal Bank will become JFB branches.
JFB has grown by leaps and bounds since its acquisition in 1998. When Jackson National first acquired the small San Bernardino thrift, deposits were $100 million -- with the closing of the Highland transaction, JFB will have assets exceeding $1 billion.
The Highland acquisition is Jackson Federal Bank's second announcement of an acquisition this year. On March 31, 2000, JFB closed on the acquisition of three retail branches with $165 million of consumer deposits that were purchased from Fidelity Federal Bank, FSB. Those branches are located in the cities of Big Bear and Blue Jay in San Bernardino County, and Fullerton in Orange County.

Insurers' execs share $8.8 million bonuses
PORTLAND, Maine (AP) - Seven top executives received bonuses totaling more than $8.8 million for helping to engineer last year's merger that formed UnumProvident, the nation's largest disability insurer.
The boards of Portland-based Unum Corp. and Provident Companies of Chattanooga, Tenn., approved the bonuses on the day the merger was approved last June, according to a filing this week with the Securities and Exchange Commission.
Since the merger, UnumProvident has struggled and its stock price has fallen by more than two-thirds, erasing more than $9 billion in market value.
UnumProvident has slashed 1,600 jobs, either through layoffs or early retirements.
The largest bonus - $5 million - was awarded by Provident to its chairman and chief executive officer, J. Harold Chandler, who went on to become UnumProvident's chairman and CEO following the resignation of James F. Orr III on Nov. 1.
Orr received a special bonus of $600,000 for his role in merging the companies.
He also received a severance package worth more than $20 million when he resigned.
The five other executives to get special merger bonuses were: Thomas R. Watjen of Provident, $1.5 million; F. Dean Copeland of Provident, $750,000; Robert E. Broatch of Unum, $360,000; Elaine Rosen of Unum, $300,000; and Robert Crispin of Unum, $300,000.
UnumProvident and those in the executive compensation field said Orr's severance package was fairly common within the industry.
Others said even if that's true, the severance package and the special merger bonuses are examples of corporate excess.
``Quite frankly, when I saw the news, I said 'this is just more corporate greed,' '' said John Hannon, an analyst with Security Capital Trading. ``A special bonus for just putting this together? How about the 1,600 people (who got laid off)? They got a special bonus too - they are working somewhere else.''

Insurance Times: Individual Life Sales Continue To Post Modest Gains: New Premium Up, While Number Of Policies Down
May 9, 2000, Vol. XIX No. 10

Windsor, Conn. - Individual life insurance sales continued to make modest gains

in the United States in 1999, according to preliminary industry estimates by Limra International. Annualized new premiums grew three percent over 1998, to $10.6 billion, the third consecutive year of increases.
The face amount of life insurance sold increased eight percent to $1.4 trillion. It was the eighth year in a row that face amount has increased.
Only the number of policies sold failed to post a gain. Three percent fewer policies were sold in 1999, the sixteenth consecutive year that this measure has declined. Just over 11 million policies were sold in 1999, the fewest number of ordinary policies sold since 1970. More than 6.6 million fewer policies were sold in 1999 than in 1983, when an all time record 17.7 million policies were sold.

Face Amount Doubles

Since 1983, while the number of policies sold has dropped dramatically, the face amount of insurance sold has almost doubled, evidence of the industry trend of selling fewer, but larger policies. Even after adjusting for inflation, the average size policy sold increased by 77 percent to $127,000. In regards to what is being sold, market shares continue to show a steady trend away from traditional products. Whole life fell to its lowest level ever, reaching a 31 percent share of annualized new premium. Variable products - variable life and variable universal -- continued to grab a larger market share, pulling even with whole life at 31 percent. Universal life fell to 18 percent, its lowest level since 1983. Term insurance inched up 1 percentage point to 20 percent.

Variable Survivorship

Contributing to the increase in variable universal life sales was a substantial increase in variable survivorship sales. Based on Limra's quarterly Individual Life Insurance Sales Survey, variable universal survivorship annualized premiums increased 70 percent over 1998.
Limra's survey measures the activity of 89 companies and their 56 subsidiary companies operating in the United States and represents about 75 percent of the total industry in terms of new premiums collected.

Triple X Term

One of the reasons for the increased sale of term insurance - which was particularly high in the last quarter of 1999 -- was the anticipated enactment of Triple X legislation. Again based on figures from the Limra survey, the number of term policies sold was up 10 percent over the fourth quarter of 1998, and face amount and premium increased 20 percent and 18 percent respectively over the same period. For all of 1999, the number of term policies sold was up 7 percent, face amount increased 13 percent, and premiums increased 9 percent when compared to 1998.
These Limra annualized premium figures include 10 percent of single premiums and excludes universal and variable universal life excess (dump-in) premiums, as well as large case corporate-owned life insurance (COLI) and bank-owned life insurance (BOLI).

The table below shows the dramatic changes that have occurred in market shares during the 1990s.
Annualized New Premium Market Share by Product Type

<table>

	Term	WL	UL	Variable
Products				
1990	13%	54%	26%	7%
1991	13	55	26	6
1992	13	54	24	9

1993	13	52	22	13
1994	14	48	22	16
1995	15	46	24	15
1996	17	41	22	20
1997	18	38	21	23
1998	19	34	19	28
1999	20	31	18	31

Source: Limra International

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Insurance Times: Strategies Can Reduce Estate Taxes By 90%

May 9, 2000, Vol. XIX No. 10

by Murray Chodos and
Adam Chodos, Esq., CPA

After a lifetime of asset accumulation, most of us face federal and state imposed estate taxes on all we own before assets can be passed on to children and other heirs. Federal estate tax rates range up to 55% (60% on larger estates) in addition to state death taxes. The general objectives of estate planning are to minimize estate taxes, limit exposure to creditor claims, position our assets in the control of those best suited to manage them, and to protect loved ones by prearranging asset management for their benefit. For well informed families there are a myriad of strategies available to achieve these, and other, objectives and it is common to retain a tax attorney to guide the family through the strategies and documentation.

Lack of Preparation
The costs associated with lack of preparation can be considerable; including the forced sale of assets, loss of control of the family business or investments, shrinkage of income producing assets, and so forth. Generally, an estate has nine months to settle the estate tax bill. During that time period vital decisions must be made as to how to create liquidity for tax payment, business continuity, and generally redistribute and manage assets during the ownership transition. For many families this is a difficult time at best.
A well structured plan will likely employ tools such as gifting programs, shared ownership, and entitization (placing assets into different entities, e.g. family limited partnerships, trusts) to achieve estate tax discounts. Many of the tools achieve tax discounts because they require relinquishment of some control. Usually there is a point where families are reluctant to further forgo control over assets to achieve tax reductions due to concerns that the assets may be needed in the future or that tax laws may change. In return for flexibility many will accept some transfer tax.
For the taxes that must be paid, what is the cost of settling estate taxes with the estate owner's funds? Even if liquid assets are set aside for estate taxes, the earmarked fund is itself taxable, thus two dollars are needed for each estate tax dollar due. The fund's earnings would be income taxable and the entire fund would be subject to creditor claims. Circumstances and time may be inopportune for creating such a large, liquid fund before the tax is due. Additionally, an estate has further challenges, including difficulty in dividing the estate amongst heirs, loss of family control over key assets, and who would

enjoy writing a large check to the government?
What if there were a means to fund estate taxes at a substantial discount? Since death triggers the tax payment, we don't truly need estate tax funding until the second death (the later death of the husband or wife). Survivorship life insurance policies do exactly that by insuring both husband and wife, creating liquidity by paying out proceeds at the second death when estate taxes are due. Survivorship policies cost approximately half that of insuring each spouse individually, and if owned properly, the proceeds are free of income tax, free of estate tax, free of creditor claims, and free of probate. The cumulative premium invested in a survivor life policy for a healthy 60 year old married couple is approximately 10% of the death benefit produced (the cost is lower for a younger couple and higher for an older couple).
Due to the opportunity to exclude life insurance from the taxable estate, life insurance can be used as a financial tool to deeply discount estate taxes by providing liquidity at the precise time it is needed. Policy ownership is important to avoid potential tax pitfalls because if one owns a policy on their own life the proceeds will be includable in their estate and subject to estate tax. To avoid estate inclusion of life insurance proceeds the policy must be owned outside of the estate, by either a third party or an entity, as you should not be taxed on a policy you do not own. The choice is predicated on control and flexibility.
The estate planning team uses available techniques and tools to reduce a family's estate taxes to the lowest practical level given the family's comfort zone. For the estate taxes that remain, life insurance can act as an effective tool to assure family control over assets and deeply discount estate taxes. If dramatic discounts are available through structured planning why would one want to pay their estate taxes at full price?p

Adam Chodos, Esq., CPA and Murray Chodos are members of the Wealth Preservation Group LLC, a Greenwich, Conn.- based planning group specializing in wealth preservation, business succession,
and executive benefits. Chodos@WealthPreserve.com; www.WealthPreserve.com

Insurance Times: Phoenix Home Life Exploring Option Of Going Public

May 9, 2000, Vol. XIX No. 10

HARTFORD - Phoenix Home Life Mutual Insurance Co. says it is exploring the possibility of going public.
The company's board of directors recently authorized the management to develop a plan to convert from a policyholder-owned business to a stock company. By going public, companies can more quickly raise capital for acquisitions.
``Phoenix is well positioned to capitalize on the wealth management opportunities in the growing high-net-worth market,'' said Robert Fiondella, chairman and chief executive officer.
Company officials said policyholders will be provided with information in a series of mailings, on the company's Web site and through its toll-free number.

12 to 18 Months
The ``demutualization'' does not happen overnight. The process is expected to take 12 to 18 months. Although the company has corporate offices in Hartford, it is a registered New York state business and a public hearing will be held by the

New York State Superintendent of Insurance.
The plan is subject to approval from policyholders, New York and federal regulators. If approved, the company has up to a year for its initial public offering.
In 1999, Phoenix reported record financial results, including a 7 percent increase in net gains from operations and an 18 percent increase in total surplus, even as the company initiated significant changes to position itself in the wealth management market. Assets under management totaled $71.9 billion at the end of 1999.
Phoenix provides insurance, investment management and trust services. Listed in the Fortune 500, it is one of the nation's largest mutual life insurers and a leading money manager through its subsidiary, Phoenix Investment Partners, Ltd. Trust services are offered by Phoenix Charter Oak Trust Company. Phoenix, with corporate offices in Hartford, Conn., was founded in 1851. For more information, visit www.phoenixwm.com.

Insurance Times: Doctor Charged In Free Drug Conspiracy

May 9, 2000, Vol. XIX No. 10

BOSTON (AP) - An Indiana urologist named in a health care fraud probe that stretches across at least seven states pleaded guilty to a conspiracy charge in federal court.
Ronald Mannion, of Long Beach, Ind., pleaded guilty to one count of conspiracy for billing insurance companies for drug samples that were provided to him for free.
The conspiracy involved the drug company's employees and doctors in Massachusetts, Maine, Connecticut, Kentucky, South Carolina, New York and elsewhere. Officials charged that Mannion received between $40,000 and $70,000 for the free drugs.p

Mannion is scheduled to be sentenced Oct. 2. He faces a maximum of 14 months in prison, said Samantha Martin, a spokeswoman for the U.S. attorney's office.
Martin said the investigation, which involves several federal agencies including the FBI and the Food and Drug Administration, is continuing.

Insurance Times: Asian Insurers Look To Multiple Distribution

May 9, 2000, Vol. XIX No. 10

Windsor, Conn. - In Asia, as elsewhere, companies are employing multiple distribution systems to increase overall premium volume, reach new markets, address consumer demands for insurance from other than face-to-face sources, to reduce acquisition costs, and to keep up with competitors.
That's one main finding of a survey of 39 Asian companies recently conducted by Limra International.
Thirty-one of the 39 Asian companies responding currently use more than one distribution channel. Of the remaining eight companies, seven employ career agents and one uses brokers. Furthermore, many companies are planning to add

additional channel(s) over the next five years. There is considerable interest in bancassurance, direct mail, and Internet.
Although the use of multiple channels is widespread, the career agency system is still dominant, bringing in the majority of new premiums.
Alternative distribution channels are expected to have only a marginal impact on this dominance, at least in the near future. In terms of current usage, the career agency system is the most widely used channel; it is used by 38 out of 39 companies.

Insurance Times: Dogged In Pursuit: Young NH Entrepreneur's Love Of Animals Drives Him To Enter Risky Pet Insurance Market With Honorpet.Com

May 9, 2000, Vol. XIX No. 10

by Mark Hollmer
InsuranceTimes

The desire to improve the lives of pets and their owners came to him during lunch.
Charles Gaudet II - a 22-year-old New Hampshire entrepreneur fresh out of college - was eating lunch with his girlfriend's father. The discussion shifted to dogs and cats, and the complaints of another individual about her high veterinary bills.
The woman had to put her dog down, Gaudet said, because she couldn't afford the cost to cure the animal.
Later, Gaudet conducted a little research and found out that while pet health insurance exists, not many people know about it.
"And there's a lot to be done to improve the current products that are out there," Gaudet added.
Gaudet is trying to fill that void with a new insurance Web venture - HonorPet.com. He's the main founder and acting chief executive officer of the project, and is seeking venture capital funding to launch the site by this summer.
Gaudet, a graduate of Babson College's Entrepreneurial Studies and Marketing program, estimates he'll need at least $7 million in start-up money to begin insuring pets regionally. That's why he attended a venture capital seminar in Washington D.C. from April 24-26.
His plan calls for selling pet health insurance directly, with HonorPet acting as a managing general agent fully responsible for marketing and servicing policies and claims. Gaudet and his partners have met with several companies and hope to reach an agreement with one to underwrite HonorPet policies.
Subscribers can choose between four different policies. They'll pay their veterinary bills as usual and then submit the bill to the company for reimbursement. A typical policy could cost $200 a year, but that number will rise or fall depending on the policy and the price negotiated with an underwriter. Deductibles will depend on the policy.
HonorPet members should be able to use their policy at any recognized veterinarian in the country. They could also use their membership with "an affinity of networked companies" to earn discounts for everything from pet food to squeaky toys and grooming.

Previous Business Launch
Gaudet isn't exactly new at launching a company.

He was 21 and finishing at Babson when he launched his first business - Voyages of Entrepreneurial Development, which helped people start their own companies. For his second business - HonorPet.com - Gaudet is working with a number of people inside and outside the industry. His founding partners include Babson College junior Heather Lee Mitchell and Carl Hedberg, a founding partner of Boston Bagel, a wholesale bagel manufacturer in Quincy. Hedberg is an adjunct professor at Babson.

Long-time insurance industry insiders round out his management team: Acting President Robert Heaney, a New York Life financial consultant, and Ronald Horton, vice president of retail marketing at John Hancock. Robert Doiron, a sales manager with John Hancock, serves on the board of directors with Dr. Arnold Plotnick, vice president of the American Society for the Prevention of Cruelty to Animals (ASPCA) and chief medical officer at Bergh Memorial Animal Hospital.

Gaudet and his team are also working with Insurance Services Office in Quincy, where they're sifting through HonorPet's policies to make sure they're viable. Gaudet said it's important for him to show that his venture is "going to make money" and be profitable.

Beginning to Gain Ground

He isn't alone in his quest. Pet health insurance has actually been around in the U.S. for nearly 30 years, but it's only begun to gain ground here in the last decade, according to the Insurance Information Institute in New York.

Between 1 and 3 percent of America's 59 million pet owners subscribe to pet health insurance, according to the III. (Traditional pet health insurance is only written for cats and dogs).

Gaudet's Boston attorney, Edward Donahue, of Morrison, Mahoney & Miller, said the numbers are more than triple that in Canada and close to 40 percent in Great Britain.

Jack Stephens - founder of Veterinary Pet Insurance, the nation's oldest and largest pet health insurance company - agrees more Europeans buy pet health insurance but maintains that Canadians buy very little of it. About 13 percent of pet owners in Great Britain hold pet health insurance, Stephens said, and the number in Sweden is nearly 60 percent.

But by either count, the numbers are still higher overseas.

Why?

Stephens, also a veterinarian, says pet health insurance began sooner in the UK (1946) and in Sweden (1952), and the product has simply had more time to catch on.

Stephens says his own company grew slowly for the first 15 years after its 1980 founding, but is now taking off just like its European counterparts did after slow starts.

What's more, he said, pet owners here are just starting to assess the risk of dealing with rising veterinary bills. In addition, he said, owners are bonding with their pets more closely than they used to.

Industry experts estimate that 10 percent of American dog and cat owners will purchase health insurance for their pets over the next decade.

Whatever the growth, Stephens said he believes there's room for more pet health insurers.

"The market," he said, "is not even being scratched yet."

In addition to VPI, two other major companies sell pet insurance in the U.S. - PetsHealth Insurance and Premier Pet Insurance.

Of those three, VPI (through National Casualty) and Premier Pet (through AIG) have filed to operate in Massachusetts. Honor Pet is also expecting to register.

Donahue said some surplus lines companies also offer pet health insurance.

Stephens launched VPI in 1980 with other veterinarians and it now has over 160,000 policyholders. Premier Pet has been selling pet health insurance since

the 1990s in Great Britain, according to its Web site. (Its domestic policy information was unavailable). PetsHeath began in Iowa in 1994, according to the Insurance Information Institute.
All offer similar products with policies hovering above or just under the $200 range, with deductibles.
Stephens said his company sells its insurance directly, through brochures, on the Web and through agents.
The Web also lists a number of other pet health insurance providers, including cooperatives similar to human HMOs. Some veterinary hospitals offer prepaid plans as a kind of insurance, according to Alejandra Soto, an III spokesperson.
But even before pet health insurance, separate health insurance policies have been around for years for non-racing horses, livestock and exotic birds.

Risky Business
The pet health insurance business hasn't been an easy sell.
According to Stephens, his company launched after "about 100 attempts" failed before him.
The failed companies, he said, "probably weren't as tenacious as we are ... and didn't understand pets and pet diseases ... their losses were really high."
The business of pet health insurance, he said, involves a high claim frequency and low premiums, so you need "a large volume to cover overhead."
VPI has lost about $17 million over the last 18 years combined, he said, and hasn't made money in the last three. But Stephens said costs associated with expanding rather than money-losing policies contributed to the latest losses.
"It's a considerable investment here," he said.
But Gaudet remains undaunted. He looks at the low domestic insurance numbers and sees an opportunity in the marketplace to fill a dog and cat health-insurance void.
After all, he said, pet owners face a 30 percent average annual increase in the cost of veterinary care, and the average pet owner can only spend less than $600 before a pet has to be put down.
He's not worried about an economic downturn, either.
"If the economy goes up, sure, we'll probably end up receiving more premium. If the economy goes down, the pet bills aren't going away."
Regardless of economic conditions, pet owners have good reason to consider owning insurance for their dogs or cats, according to III's Soto said. citing "great advances" in veterinary medicine over the last 20 years. Pet kidney transplants, heart surgery or other complicated procedures used to be too expensive, so owners simply put their sick pets to sleep. Those procedures are more common now, she said, but they're still expensive.

Pet Fraud
Before launching his company, Gaudet is also working to address concerns about risk and fraud.
HonorPet won't cover pre-existing or hereditary diseases, he said, and pets will be covered and premiums will be set depending on their age, just like human health insurance. Rates will be dependent on such factors as breed, age, and if a dog or cat is spayed or neutered.
Gaudet said he's looking at a number of other ways to address fraud, but will only pick solutions that are "in the best interest of the pet." Some industry options include ear tagging --- attaching a computer chip to a pet's ear --- or tattoos.
Gaudet isn't under any illusions about starting his business. He realizes his company will have to make money to succeed. But at the same time, he said, the thought of making money isn't driving him.
"I absolutely love what I'm doing."
He's also very familiar with pets.

Gaudet owns two ferrets - Buddy and Buffy (the latter named by his sister, Jolie). The two family dogs - Newfoundlands named Ben and Bambi, died in 1998 and 1999 at ages 12 and 11, respectively.
The family never had pet health insurance, Gaudet said, because "we never knew about it.
"My family spent a ton of money trying to keep both animals alive" after they became ill, he said. Eventually, they had to be put down for health reasons.
"The pain of losing an animal," he said, "is similar to losing a loved one."

Insurance Times: Employee Benefits & Managed Care: Hospitals Not Required To Accept Mass. Plan

May 9, 2000, Vol. XIX No. 10

Doctors and hospitals affiliated with Partners HealthCare in Boston don't have to accept patients covered by a new insurance plan offered by Blue Cross & Blue Shield of Massachusetts, an arbitration panel has ruled.
Blue Cross & Blue Shield had argued that two of Partners' hospitals, Massachusetts General Hospital and Brigham and Women's Hospital, were obligated to accept patients of the newly introduced Access Blue because Partners had agreed to accept the basic HMO Blue.
But Partners said its doctors should not have to accept Access Blue because the plan did not require patients to see a primary care physician before going to specialists. That could lead to higher costs that the hospitals would have to pay for, Partners said.
A three-member private arbitration board last week ruled that Partners' agreement with Blue Cross & Blue Shield did not require it to recognize Access Blue patients.
Access Blue was announced last summer. Blue Cross hoped it would attract 150,000 members over five years, but it attracted just over 100.
Statewide, Blue Cross & Blue Shield has 1.4 million members in its managed care plans, qualifying it as the state's largest provider of managed health care. About 234,000 new members enrolled between Jan. 1 and March 31, said John Schoenbaum, a Blue Cross & Blue Shield spokesman.
Harvard Pilgrim Health Care had been the state's largest managed care provider before being placed into state receivership on Jan. 4 after reporting losses of $200 million in 1999. State regulators said last week that Harvard Pilgrim had lost 215,000 members. It now has just over one million members, said Eric Linzer, a Harvard Pilgrim spokesman.

EmployeeMatters manages benefits online
STAMFORD, Conn.-- Recognizing that small and medium-sized businesses typically do not have the expertise or resources to effectively manage employee administration and human resource functions, EmployeeMatters (www.employeematters.com)-- an integrated, full-service Web-based provider of benefits, human resources and payroll services to small and medium-sized businesses-- announced a new employee administration service.
EmployeeMatters integrates and automates employee administration and HR functions, including payroll, insurance, health benefits, retirement plans and HR compliance. EmployeeMatters' products and services can be administered through its Web interface on a 24 hours/7 days a week basis, and through its call center, staffed by HR professionals and licensed product experts.
"Currently, owners of small businesses spend 25% of their time on employee administration and often don't have the time, expertise or money to compete

with the benefits programs of larger companies," said Elliot S. Cooperstone, CEO and Co-Founder of EmployeeMatters. "EmployeeMatters offers these companies a time-saving solution which allows them to spend more time growing their businesses and less time dealing with the administrative requirements of health care carriers, payroll services, and state and federal regulations."

To date, EmployeeMatters has signed a range of service providers including: Empire BlueCross BlueShield, The Guardian Life Insurance Company of America, Horizon Blue Cross Blue Shield of New Jersey, Oxford Health Plans, ReliaStar, Authoria, eMind.com, US SEARCH.com, The Bureau of National Affairs, Inc. (BNA, Inc.), RecruitUSA, YouDecide.com, and Financial Engines.

Liberty Mutual enhances integrated STD/LTD

Liberty Mutual has announced an enhanced integrated group short-term/long-term disability product, Liberty Advanced DayOne Disability.

The policy features contract enhancements and a "best outcomes approach" which include return-to-work programs to help ill and injured workers get back to work quickly. One enhancement requires employees to receive appropriate medical treatment in order to be eligible for STD or LTD benefit payments.

Similarly, a new non-verifiable disease symptoms limit option provides benefits to an employee with a difficult-to-diagnose claim while the employee pursues appropriate medical testing. The policy caps the benefits to a pre-defined period of time, unless the employee can provide medical verification of the disability diagnosis.

New policy options include a survivor benefit for a domestic partner and workplace modification, which provides $1,000 or two months' benefits to modify the workplace to accommodate a return to work for a disabled employee.

Insurance Times: Shareholders Press Aetna Chief On Poor Stock Performance

May 9, 2000, Vol. XIX No. 10

by Phil Galewtiz
Associated Press

HARTFORD- Aetna Inc.'s new chairman told disgruntled shareholders last week that the nation's largest health insurer is not for sale. But mindful of dissatisfaction with the performance of Aetna stock, William H. Donaldson said he would consider any meaningful offers.

``If there is a legitimate and compelling proposal brought to our attention, we will take a look at it,'' Donaldson told about 1,000 shareholders at the company's annual meeting held at its Hartford, Conn., headquarters.

Two Separate Companies

Rather than putting itself on the market, Aetna is speeding to carry out plans announced in March to split into two publicly traded companies: One for health care, the other for financial services. The breakup is expected this summer.

Last month, Aetna rejected a $70-per-share, or $10 billion, takeover offer from Wellpoint Health Networks and ING Group, saying it was inadequate. That move perturbed some big shareholders.

Shares of Aetna fell $2.06, or by 3.4 percent, to close at $57.87 on April 26 on the New York Stock Exchange. The decline came as most of the health maintenance sector was retreating following an announcement from HMO Sierra Health Services

that it would have lower-than-expected earnings in the first quarter, said David Shove, an Prudential Securities analyst.
Aetna's stock has been stagnant since 1995, the year before it bought fast-growing health maintenance organization U.S. Healthcare.
Several shareholder activists told Donaldson that they agreed with Aetna's decision to split into two companies, but stressed the company needs to move more quickly to increase the value of their stock.

'Surgery' Called For
``We need some surgery here,'' said Evelyn Davis, a shareholder activist from Washington, D.C., who was dressed in surgery scrubs.
Frederick Lens, an Aetna shareholder and former employee, said Aetna put too much faith in U.S. Healthcare to improve its health insurance business. ``The assumption was U.S. Healthcare had all the knowledge,'' he said. ``We've all seen the wisdom of that decision.''
Donaldson, a Wall Street veteran who has been on Aetna's board for two decades and took over as chairman in February, said Aetna will be operating as two separate companies by July. But he cautioned it will take longer to get all the regulatory approvals for the change.
He said working as two companies will ``unleash the entrepreneurial energies'' of its employees.
In an effort to build on its online efforts, Aetna said it has signed an agreement to partner with Harvard Medical School to provide information for its consumer health Internet site (http: www.intelihealth.com). Harvard replaces Johns Hopkins University on the site.
Aetna's stock has been under severe pressure since last fall, when the company became one of the targets of several class-action suits filed by the same trial attorneys who won big settlements from the tobacco companies. Among other things, Aetna was accused of withholding information from its HMO members that it provided financial incentives to doctors to influence their treatment decisions. The company has said information is provided members through such channels as member handbooks and Internet postings.
The company has also had more difficulty than expected in turning around the money-losing Prudential health care business which it bought last year.
Aetna has also been waging a public relations battle to maintain its image as consumer-oriented company. Medical providers argue that the company skimps on care.
``It's no secret that we have disappointed shareholders, customers, providers and employees,'' Donaldson told shareholders. But he said his strategy will restore confidence in Aetna and increase profits.
Aetna plans to generate $500 million to $1.5 billion for the sale of some of its international operations. It also said it will save up to $150 million this year by cutting costs, including reducing employee travel and cutting the workforce through attrition.
Davis, the shareholder activist who holds court at many stockholder meetings, said Aetna could go further to reduce expenses. When Donaldson said the company has 80 in-house attorneys, she quipped: ``Why not just have eight good ones.''
Aetna officials have remained silent on how they will change its Aetna U.S. Healthcare business, which has been criticized for restricting patient access to doctors.
Donaldson suggested Aetna was looking at developing plans that would give consumers more freedom to choose doctors and reduce restrictions on health providers. ``We want to lead not only in size and scope, but in quality of operations.''

Insurance Times: Doctor Drops Insurance, Charges $2 Per Minute
May 9, 2000, Vol. XIX No. 10

by Lisa Rathke
Associated Press

WALLINGFORD, Vt. - The board hanging in the waiting room tells patients what they'll be charged: $2 a minute for labor; $5 for an ear wash; $30 for a knee splint; $2 for a large bandage, $1 for a small one; $10 for a suture, $5 for a breathing treatment.
If it sounds like being at the mechanic's it's intended to. That's what Dr. Lisa Grigg had in mind. She was waiting for her car at her mechanic's when she scanned the board in the garage listing the charges and wondered why medicine couldn't be that simple.

Simply Medicine
A year later she's made it almost that simple. At Simply Medicine, an acute care walk-in clinic, Grigg takes only cash as payment. She does not take insurance.
``You put a board up and tell people what you're going to charge them and skip all the middle people. Just make it reasonable,'' Grigg says.
At $2 a minute, the 36-year-old osteopath treats ear infections for as little as $8 and wraps simple sprains for $20. For a $40 flat rate, she will make house calls.
She says she doesn't need to make a lot of money and hopes to turn a profit next year.
Only about a third of her patients lack health insurance. The amount Grigg charges is comparable to or even higher than the co-payment patients would make to see their regular doctor, she says.
Most of the patients with insurance would rather walk in to Grigg's clinic with something as simple as a cold than drive the often-congested seven miles into Rutland to see their doctor. She will provide a receipt that patients can send on their own to their insurance companies.
Patients usually don't have to wait before getting to see the doctor.
``This is just walk right in, look down your throat: $7. You're in and you're out,'' says Carol Martin, who works next door at the post office.
She has health insurance and a doctor up the road.
``I went with a sore throat and she gave me antibiotic. I would have waited until it got worse'' to see a doctor, she said.
Grigg insists she doesn't want to lure patients away from their primary care physicians. She urges them to see their doctors for more serious ailments.
Martin even brought her daughter in. It turned out the 16-year-old had mononucleosis and Grigg hand-delivered the lab results to the post office the next day, Martin says.
In the age of managed care, when patients don't always choose their doctors, this type of encounter is rare. It is the one-on-one doctor-patient relationship taught in medical school and one that Grigg wants to return to.
``The other reward about doing this is helping to repair the doctor-patient relationship,'' the soft-spoken doctor says from the old house turned clinic.
``I wanted a way to return some control to the patient, especially about time. ... a lot of people come in quite troubled and you're supposed to be able to see them in between 5 and 10 minutes and you're always pushing people. I have a real distaste for doing that.''
Now patients can talk to Grigg as long as they want to pay for the time. She keeps track with a stop clock in her office, which she punches only after she's

introduced herself and had a minute to chat.
Grigg had spent three years in family practice in Rutland before opening the clinic. Many of the patients were on Medicare. She grew tired of writing and phoning insurance companies to fight for coverage.
``I was very frustrated by insurance,'' she says. ``The demands don't stop.''
When the owners of the family practice decided not to subsidize the business, it dissolved, Grigg said. She left in July. She'd already reduced her hours to part-time to pursue an MFA in poetry at Goddard College, a hobby she'd picked up to calm herself during medical school. She's still working on her degree and teaches a class at Goddard one day a week that combines anatomy and creative writing.
Grigg is not the first to shun insurance. A group of doctors in Seattle set up a program called SimpleCare made up of 200 physicians around the country.
The doctors offer patients who pay in cash their ``best prices'' on office visits.
A husband and wife pair in Denver has set up a practice called HMNo. Doctors Heather Sowell and Jonathan Sheldon say they wanted to treat patients based on medicine and not on insurance coverage.
Patients pay in cash. Sowell and Sheldon charge $80 for a 20-minute interview and $240 for a full hour. If they know they have an ear infection, the appointment will be quick. They even do house calls and take phone calls at home.
They opened the practice in Colorado two years ago after working for Community Health Plan in Montpelier. Sheldon said he wanted to perform a bone density test on a woman for $150 to see how to proceed, but the HMO wanted him to prescribe drugs that would cost more than $300 a year.
They say their method of getting to know the patient cuts down on the amount of tests and prescriptions they would have otherwise prescribed.
``It's odd that it becomes news when doctors simply rediscover our role as healers and passionate patient advocates,'' Sheldon said.
Skeptics say they appreciate the concept of doing away with insurance, but it can only go so far.
``In concept I think it's nice. Those of us that deal with the nightmare of insurance, government and regulation would love to be free of it,'' says Dr. Stephen Brittain, a neurologist at Rutland Regional Medical Center.
``I think it's very nice when patients are paying... They really will think about what they're paying for, presumably the physician will also think about that. The problem is with all the (expensive) higher tech diagnostics,'' he said.
Grigg admits her way of doing things would not work for more complicated cases. She also admits she doesn't need to make a lot of money. For acute care sinus infections, ear aches, and sprains the concept appears to be working.
A medical doctor works at the clinic one day a week and a registered nurse Grigg knew works part-time, at half her emergency room salary.
``Just because I believe it in so much, I'm willing to hang in there,'' Jeanne Raiche says.
Patients cross the border from New York and drive from Rutland to see Grigg. She figures she'll have to see 9 to 11 patients an hour to make a profit. That could happen next year.
``My biggest fear is that she'll be a tremendous success,'' says Martin. ``That you won't be able to get in their and sign your name because there will be 40 people ahead of you all the time. And then the whole purpose will be defeated.''

Insurance Times: Study Shows Increase In Low Income Families Losing Health Cover: Marked Increase In Poor Parents Without Coverage
May 9, 2000, Vol. XIX No. 10

by Karen Gullo
Associated Press

WASHINGTON Fewer low-income workers with children are offered health insurance by their employers, and many who are can't afford the premiums, according to a new study. The result is a marked increase in the percentage of poor parents without health benefits.
The rate of uninsured parents rose to 35 percent in 1999 from 31 percent in 1997, said a report released Monday by the Center for Studying Health System Change, an independent research group that looked at 30,000 families.
The increase reflected what researchers say is an unfortunate circumstance: Poor people moving off welfare earn too much to be eligible for federal health programs but the jobs they get either don't include benefits or pay wages so low that they can't afford to purchase insurance.
``The findings of more low-income parents becoming uninsured was the most alarming,'' said Jocelyn Guyer, policy analyst at the Center on Budget and Policy Priorities, who studied the findings.
The study also showed low-income children, too, are losing private health insurance coverage, offsetting government efforts to increase the number of poor kids with health benefits.
As a result, the percentage of poor children with health coverage has remained about the same, although the government has signed up more children for a special public insurance program.
The study, funded by the Robert Wood Johnson Foundation, a philanthropic organization that advocates better access to health care coverage, showed the percentage of children with private coverage, such as employer-sponsored health plans, fell to 42 percent from 47 percent from 1997 to 1999.
About 33 percent of children in the center's study were covered by Medicaid and the state Children's Health Insurance Program (CHIP) in 1999, up from 29 percent in 1997. Medicaid and CHIP are funded with state and federal money.
The government created CHIP in 1997 to help children whose families earn too much for Medicaid but can't afford insurance on their own. Some 2 million children have signed up for the program.
But children are being dropped from private insurance plans just as quickly as others are joining CHIP so the problem of the uninsured hasn't improved, researchers said.
Despite the increase in public enrollment, the study showed that 20 percent of kids living in families making less than $26,000 a year lacked health insurance in 1999, which is about the same as in 1997.
Some 11 million children and 33 million adults in the United States have no health benefits, according to government studies.
Researchers said the biggest factors in families losing private coverage probably were higher health care costs and fewer small companies offering health benefits to low-income workers.
Premiums at small firms -where many low-income employers are likely to work increased 5.2 percent in 1998 and another 6.9 percent in 1999. Workers' share of premiums averaged $145 a month in 1999, up from $122 in 1996. Many go without insurance to preserve money for food and housing.
Small companies don't offer workers health benefits, pay a smaller share of the premium when they do or don't cover dependents because insurers are charging them more for health plans, said Neil Trautwein, director of employment policy

at the National Association of Manufacturers.
``The size of their work force tends to be more volatile and more expensive for insurers and they charge higher premiums,'' Trautwein said.
Earlier this month, Texas Gov. George W. Bush said he would give low-income families a $2,000 tax credit to help them purchase private insurance. Vice President Al Gore wants to expand CHIP, allowing adults to sign up, which would cost the government $146 billion.

Insurance Times: Aetna Inc.'s first-quarter operating profits leaped a better-than-expected

May 9, 2000, Vol. XIX No. 10

Aetna Inc.'s first-quarter operating profits leaped a better-than-expected 28 percent as the nation's largest health insurance company benefited from higher premiums and slightly lower medical costs.

Aetna earned $184 million, or $1.29 per share, compared to $158.4 million, or $1.10 per share a year ago. Results easily beat Wall Street expectations by 17 cents a share, according to First Call/Thomson Financial.
Revenues rose 39 percent to $7.9 billion from $5.7 billion. The big increase was largely due to Aetna's acquisition of Prudential Health Care, which it bought last year.
``Things are more optimistic,'' said David Shove, an analyst with Prudential Securities. ``The company is in a rebuilding process operationally and with its credibility, and these numbers were the first step in that process.''
Shares of Aetna rose $4.75 to $59.93} on the New York Stock Exchange.
Aetna's U.S. Healthcare business provided much of the first quarter earnings growth. The managed care division had operating earnings rise 24 percent to $131.8 million from $106 million.
Aetna this year has increased premiums about 10 percent of its U.S. Healthcare business and about 14 to 16 percent on its Prudential business.
The company its still struggling to control costs for its Medicare HMO business. It said it plans to quit the Medicare HMO business in several markets next year.
Aetna's financial services division had operating earnings rise of 27 percent to $60 million from $47.3 million a year ago.

Insurance Times: Agency Profile

May 9, 2000, Vol. XIX No. 10

by Penny Williams

Bragdon Insurance Agency, Inc.

286 York Street, York ME 03909
Phone: 207-363-3200 Fax: 207-363-1023
Susan Leslie, President

Agency's total 1999 insurance premium volume:
$1 to $3 million

Approximate breakdown of agency premium volume(percentage):
Property, Casualty: 100% (Personal 70%; Commercial 30%)

What automation system(s) does your agency use?
Applied Systems

What agency functions are automated?
Almost all systems - scanning, etc.

Total number of employees: 4

How many companies does your agency represent? 6

Approximate population of town where agency is headquartered. 12,000 year round
The following is an Agency Profile conducted by Penny Williams of InsuranceTimes with Susan Leslie, president of the Bragdon Insurance Agency, located in York, Maine. Leslie is the current president of the Maine Insurance Agents Association.

How long has your agency been in business?
The agency has been in business for 102 years.

Describe the local community and any target markets your agency serves.
York is a small, seasonal coastal and relatively affluent community. The agency's target markets are high-end personal lines and tourism in the form of hotels, restaurants, etc.

What do you think are the major reasons for your agency's success?
The key to our success lies in our knowing who our clients are and how to give them better service and products than they expect.

What makes your agency different or sets it apart from others?
I think it is because the staff 'feels' a real ownership in the agency and in agency decisions. And, they understand who pays their salaries their clients!

How does your agency attract new business?
We use some local print advertising but primarily we attract new business through referrals from our clients and referrals from local Realtors and attorneys. We purposely make the insurance piece of a real estate closing easy and seamless.

In what community and/or industry activities are you, your agency or employees involved?
Locally, the agency is involved with the Chamber of Commerce. The agency makes generous contributions to important community issues such as the library, the volunteer ambulance association. The staff and I are very involved with association work.

How long have you been in the insurance business and how did you happen to get into the agency business?
I have been in the insurance business for 30 years. I got into the business when I walked into an unemployment office as an unskilled mother of two looking for - who knows what!

Please describe your own role in the agency. How you are involved with clients, with employees, with insurance companies?
I manage this relatively small agency, act as producer on commercial accounts, take care of the bookkeeping duties and am the primary contact with carriers and I am not afraid to play CSR if that is what is required.

What parts of your job do you like best which the least?
Motivating and mentoring my staff and being to 'go to person' with coverage issues are the parts of the job I like best. I like being the computer 'techie' - that I'm not - the least.

As an agency owner or principal, what is your biggest challenge your greatest reward?
The biggest challenge as an agency owner is helping the staff stay focused on the 'big picture' and keeping my companies satisfied with respect to volume. The biggest reward for me is knowing I have accomplished two goals: having committed employees and loyal clients.

What do you see as the primary issues in Maine facing agents, companies, regulators and consumers as you lead your association into the new century?
For all of the above - keeping a stable workers' compensation market. We need to leave the current system alone for a couple more years. Let's deal with the exceptions rather than changing the system for a few.

What are your principal goals and challenges for your term in office?
My primary goal and challenge is attempting to get our members to be aware of the value of our association legislatively in Maine and on the national scene. We need to support these efforts through the use of our products, such as education.

The world, the industry and especially the marketplace have undergone tremendous changes in recent years. Given these changes, how has the role of the association changed both on a state and national basis?
We spend a lot of energy making information more accessible through automation; because of the demands on people's time, we have to offer more than a social club mentality to our agents both state-wide and nationally.

Briefly describe your office in terms of furnishings, equipment, decorations etc.
We are very pleased to have a newly redecorated building, done in keeping with our very New England little village.

Is there one maxim, guiding principle or piece of advice that has guided you in your career?
Nothing very profound - but I have drilled this in every class I have ever taught and into every employee I have ever mentored 'Don't ever, ever lie to a client.'

If you were not an insurance agent, what other career or job would like to try and why?
Some days I think perhaps a toll taker on the Maine Turnpike! But seriously, I have had two of the best jobs in the world being a mother and being an insurance agent.

What advice would you give someone entering the agency business and hoping to own an agency someday?

For Personal Lines and Main Street Commercial Lines, I would strongly suggest developing strong ties to regional companies and give your clients better service than they anticipate; and, participate in your insurance association.

In what areas do you think the insurance industry today does a good job serving the public and in what areas do you think it needs to do a better job?
We do well protecting the assets of our clients but sometimes we need to be less reactive with a knee jerk approach.

How do you see the insurance agency system and/or your own agency changing over the next five years?
We are going to have to become more accessible in more creative ways.

Cite a law, regulation, insurance company requirement or industry tradition you would like to see changed, added or eliminated for the benefit of your insureds and why?
I want my companies to offer replacement and original manufacturers' parts for repairs to vehicles less than 5 or 6 years old.

Discuss any other insurance issue you feel strongly about.
After market auto parts are an issue. We have sometimes nickeled and dimed our good clients over this issue and, furthermore, it is creating a poor public image in the meantime.

Insurance Times: The Workers Compensation System: An Analysis of Past, Present and Potential Future Crises American Academy of Actuaries
May 9, 2000, Vol. XIX No. 10

The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.
The following members and interested parties of the Workers Compensation Work Group contributed to the compilation of this monograph:

Nancy Treitl, F.C.A.S., M.A.A.A., Chairperson
Michelle Bernal, F.C.A.S, M.A.A.A.
Brian Brown, F.C.A.S, M.A.A.A.
Ann Conway, F.C.A.S, M.A.A.A.

Thomas DeFalco, FC.A.S, M.A.A.A.
Daniel Goddard, F.C.A.S, M.A.A.A.
John Herzfeld, F.C.A.S., M.A.A.A.
Richard Hoffman,A.C.A.S., M.A.A.A.
Michael Lamb, F.C.A.S., M.A.A.A.
Ramona Lee, A.C.A.S.
Barry Llewellyn, A.C.A.S., M.A.A.A.
Dee Dee Mays, F.C.A.S, M.A.A.A.
David Mohrman, F.C.A.S., M.A.A.A.
Layne Onufer, F.C.A.S., M.A.A.A.
Jill Petker, F.C.A.S., M.A.A.A.
Mark Priven, F.C.A.S., M.A.A.A.
Lee Smith, F.C.A.S., M.A.A.A.
Tim Wisecarver, F.C.A.S., F.C.A., M.A.A.A.
Richard C. Lawson, Executive Director
Tom Wilder, Director of Public Policy
Ken Krehbiel, Director of
Communications
Greg Vass, Casualty Policy Analyst

American Academy of Actuaries
1100 Seventeenth Street NW
Seventh Floor
Washington, DC 20036
Tel (202) 223-8196
Fax (202) 872-1948
www.actuary.org

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Insurance Times: Executive Summary

May 9, 2000, Vol. XIX No. 10

Workers compensation countrywide combined ratios (sum of an expense ratio and a loss ratio) for accident years 1988-1990 were in excess of 120% as reported by the National Council on Compensation Insurance (NCCI). At the end of the 1990s, workers compensation countrywide combined ratios are once again estimated to be in excess of 120%. This monograph contains a review of the forces that caused the workers compensation crisis of the 1980s, discusses the changes that have occurred in workers compensation over the past decade, and raises awareness that another significant crisis may be brewing as we approach the new millennium. The tools for dealing with the worsening workers compensation combined ratios of the late 1990s differ from those of a decade ago. Insurers have more flexibility in pricing and, therefore, may be better able to respond more quickly to changes in cost trends as they start to rise. Existing self insurance programs and the development of new products have given employers more options for funding their workers compensation programs. Efforts are already underway to develop better measures of system outcomes. This may enable future reform initiatives to be based on a more objective process that balances the adequacy of benefits with

the affordability of the system, rather than having such initiatives be crisis-driven. The issues and tools available are discussed further in this monograph.

Introduction

After a prolonged period of rising costs and operating losses for the insurance industry in the latter half of the 1980s, the American Academy of Actuaries (Academy) published a report in 1993 that expressed concerns about the financial health and ultimate survival of the workers compensation system. In addition to identifying factors that contributed to the workers compensation crisis of the 1980s, it focused on the need to implement a number of reforms to end to the crisis. This was a crisis for employers because loss costs were increasing rapidly and eroding profit margins for reasons that were at least partially beyond their control. It was also a crisis for insurers because insurance rate increases did not keep pace with rising workers compensation costs in most states.

Workers compensation countrywide combined ratios for accident years 1988-1990 were in excess of 120%, as reported by the National Council on Compensation Insurance (NCCI). Starting in the early 1990s, workers compensation costs began to fall.

Some factors that contributed to this include: a strong economy; efforts of employers and insurers to prevent accidents and better manage the cost of workers compensation claims; and substantive benefit and administrative reforms in some states.

During the mid-1990s, the financial results for workers compensation were generally favorable for insurers, as loss trends were better than expected. Consequently, price competition in the mid to late 1990s heated up. While employers benefited from reductions in their workers compensation costs, financial results for workers compensation insurers once again deteriorated. At the end of the 1990s, workers compensation countrywide combined ratios are once again estimated to be in excess of 120%.

The purpose of this monograph is to review the forces that caused the workers compensation crisis of the 1980s, discuss the changes that have occurred in workers compensation over the past decade, and raise awareness that another significant crisis may be brewing as we enter the new millennium. While insurance industry results are similar to those of a decade ago, many of the underlying factors are different. This monograph covers:

History of Workers Compensation Crises & System Reforms - a summary of the relationship between crises and benefit reform efforts over the past three decades;

Economic Influences on Workers Compensation Costs - a discussion of how the strong economy of the 1990s contributed to cost reductions and how a change in economic conditions may exacerbate the current insurance crisis;

Introduction of Managed Care Techniques - a review of how the introduction of managed care techniques contributed to declining claim severities and why by the end of the current decade the claim severi-ties are rising again, but at a slower rate;

Price Competition- - an overview of how price competition has changed over the past decade;

Residual Market Reforms & Depopulation - a discussion of the trend away from assigned risk plans toward state funds or other alternative self-funding mechanisms.

Insurance Times: History of Workers Compensation and System Reforms
May 9, 2000, Vol. XIX No. 10

Workers compensation system reforms have generally been enacted in response to crises. Typically, business wants affordable costs, labor wants adequate benefits, insurers want reasonable profits, and hospitals, doctors, lawyers and a host of other service providers want to preserve or expand their respective shares of the system. These conflicting pressures have usually resulted in a political stalemate until a crisis forces state legislatures to take action.
During the 1970s, reforms centered around issues related to the adequacy of benefits. The benefit expansions that resulted produced significant increases in workers compensation costs for employers. The National Commission on State Workmen's Compensation Laws, established by Congress through the Occupational Safety and Health Act of 1970, produced a report in 1972 with 19 essential recommendations, including higher weekly maximums and escalating benefits.
Most states adopted at least some of the recommendations. Rating bureaus adjusted rates for changes that could be quantified, but they could not adequately anticipate increased benefit utilization and the expanded role of service providers in the new, larger systems. It took several years for these cost increases to be fully reflected in rate filings. Due to these significant cost increases during the 1970s, many employers opted for self-insurance in order to gain better control of their costs.
In the 1980s, there were relatively few significant statutory benefit changes enacted. Despite this, in the late 1980s, costs were rising at 10% to 15% per year.
This was driven by:
high rates of medical inflation and cost shifting from the general health care arena to workers compensation;
lingering effects of the benefit increases from the 1970s;
increased benefit utilization impacting both the frequency and duration of claims; and
expansion of benefits in some states through judicial interpretation of statutes.
It was difficult for approved rate changes to keep pace with these cost increases. Thus, loss ratios deteriorated and a crisis ensued.
This cost crisis of the late 1980s drove the wave of administrative reforms, benefit reductions and other changes that occurred during the early 1990s. (A synopsis of some of these key statutory benefit reforms is contained in Appendix A, available from the Academy.) With some exceptions by state, the benefit structure is rarely cited as a key cause for poor financial results for workers compensation insurers.
In the future, reform initiatives could continue to be crisis-driven. It would be preferable, however, for reforms to be driven by an objective process, balancing the adequacy of benefits with the efficiency and affordability of the system. For this to occur, measures of outcomes are needed that encompass not only the dollar-cost of benefit changes, but their cost in terms of the socioeconomic impacts as well. The rating bureaus expanded their data reporting requirements in the 1990s, requiring additional fields to be added to unit statistical reports and requiring detailed claim information to be filed in all states. This was one step toward improving the industry's ability to better monitor system costs. Organizations such as the Workers Compensation Research Institute and some state administrative agencies have also begun to work on

initiatives to develop tools to better measure outcomes.

Economic Influences on Workers Compensation Costs

Complex economic forces influence workers compensation results in several important interrelated ways. Actuaries evaluate workers compensation cost trends by analyzing historical loss costs. Loss costs can be divided into two components: the frequency of claims (i.e., the number of claims per unit of expo-sure); and the severity of claims (i.e., the average cost per claim).
Claim frequency is believed to be influenced by the following factors:
level of employment and availability of gainful employment (concerns about layoffs or plant closings tend to drive up claim frequency);
the degree of experience of the workforce (less experienced workers tend to have higher claim frequency);
the amount of overtime (tired workers tend to get injured more);
shifts in the mix of employment from manufacturing to the service sector;
infrastructure investments in safety and ergonomics along with the general level of safety and loss prevention at the employer's site; and
many other economic factors influencing the relative attractiveness of filing a claim for benefits versus staying in the workforce.
How these forces interact is complex and may change from time-to- time as the economy changes.
Claim frequencies have generally fallen throughout the 1990s, but this pattern cannot be expected to continue forever. The latest available insurance industry data indicate that the rate of decrease in claim frequencies is declining and, in some states, frequencies may now be rising.
Economic forces also influence the size of claims. Some of these forces are the same as those that affect frequency:
the availability of substitute employment may lead to a more rapid return to work and reduced losses from a particular injury;
the aging work force may lead to longer durations because older workers may have more difficulty returning to work than younger workers. It may also lead to higher weekly workers compensation benefits as older often earn more than younger, less experienced workers;
the amount of overtime and the number of workers holding multiple jobs influence the level of wages lost when an injury occurs;
medical cost drivers in the economy influence the medical costs of workers compensation at large;
many other economic factors, including welfare reform, may significantly affect return to work efforts.
During most of the late 1980s, the annual percentage change in workers compensation claim severities was much higher than the rate of inflation. Indemnity claim severities grew at a rate of approximately 8% per year from 1980-1990, while wage growth during that period averaged 5% per year. During the same time period, medical severities grew at a rate of approximately 12% per year while the medical consumer price index (CPI) increased at 8%. Medical severities for workers compensation increased at a much lower rate in the 1990s, as did medical costs for the economy at large. Indemnity severity trends also improved significantly.
The key question for policy makers today is: Where are workers compensation costs heading as we enter the new millennium? As noted above, this is a difficult question to answer. We are currently in one of the longest economic expansions ever. Someday, the expansion will likely cease and the economy will contract. The impact of this contraction on workers compensation costs is uncertain but is more likely to increase costs than to lower them.

Introduction of Managed Care Techniques

The use of managed care techniques by workers compensation insurers and self-insurers has evolved over the past two decades. Managed care influences both indemnity and medical costs. The mid-to-late- 1980s experienced significant cost increases for health care costs. As mentioned above, workers compensation medical costs were increasing much faster than general health care costs. Many insurers used some elements of managed care, especially for large catastrophic claims. However, comprehensive managed-care programs were virtually nonexistent. The managed care techniques used in the 1980s were predominantly:

comparing bills to state-approved fee schedules in states with medical fee schedules in place and to usual and customary charges in other states;

using nurses to manage catastrophic claims (with rehabilitation nurses working primarily on-site);

focusing on returning the injured worker to work.

During the early 1990s, the workers compensation industry began more aggressively to address medical and indemnity costs. In addition, many states passed reforms that allowed for the implementation of some further managed care techniques, although some states also restricted carrier flexibility by mandating programs.

In the field of general health care, managed care programs and techniques grew rapidly. The workers compensation industry also began to expand its use of managed care techniques to include:

adopting medical fee schedules in many states that did not previously have them;

negotiating preferred provider organization rate discounts (thus obtaining discounts below workers compensation medical fee schedules or below usual and customary charges in non-fee schedule states);

implementing utilization review (pre-authorizing hospital procedures ; concurrent and retrospective reviews of provider practices);

using nurse case management on more claims, including problematic temporary total and permanent partial claims (telephonic nurse case management brings rehabilitation nurses to a much wider group of claimants);

developing and implementing treatment protocols specific to workers compensation; implementing more exhaustive bill review;

introducing programs in which managed care organizations participate financially in workers compensation results;

piloting exclusive provider organizations, specialty networks, HMO's for workers compensation, and 24- hour programs;

enhancing the partnership between the employer and the insurer (with a heavy emphasis on return to work and directing care to select providers).

The above steps, along with other changes in the health care delivery system, are believed to have substantially reduced workers compensation medical costs. In the early- to mid-1990s, medical severity trends for workers compensation returned to levels similar to those of the general health care system.

General health care costs themselves were also trending up at a much slower rate than in the 1980s. In addition, managed care has contributed to a reduction in the duration of indemnity benefits by enabling injured workers to return to work sooner. As a result, average severity trends for workers compensation indemnity fell below general wage inflation in many states.

As we close out the decade, workers compensation medical and indemnity costs are growing at a quicker pace than in the mid-1990s. Managed care techniques in some states are reaching saturation. Many insurers have implemented comprehensive managed care programs, and new techniques and programs are being added at a decreasing pace. It is thought that workers compensation costs may begin to rise more rapidly as the majority of managed care savings has worked its way through

the system.
Additional concerns also exist. General health care costs are on the rise, which will likely lead to higher workers compensation medical trends and to cost-shifting to workers compensation from health care programs where employees pay the deductibles, coinsurance, and copayments. There are concerns about a potential managed care backlash and attempts to reverse some of the favorable managed care reforms implemented in the early 1990s. Legislatures are discussing Medical Privacy acts at the federal and local levels. The potential lack of access to medical information is significant because medical issues often drive the eligibility for, and the duration of, workers compensation benefits. Depending on whether workers compensation is exempted from these acts, there may be a significant impact on workers compensation medical costs and on the ability of companies to continue to use various managed care techniques.

Price Competition

"Upfront" price competition in the workers compensation marketplace has increased in recent years. Prior to the 1980s, workers compensation insurers operated in an "administered pricing" environment. Rating bureaus filed rates and rating plans on behalf of all insurers, which were required to adhere to their rates. Competition could only be achieved through service and "back end" dividend plans. In the 1980s, states began passing various types of competitive rating laws. In their least flexible form, these competitive rating laws allow insurers to file deviations from the bureau rate level. However, many states passed laws that prohibited rating bureaus from publishing advisory rates. Instead, they must publish advisory "loss costs" by class. In these states, insurers are required to file their own independent rates based on their own expenses and profit requirements, and may reflect their own expected loss levels as well. These changes increased price differentiation in the marketplace and addressed complaints about the appearance of monopolistic pricing in an administered pricing environment.
In addition, during the 1990s, schedule rating was expanded from 24 to 34 states -- including large states such as California. Schedule rating further increases the insurer's pricing flexibility by allowing price adjustments based on individual risk characteristics.
Competition is not always in the form of price. The competitive drive of insurers to write the best risks has also fostered new product development and new cost control techniques. For example, competitive rating laws allowed insurers to file independent large-deductible programs and competition for large accounts focused on loss control facilities, claims management capabilities, and management information reports. Insurers also now have the ability to develop their own experience rating plans in some states.
Both large and small employers have benefited tremendously from competitive pricing during the 1990s. As costs began to fall because of state benefit reforms, loss control efforts, and the implementation of managed care programs, quantifying the impact of these cost decreases became a challenge. In hindsight, bureau rate indications tended to overstate the actual costs that emerged, in part because of time lags involved with data reporting. Therefore, many insurers looked to their own more current data and formed their own opinions. Competitive rating laws provided a mechanism for insurers to reflect those different opinions in their pricing. Price competition today is so intense that many large employers have abandoned self-funded programs to purchase guaranteed cost policies at very low prices.
Accident-year combined ratios at the end of the 1990s once again appear to be in excess of 120%, yet significant price competition continues. The high combined ratios are raising concerns for regulators and insurers. The crisis for employers may come early in the next decade if contraction in the insurance

marketplace leads to sudden and dramatic price increases by insurers akin to those of the liability insurance crisis of the 1980s.

Residual Market Reforms and Depopulation

Most state laws require that employers fund their workers compensation liabilities by purchasing insurance or qualifying as an approved self - insurer. Therefore, most states provide a "residual market" mechanism to guarantee the availability of insurance coverage to all employers who are unable to obtain coverage in the voluntary market. Traditionally, there have been two main types of residual market mechanisms: self-funded plans (mainly state funds), which bear the risk for residual market profits/losses; or assigned-risk plans, which distribute the residual market profits/losses proportionately among voluntary market insurers via a pooling arrangement and make direct assignments to those insurers not participating in the pool. (Appendix B provides a description of these mechanisms and their current use by state and is available from the Academy.)

Despite the advent of competitive rating, assigned-risk plans grew rapidly during the late 1980s. One reason is that residual market rates acted as a cap on voluntary rate levels, and neither set of rates was keeping pace with rising insurance costs. This put the residual market mechanism in direct competition with voluntary- market insurers. Because the residual market rates approved by regulators were often severely inadequate during the late 1980s, most assigned risk pools operated essentially as insolvent insurance companies .

Voluntary-market insurers were forced to absorb the residual market operating losses as residual-market "burdens" and incorporate these costs as additional expenses in their voluntary-market risk selection and pricing decisions. This rendered voluntary - market rates more inadequate, causing growth in the size of the residual market.

During the late 1980s, the size of the voluntary market was relatively stable in states with state funds, while the burden of subsidizing the residual-market mechanisms in states with assigned-risk plans resulted in significant constrictions of the voluntary market. In a few states it became so extreme that the voluntary insurance market collapsed. Consequently, in the 1990s, nine states opted to replace their assigned risk plans with either state funds or with private insurance companies taking on the risk (although one state, Nevada, went in the opposite direction moving from a state fund to an assigned-risk plan). In other states with assigned-risk plans, a number of changes were implemented to address regulatory and insurer concerns.

The changes to assigned-risk plans that took place in the 1990s included:

In most states, rules related to the administration of assigned-risk plans were filed with regulators for approval, thereby formalizing the requirement that voluntary writers of workers compensation insurance participate in the assigned-risk market via participation in a reinsurance pool. In 11 states, insurers were also given the option of taking direct assignments and a number of insurers exercised that option;

Most states retaining assigned risk pools put servicing carrier services out to bid, resulting in reductions in both the number of servicing carriers providing services in a state and in the servicing carrier allowance they received. In some states, plan administration was also put out to bid;

Pricing programs were implemented to increase residual-market premium levels in most states. The programs included rate differentials, surcharges, elimination of premium discounts, the introduction of a more loss-sensitive experience rating plan for risks with debit experience modifications via an assigned-risk adjustment plan (ARAP) surcharge, and mandatory retrospective rating plans for risks above a certain premium threshold;

States implemented programs aimed at depopulating the assigned-risk pools. The

programs ranged from providing insurers with take-out credits, reducing their share of the residual-market losses, to more proactive programs helping employers find insurance in the voluntary marketplace. For example, effective January 1, 1998, Alabama introduced a new requirement that employers must obtain one of the two required declinations from a private insurer that has offered a broad-based depopulation program before acceptance into the state's assigned risk plan. Although the Alabama plan had already been depopulated dramatically due to competition, 90% of the remaining risks were removed from the Plan in the first year of the program.

There was a dramatic turnaround in the results of the residual market in the 1990s when compared to the huge residual-market operating losses in the late 1980s. At its peak, the residual market averaged close to 25% of the insurance market in states with assigned - risk plans, with some variation by state. The average residual- market operating loss as a percent of voluntary-market premiums in those states was in excess of 10%. Residual-market pools became largely self-funded in the mid 1990s, and in some cases were actually profitable.

By the 1990s, the residual market was generally so small that its operating results became inconsequential relative to voluntary-market premiums. Alternatives to the traditional residual-market pools have been implemented in a number of states. As we enter the new millennium, we can only speculate as to what will happen to the size and cost of funding the residual market if competition for voluntary-market risks decreases. It's also still unclear how the alternative approaches to the residual market will fare if we once again end up in a situation, similar to that of the late 1980s, in which cost increases significantly out-pace changes in premium levels.

Conclusion

Countrywide combined ratios for workers compensation at the end of the 1990s may mirror those of the late 1980s, but the causes of the high combined ratios differ in many ways. Although insurance industry results differ by state, concerns about the health of the economy, rising medical costs, and employment levels existed in both decades and impact all states. In the 1980s, loss costs were rising, the residual market had become a large burden on the voluntary market, and price levels in many states were only beginning to be deregulated . In contrast, in the late 1990s, price competition is driving up combined ratios. Competition has also dramatically increased the availability of voluntary - market insurance. Residual markets in most states are now so small that their operating results are inconsequential relative to voluntary - market premiums. Employers have benefited from several years of sustained improvement in the affordability of workers compensation costs, and pressures to increase benefits are beginning to emerge.

The chart to the left compares and contrasts workers compensation issues over the past decade.

As we enter the new millennium, the tools for dealing with the worsening workers compensation combined ratios of the late 1990s differ from those of a decade ago. Insurers have more flexibility in pricing and therefore, may be able to respond more quickly to changes in cost trends as they start to rise. Existing self-insurance programs and the development of new products have given employers more options for funding their workers compensation programs. Efforts are already underway to develop better measures of outcomes. This may enable future reform initiatives to be based on a more objective process that balances the adequacy of benefits with the affordability of the system, rather than having such initiatives be crisis driven.

<table>

Workers Comp Issue	Late 1980s	Late 1990s
Cost to Employers	Rose rapidly, often with double digit increases .	After several years of decreases or flat price changes, employers are concerned that costs may once again start to rise .
System Reforms	Benefits expanded due to increased utilization of the WC system. Pressure to reform systems led to substantive administrative and benefit reforms in the early 1990s.	Pressures to increase benefits.
Economy	Increased claim frequency. High rates of medical inflation for general health care exacerbated the already high WC medical inflation rates.	Downward trend in claim frequency of mid 1990s may be reversing. Concern that recent price increases for general health care will drive up WC medical costs.
Managed Care	In infancy for WC, but expanding use of programs in the general health care place . System shifted more costs to WC .	Mature market with numerous WC programs in place. Some political backlash emerging.
Price Competition	Insurers used some deviations and sche - dule rating. Some states introduced "open rating", but insurers were con - cerned with adequacy of rates.	Widespread price competition, with insurers extensively using independently filed rates and other pricing tools introduced over the past decade.
Residual Markets	Grew rapidly, placing major burden on the voluntary market.	Rapid pool depopulation of mid 1990s continuing. Improved pool operating results.Residual market burdens are generally insignificant.
Insurer Profitabiity	Deteriorated rapidly.	Deteriorating significantly and persistently since 1995, after having improved for several years.

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Insurance Times: Early Reporting Of WC Injuries Adds Up To Big Savings
May 9, 2000, Vol. XIX No. 10

Hartford A company's prompt reporting of workers injuries can have a considerable influence on its bottom line.
A new study by The Hartford Financial Services Group, Inc., a leading providers of workers compensation, found that claims filed five or more days after an injury cost an average of 15 percent more for medical and income-replacement benefits than similar claims that had been filed promptly.
"With medical and indemnity costs rising at an annual rate of seven to eight percent," according to Richard W. Palczynski, senior vice president and chief actuary at The Hartford, "controlling workers compensation costs has become increasingly important for companies. The Hartford's study demonstrates that early reporting can be one of the most effective ways risk managers can keep costs in check."
The Hartford analyzed more than 30,000 lost-time workers compensation claims over a five-year period from 1994 - 1998. The injuries fell into three categories -- back injuries, carpal tunnel syndrome and other nerve disorders, and miscellaneous injuries -- which represent about two-thirds of all lost-time workers comp. claims. The study excluded claims for open wounds, fractures, and dislocations, which are already typically reported within 48 hours of occurrence.
The analysis shows early reporting of nervous disorders such as carpal tunnel syndrome can save an average of 20 percent of medical and lost-time costs. Delaying reporting of a back injury increases claim costs by an average of 10 percent, and all other injuries cost 12 percent more.
"Our study confirms what we've long believed, that early reporting on workers compensation claims saves money and speeds an injured worker's return to work," said Cal Hudson, The Hartford's group senior vice president for claims. "When policyholders report claims promptly, we can quickly institute our case management services to ensure that injured workers receive the appropriate medical care and rehabilitation services."
Hudson noted that soft-tissue injuries, such as back injuries or sprains, can be particularly vulnerable to delays. "It's not unusual for a worker to strain his back, continue to work for several weeks and then seek medical attention only after the injury has been aggravated and the damage intensified. Companies need to emphasize to their employees that all occupational injuries -- no matter how minor -- need to be reported promptly so they don't become major problems," he said.
The Hartford has a 24-hour, toll-free TeleClaim service for policyholders reporting a loss.

NCCI: WC outlook 'not real bright'

The outlook for the workers compensation industry is "not real bright" according to the head of the nation's major workers compensation organization.
In a preview of his remarks before this organization's annual issues symposium last week, Bill Schrempf, president and chief executive officer of the National Council on Compensation Insurance, said that over-capacity continues to define the market.
The 1999 combined accident year loss ratio for workers compensation was an estimated 130, "as high as it's ever been" and comes at a time when loss costs are stable.
Results show workers compensation carriers are some 32 points away from earning a respectable 15% on return on equity.

Insurer discounting has opened up a gap of more than 20 percent on average between NCCI filed rates and discounted rates.

Indicators of what's ahead are "very ugly," said Schrempf. Loss costs have been rising-- with preliminary numbers suggesting as much as10 to 15 percent in 1999 over 1998.

If frequency is not falling at the same time, the industry will be in for a rough ride, he pointed out.

At the same time that loss costs are rising, pressure from labor and trial attorneys is building for benefit increases and rollbacks of reforms. This could put regulators in a difficult position and contribute to the overall conclusion that "comp costs are poised to deteriorate dramatically."

Insurance Times: Personal Lines
May 9, 2000, Vol. XIX No. 10

Protector Group appoints Morrison, Quinty; Vermont Mutual re-elects Brooks and Tierney; ASU sports agency merger finalized; National Grange Mutual appoints 6 to posts

The Protector Group

The Protector Group Insurance Agency, inc., Worcester, Mass., announced several appointments.

Ronald D. Morrison join the firm as an account executive in the sales division. Morrison will develop and expand coverage tom existing clients while also increasing the company's client base. He comes to the agency after years with Harvard Pilgrim Health Care, Blue Cross Bluer Shield and other organizations.

Kathleen M. Quinty is the new human resources manager and will direct recruitment, orientation and performance management programs; administer benefits; coordinate training activities; develop career succession plans and oversee regulatory compliance issues.

Vermont Mutual

At its recent 173rd annual meeting, the Vermont Mutual Insurance Co. re-elected William H. Brooks as chairman and Thomas J. Tierney as president and chief executive officer.

Other officers elected include Richard N. Bland, vice president, general counsel and secretary; William A. Catto, senior vice president; Joanne M. Currier, vice president for information systems; Brian C. Eagan, vice president, chief financial officer and treasurer; Peter P. Fresco, vice president of marketing; Julia C. Morgan, vice president of human resources; Allen L. Prior, vice president of claims;, and James F. Sloan, assistant secretary.

In 199, Vermont Mutual wrote $101 million in premium in 10 states.

ASU International

ASU Enterprises, an insurance provider to the sports, entertainment and other specialized industries, and American Specialty Underwriters, a provider of sports, entertainment and executive disability insurance, have merged to form ASU International.

William F. Hubbard, formerly president of ASU Enterprises, has been named president and chief executive officer of the new company which is based in

Woburn, Mass.
Edward A. Dipple, founder of the company, will serve as chairman of the board of the new company and oversee efforts to broaden its international presence.
Other senior management appointments include: Candace J. Hallett, executive vice president and chief operating officer; Mark L. Barry, senior vice president for global marketing; Erica Brennan, senior vice president for U.S. operations; Marc Idelson, senior vice president of underwriting; and Christopher Rackcliffe, managing director, London.
In addition to its Woburn, Mass. office, ASU International maintains offices in Atlanta, Georgia; Pasadena, Calif.; and London. Other ASU International, Inc. companies include ASU Risk Management in Atlanta and ASU Services in Danvers, Mass.

National Grange Mutual
Geoffrey S. Molina has been named director of internal audit for National Grange Mutual Insurance Co. in Keene, N.H. He will be responsible for the management and development of internal audit programs, while also serving as liaison with the board of directors' audit committee. Most recently, Molina has been manager of commercial lines underwriting at The Netherlands Insurance Companies, also in Keene, N.H.
Jeanne H. Eddy has been named executive vice president at the company. She has responsibility for finance, audit, actuarial, information technology, investments and information systems and services. Eddy joined NGM in 1999 as a senior vice president and chief financial officer.
Gerald Ganley has been named assistant secretary. He is also director of personal lines field underwriting. Gerry has been with the company since 1973.
Edward J. Kuhl is the new vice president, controller and treasurer at NGM. Previously, he was controller and treasurer.
NGM also named Michael Robie as assistant secretary. Kuhl also serves as director of personal lines staff underwriting and has been with the company since 1974.
And Kevin Smick has also been named an assistant secretary. He is also the director of project management.

Plymouth Rock
Geoffrey A. Gordon, president of Andrew Gordon Inc., an independent agency in Norwell, Mass., has been named to the Plymouth Rock Agency Advisory Council by Plymouth Rock President Hal R. Belodoff.
The four-person council meets monthly with senior management to discuss industry trends, technology, product development and other issues.
The council, chaired by Normand A. Dion, of Columbia Insurance Agency in Lynn, Mass., also includes Sheila Doherty, Doherty Insurance Agency in Andover, Mass., Maureen S. Armstrong, Sylvia & Co., Insurance Agency in North Dartmouth, Mass.
Plymouth Rock sells through 130 independent agencies in Massachusetts.

Provident Mutual Life
Sarah Coxe Lange has been promoted to senior vice president and chief investment officer at Provident Mutual Life Insurance Co. on Berwyn, Pa.
Lange serves as president of Providentmutual Investment Management Co. , the investment advisor for several of the market Street Fund portfolios, and will continue to oversee the investment management for each of the company's major product lines.
Before joining Provident Mutual, Lange was with Penn Mutual Life and Girard Bank.
Daniel C. Danese was promoted to senior vice president for distribution and will have overall responsibility for all distribution channels and in setting policy for sales and marketing.

He joined Provident Mutual in 1999 as a regional vice president from New York Life.

Insurance Times: American Modern Home Insurance Company
May 9, 2000, Vol. XIX No. 10

American Modern Home Insurance Company
7000 Midland Blvd.
Amelia, Ohio 45102

The above company has made application to the Division of Insurance for a license / certificate of Authority to transact Legal Services insurance in the Commonwealth
Any person having any information regarding the company which relates to its suitability for a license or Certificate of Authority is asked to notify the Division by personal letter to the Commissioner of Insurance,One South Station, Boston, Massachusetts 02210 Attn: Financial Surveillance and Company Licensing, within 14 days of the date of this notice.

Insurance Times: The Princeton Excess and Surplus Lines Insurance Company
May 9, 2000, Vol. XIX No. 10

The Princeton Excess and Surplus Lines Insurance Company
555 College Road East
Princeton, NJ 08543

The above company has made application to the Division of Insurance for authorization as a Surplus Lines Company under section 168, Chapter 175 Massachusetts General Laws.
Any person having any information regarding the company which relates to its suitability for such authorization is asked to notify the Division by personal letter to the Commissioner of Insurance,One South Station, Boston, Massachusetts 02210 Attn: Financial Surveillance and Company Licensing, within 14 days of the date of this notice.

Insurance Times: The Complete Score
May 9, 2000, Vol. XIX No. 10

Imagine a local sports report that gave partial game scores, or covered only one sport. That's the way some regional trade publications view the insurance industry.
But not InsuranceTimes.
We cover every segment, from personal lines and workers comp to managed care and life insurance.

Get the complete score.
Get IT.
Insurance Times

Insurance Times: Use Of Internet For Commercial Insurance To Jump Significantly

May 9, 2000, Vol. XIX No. 10

While U.S. corporations today make minimal use of the Internet for their commercial insurance or risk management needs, a significant increase is expected over the course of the next 24 months, according to a survey by the Association for Financial Professionals (AFP).

Of the individuals participating in the survey, only 12 percent or fewer use the Internet to buy business insurance or risk management products. However, nearly half (49 percent) of the survey respondents will use the Internet to buy primary property/casualty insurance in the next 12 months, and 64 percent plan to do so over the next two years.

For excess liability coverage, 45 percent say they would use the Internet a year from now, increasing to 59 percent in two years. Twenty-four percent predicted use of the Internet for reinsurance in one year and 38 percent in two years; and 43 percent will go online for alternative risk products in one year and 52 percent in two years.

Respondents ranked the largest barriers to buying and managing commercial property and casualty insurance online as their broker relationship (83 percent), security of the information (81 percent), and administration concerns (80 percent).

The mid-March 2000 survey was administered to corporate financial professionals who previously identified themselves as having job responsibilities in either risk management or insurance risk management. The 91 responses were received from professionals in manufacturing, retail, communications/media and other industries. Approximately 25 percent of survey participants work in companies with less than $250 million in revenues, 41 percent between $250 and $999.9 million and 32 percent with $1 billion or more.

These conclusions support those of an October 1999 semi-annual AFP survey in which financial professionals reported that their use of the Internet to conduct a variety of financial transactions will increase as much as 12-fold over two years. The complete text of the survey can be viewed on the AFP Web site, www.afponline.org.

Insurance Times: Berkshire Hathaway Buying Insurers U.S. Investment, U.S. Liability, Mt. Vernon

May 9, 2000, Vol. XIX No. 10

U.S. Investment Corporation, a Wayne, Pennsylvania insurance holding company signed a merger agreement with Berkshire Hathaway, Inc. on April 20, 2000. Once all approvals required for the merger are obtained, U. S. Investment Corp. and its three insurance companies, United States Liability Insurance Co., Mount

Vernon Fire Insurance Co. and U.S. Underwriters Insurance Co. will become wholly owned subsidiaries of Berkshire Hathaway (BRK). The parties expect that all approvals will be received, and the merger consummated, in the third quarter of this year.

BRK is a holding company owning subsidiaries engaged in a number of diverse business activities including insurance through such companies as GEICO, General Re and National Indemnity.

United States Liability Insurance Group is a specialty insurance group underwriting commercial lines, professional lines and personal lines insurance. The group has the highest rating, A++ superior, available to an insurer by A.M. Best. All products are marketed exclusively through wholesale agents.