Insurance Times: Mass. WC rate methods called likely to produce inadequate rates

April 17, 2001, Vol. XX No. 8

by Mark Hollmer
InsuranceTimes

BOSTON - An actuary speaking for Massachusetts insurance companies is criticizing methods used to calculate workers compensation rates in the state in recent years, warning that failure to adjust could produce inadequate rates and a return of market problems faced in the 1980s.

The criticism by John Dawson - on behalf of the Independent Property Casualty Insurers of Massachusetts - is unusual because this domestic insurer group's membership overlaps with that of the Workers Compensation Rating Bureau, which has adopted the methods in its own rate filing.

"...The traditional methods used in determining workers compensation rates are not well equipped to anticipate changes in underlying trends, and the impact of not doing so on the adequacy of rates is potentially significant," said Dawson a partner with Ernst & Young.

Dawson submitted his comments during the WCRB's rate case public hearing on April 5. The WCRB recommends a 7.7 percent rate increase after years of rate decline, in part to cover rising loss ratios caused by higher medical costs. Eastern Casualty filed its first ever separate rate request seeking an 11.6 percent rate increase; its public hearing was held after the WCRB hearing.

The State Rating Bureau's responses in both hearings should be filed sometime in May. Insurance Commissioner Linda Ruthardt must decide on rates in both cases by Sept. 1.

Ed Donahue, vice president of the Independent Property Casualty Insurers of Massachusetts, said Dawson's comments are merely "an informed observation on the recent history of this market and a different interpretation of some of the essential inputs into the method for calculating workers compensation premiums."

He said the testimony is "significant in that it makes an acknowledgement that rates may have been somewhat redundant in the early 1990s."

But the testimony also reflects hope, Donahue said, that Ruthardt recognizes that the "same mistake seems to be leaning toward an inadequate rate allowance in the last and in the next filing."

The WCRB and other parties have filed petitions to change the methodology in the past, and changes have been made in previous filings.

This year, however, the WCRB is using the methodology established by the State Rating Bureau and approved by Ruthardt in 1999.

Donald Bashline, vice president and WCRB actuary, said the method his bureau is using is new for the organization. The WCRB made a conscious decision to stick to formulas from the last approve rate, he said, "to avoid drawn-out litigation on technical issues.

"The point of our filing," he said, "is to get a good rate for our members, an adequate rate with a minimum of technical wrangling. We thought the simplest way to do that would be to file, essentially, what the Commissioner approved two years ago.

"That doesn't always denote complete agreement with the Commissioner's decision," he said, "but (she) found these methods reasonable two years ago."

Dawson's comments aren't the only statements in the rate case hearing to focus on actuarial methods. Actuarial analysis, for example, is expected later in the rate case from the Workers Compensation Advisory Council.

Dawson, in his written comments, said he's afraid of what will happen "if the unfavorable trends that are now beginning to emerge are not accounted for.
"I fear that the rates will not be adequate to cover costs, and we face the possibility of a return to severe market problems similar to those of the late '80s."
Dawson said that "traditional actuarial methods" used in workers compensation rate determination estimate future losses assuming that average inflationary trend in losses experienced in recent years will continue "even though the most recent data may indicate to the contrary."
But the method using past experience to predict the future only works when trends are stable, he said.
"When the trend is changing, the traditional methods don't work well in forecasting ultimate losses or required rates," he said.
Dawson said he believes loss cost trends began to turn in 1997-1998.
He said the change, in part is due to the end of savings from legislative reform and higher medical costs.
But this trend turn, Dawson said, "is not reflected in the Bureau's filing because the approach and methods used in the filing are essentially the same as those used, and accepted by the Commissioner in the past.
"The result," he said, "is overly optimistic trend assumptions and a projected rate increase that is, in my option, likely to be inadequate to cover all future costs."
Bashline said the WCRB, in its filing, points out that there "is always a danger that a method in which you look at the past is capable of missing a turning point."
The WCRB filing, presented by attorney Scott Lewis, does acknowledge future "trends such as rising loss ratios, average wage increases and higher medical costs.
In addition, Lewis said in his filing, the Assigned Risk Pool population is growing, climbing from 4 percent in 1999 to 6 percent last year. So far this year, he said, pool application numbers have jumped 30-40 percent compared to last year.
"Increasing numbers of both small and large employers are finding themselves without coverage in the voluntary market and must seek Pool policies," he said.
This year's filing, Lewis said, "is consistent with the industry's efforts to achieve stability and predictability" in the market.
Bashline said the WCRB decided to forego adjustments in its trending and write up its filing based on Ruthardt's approved trending mechanisms ultimately because of being "constrained by the process."
"We filed this filing to have it approved by (Ruthardt). It's much easier and happier for us and for (her), too, if we make a filing that everyone can be happy with and that she can approve.
"We're not looking for a 96-day hearing and I believe neither is anyone else."

Insurance Times: Medical bureau expansion to health raises privacy concerns

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MIB sees role as fraud prevention aid

by Mark Hollmer
InsuranceTimes

The Medical Insurance Bureau has existed for nearly 100 years, but few outside of the life insurance industry know what it is.
And now it's expanding in a move that's causing some concern among local privacy advocates.
Based in Westwood, Mass., the MIB has acted as a repository of information for hundreds of life insurance companies across the country.
Virtually everyone who applies for a life insurance policy deals with the MIB. Applicants with member companies are asked to sign an agreement allowing their information to be submitted to the organization's database - now containing medical information for about 16 million people.
The submission takes place only with a customer's consent. And it helps fight fraud, because members who come across something suspicious in the underwriting process can pay a fee to cross-check their information by using the database.
Recently, the MIB expanded its membership to individual and small group health insurers. More than 20 across the country have signed up so far, said Fred Pritikin, MIB's vice president and chief marketing officer for its e-Services Corporation.
The expansion concerns people like A.G. Breitenstein, a Cambridge attorney who helped write a privacy bill pending in the State House.
"This is part of a very large trend," she said. "There are very many companies springing up all over the place who are going to be dealing with health data.
"Patients don't realize what they're doing."
Pritikin said the goal is to give health insurers another way to fight fraud, and also to "gather the underwriting data from health insurance companies as service to our life insurers."
Member insurance companies aren't allowed to use the information to deny coverage or make underwriting decisions, he said, and they must verify any warning signs independently of the MIB.
"We audit them" to make sure companies comply, Pritikin said.
Breitenstein questioned if health insurance consumers would be penalized for opting out of having their application records placed in the MIB database.
"The devil is in the details, as is most things," she said.
Each insurance carrier has its own set of rules as to how it deals with opting in or out on policies, Pritikin said.
MIB is essentially owned by the insurance industry through its members, and the organization estimates it saves members more than $1 billion annually regarding fraud prevention.
According to a company fact sheet, once an applicant has given consent, member companies submit that person's information in a coded report only if the individual "has a significant condition that could affect health or longevity."
Companies can't retrieve or input information into the MIB system without an applicant's permission.
The agreement lets a member insurance company use the MIB database to look for "any medical codes or alerts" on record from other insurance applications.
The existence of the MIB, according to the organization, has helped prevent applicants from leaving out or concealing medical details.
Pritikin says the MIB complies with the Fair Credit Reporting act and maintains a consumer disclosure office. This means anyone with a signed authorization can find out what is in their MIB record and ask for a review if they disagree with the contents.
Any mistakes identified are corrected, Pritikin said. If a customer disagrees, he or she can have a statement placed in their record stating as much.
The business of collecting health information is growing, even leading to Web-based services like MediConnect.net, which gathers medical, policy and billing records for organizations in the life insurance, property casualty, workers compensation and legal fields.
Still, Pritikin says MIB hasn't had any major competitors in the life insurance

industry, in part because company members are owners and "the sensitive nature of the information exchanged.
"By pure virtue of the fact we've been able to withstand the test of time and be allowed to continue to exist," he said, "we have some strong processes in place to protect individual information."
He also said the MIB complies with recent federal laws regarding privacy standards.
MIB officials decided to expand membership for some health insurers, Pritikin said, because the organization found most health insurers focus their fraud prevention efforts at claims time, with their efforts concentrated on providers.
A recent managed care conference made this perfectly clear, he said.
"The general feeling," he said, "was there are not a lot of resources available at underwriting time. We thought that they could probably use us."
Maybe so, but Breitenstein disputes the notion that health insurance fraud is a huge problem among patients, for example. She suggested the MIB membership expansion could hurt patients as a result.
"Fraud perpetrated by patients is about one million of one percent of all fraud in the health care system," she said.
Massachusetts State Rep. Jay Kaufman, with Breitenstein's input, sponsored a medical records privacy bill that died in committee last year, but has been refiled for the new session.
He said he's neutral on the MIB's existence in and of itself, but is cautious about its membership expansion to include some health insurers.
"There's no inherent problem with it," he said, "so long as there are impenetrable firewalls of security to protect data.
"One of the challenges I think we face protecting privacy in an information age is to try and balance legitimate needs for data," he said, "with equally legitimate needs for privacy."
Breitenstein agreed, but said consumers should still be wary and make sure they know what they're doing when they give permission for their personal application information to be shared.
"In and of itself, in theory it is not doing anything wrong, that people are giving consent for information to be deposited in the MIB," she said.
But "if you ask the average person on the street if they understood what they were signing and even knew what the MIB was, they don't generally know...
"Although (the MIB does) have consent, the consent is fairly meaningless."
Breitenstein added that insurance applications "often include quite a bit of health information," with records tacked on as part of the process.
And consumers, she said, should consider that factor too.

Insurance Times: Mass. LTC partnership proposal gaining more support each year

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The fourth year may be the big one for an LTC partnership plan

by Mark Hollmer
InsuranceTimes

BOSTON - For more than three years, Massachusetts State legislators have failed to pass a bill to establish public/private partnerships encouraging people to buy long-term health care insurance.
This year, the fourth time could be the charm.

Legislators have filed two identical bills in the State Senate and House that would reward senior citizens who purchase long-term care insurance to help defray nursing home costs.
The Massachusetts Extended Care Federation, which represents the state's nursing homes and assisted living facilities, once again has thrown its support behind the bills. The group sponsored legislation three previous times, though it never made it out of legislative committee.
This year could be different, said Scott Plumb, the group's senior vice-president.
"It's getting more attention," he said. "People are looking at long-term care and they're looking at demographics ... and the ... dependency of nursing homes on Medicaid....
"You look and see 7 of 10 people are on Medicaid and (you) will get more."
As a result, Plumb said, legislators are looking to increasingly "encourage the growth of private resources to cover long-term care, and long-term care insurance is one of those resources."
Similar public/private long-term care partnership bills have already been passed in New York, Connecticut, Iowa, Indiana and California.
Right now, Medicaid kicks in for eligible long-term-care residents after they first exhaust their insurance coverage. Without coverage, they must whittle down their assets to about $2,000, in a process known as "spending down." And when those individuals die, Medicaid usually comes in to recover its expense.
New Massachusetts legislation, if approved, would reward seniors who buy approved, private long-term care policies by allowing for Medicaid coverage after insurance coverage ends without requiring spending down of assets.0000..
Connecticut was the first state to establish a public/private partnership back in 1992. The state's Office of Policy and Management runs the program, known as the Connecticut Partnership for Long Term Care.
David Guttchen is the Partnership director, and he says the program has succeeded since its launch.
At the end of December 18,000 policies had been written through the program and the number was close to 20,000 as of March, he said.
Sales have climbed each year, he said, jumping 34 percent in 2000 over the previous year.
"We think the program is doing quite well," he said.
The program is relatively simple. In Connecticut, without participating in the long-term care program, a person would have to spend down their assets to $1,600 to become eligible for Medicaid.
But if the individual needing coverage uses a Partnership-approved long term care policy and it paid out $100,000 in benefits, they'd be allowed to keep their assets at a level equal to what the insurance paid. And the patient would still be eligible for Medicaid coverage.
Of those 18,000 Connecticut policies, only about 90 people have used the insurance coverage so far. Seven ran out of their insurance and need to go on Medicaid.
For those seven people, Guttchen said, "the program is an absolute success" because they could protect their assets equal to what their insurance policies paid.
At least in Massachusetts, it may not be so simple to pass a long-term care bill this year or anytime soon.
The five states with public/private long-term care policies were able to revise their Medicaid requirements only with a waiver from the federal Health Care Financing Administration first.
But Massachusetts only has a partial waiver, according to Jenny Erickson, vice president for legislative affairs at the Life Insurance Association of Massachusetts.
"And to be set up in the first place, most experts don't think you could set

this program up in Massachusetts under the waiver they got...," she said.
As a result, Erickson said, LIAM isn't taking a position on the proposed legislation, but instead is urging legislators to determine if its legislation is legal before moving ahead.
At the same time, Erickson said, LIAM members have supported public/private long-term care programs in other participating states.
"They have been a good idea and have worked well in other states," she said.
A third long-term care bill is also pending.
The bill would limit the waiting period to qualify for MassHealth home health care benefits to no more than 100 days rather than up to 360 days. And those benefits, according to the bill, must be at least 50 percent of nursing home coverage or $100 per day, whichever is greater.

Insurance Times: Foes unite behind Maine proposal on care for dying

April 17, 2001, Vol. XX No. 8

by Glenn Adams
Associated Press

AUGUSTA, Maine (AP) - Activists who were on opposing sides in last fall's doctor-assisted suicide referendum campaign are now teamed up in support of a bill to improve care for the dying in Maine.
About 70 of the Legislature's 186 members, including seven Democratic and Republican leaders, have signed on as co-sponsors of a bill that was reviewed last week by the Banking and Insurance Committee.
The King administration is opposing it, while the organization representing Maine's four health maintenance organizations is neutral.
Maine voters on Nov. 7 rejected a citizen-initiated proposal to allow doctors to help terminally ill patients take their own lives. Maine would have become the second state, behind Oregon, to allow physician-assisted suicide.
After their election day loss, supporters of the proposal said they had succeeded in heightening public awareness of the need to improve care for the dying.

Last week leaders of the campaigns that had been at odds a few months ago stood side-by-side in support of the seven-point bill.
"Today, we stand with one voice. We both feel a responsibility to carry forward promises we made last year - to do everything we can to help terminally ill patients in our state,'' Kate Roberts, who worked for last year's referendum campaign, and former adversary Edie Smith, said in a joint statement.
Roberts, a clinical social worker, said she has seen patients and families "struggle with the challenges of terminal illness.
"While the illness is difficult enough, I have also seen patients and families forced to wrestle with the challenges of an inadequate system of care.''
Former legislator Joseph Mayo, who has Lou Gehrig's disease and is confined to a wheelchair, appeared before the committee in support of the bill. Mayo now serves as House clerk emeritus.
In a statement read by his wife Rebecca Wyke, Mayo said, ``There are many people in Maine, also enduring a terminal illness, who do not have the wealth of support I do. I appear here for them.''
Also supporting the bill were several health-care providers, medical and religious groups.
Among the bill's provisions is one to set a Medicaid hospice care benefit of

$130 a day.
The bill would require health insurance and health maintenance contracts to cover pain-control, hospice and end of life care.
It would also direct the state to establish a center to educate health professionals in end-of-life care. In addition, it calls for further studies and reports on issues related to care for the dying, and a $50,000 appropriation to the Maine Hospice Council.
All of Maine's HMOs already cover some form of hospice, end-of-life and palliative care, although each may have different benefit levels, Joseph Mackey of the Maine HMO Council said.
While the council spoke neither for nor against on the bill, ``in reality we support this,'' said Mackey.
The state Human Services Department, while supporting Medicaid reimbursement for hospice care, opposed the bill because of "significant problems'' with the way it's implemented, said Marianne Ringel of the department's Medical Services Bureau.
DHS implemented a Medicaid hospice benefit as of Jan. 15, which makes it unnecessary for the Legislature to mandate such a benefit, Ringel said.
She added that the $130 per day hospice Medicaid rate proposed in the bill is well above the $100 Medicare rate, which would make the benefit substantially more costly. Ringel asked the committee to take a closer look at the implications of the bill.
A study released last fall that followed 988 dying cancer patients for six months concluded that very few terminally ill patients consider ending their own lives.
In his study, Dr. Ezekiel Emanuel of the National Institutes of Health found that 60 percent of those he tracked said euthanasia or physician-assisted suicide should be an available option, but only 10.6 percent admitted considering it for themselves.

Insurance Times: Equale exits IIAA; Rusbuldt named CEO

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Robert A. Rusbuldt is the new chief executive officer of the Independent Insurance Agents of America. Rusbuldt succeeds Paul A. Equale, who is leaving IIAA to focus on his role as chairman of the Democratic Business Council.
Rusbuldt, a 15-year IIAA veteran, joined IIAA as senior lobbyist in 1986. He was named executive vice president and chief operating officer in 1998 after heading the group's government affairs efforts for several years.

Insurance Times: NH issues cease and desist against Bankers Life

April 17, 2001, Vol. XX No. 8

by Penny Williams
InsuranceTimes

CONCORD, N.H. - Based on complaints received from senior citizen policyholders, the New Hampshire Insurance Department (NHID) issued a Cease and Desist Order to Bankers Life and Casualty Co., an Illinois domiciled company licensed to do business in New Hampshire.

Negotiations between the insurer and the NHID, department and insurer sources said, were expected to produce a settlelement at press time.
The NHID alleges that Bankers Life and Casualty Co. violated several New Hampshire insurance laws and regulations by systematically selling life insurance and annuity products to senior citizens in the state without determining whether the policies were suitable for the individuals.
Specifically, the NHID alleges Bankers Life misrepresented the benefits of annuity and life insurance products to induce senior citizens to purchase unsuitable products; sold costly annuity and life insurance products to seniors without first determining need or financial affordability; had applicants attest to false and erroneous medical information on its "easy issue" applications resulting in claim denial if the applicant dies within the contestable period; and sold multiple annuities to seniors without first determining need, financial affordability, suitability or valid purpose.
As a result of the foregoing, the C&D order stated, "Bankers Life and its agents shall cease all sales of life and annuity insurance products to New Hampshire citizens 65 and older until, at a hearing specified herein, the Company shall show cause why its authorization to conduct business in New Hampshire should not be revoked or limited based upon the above violations."
Spokesperson for Bankers Life, Patricia Milner, vice president for internal affairs said that as of Tuesday, April 10, the two sides had resolved all but two items.
"While we disagree with the C&D order," Milner said, "we want all sales practices to be suitable just as much as the Commissioner does and we are eager to improve and serve our customers better."
NHID Director of Consumer Affairs Gyda DiCosola agreed a resolution was in sight. "We are significantly down the road in terms of the C&D Order issues, but everything has not been resolved yet," she said.
A hearing on the New Hampshire C&D order was scheduled for March 5 but was postponed indefinitely.
DiCosola noted that while the number of complaints was small compared to the company's total business in the state, it was the "severity" of the problems that concerned the NHID the most.
Bankers Life doesn't agree with the C&D order and doesn't admit to inappropriate sales practices.
In related action, the NHID is also actively involved investigating Bankers Life in conjunction with Maine and Vermont, with investigators working both in Illinois and New Hampshire.
Bankers Life is a member of the IMSA, the Insurance Marketing Standards Association, a voluntary membership organization that promotes ethical market conduct for providers of individual life insurance and annuity products.

Insurance Times: Deal struck over NY workers comp levies
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Twelve workers compensation insurers in New York will be getting back 51 percent of their assessment - about $13.5 million - stemming from 1996 reform legislation.
The deal grew out of negotiations between the American Insurance Association and New York State officials that began in 1998.
State legislators in March approved a $23.5 million appropriation to cover items in an annual deficiency budget, part of which will fund the settlement, according to the AIA.

Events leading to the partial return of assessments grew out of the 1996 Omnibus Workers Compensation Reform Act, specifically its repeal of the New York Court of Appeals decision "Dole v. Dow."

1972 Case

The 1972 case allowed a third-party manufacturer responsible for an employee's work-related injury to recover part of the judgment stemming from an employer's responsibility for an injury.

AIA said the case "placed New York well out of the mainstream of other state workers compensation laws."

Initially, after the reform bill passed, the state said repeal of "Dole" was retroactive prior to 1996. The bill, as a result, contained a one-time assessment of $98 million on excess reserves for all workers compensation insurers in the state.

But insurers said the assessment wasn't fair because there were not excess reserves. The provision was challenged in court, and the Court of Appeals ruled in 1998 that Dole's repeal took effect after the law was signed rather than retroactively.

AIA has been negotiating with state officials since then to resolve the dispute over the assessment.

The money goes to 12 member companies and their 107 subsidiaries doing business in the state.

Insurance Times: Local agencies not afraid to tackle challenges of e-commerce

April 17, 2001, Vol. XX No. 8

by Mark Hollmer
InsuranceTimes

For Ed Higgins, the future is now.

Higgins, the owner of the Thousand Islands Agency in Clayton, N.Y, spent the last three years and more than $60,000 putting a long-range strategic technology plan into action.

Higgins, 55, says he made the investment largely to increase efficiency. But he is also trying to reposition his agency as high-tech-savvy and ready to dive into the e-commerce age.

"If you want to play in the new marketplace you need to be able to play. The ones who get there soonest are going to have the best time and make the most money," Higgins says.

He adds: "The ones who stay behind are going to watch their customers migrate to those who went there."

Electronic, or e-commerce in its narrowest sense refers to a business transaction online. It's a concept that independent agents like Higgins are gradually beginning to confront.

Agents who have jumped in, however, are making the biggest progress in the broader sense of e-commerce, using the latest technology to sharpen their customer service or improve the convenience of shopping for or changing coverage.

At the same time, however, agents interviewed for this story add that the technological advances go hand in hand with the traditional face-to-face interaction between agent and customer.

"We're not replacing the relationship the client has with an agent," says Keith

Savino, of Insurehelp.com in Warwick, N.Y.
Adds Henry Risman, of the Risman Insurance Agency in Medford, Mass.: "In-person is a much more effective sales tool than the phone or e-mail is."
And while insurance e-commerce may be growing, it hasn't exactly taken over the industry at the moment.
There's "a very small amount at this point," Risman says.

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Higgins invested in all-new personal computers for his three-member agency, plus a digital camera, scanners at each workstation, CD-ROM's and a CD ROM burner to allow for electronically stored files. Employees each have their own individual email address, too, and they're printed on agency stationary.
What's more, Higgins and each employee has his or her own official electronic signature that allows the agency to generate a binder completely by email.
Email becomes an e-commerce tool, Higgins says, because each electronic correspondence is copied and pasted to the appropriate client file, allowing for a "full chronicle of transaction activities" with a customer.
His customer service representatives can use their computers in every part of a claims process, to email or fax information to everyone from body shops to underwriters as long as they're connected, too, he says.
Higgins' advances in the electronic world are relatively recent.
For the last six months, his office has been able to handle repair estimates online, where an estimate and photo can be scanned, attached to a claim and then emailed to an insurance company.
He's also on the verge of plowing further ahead in the e-commerce world than many of his rivals.
This spring, Higgins expects a contract with Ebix to kick in that will offer online services that's essential to a true, 24-hour agency gearing up for e-commerce. As planned, the system will let customers click a button on the agency Web site and access their insurance accounts, examine deductibles, make coverage changes or request new products.

Risman isn't quite far along as Higgins, but says his 11-employee agency has made huge technological strides, bringing him tantalizingly close to the e-commerce world.
For example, Risman's Medford agency has used high-tech imaging and scanning for all documents since 1999, for documents including policy surveys, notes, or customer or client letters. This advance has allowed Risman to convert two storage rooms into offices, because it no longer keeps paper files (except for the first 60 days).

Risman also updated his software(using AMS for Windows) bought new personal computers and a separate database server - spending about $20,000 for his initial investment.
He says his office is now ready for full-fledged e-commerce because when Web sites improve their ability to facilitate business transactions, he'll be ready.
"Customers may be able to access their accounts and see everything from our site," he says.
Risman practices elements of e-commerce, such as handling electronic correspondence from clients and companies. He also uses the Web to research prospective customers and marketing ideas.
But, Risman says, he doesn't believe that technology has reached a point that allows independent agents to fully jump to an e-commerce business model, closing deals online as well as providing customer service information.
"The consistency of software isn't quite there yet, at least from the agency prospective," he says. "Some of the things I thought were going to be available

a year ago still aren't."
For example, Risman says, he wanted his Web site to have a rating mechanism to allow clients to rate their auto or homeowners policy.

Some Web sites can conduct ratings, he says, but they're not reliable yet.
Savino, president of Insurehelp.com, presents an unusual foray into the insurance e-commerce world.
Savino also owns Warwick Resource Group, and formed his "virtual agency" in a partnership with nine different agencies.
Savino says his company lets insurance agencies become "e-commerce-enabled" because their Web sites can offer his product rather than just information.
"Most agents have no product on their Web sites. They have inquiry forms," he says.
Insurehelp.com sells unique insurance products such as coverage for wine collections or photography equipment, but only through other agencies' Web sites. Customers may click onto an agency Web site and then click a connecting button that leads them to Insurehelp.com and its products, though they still believe they're on the original agency Web site.
Some of the coverage can be purchased online with a credit card, and other products need a signature, but customers can print out an application and then send it in signed with a check.
"What's beautiful about this is that the agent could be playing golf and writing this business," Savino says.
But after a customer buys the online product, Savino says, the agent still needs to find the client "and have a conversation with them" about other sales opportunities.

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Each agent admits that e-commerce business isn't a large part of their sales yet, but they believe it will be.
Higgins, for example, says about five percent of his business takes place electronically right now, but he's seen growth anyway.
"We've already seen with our customers that a surprising number of them are using email," he says.
And at least 15 have signed up so far for the new Ebix 24-hour service, he says.
Higgins adds he wouldn't be surprised if his e-commerce business grows to 30 percent of the total within a few years.
"Remember the guy who was 18 two years ago is now 21," he said. "And you will see a younger, aging population go through and their set of expectations and minimum standards are going to be significantly different."
Higgins said he was anxious about making the technology change but now he's glad he did so, giving his customers a greater number of choices through which to buy products in the long run.
"When we made the change we found it was at least twice as terrorizing as we expected it to be," he said.
"When you change from one operating system to another and you're almost completely electronic, that change creates essentially instant chaos.
"But once you come through the window of transition and realize you're more powerful than you were, you look back and you're glad you made the leap."

Insurance Times: U.S. Chamber, Mass Mutual ink major LTC discount program

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Thousands of Chamber of Commerce members will be offered nursing home coverage at discounts of up to 15% to encourage families to buy coverage

by Anjetta McQueen
Associated Press

WASHINGTON - Thousands of businesses and their workers will pay less to insure themselves against expensive nursing-home costs, under a new deal with a leading insurance company that the U.S. Chamber of Commerce announced.

The national membership group of small and large companies has contracted with Massachusetts Mutual Life Insurance Co. to give thousands of member firms discounts of as much as 15 percent on long-term care insurance, which generally runs families $1,200 to $2,500 a year.

Officials say the savings - one of largest given in the industry - will encourage more businesses and families to buy such insurance.

"Caring for an aging family member doesn't come cheap,'' said Chamber president Thomas Donohue. "Without coverage, these expenses have the potential to deplete a family's savings.''

Few government programs cover the costs of keeping a loved one in a nursing home or paying for in-home nursing care, and a $55,000 average price tag for a year's stay makes it hard for families to pay out of their own pockets.

Lawmakers and government researchers warn that such burdens will grow as Americans live longer and the costs of hospitals, doctors and medicines rise. Yet few people have long-term care policies, which tend to cost more the longer a policyholder waits to buy it.

Tax Incentives

Businesses, especially small ones, are seeking tax incentives and other help in offering long-term care insurance to their workers, much like the general health care coverage most employees get now. More Americans, trying to care for their aging relatives at home, often miss work, cut back hours or quit altogether.

"When a small business owner or employee is faced with the need to provide long-term care, the last thing they want to worry about is how to pay for it,'' said Robert O'Connell, chief executive of MassMutual, which will provide the discounted insurance exclusively to U.S. Chamber members.

The Springfield, Mass., company was named in a 1998 lawsuit accusing it of imposing hidden charges on policyholders who pay premiums in installments rather than in lump sums.

Natural Choice

Chamber officials said MassMutual was a natural choice from the many insurers that belong to the business group.

"Mass Mutual is a very financially stable company,'' said Jane Sanders, who directs business research and projects for the Chamber.

Under the two-year program, member businesses will purchase the insurance, which workers can use to cover themselves, their parents or grandparents. Rate reductions will vary by state, Sanders said.

Besides the U.S. Chamber's almost 150,000 member businesses, up to 3 million firms in trade groups and local chambers of commerce will be eligible for the discounts, Sanders said.

Congress is considering several plans to create tax deductions for long-term care insurance premiums.

Insurance Times: Phoenix Mutual policyowners approve stock plan

April 17, 2001, Vol. XX No. 8

HARTFORD (AP)- Phoenix Home Life customers have approved the Hartford-based company's switch to stockholder ownership.
The insurer announced that 189,864 policyholders approved the switch and 10,664 voted against it. Roughly 500,000 policyholders of Phoenix Home Life Mutual Insurance Co. were eligible to vote.
The plan would change Phoenix from being a ``mutual,'' owned by policyholders, to a publicly traded stock company.
However, some Chicago attorneys filed a policyholders' lawsuit that calls the plan illegal and questions executives' motives.
Phoenix declined to comment on the lawsuit.
Executives of the company have previously said the conversion is meant to give Phoenix access to capital for growth, and to ease future acquisitions. Stock and stock options will help attract and retain employees, but aren't the primary reason for the demutualization, they have said.
The conversion would take place at the same time as an initial public stock offering, which Phoenix hopes to do by mid-year.
Within 45 days of the offering, policyholders would receive compensation such as stock, cash or policy credits for giving up membership rights.
The plan still needs regulatory approval.

Insurance Times: NH: auto insurance doesn't cover dog bites

April 17, 2001, Vol. XX No. 8

CONCORD, N.H. (AP) - Auto insurance should not cover dog bites, the state Supreme Court said.
Judy Rigmont was bitten by a dog while loading brochures into a car in 1996. She sued Gretchen Lebroke, who owned the car and the dog. She eventually reached a settlement with Vermont Mutual, the company that provided Lebroke's homeowner's insurance.
Vermont Mutual and Lebroke then tried to get United States Fidelity & Guaranty Insurance Co., which provided Lebroke's car insurance, to pay the settlement. A superior court agreed, but the Supreme Court reversed the decision.
The justices agreed with a decision reached by a Texas court in 1995. They wrote that the "Texas court narrowed the definition of 'auto accident' to require, at the very least, the involvement of an automobile.''

Insurance Times: Conn.'s Blue Ridge to merge with Wisconsin unit

April 17, 2001, Vol. XX No. 8

SIMSBURY, Conn. - Connecticut-based Blue Ridge Insurance will be absorbed into General Casualty, its Wisconsin corporate sibling.
General Casualty announced the move on April 5. The Connecticut Insurance Department approved the process at the end of March.
Swiss-based Winterthur Insurance Group owns both companies.
Under terms of the deal, Blue Ridge stock transferred from Winterthur U.S. Holdings to General Casualty on April 1. Integration of both companies should

take up to two years to finish, according to press information.
Blue Ridge's Simsbury, Conn. headquarters will become a General Casualty regional office.
Blue Ridge Insurance Company is headquartered in Simsbury, Conn., and was formed by Winterthur Insurance Group in 1995 out of two existing companies.
General Casualty dates back to 1925 in Madison, Wis. as an auto insurer and has been owned by Winterthur since 1990.
Right now, General Casualty operates in 12 Midwestern states and Blue Ridges writes business in eight states - Connecticut, New Hampshire, Maine, Maryland, Massachusetts, New Jersey, New York and Pennsylvania.
Blue Ridge employs 200 people and also maintains service offices in Massachusetts and New York.
General Casualty plans to continue contracts with Blue Ridge's 512 independent agents regarding underwriting, claims, loss control and marketing from its Connecticut office.

Insurance Times: Employers Re acquires CyberComp

April 17, 2001, Vol. XX No. 8

OVERLAND PARK, Kan. - Employers Reinsurance Corp., a GE company, has acquired and reactivated CyberComp, an online system that quotes and binds workers compensation policies, through its subsidiary Westport Insurance Corp. Prior to the acquisition, CyberComp was an operating unit of Reliance Insurance Co.
Westport will use "GE CyberComp" as the brand name for this online service.
Twenty-five employees of Lawrenceville, N.J-.based CyberComp will join ERC.
Westport will accept new business and consider renewal of existing business but is not assuming any of the existing 25,000 CyberComp policies.
CyberComp is known for allowing agents to conduct business entirely online.

Insurance Times: NY highest court voids car rental shift of auto liability to car renters

April 17, 2001, Vol. XX No. 8

by Joel Stashenko
Associated Press

ALBANY, N.Y. - The state's highest court gave consumers a victory recently by denying a rental car company's attempt to place all liability for accidents involving its vehicles on renters.
The seven-member Court of Appeals decided unanimously in four similar cases that rental companies, even self-insured ones, are bound by state law to provide the minimum liability insurance mandated by the state of $25,000 for bodily injury and $50,000 for death.
In an outcome praised by a car rental company, however, the court's ruling also found that the company was not bound for property damage coverage of its vehicles.
Self-insurers run the risk of having to pay liability judgments themselves, unlike those who are covered by private insurers.
The Enterprise Rent-A-Car company had tried to argue that its self-insured status in New York allowed it to include complete indemnification clauses in

rental contracts. Those clauses say the company provides them with no personal injury or property damage liability coverage. The clauses also stipulated that renters are responsible to pay for ``all losses, liabilities, damages, injuries, claims, demands, costs and expenses'' caused by accidents involving Enterprise vehicles.
Chief Judge Judith Kaye ruled that Enterprise's indemnification clauses violate "plain and precise'' state laws which stipulate that rental companies have to provide minimum bodily injury and death coverage to customers.
She said Enterprise does not have to provide coverage above the minimum levels and can seek to collect damages above those amounts from customers who get into accidents. She also found that Enterprise is not bound to cover property damage.
The ruling overturned four decisions by the Appellate Division of state Supreme Court in New York City which found the indemnification clauses valid.
State Attorney General Eliot Spitzer praised the court for the recent decision.
In a friend-of-the-court brief in the case, Spitzer said thousands of consumers would be affected by the court's ruling, whichever side it came down on.
"This is a great decision for consumers who will no longer be deceived by rental car companies into paying additional fees for unnecessary liability insurance costs,'' Spitzer said.
The attorney general sued Enterprise in May 2000 in a case separate from the four decided by the Court of Appeals. Spitzer's suit argues that Enterprise was not providing a legal defense or coverage to renters that it should be. Spitzer also argued that Enterprise customers were being charged an additional $6.95 a day for insurance that the company should be providing customers without an extra fee.
Spitzer said his office runs a help line at 1-800-771-7755 to answer questions from consumers.
The cases involved ELRAC, owner of the Enterprise Rent-A-Car chain. The company succeeded in winning judgments against drivers who'd gotten into accidents with Enterprise cars for between $2,074 and $50,000. Those were overturned Tuesday.
Enterprise's lawyer Christopher Jeffreys said there was a lot for the rental company to like about the ruling, especially Kaye's determination Enterprise can indemnify customers for property damage and that there is no minimum coverage level required for such damage.

Insurance Times: Court blasts State Farm aftermarket parts practice

April 17, 2001, Vol. XX No. 8

by Susan Skils Luke
Associated Press

An Illinois state Appellate Court has upheld most of a lower court's verdict in a nationwide class-action lawsuit against State Farm Mutual Automobile Insurance Co., ruling the country's largest auto insurer acted with ``calculated deception of its policy holders'' in supplying them with auto-body parts that critics claimed were substandard.
The verdict, handed down April 5 in the Fifth Circuit Illinois Court of Appeals in Mount Vernon, upheld most of the $1.2 billion awarded by a Marion judge and jury to 4.7 million plaintiffs nationwide in October 1999.
The appellate court reduced the award by $130 million because of damages that had been computed twice by the lower court.

State Farm to Appeal

A spokesman for Bloomington-based State Farm says the company will appeal it to the Illinois Supreme Court.
But lawyers representing the plaintiffs say the language the judges used in the 40-page opinion was unusually strong.
"There is overwhelming evidence of State Farm's calculated deception of its policy holders in a deliberate disregard of its express written promises contained in the policies issued,'' Judge Gordon E. Maag wrote in the opinion.
"They could take it to the United Nations if they want to, but no court will overturn this opinion,'' said Lexington, Miss.-based attorney Don Barrett, one of the plaintiff lawyers.
The plaintiffs claim that they had no choice but to repair their cars with so-called aftermarket body parts. Critics say the parts fail to deliver the same level of fit, finish, corrosion resistance and safety, as original parts.
State Farm argued that the cheaper parts held down insurance premiums. They also claimed that no one was forced to accept anything, since any parts used are guaranteed by the company.
"If a problem occurs with a generic replacement part, we're going to replace it until you're satisfied. And we'll pay the bill,'' said Steve Vogel, a State Farm spokesman. "How is that bad for the consumer?''
Plaintiffs' lawyers also say the decision strengthens several similar lawsuits filed in other states against other large auto insurers.

Insurance Times: NH CPCUs hear cautions about use of credit scoring

April 17, 2001, Vol. XX No. 8

by Penny Williams
InsuranceTimes

MANCHESTER, N.H. - New Hampshire insurance professionals recently turned the spotlight of March as Ethics Awareness Month on the use of credit scoring for insurance underwriting.
While banks have been employing credit scoring as a determinant for several decades, insurers have only relatively recently been using the criteria.
Some panelists expressed skepticism about credit scores and even insurance company proponents urged caution and consumer education about the practice. The independent agent participant was critical of the accuracy of credit reports.
Attorney Jeffrey Klein, vice president for government and industry affairs at Royal & SunAlliance, gave the use of credit information a qualified thumbs-up.
"Yes, use of credit in personal lines underwriting and pricing is ethical if it is truly a predictor of behavior and loss experience, but it should be used judiciously and there needs to be disclosures provided and education regarding its use," stated Klein.
Klein said industry people have convinced him of the accuracy of the predictive nature of credit scoring.
However, he said, there needs to be balance. "There is a need for the industry not to act arbitrarily, but rather be judicious in the use of such a tool."
Joining the N.H. Chapter of the Society of Chartered Property Casualty Underwriters as sponsors of the ethics panel were the N.H. Insurance Women's League, Insurance Women of Central N.H., the Southern N.H. and Vermont Associations of Insurance Women, Seacoast Insurance Women's Association and the N.H. Field Association.
Another insurer representative tried to downplay the use of credit as a determining factor. "The value of credit scoring is that it should be used as

an additional piece of underwriting information that can tell more about the customer," added Robert Desauliniers, agency marketing manager, Royal & SunAlliance
But Klein questioned the need for a pending New Hampshire bill (S. 126) on this issue sponsored by fellow panelist Senator Ned Gordon.
"The bill prohibits increases in premium in auto/homeowners in whole or in part based on credit history after a 'policy has been established,' " said Klein. The industry is uncertain as to exactly what is meant by "established."
Along the same lines he said the industry is concerned with the recent New Hampshire Insurance Department (NHID) proposed regulation regarding use of credit information because it requires written authorization before a carrier or agent can obtain a credit score. Klein sees this as unworkable from the standpoint of a consumer coming to an agent seeking bound coverage before leaving the office.
However, bottom line, said Klein, "more education of consumers is needed as to what the nexus is between credit information and predicting risk."
He said that Senator Gordon's concern "centers on the fact that the law in New Hampshire prohibits carriers from using credit scoring as the sole criteria for increasing premiums or non-renewing auto and homeowner policies." Yet, Klein added, carriers are doing just that but none has questioned about the practice since that law went into effect.
"Six years after the law was enacted nothing has changed," Klein maintained.

Sen. Gordon's Response
Sen. Gordon said his bill is clear in its language affirming that an automobile or homeowners insurance policy cannot be changed based in whole or in part on a change in credit rating or credit status of an insured. "Any change in such policies shall be directly related to the record of the insured. What's not to understand?" he wondered.
As far as he is concerned, the use of credit information "may serve carrier profitability, but it is economic redlining," Sen. Gordon said.
Insurance Commissioner Paula Rogers acknowledged that no carrier has been called on for charging premium rates solely based on credit information although there have been complaints to that effect.
"There is only one way the department can pick-up on this type of activity and that is through market conduct exams," she maintained. She said she plans increased market conduct examination activity in the state in the future.
Rogers considers the entire credit scoring issue a "huge challenge." While the use of credit information is here to stay, she believes there is much that needs to be examined in terms of how it is used and the material that is actually used in credit scoring models.
She suggested that the vendors of the credit scoring models such as Fair Issacs might need tighter regulatory oversight. At her request, Fair Issacs is scheduled to make a presentation to her agency about the details of the model it uses in the very near future.

Agent Foy's View
More often than not the person in the middle in credit scoring is the independent insurance agent. Offering the viewpoint of the agent, Jeff Foy, chief operating officer of Foy Insurance Group, cast doubt on the use of credit scores.
"Credit scores gathered without written authorization are a concern. Is it ethical to use credit information? Probably. But it doesn't meet my ethical standard at this time."
Foy 's concern with the use of credit information is based at least in part on what he believes is its questionable accuracy. "We have heard that 70 percent of credit histories will have at least one error," he said.

To test this he pulled his wife's credit history. "I checked and found information that was inaccurate," he said.
"If the level of accuracy is improved, the use of credit information can reach the level of ethical acceptance, but right now, I'm not particularly comfortable with it."
Foy called for balance and accuracy and agreed with Senator Gordon that "credit should not be the sole criteria for raising rates but said in some cases it is.
"To be eligible for the best price in many cases, you need exceptional credit," he said.
Is credit truly predictive? Foy didn't deny it might have predictive value, but made the point that it doesn't apply to all. "There are clients who don't have the best credit history but have all the other characteristics that make them a good credit risk."
Some companies use credit information and others don't. When trying to secure coverage for a driver with poor credit history, Foy suggested it is prudent to go to a company that uses traditional underwriting. However, he continued, if a customer has reasonable credit but a number of speeding tickets, then an agent will gravitate toward a company using underwriting decisions based on credit scoring rather the traditional underwriting criteria.

Insurance Times: Hilb, Rogal buys Conn. agency

April 17, 2001, Vol. XX No. 8

HARTFORD - Hartford-based B. Perkins & Co. Insurance Agency is being absorbed by a larger company.
Hilb, Rogal and Hamilton Co. of Virginia recently announced it acquired Perkins' stock, but did not reveal details of the deal.
Both companies are now in the process of blending Perkins into Hilb, Rogal and Hamilton's Hartford offices and management team.
Perkins' founder and president, Brewster Perkins, will join Hilb, Rogal and Hamilton's Connecticut branch as executive vice president, while Kimberly McGillicuddy, president of HRH Connecticut will run the combined operation.
B. Perkins generates more than $3 million in annual revenues. Hilb, Rogal and Hamilton has 80 offices around the country.

Farm Family bought
GLENMONT, N.Y. - The New York Insurance Department has approved American National Insurance Co.'s acquisition of Farm Family Holdings, Inc. The companies were to complete the transaction on April 10, 2001.
American National is acquiring Farm Family at a price of $44 per share for Farm Family's common stock and $35.72 per share for Farm Family's Series A Preferred Stock in cash.

Insurance Times: Life insurers applaud long term care tax incentives as vital to retirement

April 17, 2001, Vol. XX No. 8

WASHINGTON - Life insurers are praising Senate Finance Committee Chairman Charles Grassley (R-IA) and Sen. Bob Graham (D-FL) for introducing legislation to establish an above-the-line federal tax deduction for long-term care

insurance premiums.
The measure would also permit the inclusion of long-term care policies in employer-sponsored cafeteria plans and flexible spending accounts.
"One of the greatest risks to asset loss in retirement is unanticipated long-term care expenses," the American Council of Life Insurers told the Finance Committee in a statement. "Tax incentives to encourage the purchase of long-term care insurance will encourage Americans to prepare for their future retirements and to be protected against the financial devastation of paying for long-term care."
ACLI, which represents 87 percent of the private long-term care insurance industry, also pointed out that there are substantial benefits to government - - and future taxpayers - - of wider purchase of private long-term care insurance among baby boomers, who will double the nation's 65-and-over population to 70 million over the next 30 years.
"Medicaid will never be able to foot the bill for the millions of baby boomers who will need long-term care services in the not-so-distant future," ACLI said. "Providing this important tax incentive means that Americans who take advantage of long-term care protection will not be a burden on the Medicaid system and will not have to spend down their retirement assets to pay for long-term care before becoming eligible for Medicaid. Instead, they will have the choice of a variety of services if they are unable to perform a specific number of activities of daily living or are cognitively impaired."

Tax Deduction
The proposed above-the-line federal tax deduction would allow all taxpayers to deduct long-term care insurance policy premiums from their taxable income, regardless of whether they itemize on their tax returns.
ACLI research indicates that the costs of virtually all forms of long-term care - - from adult day care to home care to nursing home care - - will quadruple by 2030. It also shows that Medicaid's annual nursing expenditures will skyrocket from about $30 billion today to $134 billion in 2030 - - an increase of 360 percent. Private long-term care insurance could reduce Medicaid's institutional care expenditures by $40 billion a year, or about 30 percent.
According to ACLI, wider purchase of long-term care insurance could increase general tax revenues by $8 billion per year, because of the number of family caregivers who would remain at work. Currently, one in four American families - - 22 million - - are caring for an elderly relative or friend. Thirty-one percent of caregivers have to stop working outside the home; nearly two-thirds have to cut back on their work schedules; more than a quarter take leaves of absence, and 10 percent turn down promotions because of their caregiving responsibilities. It costs the typical caregiver about $109 per day in lost wages and health benefits to provide full-time care at home - - which is almost as much as the cost of nursing home care.
"We believe that protection and coverage for long-term care is critical to the economic security and peace of mind of all American families," ACLI said. "Private long-term care insurance is an important part of the solution for tomorrow's uncertain future. As Americans enter the 21st century, living longer than ever before, their lives can be made more secure knowing that long-term care insurance can provide choices, help assure quality care, and protect their hard-earned savings and assets when they need assistance in the future.

by Laura Meckler
Associated Press

WASHINGTON (AP) - About a year ago federal officials started to catch on: States were bragging about a new way to collect federal money intended for medical care

for the needy and funnel it into general coffers.
In Washington, the inspector general investigated, concluding that states were pretending to spend billions of dollars for Medicaid, the health insurance program for the poor and disabled, to draw inflated matching money from Washington. In most cases, the extra money ended in the state coffers, available for just about anything.
Over protest from states, the Department of Health and Human Services put regulations into effect this month to close the loophole. President George W. Bush's administration is continuing the policy put in motion by the previous administration, seeking to cut an additional $17 billion over the next 10 years.
It's unclear how far the administration will get, given the fierce opposition HHS met last year from members of Congress whose home states have been benefiting handsomely from the situation.
For now, the administration is talking tough, and last week HHS announced plans to further crackdown on what investigators call a sham and a shell game.
"The loophole has allowed states to draw down billions of dollars in federal reimbursement for hospitals and nursing homes without any assurances that these payments were used for their intended purpose,'' the administration said last month in its budget blueprint.
The blueprint notes that while HHS and Congress addressed the issue last year, what is called the upper payment limit loophole continues to cost the federal treasury billions - an estimated $6 billion above and beyond what Medicaid would normally cost just this year.
Medicaid is financed by a combination of federal and state dollars. On average, Washington pays 57 percent.
States are allowed to set their own payment rates to doctors, hospitals and nursing homes, but there's a ceiling: They can't pay more than Medicare, which mainly serves the elderly, pays for any one service.
For years, this was irrelevant, because typically Medicaid pays much less than Medicare. But beginning in the early 1990s, a few states discovered a lucrative accounting trick.
States would massively inflate their payments to state- or county-owned hospitals or nursing homes. When those payments were averaged with the lower payments made to private facilities, the state as a whole would be at the maximum charge, making the situation technically legal.
Those overpayments, however, were not being used to enhance care.
The state would transfer the money to the hospital or nursing home, and it would stay there just long enough to draw inflated matching money from Washington _ perhaps just a few hours. Then the facilities returned the money to the state, which could use it for any purpose.
By late 1999, state officials were buzzing about the accounting trick. HHS promised to crack down, which had one immediate effect: Even more states applied for these financing arrangements, wanting to get in on the extra cash before the law changed.
In September, 19 of the 50 states were receiving inflated payments. Today, 26 states are in on it, and five others have applications pending.
Last fall, HHS proposed regulations phasing out the procedure over five years.
State governments and their representatives in Congress protested loudly, arguing that states had come to rely on the money. While the money might not be spent on Medicaid patients, they said, it was being used for health care and other important programs.
Critics responded that once the money is put back into state treasuries, there's no way to know what it's paying for.

Insurance Times: NH bill would ban cover for injuries related to job review

April 17, 2001, Vol. XX No. 8

by Lori Ayotte
Associated Press

CONCORD, N.H. (AP) - Employees stressed out over poor performance evaluations will have a tougher time getting workers compensation if a bill before the Senate Insurance Committee passes.

The bill specifies that mental injuries resulting from disciplinary actions and work evaluations would not be included under workers compensation provisions, as long as employers have acted in good faith. Stress resulting from job transfers, layoffs, demotions, and firings would also be excluded from compensation.

Wrongfully Fired

Former employees would still have the right to make a stress claim if they are wrongfully fired or if the workplace was made so miserable for them, they were essentially forced to quit. But former employees who make compensation claims would waive the right to bring their cases to court. Similarly, if they seek court action, they could not pursue compensation claims.

Rep. Robert Clegg, R-Hudson, said the proposal is an attempt to clarify the current law.

Last year, the state Supreme Court ruled that a woman who became depressed after her supervisors criticized her poor work performance was entitled to compensation. The court upheld a ruling by the state Workers Compensation Board of Appeals, which found in 1996 that although the supervisor's criticism was justified, stress from the poor performance reviews caused Gail Sirviris-Allen to become depressed.

Although they ruled in favor of the claim, the judges said the Legislature should review whether a "good faith criticism'' of an employee's work performance should be included under workers compensation laws.

Clegg said the bill carries out the court's request.

Nancy Huntley, representing BAE Systems of Nashua and the Greater Nashua Chamber of Commerce, supports the measure. The legislation would make it easier for companies to defend themselves against stress claims from employees who receive justified criticism in regular evaluations, she said.

But Rep. Charles Weed, D-Keene, said he fears employees with legitimate claims might have a more difficult time getting compensated under the current wording in the bill.

The bill specifically protects companies against stress claims when they carry out disciplinary or other actions in "good faith,'' which Weed argued is too ambiguous.

But Clegg said that the term is sufficient and is used consistently throughout the statutes.

by Jim Fitzgerald
Associated Press

WHITE PLAINS, N.Y. - Fourteen men with ties to the Orange County village of Kiryas Joe have been charged with stealing or making up identities to get $4.5 million in fraudulent tax refunds, business loans and life insurance payoffs.

The group "exploited today's world of relatively anonymous, fast-moving commerce,'' U.S. Attorney Mary Jo White said. "Its methods were a complex and layered web of deception.''

The five-year-old scheme made victims of private citizens, banks, insurance companies, credit card companies and state and federal agencies, she said.
Nine of the men were arrested in New York and Louisiana and the other five were being sought, said Barry Mawn, who heads the FBI's New York office. Prosecutors, citing some defendants' use of fake passports, were asking that they not be released pending trial.
One fake passport used a photo of NBC newsman Tim Russert and another used a picture of CNBC "Squawk Box'' host Mark Haines, White said. She said she did not know why.
Eight of the men were accused of racketeering, which is punishable by up to 20 years in prison. The others were charged with various frauds.
White said the group, known as the Samet group after lead defendant Mordechai Samet, 41, used computers and sophisticated telecommunications systems in homes and a shopping center in Kiryas Joel but "respected no limitations either of geography or category of victim.''

"Fraud Factory'
Mawn said the defendants operated "a full-service fraud factory, which produced one fraudulent scheme after another all based on an array of fictitious identities, phony claims and fake documents.''
Calls to Samet's home went unanswered.
According to the indictment, the group would apply for taxpayer identification numbers, Social Security numbers, passports and other sources of identification, then use those fake names and some real ones to apply for refunds on taxes that had never been paid, insurance benefits for people who had not died, loans for businesses that did not exist. Bank accounts in fake names would be used to collect and launder the money, White said.
After using mass mailings to solicit investments, including entries in fake lotteries, they also set up "an extensive call-forwarding and voicemail system in which frustrated callers would invariably and deliberately be unable to reach anyone knowledgeable or receive any meaningful information about their investments,'' White said.
Kiryas Joel is an Orthodox Jewish community, as is New Square in neighboring Rockland County, where four men were convicted of swindling government programs and using some of the proceeds to help other residents. Asked to compare the cases, White said only that in the Kiryas Joel case, there was "no evidence that the motive was for anything other than personal gain.''

Clinton Case
White would not comment specifically on the New Square case, which is back in her office as she investigates whether former President Clinton commuted the convicts' sentences in exchange for the village's bloc vote for New York's U.S. Senate candidate Hillary Rodham Clinton.

Insurance Times: OpinionExchange

April 17, 2001, Vol. XX No. 8

The property and casualty industry is still trying to recover from years of price competition, the latest results show.
Efforts to correct pricing are in full swing but it will take some time before they are reflected in financials.
How bad was the impact of price competition on last year's results?
According to the Insurance Information Institute, the Insurance Services Office

and the National Association of Independent Insurers, property and casualty insurers reported a total underwriting loss of $32.6 billion in 2000 compared with $23.1 billion a year ago,

In 1999, the industry had total net income of $21.9 billion.

Results from the study are based on reports from 96% of the U.S. property and casualty companies in the United States.

"Years worth of underpriced business continued to assault the industry's balance sheet," said III's Chief Economist Robert Hartwig.

Hartwig said that premium rates should continue to rise, fixing the damage down to the industry for over a decade.

"As the industry gradually recovers from its soft market hangover, insurers will likely begin, and in many cases continue, to experience improved earnings," Hartwig said.

More frequent and severe fraudulent crimes, and a rise in the number of lawyers involved in claims cases, particularly in New York and Florida, also worsened underwriting losses, according to the study.

Insurance company executives are working with the National Insurance Crime Bureau to combat these problems, which are seemingly becoming more prevalent, Hartwig said.

While property and casualty stock prices fell last year, the industry faced $18 billion in unrealized capital losses last year, compared with $1.9 billion in 1999, forcing surplus to drop for the first time since 1984 by 4.5%, according to the study.

About $16.5 billion in dividends to shareholders and $5.1 billion of miscellaneous charges also caused surplus to drop last year.

Amid some less than encouraging results, the study showed that at least premiums increased last year, confirming that rates are continuing to rise.

"Premium growth provided at least one bright spot in the industry's otherwise bleak numbers," said John Kollar, ISO's vice president of consulting and research.

Premiums for the year increased 5.1% to $301.6 billion. In 1999, premiums grew 1.9% to $286.9 billion. During the fourth quarter, premiums grew 6.4% compared with 2.1% for the same period a year ago.

Analysts estimate premiums will grow about 7.4% this year, according to the study. If this forecast is accurate, than the industry would have grown faster than it has in the last 15 years.

"If the industry can sustain premium increases, it would bode well for future results," Kollar said.

More disciplined policy pricing, including more accurate estimates for higher risk policies, contributed to higher premiums last year. The study said commercial lines are increasing their rates, on average, between 6-9%, while workers compensation insurers, perhaps in the most dire need for aid, are increasing their rates by about 9.5%, during the second half of 2000 and appear to be continuing this year.

The III forecasted auto insurance rates would rise about 3-6% this year.

"The forecasts for 2001, for the first time in years, show an industry with significantly improved growth prospects and a slight improvement in underwriting performance," Hartwig said.

With a combined ratio of 110.5, the industry has yet to achieve an overall underwriting profit, but the III expects a slight improvement, predicting the ratio to be about 109.1 at the end of 2001. However, a relatively calm year for catastrophes helped to make the insurance industry look a little better than it actually is.

"Bad as they were, underwriting results benefited from the decline in catastrophe losses," said the NAII's vice president of research, Diana Lee, adding that if catastrophe losses had remained the same as 1999, the combined ratio would have been 1.3 points worse than it actually was.

"It's a simple truth: If losses keep growing faster than premiums, underwriting results are going to keep on deteriorating," Kollar said.

Insurance Times: Serio tapped to replace Levin as NY superintendent
April 17, 2001, Vol. XX No. 8

by Mark Hollmer
InsuranceTimes

NEW YORK - New York Insurance Superintendent Neil Levin has move onto another job, and a long-time member of the department is nominated to replace him.
Gov. George Pataki has chosen Greg Serio to replace Levin, who recently left the Insurance Department top spot after almost four years to head the Port Authority of New York and New Jersey.
Serio has served as first deputy superintendent and general counsel for the department since 1995, and rumors of his appointment circled among industry insiders in the days leading up to the announcement.
Minutes after the Insurance Department posted Serio's nomination on its Web site on April 10, the American Insurance Association released a statement applauding the news.
Serio's "experience has prepared him to provide the leadership that will be needed as New York's Department of Insurance meets the challenges ahead," said Michael Murphy, AIA's assistant vice president, northeast region.
Serio's initial title is "acting superintendent." He must also go through a state senate confirmation process.
He'll be heading one of the nation's largest state insurance departments with 1,500 department employees.
In addition, Serio will have regulatory oversight over more than 1,000 insurance companies and 100,000 brokers, agents and financial experts.
Serio was rumored to be under consideration along with Senior Deputy Superintendent Kevin Rampe and Deputy Superintendent John Cashin.
One industry insider said agents wanted Serio in the top job because he's served longer in the department than the other deputies, and also because of his "willingness to listen to what our concerns are."
Levin announced his planned departure on March 30. He became insurance superintendent in April 1997 after two years as the state's banking superintendent.
He's credited with trying to improve efficiency at the department along with working for more consumer protection. Levin also developed the Insurance Department Web site and consumer-related outreach efforts.
Last year, Levin made headlines after launching an investigation into past practices of race-based underwriting.
Steven Spiro, president of the Independent Insurance Agents Association of New York, said he wished Levin well in his new job. He said Levin ran a department that was "very open to discuss our concerns and the concerns of the insurance community."
Interviewed before Serio's nomination, Spiro wouldn't speculate on Levin's replacement. But he credited Serio with being "the constant" in the department who would guarantee a smooth transition.
"He has been in this position before Levin (and) through at least two previous superintendents," Spiro said.
"He's very knowledgeable and his door is always open. He's always encouraged an open dialogue."

Serio also brings extensive legislative experience to the job. He was chief counsel for the State Senate insurance committee, judiciary committee, and counsel to the Senate Deputy Majority Leader.
As first deputy superintendent, Serio was involved in speed-to-market and workers compensation reform efforts.
He also took part in the creation of the Healthy NY low-cost insurance program, according to the Insurance Department Web site.

Insurance Times: IMMS now offering online commercial financing
April 17, 2001, Vol. XX No. 8

IRVINE, Calif. - Insurance Marketing & Management Services (IMMS), a provider of management and marketing information to independent insurance agencies, is teaming up with Oinke, Inc., a provider of Internet-based commercial financing. Business loans, equipment financing and commercial real estate loans from $5,000 to $500 million can now be sourced through the IMMS loan center on the web site www.imms.com and from the web sites of IMMS' members.
The IMMS Online Commercial Lending Marketplace, powered by Oinke, gives borrowers access to a competitive Internet auction marketplace consisting of more than 160 lenders. Lenders whose criteria match those of the loan request bid on the borrower's financing needs.
George Nordhaus, chairman of IMMS, said the Oinke financing service is the first of a full line of banking products IMMS plans to offer.

Insurance Times: Great American offers stand-alone fiduciary liability
April 17, 2001, Vol. XX No. 8

Great American Insurance Co.'s Executive Liability Division announced new state-of-the-art fiduciary liability coverage within its ExecPro series of products. The policy, combined with many optional enhancements, is one of the broadest fiduciary liability coverages available in the marketplace. The new policy is available in most states.
Great American's ExecPro Fiduciary Liability Insurance Policy includes the following features: claims made policy with limits of liability up to $25 million; option for defense costs in addition to limit of liability; duty to defend with the insured having the right to assume the defense; no retention if insurer defends; advancement of defense costs if insured defends; either/or discovery option and broad definitions of "Claim", "Loss" and "Insured".
Visit www.greatamericaninsurance.com for more information.

Insurance Times: CNA Pro's E-Pack policy now admitted in 40 states
April 17, 2001, Vol. XX No. 8

CNA Pro's E-Pack, a comprehensive management liability insurance policy designed to serve the unique needs of small to mid-size private companies, has been admitted in over 40 states. E-Pack is one of the few approved policies in the

country that offers both Miscellaneous Professional Liability and Employment Practices Liability.
CNA Pro's E-Pack provides Employment Practices Liability, Miscellaneous Professional Liability, Directors & Officers Liability, Fiduciary Liability and Entity Liability coverage. This policy offers applicants the flexibility to purchase a single coverage or a combination of two or more coverages. Limits and retentions can be shared between coverages or be separate for each coverage.
CNA Pro also recently revised the risk management services that are available for their customers who purchase the Employment Practices Liability portion of E-Pack. Services include a sample handbook, employment guidelines and self audit available on CNA Pro's website, plus a free employment hotline for managers. CNA Pro customers are also eligible for discounted fees charged by Fisher & Phillips LLP and AGOS Consulting Services for employment related loss control services.
Other important features of E-Pack include CNA's duty to defend, which provides small to mid-size companies with an extra measure of security. The insured is free to continue the day to day affairs of the business, while CNA assumes all obligations of investigating and defending covered claims. Punitive damages are also covered, where insurable by law, and there are no exclusions for acts occurring prior to the policy period for most coverage parts. This means that acts that occurred before an E-Pack policy was in place may still be covered. Coverage for bankruptcy proceedings and spousal liability is also automatically included.
For more, 800-852-0393 or try www.cnaprocom.com

Insurance Times: New Dimensions assumes GoPro specialty name

April 17, 2001, Vol. XX No. 8

New Dimensions Underwriting Group, a Princeton, N.J.-based managing general underwriter established by Aon Corp., has assumed management of several programs previously marketed under the Go Pro Underwriting Managers name. Go Pro ceased operations in january.
New Dimensions plans to add two or more specialty programs to the company each year. The current programs are Waste Insurance Network, First Firefighters, Public Risk Underwriters, Rural Electric Underwriting Managers and Huntington T. Block. The niche markets served include waste hauling operations, independent fire departments, rural electric utilities and cooperatives, municipal services and fine arts collectors.
Although New Dimensions has inherited Go Pro's programs, the new company is structured very differently. Each program under New Dimenssions will operate independently thus making t hem more agile and able to respond more quickly to client needs, company officials said.

Insurance Times: P&C insurers on track for poor results despite signs of improvement

April 17, 2001, Vol. XX No. 8

Amid signs that the property/casualty insurance market is improving, insurers' prospects for greater profitability may actually be diminishing in today's rapidly slowing economy, an industry leader has warned.
At present growth rates, the industry's combined ratio is on track to be 114.9 -

4.5 points worse than 2000 - and could hit an all-time record poor combined ratio of 139.6 five years from now, according to Frank J. Coyne, president and chief executive officer of Insurance Services Office, Inc. (ISO). The combined ratio is the percentage of each premium dollar an insurance company has to spend on claims and expenses. When a combined ratio is more than 100 percent, the insurer has an underwriting loss.

Could Spell Disaster

Combined with poor underwriting performance, lower investment gains in today's declining equities markets could spell disaster for many insurers, Coyne told insurance company executives at the Pacific Insurance & Surety Conference here. "Recognize underlying dangers amid signs of market improvement" to prevent the ISO extrapolations of severe deterioration from coming true, he said.

Insurers' net income continues to decline, said Coyne, noting that in 2000 the industry posted net income of $19 billion, down more than 13 percent from 1999 and down nearly 50 percent from a peak in 1997.

Premium Growth

Last year's premium grew 5 percent - more than twice the growth of 1999 - but failed to keep pace with economic growth, based on the national gross domestic product, which rose 7.1 percent, said Coyne. "The up-tick in premium growth thus far may signal only that rates have stopped declining for the moment," he said.

Moreover, at an estimated $240 billion in 2000, loss and loss-adjustment expenses were up in 2000 nearly 8 percent from 1999 and could easily have increased 10 percent - twice as fast as premiums - but for a sharp decline in 2000 catastrophe losses, noted Coyne.

"As long as growth in losses outpaces growth in premiums, underwriting results will continue to deteriorate - no matter how good anecdotal reports of price firming may sound," said ISO's CEO.

Coyne also warned insurers not to be lulled by last year's low catastrophe losses, which at $4 billion were half the 1999 figure. With the population in the country's most earthquake- and hurricane-prone areas continually growing, catastrophe losses will continue to worsen.

Citing a decade of sub-par underwriting performance, Coyne said the industry had developed an "unhealthy" tolerance for low premium growth because "investment gains in an unprecedented bull market would always pull insurers through - or so it seemed."

Coyne noted that ever-increasing investment gains that insurers need to counterbalance ever-escalating underwriting losses are now being threatened by declining stock markets. Insurers' total investment gains, consisting of investment income and capital gains, have been on a sharp downward trend.

In just three years, the excess of investment gains over underwriting losses dwindled nearly 95 percent - from $75.5 billion in 1997 to just $4.1 billion.

"If stock prices continue falling at the rates they have been, investment gains could easily fall short of underwriting losses. Year to date, the Dow Jones is down 7.54 percent, the S&P 500 is down 11.63 percent and the NASDAQ is down 20.18 percent.

Coyne cited other "warning lights flashing on the industry's economic dashboard." He noted the industry's surplus, projected to be $320 billion, fell more than 4 percent at year-end 2000. "Last year's decline in surplus is the first since 1984, when surplus fell more than 3 percent at the bottom of the worst underwriting cycle in the industry's history."

But even with a smaller surplus, the industry's 2000 GAAP rate of return at 5.6 percent remained below the average yield on risk-free U.S. Treasury notes.

"Unless returns on capital improve, you might expect pressure on company management to return capital to its owners so they can re-deploy it more advantageously," warned Coyne.

Another warning light is the 26-percent cut in dividends to shareholders in 2000 - the first such drop since 1994, when dividends were cut 13 percent following the Northridge, Calif., earthquake.
Increasing insurer insolvencies are another key concern, said Coyne. In 2000, 31 property/casualty insurers were declared insolvent, up from just seven in 1999. "Company failures could surge still higher," if stock prices continue falling or if the industry is hit by a megacatastrophe, according to Coyne.
Other concerns include the sharp, downward trend of insurer cash flows, continuing exposure to asbestos and environmental liability, and an estimated $3.5-billion decline in the industry's reserves for losses and loss-adjustment expenses.
"Astute leaders will recognize the underlying dangers amid signs of market improvement and will not be distracted or deterred from executing fundamentals of solid underwriting," Coyne said.
Referring to ISO's extrapolations of perilously high combined ratios, Coyne reminded listeners that last year he "raised a few eyebrows when I told you that based on then-current conditions, the industry's combined ratio could hit 111.7 in 2000 and was on track to reach 136.2 by 2005." The combined ratio for 2000 would have been exactly 111.7 had catastrophe losses not dropped to unusually low levels, he noted.
Coyne said ISO's extrapolations of perilously high combined ratios are a warning. But "what could be is not what has to be," he said. "Recognize that risk-based pricing and sound risk assessment, along with efficient and effective risk evaluation, adjudication and settlement are still the single most important determinants of success."

Insurance Times: Bankruptcy effects among trends shaping D&O claims

April 17, 2001, Vol. XX No. 8

New York - Bankruptcy implications, rescission issues and coverage counsel conflicts are significant factors currently affecting claims handling of Director &Officers insurance, according to panelists at the PLUS D&O Liability and Insurance Issues Symposium, last month.

Bankruptcy Implications
Dan A. Bailey, Esq., chairman of Arter & Hadden's D&O practice group, discussed bankruptcy implications in light of entity coverage. When an entity files a bankruptcy petition, he said, an "estate" is created which is comprised of all legal or equitable interests of the debtor in property owned at the time of the commencement of the case or acquired thereafter, including a corporation's insurance policies.
"Although the D&O policy is generally considered an asset of the bankruptcy estate," he said, "some courts have held that the proceeds of certain D&O policies are not assets of the estate, but instead belong to the directors and officers as beneficiary of the policies."
According to Bailey, the most effective way to avoid this undesirable result for D&Os, while still having entity coverage may be to include a "pre-petition waiver" -- a provision in the D&O policy which states that the insured agrees to waive the automatic stay with respect to the D&O policy in the event a bankruptcy petition is subsequently filed.

Rescission Issues
Theodore A. Boundas, chairman, Peterson & Ross, discussed rescission issues,

particularly with respect to misrepresentation of information. "The financial condition of a company is very important when writing a D&O policy," he said. He explained that if financial statements submitted to the underwriter contain false information, the carrier has the right to rescind the policy based on fraudulent information.

He added, "If you have a non-severable policy you can run into the problem of the entire policy being rescinded and the innocent directors are left exposed." While the alternative to rescinding a policy is to deny coverage, Boundas recommended that all D&O policies contain language regarding rescission.

Coverage counsel conflicts were outlined by Steven J. Gladstone, senior vice president of claims, Executive Liability Underwriters, who explained that there is a relatively small fraternity of coverage counsel who have multiple clients with adverse interests.

A frequent type of conflict is triggered when the coverage counsel representing his company on various matters has been retained to represent one of his fellow professional liability insurers on a new claim, according to Gladstone. That same coverage counsel is asserting that one policy should pay on the claim while the other professional liability insurer client should not pay.

"Due to the small universe of coverage counsel, the sharing of confidential information on how or why a policy might be exposed can occur," he said.

As an insurer, Gladstone said he views coverage counsel as playing an integral role in the claims handling process. In many ways, he observed, coverage counsel is an extension of the claims department.

"Therefore," said Gladstone, "when I utilize coverage counsel I need to make certain that their ability to properly and effectively respond to a claim is not in anyway compromised by way of a conflict. If such a situation does arise, I as the insurer need to come up with a workable solution that will allow the claim process to move forward."

If a conflict does exist, Gladstone suggested: ask coverage counsel for a complete explanation of the conflict or potential conflict and whether coverage counsel reasonably believes it is feasible to waive the conflict; determine the methods to waive the conflict; and devise an exit strategy with respect to the conflict becoming live or unworkable.

He noted that early detection of a conflict is best; replacing coverage counsel in midstream is very expensive and time-consuming.

Sallie Kim, special counsel, Duane Morris & Heckscher LLP, discussed the potential for bad faith and ethical dilemmas when Loss Mitigation Underwriting (LMU) is used. Loss Mitigation Underwriting refers to the process by which an insurer underwrites, and issues an insurance policy for, an existing and/or imminent litigation.

"When a primary carrier writes an LMU on top of a policy, the excess insurer may find breach of duty," she explained. While LMU's are not used too often and are quite expensive, they are useful in dealing with Mergers and Acquisitions.

Donna Ferrara, Esq., vice president, Executive First (the professional liability division of Arthur J. Gallagher), reviewed issues arising under transaction specific coverage, where policies respond to financial loss due to errors in the due diligence process, changes in relevant law or markets, currency fluctuations, excessive losses in a product line or pending claim or other specific enumerated triggers.

"For a professional to evaluate such claims in order to post adequate reserves, the first step is education," suggested Ferrara. With transaction specific coverage, a traditional claims professional can't "go it alone." Often these coverage issues involve investment bankers, attorneys and analysts.

"Since the lines between insurance and financial services have become blurred, and insurance policies and concepts have become more complex, it is incumbent upon all insurance professionals to educate themselves to the risks -- and the advantages -- inherent in this transition process," said Ferrara.

This panel was moderated by Joseph P. Monteleone, a trustee of the Professional Liability Underwriting Society and senior vice president and underwriting counsel of Kemper Insurance Companies in Berkeley Heights, N.J.

Insurance Times: Accountants seek lawsuit protection when clients' businesses fail

April 17, 2001, Vol. XX No. 8

by Adrian Brune
State House News Service

BOSTON - As the economy tightens and executives face new challenges, a group of certified public accountants wants legislators to pass a law that would ensure they won't be left holding the bill if a client,s stock price plummets or business folds.

The Committee on Government Relations recently heard requests for liability exemptions from representatives of local accounting firms and Massachusetts Society of Certified Public Accountants.

The proportional liability standard they're seeking would shield them from the fallout of failed business ventures or fraudulent lawsuits resulting from inaccurate audits. While non-audit services that accountants provide to businesses are fair legal game, they should not be held liable for audits based on fraudulent or erroneous financial statements that have been compiled by their clients, said Jean M. Joy, president of the Massachusetts Society of CPAs and an accountant with Wolf & Company P.C.

Success of Failure

"A company's success or failure is not determinable by an audit," Joy told committee members. "We are sometimes unfairly targeted because of professional liability insurance policies we hold and without this legislation, we are exposed to liability of an undeterminable amount when we are not even involved in the day-to-day operations of a business," Joy said 38 states have proportionate liability standards.

A liability law would reduce frivolous lawsuits filed after a business fails, when owners may be looking for someone to blame, especially a large accounting firm with seemingly deep pockets, Joy said. She and three other CPAs called to testify maintained that CPAs are different from other professions because they are not in total control of their work product and therefore, are deserving of different liability status.

"A lot of the cases never make it to the jury and an accounting firm is often left to stand for the company," said David Trusdale, a CPA. "Settlements are many times made before a trial because most firms never want to publicize that they are getting sued.

"Underwriters of a business have all of the upside and none of the down, while an accountant has none of the upside and is faced with all of the down if something goes wrong."

The accountants received an intense grilling from Rep. Michael Festa (D^Melrose). He said he didn't see a reason for pursuing this bill unless professional liability insurance premiums have risen so high that CPAs are unable to perform audit work or future CPAs are being deterred from the profession. Committee members questioned how the bill wound up before them, and not the Judiciary Committee.

"I still don't understand how this bill will keep you from getting scooped up

in lawsuits," Festa said. "A doctor, like a CPA, does not have complete control of the information his patients provide him and he still gets sued. Why would a jury hold you liable, if you have no negligence?"
Lawyers from the Massachusetts Association of Trial Attorneys and the Massachusetts Bar Association were on hand to oppose the legislation, saying CPAs should be held to the same standard of the law as every other professional, in that each person involved in the demise of a business is held fully responsible.

Insurance Times: Latest GE LTC product stresses patient choice

April 17, 2001, Vol. XX No. 8

GE recently launched a first-of-its-kind long term care insurance product that offers coverage from day one, GE Long Term Care Choice. An integrated policy that covers the full range of long term care options, this offering provides reimbursement for in-home health care from the first day without an elimination period as a standard policy feature.
"With GE Long Term Care Choice, 'choice' is truly the operative word," says Thomas A. Skiff, president of GE's Long Term Care Division. "Policyholders have the choice to remain in their home, to choose adult day care, assisted living facilities, or a nursing home." Facility care obtained outside the home is included subject to an elimination period decided upon at th time the policy is purchased.
The policy also offers the option to use services of an independent Privileged Care Coordinator at no cost. These nurses and licensed social workers assess each individual situation, then offer recommendations and help arrange for services.
Additional benefits of GE Long Term Care Choice include: full reimbursement of covered home care costs up to the pre-selected daily benefit amount; days of paid home care benefits can satisfy the elimination period for facility care, and a couples discount of 25 percent.

Insurance Times: Hancock revamps single life variable line

April 17, 2001, Vol. XX No. 8

BOSTON - John Hancock has introduced a new variable universal life insurance policy targeting the brokerage market, Medallion VL Edge (MVL Edge), and repriced its existing VUL policy and renamed it Medallion VL Plus (MVL Plus). Both products are advantageous vehicles for retirement accumulation, business markets and estate planning, and perform well regardless of clients' age, funding objectives or financial needs.
In general, MVL Edge offers higher long-term cash values. MVL Plus also is strong over the long term, but offers higher early cash values.
MVL Edge has a brokerage orientation, with trail compensation a primary component. MVL Plus retains a traditional compensation structure for its distributors. MVL Plus' new pricing also applies to its predecessor product (MVL II).
The innovative Unison rider is available with both policies. The rider transforms the life insurance coverage into a benefit pool that can be used for life and/or long-term care insurance needs.

Both products include an optional Additional Sum Insured feature for flexibility in case design. They also offer a choice of death benefit guarantee periods -- age 65 (or 10 years, whichever is later) or 100 -- for individuals who want to participate in the equity market while guaranteeing the initial life insurance protection regardless of investment performance.
Other features of MVL Edge and MVL Plus include: fixed loan rates and reduced loan spreads; expanded issue ages (MVL Edge is now available for ages 0-85; MVL Plus is available for age 0-80); an optional rider to maintain coverage at age 100 and beyond and automatic rebalancing of funds.

Insurance Times: Lincoln Life launches universal life product
April 17, 2001, Vol. XX No. 8

HARTFORD - The Lincoln National Life Insurance Corp. has introduced a new individual universal life insurance product - Lincoln UL-III Life Protection(a) - emphasizing policy guarantees through its innovative Lapse Protection rider.
The guaranteed death benefit protection associated with Lincoln UL-III is made possible through its Lapse Protection Rider, automatically included on all policies at no additional charge.
The Lapse Protection Rider, which Lincoln pioneered, allows the client to determine a premium funding pattern that will support, on a guaranteed basis, a specified death benefit for a period of up to 50 years, or age 100.
Unlike some premium-based guarantees, Lincoln UL-III and the Lapse Protection Rider offers policy owners the flexibility to adjust or skip planned premium payments, without completely forfeiting the guarantee. The owner can either pay additional amounts at a later time to restore the length of the original death benefit guarantee period, or simply change the length of the guarantee period.
Similarly, borrowing against, or withdrawing a portion of the policy's cash value will not terminate the lapse protection coverage; it will simply shorten the length of the guarantee.
Lincoln UL-III Life Protection also contains an Extended Maturity provision that provides death benefit protection beyond age 100 as long as the policy remains in force to age 100. The face amount, not the cash value, is available through this provision, and similar to the Lapse Protection Rider, it is provided at no additional charge.
The availability of several business riders, including the Accounting Value Rider and Exchange of Insured Rider, makes Lincoln UL-III an appealing choice for business-focused sales.

Insurance Times: HARTFORD - Hartford Life has automated its information gathering for underwriting individual life insurance, making the process of issuing policies faster than ever.
April 17, 2001, Vol. XX No. 8

By launching the TeleLink system, Hartford Life is streamlining its in-house, telephone-based underwriting process known as tele-interviewing. Tele-interviews are now automated, thereby making the process faster, more efficient and more accurate. The TeleLink and tele-interviewing processes, combined with a streamlined request-for-application system, reduces the process of selling, underwriting and issuing life policies by four weeks.

The TeleLink system was developed as part of Hartford Life's SimplifyLife strategy to make it simpler and easier for stockbrokers, financial planners and bank investment representatives to sell life insurance.
The tele-interviewers, many of whom have medical training, contact clients to fill out life insurance applications, ask medical questions and submit the information for underwriting. There is no need for the financial professionals to undertake these tasks. Instead, they simply submit a request for an application.

Insurance Times: Aging Baby Boomers find health insurance can be tough to find

April 17, 2001, Vol. XX No. 8

Problem could worsen as Baby Boomers reach retirement age

by Lisa Sunghania
Associated Press

NEW YORK - Health insurance was the last thing on Fernando Otero's mind when he left his management job as part of a restructuring.
Medical benefits weren't part of his severance package, and when he started looking for coverage for himself and his wife, the Davies, Fla., man got an unpleasant surprise.
"We were going a little bit out of our minds trying to find something with a decent price,'' recalls the 53-year-old, who now has a home inspection business. "Right now we pay about $500 a month for a straight health plan with prescription drug coverage but with no vision or dental coverage.''
Individual health insurance policies have never been cheap, but for Americans in their 40s and 50s, they are increasingly expensive and difficult to obtain. The problem is likely to grow as more Baby Boomers - those born between 1946 and 1964 - approach retirement.
Fewer businesses offer health coverage to retirees, and employees are less likely to spend their entire careers with the same company and qualify for retirement benefits.
All of this is squeezing workers who leave jobs before 65 - the age when they qualify for Medicare, the government health insurance program.
"If you're lucky in the stock market and are relatively healthy, you can find health insurance,'' said Roberta Milman, director of member health products at AARP Services. "For a lot of people, these plans are not affordable or, if you have a serious health condition, they may not be able to get insurance or afford coverage.''
In 2000, about 31 percent of companies offered coverage to their retirees who were too young to qualify for Medicare, down from 46 percent in 1993, according to William M. Mercer, a human resources consulting firm.
For those who don't qualify for Medicare, the options are limited and pricey. Estimates vary, but generally monthly premiums can range from $400 to $600 per person in this group.
"Your rates are going to depend on where you live, how healthy you are and how long you are going to need the policies for,'' said Karen Pollitz, a senior health policy researcher at Georgetown University, whose 64-year-old mother was quoted $800 a month for health insurance.
Workers leaving their jobs should look into COBRA, a federal law that generally

allows workers to buy into an employer's health plan for 18 to 36 months.
Under COBRA, employees pay the full cost of an insurance premium, which is calculated at the employer's group rate. Although COBRA can be expensive, it is frequently cheaper and more comprehensive than an individual policy. Individuals who use COBRA may also be protected under the Health Insurance Portability and Accountability Act.
"What HIPAA says is that if you meet these conditions, in any state, you have to be protected from health screening for some kind of health insurance. But the state gets to decide what kind of plan you get,'' Pollitz said. "Insurers can't turn you down for coverage for these plans and can't impose a pre-existing condition exclusion. But there's no limit on what you can be charged.''
It's a good idea to shop around before COBRA benefits expire to get some idea of what coverage is available. Pre-existing conditions, ranging from diabetes to allergies, might make getting health insurance expensive or impossible.
Being part of a group such as a chamber of commerce or professional association can help, since group insurance plans are regulated under different laws than individual policies.
Otero, the Florida house inspector, said one insurer refused to cover him under an individual policy because his wife had a pre-existing health condition. When he applied as a small business owner, he got a policy.
Geography can also be a factor. Carol Boyd, who left a public relations job to work independently, was shocked at the difference in options between Ohio, where she had worked, and Kentucky, where she lived.
"There were about 100 different plans in Ohio to pick from,'' said the 47-year-old. "In Kentucky, there were about three.''
Ultimately, cost is the biggest frustration.
Amy Shih, a retired software analyst, found insurance before she left her job a year ago, but she didn't realize how quickly the premiums would rise. Today, she and her 62-year-old husband pay nearly $400 a month.
Shih recently increased her deductible to $5,000 from $1,500 to avoid a 30 percent rate hike.
"Luckily, my husband and I are healthy people. But the costs keep going up,'' said the 57-year-old Houston woman, who is considering going back to work to get benefits. ``If they keep jacking up rates at this pace every year, my health insurance will be higher than my house payment.''

Insurance Times: Iuppa hopes rate freedom will ease Maine 'crisis'

April 17, 2001, Vol. XX No. 8

AUGUSTA, Maine (AP) -Thousands of Mainers are paying well in excess of $1,000 a month for individual health insurance policies, and experts say the costs are likely to continue rising sharply this year.
State Insurance Superintendent Alessandro Iuppa and others say the rising costs push more people to the ranks of the uninsured, leaving fewer people with bigger medical bills to pick up the soaring costs of premiums.
``The individual market is in a death spiral,'' Iuppa said. ``If we do nothing, realistically in the next three or four years we would have no individual market in the state of Maine.''
Iuppa plans to submit legislation to try to remedy the situation. He wants to give insurers more latitude in setting rates for different risk pools, and to let insurers develop pilot projects that offer lower rates for healthier people, such as nonsmokers, as a way to get them back into the individual market.
Within the past five years, rates for individual, or non-group, plans have

swelled anywhere from 99 percent to 167 percent, costing 35,000 Mainers up to $1,226 a month for basic coverage alone.
State estimates show 13 percent of Maine people have no insurance, a figure higher than any other New England state but lower than the national average.
"Politicians use the word 'crisis' too much, but this is a crisis,'' said Robert Giroux of Wales, who doesn't know how much longer he and his wife can keep paying $6,500 a year for health insurance.
"Who can afford a thousand dollars a month? The rates are going to continue going up and more and more people are going to lose their coverage,'' said Giroux, a self-employed paramedic who performs life and disability insurance physicals for a Boston-based company.
Dan Bernier, a Waterville lawyer who represents Maine's independent insurance agents, said the individual insurance market "has been slowly deteriorating for five years, but in the last 12 to 24 months it's begun to collapse.''
Bernier said a top-notch individual policy for a Maine family costs about $13,000 a year, or $1,100 a month, a sum many families cannot afford.

Insurance Times: Mass. pioneers with senior drug insurance program

April 17, 2001, Vol. XX No. 8

by Michael P. Norton
State House News Service

BOSTON - Vowing to let every senior citizen in the state know about it, state officials last week launched an unprecedented state-run insurance program that guarantees affordable prescription drug coverage to anyone 65 or over.
Officials said the program, called Prescription Advantage, is an overdue substitute for a drug benefit under Medicare, an idea still being discussed in Congress. They hope to attract 100,000 participants but acknowledge that goal is dependent on a grass roots recruitment effort that's just getting started.
Senate President Thomas Birmingham and House Speaker Thomas Finneran each proclaimed it a "happy day" for seniors, especially those who have sacrificed some of life's necessities to afford the rising cost of sometimes life-saving prescription drugs.
The plan is designed to appeal to all senior citizens, regardless of income. A "catastrophic" benefit caps a participant's annual expenses at $2,000, or 10 percent of annual income, whichever is less. That benefit, officials say, should be attractive to elders facing insurmountable drug costs.
The program will be financed through a combination of income-based premiums, co-payments and deductibles and state appropriations. Gov. Paul Cellucci proposed $110 million in state spending on the program next year. The administration does not have program cost projections beyond fiscal 2002.
Premiums will range from $15 to $82 a month, depending on income. Deductibles range from $100 to $500 a year. Co-payments start at $5 for generic drugs. The state covers premiums and deductibles for enrollees with gross annual incomes of less than $15,708. The program officially started on April 1.
Finneran urged the Cellucci-Swift administration, which is in charge of implementing the program, to be flexible and not to consider it the "perfect prototype." Finneran warned that the world of prescription drugs and insurance represents "very, very tricky and troubled waters."
Praising it as an insurance plan that shares risks among participants and taxpayers, Finneran said the new program is also significant because it avoids price controls, which put a damper on research and development, according to

those in the pharmaceutical industry.
The state's share of the program is being paid for with revenues from a lawsuit settlement with the tobacco industry concerning the smoking-related costs of treating smokers. In the fiscal year ahead, Massachusetts is due to receive $287 million. State law requires that 70 percent of annual settlement revenues be placed in a savings endowment. Cellucci administration officials are recommending that 30 percent be saved - and 70 percent spent annually - in part as a way of funding the new program.
State Elder Affairs Secretary Lillian Glickman said the program continues the state's tradition of helping its senior citizens. Massachusetts was the first state to create an elders affairs secretariat, Glickman said. An all-out recruitment campaign, including repeated TV and radio ads, is forthcoming. "A plan like this is an opportunity only for those who know about it," said Glickman.

Insurance Times: Burlington Northern settles genetic testing lawsuit
April 17, 2001, Vol. XX No. 8

OMAHA, Neb. (AP) - The Burlington Northern Santa Fe Railroad has agreed to settle a union lawsuit filed after secretly subjecting employees to genetic testing, the Omaha World-Herald has reported.
The railroad agreed to stop genetic testing of employees represented by the Brotherhood of Maintenance of Way and the Brotherhood of Locomotive Engineers. Burlington Northern also agreed to destroy the test results and blood samples from the 18 workers who were tested. The results also will be purged from the employees' records, according to the newspaper.

The railroad also said it would seek federal legislation to limit the scope of genetic testing by employers. As part of the settlement, the railroad denied violating any law.
There was no mention of damages in the settlement other than the railroad agreeing to pay $39,500 in legal fees.
Last month the company offered an apology to its employees who were secretly subjected to genetic testing.
Fort Worth, Texas-based Burlington Northern was conducting the testing to see if employees were predisposed to carpal-tunnel syndrome, a wrist condition believed to be caused by repetitive hand motions.
The company agreed in February to stop its testing program after the federal Equal Employment Opportunity Commission filed a lawsuit contending it violated the Americans with Disabilities Act. It was the first time that the EEOC had challenged genetic testing.
That lawsuit is still pending, said Laurie Vasichek, senior trial attorney for the EEOC's Minneapolis office.
She told the World-Herald a union settlement does not affect the EEOC lawsuit, which seeks a court order that bars all genetic testing of workers and prevents genetic test-based discrimination.
The testing, which began a year ago, involved employees who filed claims for carpal tunnel syndrome.
The railway, which has about 40,000 employees, said of the 125 workers who filed claims for carpal tunnel syndrome since March 2000, 18 were tested.
The tests looked for a genetic trait called chromosome 17 deletion. Some studies have suggested that trait is more likely to produce some forms of carpal tunnel syndrome.

Burlington Northern's testing program came to light when workers from Nebraska, North Dakota and Minnesota complained to the Brotherhood of Maintenance of Way. The EEOC charged that a worker who refused to provide a blood sample after filing an injury claim was threatened with termination. The railway countered that no one was disciplined and that it intended that the nature of the tests be disclosed to affected workers.
Burlington Northern officials declined comment to the World-Herald on Friday. Phone calls left Friday evening with company officials by The Associated Press were not immediately returned.

Insurance Times: Coalition presents roadmap for long term care
April 17, 2001, Vol. XX No. 8

Recommendations include both private and public financing, with emphasis on encouraging purchase of private LTC coverage as employee benefit

WASHINGTON, D.C. - An unprecedented coalition of long term care providers, consumers, insurers and workers set forth a plan for reforming the nation's long term care financing system last week.
The group, Citizens for Long Term Care, issued a report, Defining Common Ground: Long Term Care Financing Reform in 2001, which outlines how financing can be accomplished using the nation's current employment and financial security structures.
The framework includes a mix of private and social insurance solutions, including a changed role for Medicare in meeting the needs of those with chronic illness or disability.
"As a critical component of our economic security system, we cannot continue to ignore the importance of long term care financing reform. To do so threatens the financial and retirement security of every American," said Sen. David Durenberger (R-MN), who chairs the coalition.
Durenberger noted that there currently is no long term care financing policy. Only a small number of Americans have private long term care insurance while the rest must pay out of pocket, often impoverishing themselves before gaining access to Medicaid. He said his group developed its framework to aid lawmakers in addressing the issue.

Tough Issues
"When the Administration and Congress now look at long term care financing reform," Durenberger said, "they'll realize that we've already spent several months working out some of the tough issues. If they make a proposal that fits within our framework, it will be given serious consideration by members of our group."
The plan includes a role for private insurers.
"There needs to be a strong emphasis on the purchase of private long term care insurance especially by younger workers, and employers need to be encouraged to lay a bigger role in educating employees and offering it as a benefit.
"In addition, we believe there must be a uniform, national system of assessment that will help consumers not only learn about long term care but understand what their needs are and how to arrange for finding the help they need when they need it."
The group recommends that financial assistance be tied to a disability model instead of the traditional financing model, meaning that reimbursement would be more flexible for those with either extended or short-term needs.

At the briefing announcing the LTC plan, Durenberger was joined by Dale Thompson, vice chairman of the coalition and chief operating officer of Benedictine Health Systems and past chairman of the American Health Care Association; John Rother, director of legislation for the American Association of Retired persons; Frolly Boyd, senior vice president of Aetna, Inc.; and Steve McConnell, vice president of public policy for the Alzheimer's Association.
Among the members of the coalition are the American Health Care Association, Aetna Insurance, the National Committee to Preserve Social Security and Medicare, the AARP, the Service Employees International Union and the ARC of the United States.

Insurance Times: Mass. insures low income HIV patients

April 17, 2001, Vol. XX No. 8

BOSTON (AP) - Massachusetts for the first time has begun offering full health insurance to poor people with HIV, treating the condition before it reaches full-blown AIDS, and officials say, saving lives and money.
Though Maine was the first to receive federal permission to fully insure low-income HIV patients, and Washington, D.C., has also received permission, Massachusetts is the first to implement it on a statewide basis, said Terje Anderson, executive director of the National Association of People with AIDS in Washington.
Until this month, when the new program went into effect, people with HIV had to wait until they developed AIDS until they could qualify for drug coverage, hospitalization, lab tests, and other benefits, said Richard McGreal, spokesman for the Division of Medical Assistance.
"There's a lot of people out there who were not getting the services that would help them,'' McGreal said. "Now we'll be able to deliver them.''
About 1,000 Massachusetts residents are infected with HIV and are poor enough to qualify for MassHealth, the state's low-income health insurance program.
Applications have already come in, and state officials hoped to draw more with a news conference.
Overall, between 20,000 and 22,000 people are currently living with HIV in Massachusetts, and about one third of those have been diagnosed with AIDS, according to the state Department of Public Health.
The expansion of MassHealth is expected to cost about $10 million per year, half of which is reimbursed by the federal government, McGreal said.
Under the newly expanded program, an HIV patient who earns less than $17,184 per year can receive primary care doctor visits, dental services, vaccinations, prescription drugs, eyeglasses, hospital stays, lab tests and X-rays.

Insurance Times: Ameritas and CNA in marketing pact

April 17, 2001, Vol. XX No. 8

Ameritas Life Insurance Corp. and CNA Group Benefits have signed an agreement that enables CNA Group Benefits to market Ameritas group dental and vision insurance plans in seven pilot markets.
William G. Seyboth, president and chief operating officer of CNA Group Benefits, said: "Many of our customers, particularly employers with 10 to 500 employees,

would like to be able to offer insured dental and vision plans as benefits for their employees. O

CNA Group Benefits, the business unit of CNA that also markets life, accident, disability and long-term care insurance for employer and affinity groups, begins selling Ameritas group dental and vision plans in Houston, San Antonio, Dallas, Denver, Orlando, Charlotte and Cincinnati. Initially, the plans will be marketed primarily to employer groups with 10 to 500 employees. However, the plans will be available to larger groups as requested.

Ameritas group dental and vision plans are underwritten by Ameritas Life Insurance Corp.

Insurance Times: UnumProvident streamlines family leave claims

April 17, 2001, Vol. XX No. 8

Unum Provident recently unveiled a program making it easier for employers to manage and track Family Medical Leave Act (FLMA) claims filed by employees.

In response to data indicating a 50 to 70 percent overlap in family leave and short-term disability claims, UnumProvident designed its FLMA/State Leave Management Services to integrate claims processing and leave processing requests, expediting results for employers by using representatives trained in the sometimes cumbersome state and federal FMLA regulations.

The Family Medical Leave Act mandates that all companies with 50 or more employees extend up to 12 weeks of unpaid leave and up to 12 months of ongoing health coverage to employees who experience a medically-related absence, such as a birth; adoption; care of a parent, child or spouse; or a serious illness or accident.

A survey by the department of Labor found that while most employers reported the FMLA had no noticeable effect on profitability, productivity or company growth, employers did find it difficulty to administer and to coordinate with other state and federal leave polices.

UnumProvident's product merges the FMLA process with the administration of short-term disability claims. The coordination helps to shorten the overall FMLA process. The product also provides employers with daily and weekly leave activity reports.

Insurance Times: HMOs turn to contractors to audit patients' medical practices

April 17, 2001, Vol. XX No. 8

BOSTON (AP) - The state's health maintenance organizations, at the behest of major employers including the state, are hiring outside companies to track insurance claims and pharmacy records to make sure patients are receiving the best care and following doctors' orders.

Tufts Health Plan is retaining Active Health Management of New York to review the health care utilization of 30,000 state employees in a pilot program.

Blue Cross and Blue Shield has retained American Healthways of Nashville to search the pharmacy and claim records of 8,000 congestive heart failure patients. They will look for patients who are not taking their medication or visiting doctors.

The state Group Insurance Commission, which manages health insurance benefits

for 263,000 state employees and their families, asked for the pilot program in its new contract with Tufts Health Plan.
Active will review the records, attempting to match the data with 600 potential scenarios that signal treatment problems, such as a patients who pick up insulin prescriptions to treat diabetes but have made no claims for eye exams. (Blindness is a long-term risk of diabetes.)
Patients' names will be deleted, and Tufts own doctors will contact the patients' physicians if potential problems are spotted.
Area employers including Gillette, Polaroid and Houghton-Mifflin are asking Blue Cross to enlist Active or a similar company to analyze claims for 120,000 employees.
Dr. Robin Richman, vice president and medical director for quality improvement at Tufts, has his doubts about the outside review.
"If over six months the computer spits out 2,00 names and after making phone calls you've found only 50 valid claims, then you have to question the cost effectiveness of this kind of program,'' Richman said. ``So far the reality and the hope of this kind of technology haven't jived.''
But premium increases during the past three years have employers looking for innovative programs that will improve care and reduce cost.
"Employers are looking for any port in a storm,'' said Bill Hubert, the manager of corporate benefits at Polaroid, which saw its premiums increase as much as 20 percent this year. ``We're watching health care costs go out of sight and we know that's waste and inefficiency.''

Insurance Times: Disability recovery: How working through illness aided one woman

April 17, 2001, Vol. XX No. 8

COLUMBIA, S.C. - "You think cancer won't happen to you," says a woman it happened to: Virginia Peninger. "But it can, and you have to get from that nightmare point where you're diagnosed, to a point where you accept it and move on."
Four surgeries later, and on the one-year anniversary of her full-time return to work, Peninger is at that point -- and wants the world to know that breast cancer isn't the end of one's personal or working life.
"I didn't have to go back to work," Peninger explains, "I wanted to go back. Being at home thinking about my problems wasn't fun. It was a relief to forget about the treatments and other sick people. I felt more normal at work. Even on the days I couldn't get to the office at all, I felt included in what was going on. Getting back to work was the best thing I could do."
Three days after her 40th birthday, Peninger, a quality-testing analyst for Systems and Computer Technology in Columbia, S.C. learned she had breast cancer that had spread into her lymph nodes. As best she could, she confronted each sad reality of cancer: endless doctor appointments, chemotherapy and radiation treatments, friends' and family's reactions and managing her way through the health care and disability systems.
Shelly Mayhak, a rehabilitation consultant for Cigna Group Insurance worked closely with Peninger during her disability. She knew Virginia wanted to feel productive and return to work. "Many people with disabilities, even those with life-threatening ones, have told me that working helps them stay focused on something other than their illness or injury and lets them feel that they're still themselves."
Cigna HealthCare also played a role during Virginia's disability, as her health

care coverage carrier. Bonnie Cassells, a nurse case manager with Intracorp, a Cigna subsidiary, was assigned to assist Virginia.

"Like many people, Virginia had little interaction with the health care system prior to her diagnosis," said Cassells. "My role was to help her learn more about her treatment options, assist her with administrative details of her health care plan, and simply be there to listen to her concerns."

"Bonnie helped smooth the bumps so I could concentrate on getting well," says Virginia. "I felt that she was my advocate and that she truly cared about me."

With numerous operations, treatments and side effects, Peninger was out of full-time work for 362 days. When her sick leave benefits ended, she began receiving long-term disability benefits through CIGNA Group Insurance.

"I'm single and the sole breadwinner," said Peninger. "And although my income was secure, I still wanted to go back as soon as possible."

But while that would have been a good idea for Peninger's mental health, it might not have been beneficial physically.

Says Mayhak, "Virginia pushed hard to resume work full time, even while undergoing treatments. But her doctors were worried she'd take on too much. They wanted a slow transition."

After consulting with her employer and Peninger's physicians, Mayhak created a work schedule, graduating from part-time -- as little as 10 hours a week -- to full-time work over six months. Peninger was excited, but knew she had to take it one day at a time. Some days she "felt energized and capable for six productive hours," while other days she couldn't get out of bed.

Now Peninger wants to help other women with breast cancer. She believes she has already made an impact on her co-workers. "Women now do breast self- exams who never did them before."

She offers some guidance for other women with cancer trying to cope with their personal and professional lives:

"Stay strong, whatever it takes, and reach out to those who love you. Decide how much you want to talk about your health. Think about going back to work, if possible. That helped me recover emotionally, if not physically. It felt good to catch up on the gossip, to know who's in charge of what. I blend into the woodwork, and that feels good."

Insurance Times: Empire Blues sues tobacco firms over smoking costs

April 17, 2001, Vol. XX No. 8

by Tom Hays
Associated Press

NEW YORK (AP) - The tobacco industry was back on trial last week, this time accused by New York's largest insurance company of conspiring to conceal the risks of smoking.

Empire Blue Cross and Blue Shield want Philip Morris, R.J. Reynolds and other cigarette makers to pay at least $800 million in damages.

Empire attorney Paul Baschorr called the figure "the pricetag of the defendants' dishonesty.''

In opening statements at the fraud trial in federal court, Baschorr said the tobacco industry had "repeatedly lied and deceived the American public'' over the last 40 years.

Claims Avalanche

He said the conspiracy had resulted in an avalanche of insurance claims for lung

cancer and other smoking-related ailments.
"Now it's Empire's turn to submit a bill to the tobacco industry,'' Baschorr said.
Tobacco lawyers have said their clients never plotted to hide the hazards of smoking. The defense was yet to make its opening statement late in a trial expected to last two months.
The case is the second to go to trial out of a backlog of 10 lawsuits brought mostly by third parties, including health insurance groups that say the tobacco industry should share the cost of treating cancer patients.
The first trial pitted a trust representing asbestos workers - many of them with lung cancer - and their heirs against R.J. Reynolds, Philip Morris, Brown & Williamson and other cigarette makers. The trial ended in January with a hung jury.
Tobacco lawyers have argued such cases have no legal basis, noting that appeals courts have ruled that third-party plaintiffs are too remote to seek damages.

Insurance Times: Webster buys Wolff-Zackin

April 17, 2001, Vol. XX No. 8

WATERBURY, Conn. - Webster Financial Corp., through its wholly owned insurance subsidiary Webster Insurance, has acquired Wolff-Zackin & Associates Inc. and Benefit Plans Design & Administration Inc., both of Vernon. Terms were not disclosed.
According to Peter K. Mulligan, senior executive vice president, Webster Bank. "Webster Insurance is now the largest Connecticut-based insurance agency, and we have greatly expanded our presence in the Hartford area."
These are Webster's fifth and sixth insurance agency acquisitions since 1998.
Gregory S. Wolff, CFP and chairman of Wolff-Zackin said, "Wolff-Zackin will bring even greater versatility to Webster Insurance and we are proud to be a part of one of the best insurance organizations in Connecticut. "

Insurance Times: Tierney named president of Hanover, Ruhl becomes regional VP, Mudie heads specialty division; ManageComp changes management team; PIACT elects young agent leaders

April 17, 2001, Vol. XX No. 8

Allmerica Property & Casualty
Allmerica Property & Casualty Cos. in Worcester, Mass. announced four senior-level appointments to its leadership team.
John P. Tierney has been named president of Hanover Insurance Co. He has overall responsibility for Hanover's operations in New England, New York and New Jersey. He succeeds J. Barry May, who recently left the company to pursue other career opportunities. Tierney first joined Allmerica in 1998 as chief underwriting officer. Prior to joining the company he held positions with the Boston office of Tilinghast-Towers Perrin.
Edward C. Ruhl has been named regional vice president for Hanover's New England office. Previously, he was president of Allmerica's sponsored markets operation. He has been with Allmerica since 1987.
Kenneth W. Mudie is the new president of Allmerica Specialty Markets, which provides tailored products to large accounts and specialized industries

including trucking and hospitality. Mudie has served as regional vice president of Hanover's New England office and Connecticut office since 1996.
Steven L. Nyberg is the new president of Allmerica Sponsored Markets, where he is responsible for personal lines group programs through affinity groups, associations, banks, payroll companies and others.

ManagedComp
ManagedComp has completed its new senior executive team with the appointment of W. Patrick Hughes as executive vice president of sales, marketing and service.
Hughes has more than 20 years experience in sales, marketing and brand management for managed care and insurance companies. He was most recently senior vice president of sales at Blue Cross Blue Shield of Massachusetts.
Harris Berman, chairman of Managed Comp's board of directors, made the announcement.
Hughes joins the team that also includes President and Chief Executive Officer Nancy Froude and Executive Vice President of Operations and Chief Financial Officer Joseph Fermano, who were named to their post in December.
Froude most recently served as ManagedComp's senior vice president and general counsel. Fermano was the firm's senior vice president and chief financial officer.
Woburn, Mass.-based ManagedComp offers workers compensation managed care services.

IIAA
Justin M. Roth and Nathan M. Riedel are the newest additions to the Washington, D.C. government affairs staff of the Independent Insurance Agents of America.
Roth is the new senior Washington representative, while Riedel will manage the group's political action committee, InsurPac.
Roth will be responsible for day-to-day work on legislative issues including state regulation, crop insurance, financial privacy and others. He replaces Thomas C. McCrocklin who has taken a position with the U.S. House of Representatives' Financial Services Committee.
Riedel assumes InsurPac responsibilities from Sally Downs, who has left IIAA for another job.

PIACT
Officers of the Connecticut Young Insurance Professional;s were elected by the Professional Insurance Agents of Connecticut at the group's recent annual convention.
Glenn Michelson of Michelson Insurance Agency will serve as president; Kyle Dougherty of The Dougherty Insurance Agency will serve as president-elect; Edward Cruess Jr. of Deming Insurance Agency is the new treasurer and Kimberly Tompkins of Associated Insurance Agencies was elected secretary. James Goodman of Associated Insurance Agencies Inc./Goodman Insurance Inc. is immediate past president.
Serving as CTYIP directors will be: Susan Bragdon, Safeco in New Britain; Carolyn DelaHunt of Associated Insurance Agencies in Hamden; Kenneth Distel of the Distel Agency in Farmington; Chestina Dowgiewicz of Peerless Insurance Co. in Rocky Hill; Robert Lesko of A.A. DiMatteo Insurance Service Center in Trumbull; Jane Melillo of Blumberg Associates in West Hartford; Mark Mullarkey of S.H. Smith in West Hartford; Michael Murren of Murren Insurance Agency in Fairfield; Donald Perillo of JN Phillips Glass in Newington; Joan Roberts of Continental Agency in Hamden; Stephen Todd of Burns, Brooks & McNeil in Torrington; and Richard Ziomek of The Patrons Insurance Group in Glastonbury.

Insurance Times: 13th time is 'lucky' for Cowan Financial

April 17, 2001, Vol. XX No. 8

Massachusetts Mutual Life Insurance Co. of Springfield, Mass. has awarded its National Chairman's Trophy to New York-based Cowan Financial Group for a record thirteenth time in 15 years for leading the company with $10.3 million first-year commissions.
Cowan Financial's total life insurance in force is up to a record-breaking $12.7 billion for its 60,416 policyhoders. It had more than $51 million in premium in 1999.
General agent Howard B. Cowan and his associates were awarded the Platinum Bowl for a "lucky" thirteenth time at the recent general Agents Conference in Las Vegas.
Cowan Financial, headquartered in New York City, is made up of 120 full time financial associates.

Insurance Times: COMMONWEALTH OF MASSACHUSETTS

April 17, 2001, Vol. XX No. 8

Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
One South Station • Boston, MA 02110-2208

Notice of public hearing of the
proposed merger of Healthsource Insurance Company with Berkshire Life Insurance Company of America

The Division of Insurance (the "Division") will hold a public hearing (the "Hearing") at 10:00 a.m. on April 19, 2001 regarding the proposed merger of Healthsource Insurance Company ("Healthsource"), a Tennessee stock insurance company, with and into Berkshire Life Insurance Company of America ("BLICOA"), a Massachusetts stock insurance company. The Hearing will be held at the offices of the Division of Insurance, Fifth Floor, One South Station, Boston, Massachusetts, 02110-2208 pursuant to Massachusetts General Laws chapter 175, section 19A.

Under the terms of the project merger, Healthsource will merge with and into BLICOA with BLICOA as the surviving Massachusetts entity. If the merger is approved, the merged company will be a wholly owned subsidiary of The Guardian Life Insurance Company of America ("Guardian"), a New York mutual insurance company, which currently has a pending application before the Division seeking approval of a merger with Berkshire Life Insurance Company ("Berkshire"), a Massachusetts mutual insurance company. The merger of Berkshire with and into Guardian will be the subject of a separate hearing to be held at a later date at Council Chambers, Pittsfield City Hall, 70 Allen Street, Pittsfield, MA 01201.

Any person who wishes to testify must file a Notice of Intent to Testify with the Division on or before April 17, 2001. All other parties who wish to testify will be heard subsequent to those who notify the Division in advance. Persons wishing to submit written comments may do so until the record of the Hearing is closed. All submissions must be sent to: Docket Clerk, Hearings and Appeals, Division of Insurance, One South Station, Boston Massachusetts, 02110-2208, and

must refer to Docket No. F2001-01A.

Michael T. Caljouw Richard A. Cody
Presiding Officer Presiding Officer

March 21, 2001

Insurance Times: St. Paul Guardian Insurance Company
April 17, 2001, Vol. XX No. 8

April 3, 2001

St. Paul Guardian Insurance Company
385 Washington Street
St. Paul, MN 55102

The above company has made
application to the Division of Insurance for a license/ Certificate of Authority to transact Boiler & Machinery 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 02110 Attn: Financial Surveillance and Company Licensing, within 14 days of the date of this notice.

Insurance Times: The First Rehabilitation Life Insurance Company of America
April 17, 2001, Vol. XX No. 8

April 17, 2001

The First Rehabilitation Life Insurance Company of America
600 Northern Blvd.
Great Neck, NY 11021

The above company has made
application to the Division of Insurance for a license/Certificate of Authority to transact 6A- Accident- all kinds, 6B Health- all kinds insurance in the Commonwealth.
Any person having any information regarding the company which relates to its suitability for a license/ Certificate of Authority is asked to notify the Division by personal letter to the Commissioner of Insurance, One South Station, Boston, Massachusetts 02110 Attn: Financial Surveillance and Company Licensing, within 14 days of the date of this notice.

Insurance Times: Insurer M&A activity expected to heat up after decrease
April 17, 2001, Vol. XX No. 8

The total number of insurance merger and acquisition (M&A) transactions decreased in 2000 despite speculation that the passage of the Gramm-Leach-Bliley Act (GLBA) late in 1999 would lead to increased M&A activity.

That's according to a recent Conning & Co. study, Mergers and Acquisitions and Public Equity Offerings: 2001 Edition.

Although hindered by several factors including stock market valuations, activity is likely to intensify toward convergence and consolidation as insurers seek to create scale and/or broaden product lines to compete in a global marketplace, Conning believes.

"Industry leaders are under new pressure to demonstrate that a merger or acquisition will deliver immediate benefits, and this has made them more conservative in their decision making," said Clint Harris, vice president at Conning and author of the study. "Large, scale-building mergers are often risky. Although there were some mergers clearly focused on building scale and product diversity, many of the transactions that occurred in 2000 were narrowly focused to build on the companies most visible strengths."

According to Conning, the total number of transactions declined about 37% - from 468 in 1999 to 293 in 2000. (This was the fewest number of annual transactions since 221 were identified in 1994.) The number of transactions declined significantly in all sectors in 2000, from a 16% decrease in property-casualty to a 68% decrease in the services sector. Although the aggregate value of transactions in 2000 exceeded that of 1999- $55.7 billion versus $41.7 billion - it was the $31.1 billion Citigroup, Inc., acquisition of Associates First Capital Corp. that accounted for the lion's share of the transaction value in 2000. There were only six large transactions (those with values reported in excess of $1 billion) in 2000, compared to 14 in 1999 and 23 in 1998.

The biggest change in the mix of M&A activity among the various sectors was in insurance services. Insurance services accounted for 20% of M&A activity in 1999; in 2000, it accounted for only 10%. Reductions in technology-related transactions account for much of this decline. Conning suggests that this decline is related to investors' disenchantment with technology companies as a whole.

Banks continued to acquire insurance agencies to enhance their distribution capabilities to sell insurance, but few opted to acquire or merge with insurers. In fact, the distribution sector accounted for 49% of all M&A transactions in 2000 and banks accounted for 34% of M&A activity in this sector. According to Conning, most banks do not yet appear interested in underwriting; rather, they are concentrating on rounding out services to their customers and generating distribution fees.

Many industry watchers expect that the GLBA (also known as The Financial Services Modernization Act) will result in a flurry of cross-industry M&A activity between banks and insurers. Conning cites the following reasons why banks and insurers have not yet participated in major cross-industry mergers or acquisitions:

- The bancassurance model in Europe is untested in the U.S.
- Insurance companies' return on investment has been unattractive for banks, which have been recording higher returns.
- Banks and insurance companies have different cultures, which may impede a successful merger.
- Unresolved privacy and other regulatory issues.
- Insurers and banks can capitalize on potential cross-industry advantages through strategic alliances.

The market for public equity offerings for the insurance industry remained weak in 2000. There were only three IPOs, all the result of demutualization, down from 10 in 1999.

Secondary offerings totaled $566 million, down 69% from $1.8 billion in 1999.