2005 Risk Management Honor Roll

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Orange County Transportation Authority

Bradley R. Wood
Marriott International Inc.

April 18, 2005
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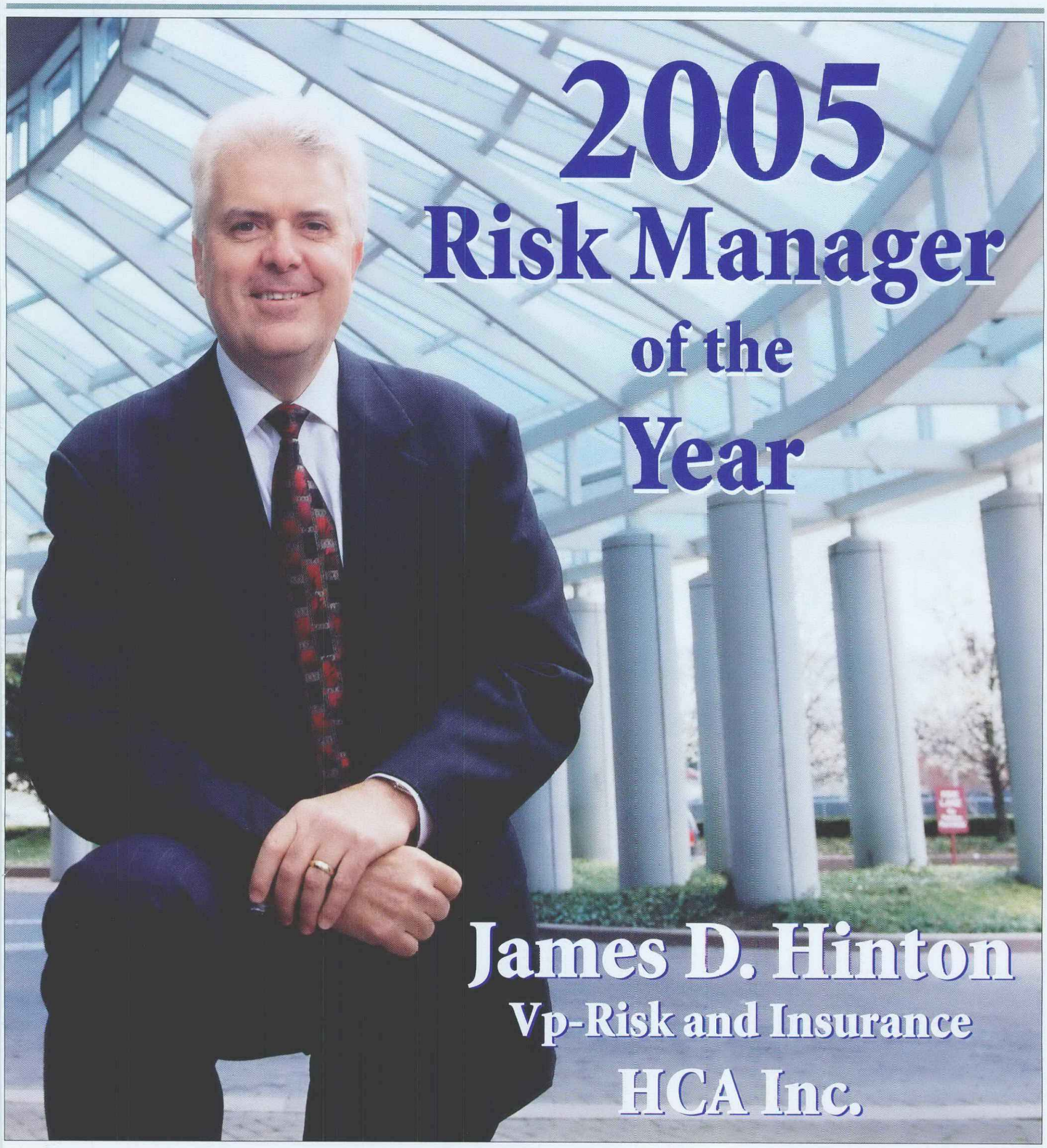

2005 Risk Manager of the Year

James D. Hinton

Vp-Risk and Insurance

HCA Inc.

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Are insurers off the hook in commission probe? / 3

Greenberg takes the Fifth on finite risk questions / 3

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EX-MARSH EXECS FORM BROKER

By SALLY ROBERTS

NEW YORK—Amid a tumultuous time for insurance brokerages, risk managers will soon have another option in the marketplace—with some familiar faces at the helm.

Three veteran insurance executives with ties to Marsh & McLennan Cos. Inc. are raising capital to start a new insurance brokerage, to be called Integro, which will target large-account business.

Spearheading the project is longtime industry executive Robert Clements, who had a hand in building such Bermuda-based powerhouses as ACE Ltd., XL Capital Ltd., Mid-Ocean Reinsurance Ltd. and, most recently, Arch Capital Group Ltd. Mr. Clements, former president of MMC and chairman of Marsh Inc., its retail brokerage unit, earlier this month stepped down as chairman of Arch Capital.

Joining Mr. Clements as partners in the venture are Peter F. Garvey, who last month left his post as co-president of Marsh, and Roger E. Egan, who was forced to resign as president and chief operating officer of Marsh last November in the wake of New York Attorney General Eliot Spitzer's suit against the company.

The three veterans are seeking to raise $300 million in a private placement—including investments from corporate buyers—and expect to open their doors for business in May, people close to the matter said.

They will not accept investment capital from insurers, though. Cross-ownership stakes by insurers and brokerages, while common in the industry, have raised concerns among some observers about potential conflicts of interest.

Mr. Clements declined to comment for the story. Messrs. Egan and Garvey could not be reached.

See INTEGRO / page 83

Finite risk deals may go on hold, but scrutiny won't end them

By JUDY GREENWALD and CAROLYN ALDRED

Insurers, reinsurers and corporate policyholders for now may hesitate to enter into finite insurance and reinsurance deals because of the current regulatory scrutiny of the products, but many will eventually re-enter the market even if the rules change, say observers.

State, federal and international regulators, as well as U.S. and international accounting bodies, are all now looking closely at financial products (see story, page 81). The expected outcome, many observers say, is more-rigorous risk transfer and disclosure guidelines, providing a clearer picture of what kinds of deals involve genuine risk transfer and, thus, may be accounted for as insurance.

After that change, deals that do not meet the amended standards will disappear, but others that do pass muster will eventually re-emerge because they fulfill a market need, observers say.

"I don't think this should be looked upon as the death knell of finite," said insurer attorney Elliott M. Kroll, a partner in the reinsurance practice of Herrick, Feinstein L.L.P. in New York. The

See FINITE / page 80

PHOTO: DAVID HITTLE

Testifying on TRIA before the Senate Banking, Housing and Urban Affairs Committee last week were, left to right, Brian Duperreault, chairman of ACE Ltd.; Frank Nutter, president of the Reinsurance Assn. of America; and Robert J. Lowe, chairman and CEO of Lowe Enterprises.

Skepticism, support voiced at TRIA extension hearing

By MARK A. HOFMANN

WASHINGTON–Congressional interest in crafting a long-term approach to ensuring the availability and affordability of terrorism insurance appears to be growing, according to some supporters of such an effort.

That sort of approach would create some kind of public-private partnership to replace the current federal financial backstop for insurers facing losses from future catastrophic terrorist attacks. The backstop is being provided by the Terrorism Risk Insurance Act, which expires this year. Although insurers and policyholders are currently focusing their efforts on extending the program through the end of 2007, they say it's not too early to consider what should follow TRIA.

Terror coverage survey
page 3

But even getting TRIA extended isn't a given,

See TRIA / page 84

Late News

Garamendi proposes rules on disclosure

California Insurance Commissioner John Garamendi has proposed requiring insurance agents and brokers to disclose various information when placing business, including revealing whether they are acting on behalf of the insurer or client, with the acceptance of a fee determining that status. Producers also would have to tell clients whether they will seek a quote from more than one insurer, and a client's agent or broker could not accept compensation from a third party without first obtaining the client's consent. Producers also would have to reveal the amount of the compensation or, if unknown, how it will or may be calculated. The rules are subject to a review period.

Judge upholds Maine PBM disclosure law

U.S. District Judge D. Brock Hornby upheld Maine's Unfair Prescription Drug Practices Act, rejecting charges in a lawsuit filed in 2003 by the Pharmaceutical Care Management Assn. PCMA contends that Maine's law, which requires prescription benefit managers to disclose remuneration arrangements with drug manufacturers and to pass rebates or volume discounts on to clients, is pre-empted by federal laws and violates due process. PCMA plans to appeal.

Insurers to pay bulk of Westar settlement

Embattled electricity provider Westar Energy Inc. said that its insurers will pay $31.3 million of a $32.5 million settlement of shareholder and derivative lawsuits brought by investors in 2003, claiming they suffered losses when former top executives

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RISK MANAGER OF THE YEAR

James D. Hinton

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RISK MANAGEMENT HONOR ROLL

Al Gorski

Bradley R. Wood

Pages 58, 70

Aon Focus
www.aon.com/focus

Transparency and full disclosure are valuable enablers for industry leadership.

APRIL 18, 2005

Serving our clients through greater transparency

Michael D. Rice is chairman and chief executive officer of Aon Risk Services Inc., Aon's U.S. insurance brokerage operation. Aon is one of the world's leading providers of risk management, insurance and reinsurance brokerage, and human capital consulting services.

Each year, the RIMS conference affords a great opportunity to discuss recent events with industry colleagues. This year, I doubt there will be much pause in the conversation. It has been a watershed year for all of us.

Greater transparency is a concept much discussed, but what does it mean to our clients? I would offer that greater transparency and full disclosure of remuneration is a logical progression of the constantly evolving changes that permeate our dynamic industry. Full disclosure is the lever that promotes real-world actions that ultimately benefit all concerned.

For clients, I believe greater transparency will mean clearer information and better understanding of the services brokers provide to them. Comprehensive disclosure on remuneration will further underscore the value of those services. Contingent commissions did raise questions concerning potential conflicts of interest. Even the appearance of a conflict is unacceptable, and I believe that changes we are undertaking at Aon will ensure that client interests are always front and center.

Corporate insurance and risk management professionals face increasing challenges in the aftermath of recent significant changes throughout corporate America. Higher levels of responsibility and expectation come with a corresponding need for more meaningful information.

Those brokers who embrace transparency, disclosure and elimination of certain past practices are responsive to this need, and, in so doing, clearly demonstrate that their clients' interests are paramount.

The concepts are easy to understand, but, in reality, there is much work to be done. Turning policy into action is an all-out effort at Aon, to be followed by training in new practices, new workflows and new internal controls. We are committed not only to continue to focus on our clients while putting these measures into place, but also to ensure that clients have a thorough understanding of what this new dynamic means to them and how they will benefit.

There are some new rules in the game, and we have made a commitment to play by them and win. We pride ourselves on our client focus, and integrity has long been one of our most important core values. Business is not exactly "as usual": It's a challenging time, but it is filled with opportunity. Transparency and full disclosure are not barriers; they are valuable enablers for industry leadership.

A new approach in outsourcing vendor selection helps companies yield greater results

The traditional means of selecting an outsourcing vendor is the request for proposal (RFP). A new approach, the reverse RFP, allows the company to proactively collaborate with select outsourcing vendors, each possessing distinctive operating models and outsourcing methodologies. This allows the company to adopt different points of view, philosophies and styles before choosing a vendor that fits its needs. In many cases, the company may modify its own business objectives and operating model to align with the outsourcer of its choice, yielding unanticipated, often greater, business results. To read the complete article visit **www.aon.com/focus**.

Effective health care communication helps employees make smarter choices

Healthy employees cost less and spend less. Consumer-driven health plans have spurred employers to wonder how they can address their business, financial and human resources issues in an era of greater benefit complexity and higher costs. To help employees make sound health care benefit choices, employers should provide consistent, continuous and effective communication about health-related behavior and the role of health care coverage. Studies show that when employees are engaged and informed about health-related issues, they tend to take decisive action in their own health management. To read a complete article, visit **www.aon.com/focus**.

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Marsh Inc.'s new compensation model faces resistance in the London market.
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Online poll - 2/14 - 2/18

Will finite-risk products continue to be sold in the future?

Participate in *BI*'s online polls at *www.businessinsurance.com.*

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Insurers implicated in investigations escaping fate of brokers–so far

By DOUGLAS McLEOD

NEW YORK—While probes launched by New York Attorney General Eliot Spitzer and other regulators are costing the world's three largest insurance brokers a collective $1.1 billion in restitution payments, several insurance companies implicated in bid-rigging or client-steering charges against the brokers have so far escaped similar liability.

Marsh & McLennan Cos. Inc., Aon Corp. and Willis Group Holdings Ltd. have all agreed to establish funds to reimburse clients, with Marsh—the subject of the most serious fraud and antitrust charges—paying $850 million of the total.

Mr. Spitzer has also extracted guilty pleas to felony or misdemeanor criminal charges from two former Marsh executives and seven former officials of an American International Group Inc. unit, ACE USA Insurance Co. and Zurich American Insurance Co.

Apart from a lawsuit against ACE filed by Connecticut Attorney General Richard Blumenthal, though, property/casualty insurers cited as colluding in bid rigging or other anti-competitive practices have so far escaped the kind of civil charges that regulators filed against Marsh and Aon. The insurers are not contributing to the broker settlements reached to date, which have been characterized as restitution rather than fines or penalties.

Whether any insurers ultimately face such civil charges remains to be seen. Mr. Spitzer said at a conference last week that more civil and criminal cases will be filed in his wide-ranging insurance industry investigation, but he did not offer further details. Much of the public focus of the investigation lately has been on financial reporting issues at AIG and on finite risk and other "loss mitigation" insurance products.

A spokesman for Mr. Spitzer's office did not respond to a question about possible civil and criminal complaints against insurers and insurer officials arising from the broker compensation probe.

A spokesman for the New York Insurance Department, which has participated in the probe and could also sanction insurers, declined to comment other than to say that the

See INSURERS / page 84

Terror coverage take-up rates double

Nearly half of surveyed companies bought coverage in 2004

By MARK A. HOFMANN

NEW YORK—Nearly twice as many companies bought terrorism coverage as a component of their property insurance in 2004 than in 2003, according to a soon-to-be-released survey by Marsh Inc.

"Marketwatch: Terrorism Insurance 2005" found the percentage of companies adding terrorism coverage to underlying property insurance policies in 2004 reached 49%, compared with the 27% who did so in 2003. And throughout 2004, the percentage of respondents reporting adding terrorism coverage to their property programs each quarter never dropped below 44%, a significantly larger percentage than the 23% who reported doing so when Marsh first surveyed buyers in the second quarter of 2003.

The 2004 survey included 2,371 firms.

The growth of interest in terror coverage comes as the Terrorism Risk Insurance Act, which provides a federal financial backstop for insurers facing future catastrophic terrorist attacks, is due to expire on Dec. 31.

Steve Lundin, managing director of Marsh's property practice in New York and the report's publisher, said that he believes the act should be extended.

"The market is continuing to develop and get a bit more sophisticated, but it's still not there yet. That's why we view a role for the government to be important; it's not where it needs to be yet," Mr. Lundin said in an interview.

The survey also shows significant differences in the take-up rate for terrorism coverage in certain metropolitan areas. Mr. Lundin said that a combination of experience, cost and what the report called "the hard-to-define notion of 'perception of risk,' all appear to play roles in the decision whether or not to buy."

For example, New York and Washington, both of which were targets of the Sept. 11, 2001, terrorist attacks, reported both relatively high premium rates and high "take-up" rates. But Boston and Philadelphia, which also have moderate to high take-up—Boston's was the highest broken out by the survey at 69%—enjoy relatively low premium rates. Buyers in both cities may have been affected

See TERROR COVERAGE / page 83

Terrorism take-up growing

Study shows more buyers opting for terrorism coverage

Source: Marsh Inc.

Greenberg takes Fifth in Spitzer probe

Former AIG chief says he needs time to review documents

By DOUGLAS McLEOD

NEW YORK—Former American International Group Inc. Chairman Maurice R. Greenberg refused to answer dozens of questions posed by investigators last week as New York Attorney General Eliot Spitzer promised that more civil and criminal charges will be filed in his insurance industry probe.

As expected, Mr. Greenberg exercised his Fifth Amendment right against potential self-incrimination and declined to answer questions under oath in an interview last Tuesday with investigators from Mr. Spitzer's office and the U.S. Securities and Exchange Commission.

"I am willing to accept responsibility and to account for the performance of my duties, but I believe that good order and fairness require that I have an adequate opportunity to be advised of tche issues to be investigated and to my alleged involvement therein," Mr. Greenberg said in a statement issued before his interview.

PHOTO: NYTIMES

Mr. Greenberg

Mr. Greenberg's lawyers had sought to postpone the interview, arguing that he had not had an opportunity to review "thousands of documents" related to transactions under investigation, many of which "took place from five to 20 years ago," the statement notes.

The interview came a day after Mr. Spitzer and SEC officials questioned Warren E. Buffett, chairman of Berkshire Hathaway Inc., about a 2000 deal in which a unit of Berkshire's General Re Corp. ceded $500 million

See GREENBERG / page 82

RIMS survey signals end to soft market for rates

By MICHAEL BRADFORD

NEW YORK—Risk managers appear to be seeing the dying gasps of the soft market, a recently released survey reveals.

In fact, commercial insurance prices that declined in 2004's yearlong softening seem to be heading back up, according to the RIMS Benchmark Survey produced by Advisen Ltd. for the Risk & Insurance Management Society Inc. in New York.

"We're seeing what we think may be the bottoming out of the soft market," said David Bradford, New York-based editor-in-chief at Advisen. "It's got a ways to go; there is still abundant capacity. But there has been some moderation."

But even as prices moderate, employers' cost of risk has risen slightly.

Advisen encapsulates the previous year's quarterly benchmark results into an annual survey and releases that information as a printed report showing yearlong trends. The 2004 results, gathered from around 1,400 U.S. and Canadian companies, showed that while prices were moderating by year's end, earlier premium increases in workers compensation and professional liability coverages helped keep the overall risk cost 3% higher than the year before.

Also contributing to a higher cost of risk were high retention levels left over from the hard market, according to the annual survey. Buyers were still funding large amounts of their property and directors and officers liability losses in those retentions, the survey said.

The online survey of pricing during the first quarter of this year showed that general liability and property lines are among those that are stabilizing or rising. Property prices were down an average 3.5% during the quarter, but that was well below the 10% drop in last year's fourth quarter, according to the survey.

"General liability has been flat or slightly up," Mr. Bradford said. The survey said that the coverage costs 1.1% more during the first quarter of 2005 compared to the last quarter of 2004.

"We have consistently predicted that this soft market would probably be short-lived and relatively shallow, especially compared to the extremely deep and prolonged soft market of the 1990s," said Daniel H. Kugler, RIMS vp-membership, in a statement announcing the survey results. "We'll wait to see if we return to the go-go pricing of the last hard market, which we doubt right now, but for the time being, pricing seems to be showing signs of stabilization."

The market changes are not surprising, according to Mr. Bradford. "In total, the market is behaving very much as we expected it to," he said.

Mr. Bradford said workers comp insurance had been expected to "move into the soft phase. It did in the fourth quarter and we expect it will continue for a little while."

As legislative changes addressing workers comp systems in Florida and California take hold, coverage prices there should further stabilize, Mr. Bradford said.

The quarterly survey shows an 8.1% decrease in pricing for D&O coverages. While that appears to be a significant drop, there is "anecdotal support" to suggest that large companies' costs for the coverage have stabilized. "We're even hearing about rate increases" for Fortune 1,000 companies, Mr. Bradford said.

D&O costs for midsize and small companies "continue to trend downward," Mr. Bradford said. "But it's far from a free fall."

The quarterly RIMS Benchmark Survey is published online throughout the year and in a single volume once per year. Details are available at *www.rims.org/benchmark*.

Risk managers who contribute data to the online survey are eligible for discounts. Those who contribute insurance schedule data to the survey can access software that allows them compare their information against the marketplace results.

Advisen's 115-page book that includes cost of risk data for various industry groups is available for purchase at *www.rims.org/2004book*.

Wisconsin river runs through cover dispute for pollution damage

By MEG FLETCHER

MADISON, Wis.—Wisconsin's pulp and paper companies and some municipalities want the Wisconsin Legislature to establish pro-policyholder guidelines for interpreting their decades-old general liability policies which they say will streamline insurer payments for pollution damage and help clean up contaminated waterways.

Fox River factions

Policyholders and insurers are battling over loss allocations for pollution of the Fox River.

Source: Wisconsin DNR

These policyholders are supporting Assembly Bill 222—and its companion, Senate Bill 137—which they say will overcome stalled negotiations with insurers over the clean up of the Fox River near Green Bay, Wis., and other sites. Specifically, the bill calls for the adoption of an "all sums" approach that would allow a policyholder to select one insurer as primarily responsible for paying losses under such policies, up to policy limits.

Opponents of the proposed legislation are insurance industry groups and a few employer associations, which maintain that such contract disputes should be decided by courts, not by legislatures. They favor the allocation of losses based on "proportional" share—also known as a "pro-rata" share—in which the damages are divided among all insurance policies based on the number of years of each contract.

Both groups are expected to air their views on the Assembly bill at a hearing scheduled for Thursday in Madison, Wis.

Seven major paper companies—some using municipal water treatment systems—polluted the river with polychlorinated biphenyls from about 1954 to 1971. Typically, those entities were insured at the time under general liability policies that may provide some pollution coverage because they were written before insurers adopted strict pollution exclusions in the 1980s.

About 90 insurers wrote about $2.5 billion in general liability limits during that period, said Wisconsin-based spokesmen for Atlanta-based Georgia-Pacific Corp., one of the companies involved. While a few claims have been settled, others are being litigated. Thus far, the paper companies have voluntarily paid $130 million toward a small, ongoing cleanup project that is ultimately expected to cost at least $400 million to $600 million.

Supporters of the "Fair Claims Act" are following a 2004 Oregon precedent of asking their respective legislatures—instead of the courts—to "clarify" the responsibility of insurers by imposing an all-sums ap-

See POLLUTION / page 82

Pension funding recovering slowly

Returns, employer contributions help boost levels

By JERRY GEISEL

Pension plan funding is improving, helped by better-than-expected investment returns, but the average funding level remains well below where it stood a few years ago.

On average, defined benefit plans plan offered by 100 large U.S. companies were 90.5% funded in 2004, up from 88.5% in 2003, according to a survey released last week by Milliman Inc.

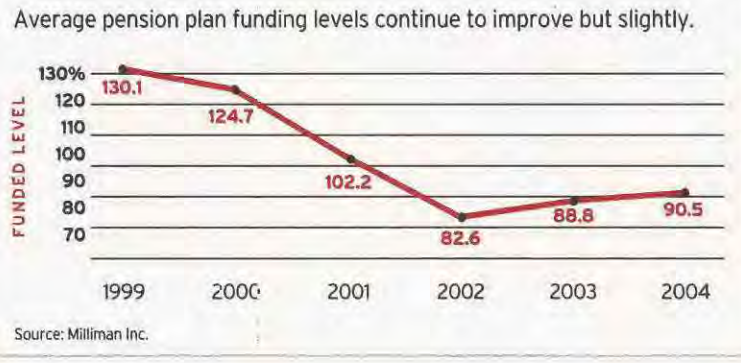
The improvement stemmed largely from a 12.4% average return on assets, considerably higher than the 8.5% rate of return employers expected to earn on average.

Employer contributions also helped improve funding levels. Last year, surveyed employers pumped $41.6 billion into their plans. While that is a decline from the $56.9 billion employers contributed in 2003, the 2003 contributions were skewed by a $19.1 billion contribution by General Motors Corp., which contributed $900 million in 2004. Excluding GM's contributions, the re-

See FUNDING / page 82

On the rebound

Average pension plan funding levels continue to improve but slightly.



Source: Milliman Inc.

Insurers, despite '04 cats, notch an underwriting profit

JERSEY CITY, N.J.—A combination of the first underwriting profit in more than a quarter century plus investment gains helped the U.S. property/casualty insurance industry to register record income last year, according to a report released Tuesday.

The industry's aggregate net income was $38.72 billion in 2004, up 29% over the previous year, according to an analysis prepared by the Jersey City, N.J.-based Insurance Services Office Inc., and the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America. That helped push the industrywide surplus to a record $393.49 billion, an increase of 13.4% over year-end 2003.

The industry's combined ratio improved to 98.1% in 2004 from 100.1% a year earlier, allowing the industry to post its first underwriting profit since 1978. In fact, net underwriting profit reached $5.04 billion in 2004, compared with a $4.85 billion loss in 2003.

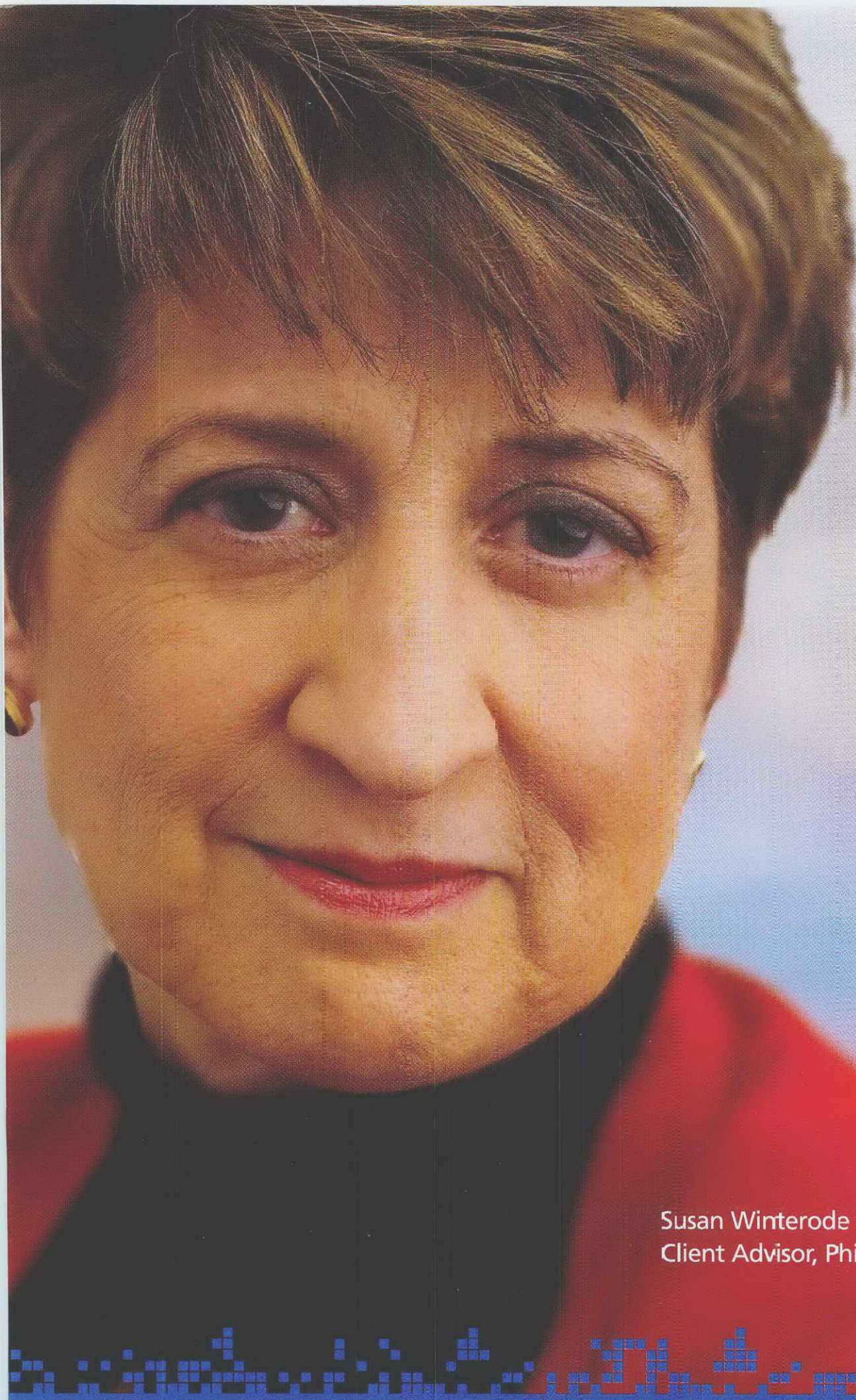
"Insurer's net gains on underwriting last year are all the more remarkable in view of the five catastrophic hurricanes that struck in 2004," John J. Kollar, ISO's vp-consulting and research, said in a statement accompanying the report.

In the same statement, Gregory Heidrich, PCI's senior vp-policy development and research, noted the role that improved investment income played in the insurers' record results. "Net investment income—primarily dividends from stocks and interest on bonds—grew 2.4% to $39.6 billion in 2004 from $38.6 in 2003.

And insurers realized $9.3 billion in capital gains on investments in 2004, up from $6.6 billion in 2003," he said.

The figures are consolidated estimates for all private property/casualty insurers based on reports accounting for 96% of all business written by private U.S. property/casualty insurers.

—By Mark A. Hofmann



For the 20 years I've been with Marsh, we've led the industry with innovative ideas.

Now we're also going to be the leader on industry reform.

That's why I'm proud to be with Marsh.

Susan Winterode
Client Advisor, Philadelphia

An open and honest book. That's what clients expect and that's what we will deliver. We've already begun implementing reforms that we believe will lead the industry. From eliminating contingent commissions for our brokerage services, to disclosing fully all compensation arrangements, to establishing written standards of conduct for compensation arrangements, these actions speak to our commitment to you. As the world of risk grows in scope and complexity, Marsh will be there. Marsh is—and will continue to be—the world's #1 risk specialist.

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Editorial

Top risk managers show their leadership

Good risk management effectively analyzes and mitigates exposures facing an organization. Great risk management goes further, helping advance awareness of risk and ways to reduce it.

We're pleased to present three examples of great risk management, profiled in this issue of *Business Insurance*.

The annual Risk Manager of the Year award and Risk Management Honor Roll recognize risk management excellence. This year's winners—James D. Hinton of HCA Inc., Al Gorski of the Orange County Transportation Authority and Bradley R. Wood of Marriott International Corp.—are innovative professionals whose commitment to risk management extends outside their own organizations.

Profiles beginning on page 10 show how these risk managers solve problems and help others see the importance of managing risk:

- Mr. Hinton played a key role in medical liability reforms in Texas, an achievement that benefited not only HCA hospitals and physicians but helped boost access to health care. He also was behind an effort that led to a landmark ruling on captive insurers and a significant tax break for captive owners.
- In addition to reducing the risks of the nation's 11th-largest transportation authority, Mr. Gorski helps educate the next generation of risk managers. His class on risk management and insurance at California State University, Fullerton, is informing students with lessons from real-world experience. Not surprisingly, he's a popular instructor who speaks with conviction.
- Marriott's Mr. Wood understands the devastating losses that terrorist attacks can wreak, and has been a leading advocate of the Terrorism Risk Insurance Act. TRIA's extension would help not only the hospitality industry but all businesses with commercial property exposures. He also created a shelter-in-place program to protect Marriott's guests and employees during emergencies.

Business Insurance created the Risk Manager of the Year award in 1977, to recognize risk management excellence and commemorate our 10th anniversary of publication. In 1981, *BI* added the Risk Management Honor Roll to highlight the achievements of risk managers in fields not necessarily represented by the Risk Manager of the Year.

As the award winners over the past 28 years prove, great risk management isn't limited by age, gender or even organization size. Anyone committed to the profession who develops effective programs to manage risk is worthy of acclaim. The awards are open to any full-time employee of a public or private entity worldwide who is responsible for that entity's risk management.

Messrs. Hinton, Gorski and Wood are leaders in the truest sense, and others can learn from them. *Business Insurance* salutes this year's winners and hopes that they, like the winners before them, will inspire best practices in risk management.

A broker sans conflicts?

Few people can pull off startup insurance entities that remain successful long term, but Robert Clements is one of them. And he's trying to do it again.

As we report on page 1, Mr. Clements has enlisted other former veteran executives of Marsh & McLennan Cos. Inc. to form a new brokerage in New York. Mr. Clements, who retired this month as chairman of Arch Capital Group Ltd., is joined in the venture by Peter Garvey and Roger Egan, both former presidents of Marsh Inc.

Other details are sketchy, though sources say the brokerage firm is seeking $300 million in capital and hopes to begin operating in May.

The new brokerage is dubbed "Integro," reflecting its philosophy of operating without conflicts of interest by rejecting investments from insurance companies.

Barring capital from insurers doesn't guarantee a brokerage will be free of conflicts, however. Whether Integro can avoid the conflicts alleged in the lawsuit against the triumvirate's former company remains to be seen.

Schillerstrom

Letters

Targets of frivolous suits are victims, too

To the editor: Maybe *Business Insurance* should report on the businesses that have gone out of business because of frivolous lawsuits and the cost of litigation. Numerous frivolous lawsuits do not even make it to the courtroom because the defendants settle due to the costs of litigation. This isn't something any judge will be aware of. Additionally, the costs of stress to the business owner, both financial and emotional, are enormous.

I would encourage you to look further into the abuses that are taking place by talking to those who are involved. I am currently a defendant in such a lawsuit.

Then there is also the issue of perjury, which seldom is addressed because "it just slips under the wire." In the meantime, ethical attorneys are leaving the law to pursue other businesses, which leaves a plethora of the unethical attorneys to represent these plaintiffs.

After two years in this system, I see the law as evolving in the wrong direction. Sorry, I don't think the judges have any idea what goes on in the "real" world. How can they, when they see only the cases that make it into their arena? They need to get into the corridors and the streets to find out the real stories.

Please don't rely on individuals who see things only from one side. I hope you will do your due diligence and get another perspective.

Nancy S. Campbell
Therapeutic Resources Inc.
Mill Creek, Wash.

Write Us

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Approach hones physicians' own risk management skills

Effort to prevent claims transformed into doctor-guided program

By DAVE LENCKUS

Hospital risk management's traditional role has not been to prevent claims by shaping clinical practices.

That would be cookbook medicine—anathema to the autonomous physicians with treatment privileges at the facilities.

But the idea of merely managing claims does not sit well with James D. Hinton, vp-risk and insurance at Nashville, Tenn.-based HCA Inc.

"I don't buy that claims are going to happen," Mr. Hinton said.

Armed with analyses from what he describes as an unrivaled database of 60,000 medical claims—captured from the hundreds of HCA hospitals and outpatient surgery centers, including those it has acquired since 1976—Mr. Hinton has taken on the dicey task of preventing claims.

It has been a nine-year process of not just winning physicians' support but, more importantly, nurturing physicians' own risk management skills. While fostered by risk management and underpinned by claims data analyses, the claims prevention effort is physician-guided.

Indeed, the effort has transformed into a patient care quality management program that is fully independent of risk and insurance.

The full measure of the success of the claim prevention effort is still a few years away.

But some figures on the perinatal safety initiative, for example, support Mr. Hinton's contention that health care providers do not have to accept the premise that claims will happen.

Since the perinatal initiative's inception in 1996, there has been a 40% reduction in closed obstetrics claims by an in-house claims handling staff that has little turnover and has not altered its claims-handling practices, Mr. Hinton noted.

In addition, new claims have fallen by 50%, the frequency of large claims has plunged, and the claim cost per birth has fallen dramatically.

Another measure of success is the steep decline in emergency C-section births that are not completed within the crucial 30-minute period from what Mr. Hinton calls "decision to incision" (see story, page 22).

Much of that success—achieved by physicians modifying clinical practices to conform to demonstrated best practices throughout the organization—has been achieved in only the last couple of years.

The loss prevention effort in the early years largely consisted of informing the organization's biggest risks—what Mr. Hinton calls its outliers—that their experience was inconsistent with their affiliates and offering them some educational programs.

"You can't underestimate the power of benchmark data," Mr. Hinton said. "A lot of times there was an incorrect perception" by hospitals that their results were better than they were.

That understanding had to come first, stressed Jan Meyers, assistant vp/quality and director of the perinatal safety initiative.

> "You can't underestimate the power of benchmark data."
>
> **James D. Hinton**
> **HCA Inc.**

Ms. Meyers credits Mr. Hinton for recognizing that the hospital industry had undergone some fundamental changes that not only would allow him to approach physicians and gain their support for this kind of effort but also that made this kind of effort necessary.

Ms. Meyers explained that in HCA's early years during the 1960s and 1970s, there was little focus within the hospital industry on medical malpractice claims. During that time and into the 1980s, "quality was a given," she said.

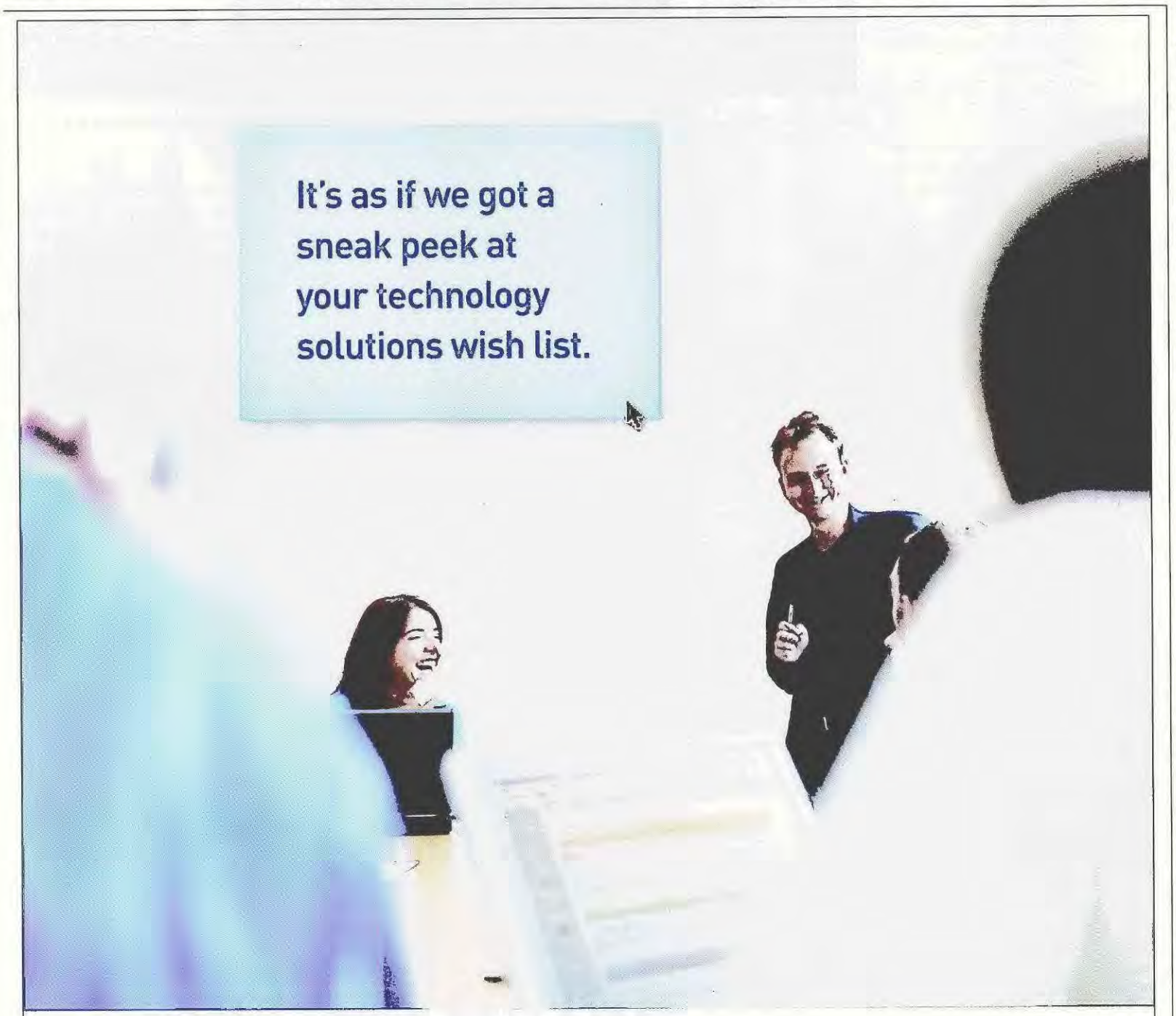
"But with managed care, hospitals had to position themselves for survival. They had to look at finances" and make some changes that were not always conducive to quality care, she said.

Initially, that involved reducing patients' lengths of stay, she noted. Attending physicians, meanwhile, were assuming larger patient volumes.

But, through claims data, Mr. Hinton recognized there were opportunities to "do a much better job" and reduce claims, Ms. Meyers said.

Every hospital handles a situation differently, based on factors that include physicians' and staff training and local culture,

See PREVENTION / page 14



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tion career, James D. Hinton was told that medical malpractice claims were a cost of doing business. But that was a perspective Mr. Hinton said he never accepted. Though not the kind of risk manager who likes

of care can be improved and then lays the groundwork that encourages management and physicians to identify and embrace the best practices in health care delivery.

health care delivery.

Besides improving HCA's loss experience, Mr. Hinton's efforts–along with those of his 65-member staff–have meant nothing less than a pos-

executives and academics.

"Risk management and loss prevention with HCA is no longer one of those 'nice-to-dos,' " wrote R. Milton Johnson, Mr. Hinton's direct su-

of-the-box ways."

Mr. Mandel, assistant vp-enterprise risk management at San Anto-

See HINTON / next page

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Prevention: Honing docs' risk management skills

Continued from page 12

she noted.

"We're just trying to show them standard approaches that produce better outcomes," she said.

"But we must give up some of our autonomy to do the right thing," Ms. Myers said, referring to the hospitals and their attending physicians.

That is easier for some and a struggle for others, she acknowledged.

Awards for implementing those changes, in the form of medical malpractice insurance premium credits from HCA's captive insurer, help the process along.

But the changes in clinical practices could not be dictated, Mr. Hinton said. They had to come from the physicians and go through different physician and hospital advisory groups that risk management helped organize.

For the last few years, efforts to prevent claims through quality initiatives designed to impart best practice standards throughout the HCA system have been the responsibility of HCA's quality management department, which was formed just for that task.

"But, it's a hand-in-glove relationship between the two departments," stressed Dr. Frank Houser, the medical director and a senior vp at HCA, who oversees the quality department.

Now Ms. Meyers reviews monthly and quarterly loss reports and responds when risk management identifies what it suggests could be claims outliers based on the claims data it pores over.

That has led to other patient safety initiatives designed to minimize problems in patient medication and emergency room, orthopedic and stroke care.

Over last couple of years, "there has been a great bridging between quality and risk management," Ms. Meyers said.

Initiatives deliver better perinatal care

Collaboration helps implement best practices

By DAVE LENCKUS

Efforts by HCA Inc.'s risk and insurance department to reduce medical malpractice claims by fostering best practices in clinical care began in the perinatal area at a group of HCA hospitals in 1995.

Under the direction of James D. Hinton, vp-risk and insurance at Nashville, Tenn.-based HCA, the effort has evolved significantly over the past decade from analyzing claims data, showing claims "outliers" their true experience compared to other hospitals and providing some consulting services.

Now, under a process that has been moved to HCA's patient care quality management department, physicians and hospital officials determine and implement clinical best practices.

The perinatal safety initiative's complete measure of success is still a year or two away, because of the long-tail nature of those claims, Mr. Hinton noted. But, to date, several measures indicate that the initiative is working.

For example, the percentage of emergency Caesarean-section births that are performed within the critical 30-minute window that opens when the emergency first presents itself has been greatly increased (see story, page 22).

And since 2002, risk and insurance, quality management, the physician advisory board and various divisional teams have worked together to develop numerous patient safety initiatives, in the perinatal and other areas.

Those initiatives, the measurable success of which is premature, are designed to:

- Improve emergency services (see story page 26).
- Improve the timeliness and effectiveness of responses to certain high-risk mother/baby conditions during and after labor.
- Eliminate errors in dispensing medications.
- Improve cardiovascular and stroke victim care.

Measures of success

Source: HCA Inc.'s Risk & Insurance Dept.

Numbers tell the story

"Senior management in the early years had to kind of accept it on faith," recalled Mr. Hinton, referring to his assertions that HCA could improve its perinatal claims experience.

See INITIATIVES / page 16

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PHOTO: MICHAEL MARCOTTE

HCA Inc.'s claims group. Front row, left to right: Karen Karcher, senior claims supervisor; Lisa Meister, director; Julie Marshall, claims supervisor. Second row, left to right: Lisa Baldwin, director; Susan Carey, claims supervisor; Judy Moon, administrative assistant; Rene Zeron, claims supervisor; Michelle St. George, administrative assistant; Jim Rachal, claims supervisor. Third row, left to right: Cookie Kimbrough, administrative assistant; Larraine Gerelick, assistant vp; Chris Gentile, director; Harriet Adrian, senior claims supervisor; Jennifer Bender, claims supervisor; Betty Radmacher, claims supervisor; Todd Hagemeyer, senior claims supervisor. Fourth row, left to right: James D. Hinton, vp; David Fausett, senior claims supervisor; Bob Krug, senior claims supervisor; Richard Baker, claims supervisor; Frank Halliburton, senior claims supervisor; Bob Nevens, director. Not shown: Lisa Kirkham, senior claims supervisor; Francis Breazeale, senior claims supervisor; Stephanie Burch, administrative assistant; Laure Hall, claims supervisor; Carolgene Galpin, senior claims supervisor; Lynn Hill, claims supervisor; Diane Batten, claims investigator; Grace Owens, claims investigator.

Initiatives: Better perinatal care

Continued from page 14

"I could show them we were spending more than $100 million a year for those events. If we could eliminate 20%, that's a lot of dollars. Senior management's position was that if it helps the patients, we should do it, but we ought to set it up so we could measure it," he said.

In 1996, claims data that Mr. Hinton's risk management team collected and analyzed showed definitive problems with perinatal claims experiences at 35 of the approximately 300 hospitals that then were part of HCA.

Mr. Hinton—who refuses to subscribe to the notion that "claims are going to happen"—began the delicate and slow process of addressing claim drivers in clinical practices. But he knew he had to be careful not to offend attending physicians by appearing to that autonomous group of professionals as either dictatorial or as a promoter of "cookbook medicine."

Rather than beginning with an organizationwide loss control initiative, Mr. Hinton began by creating a program for the 35 hospitals with the worst claims experience. He also added five facilities with excellent claims experience, so they could contribute information to the group about their own successful experience.

Mr. Hinton recognized, though, that "some hospitals wound up in that category because of the jurisdiction they were in." The claims experience of some of the hospitals in Texas, then a plaintiff-friendly forum, would not have been nearly as bad if those hospitals had been located in California, Mr. Hinton said.

The situation in Texas would later change under a state tort reform law that Mr. Hinton was heavily involved in suggesting and promoting (see story, page 44).

For the initial group of 40 hospitals in the perinatal safety initiative, Mr. Hinton arranged several services provided by MMI Risk Management Resources Inc. of Deerfield, Ill.

One key service was taking the data that each of the 40 HCA hospitals collected on thousands of births and benchmarking it against the data MMI had gathered from other hospital clients.

MMI also provided some consultation, based on its analysis of the benchmarking data, and conducted annual educational seminars for clinicians, quality managers and risk managers at the 40 facilities.

In 1998, Mr. Hinton decided that HCA was large enough for risk management to collect and benchmark data only from hospitals within the organization. In doing so, risk and insurance believed that it could improve the consistency of the benchmarking data.

For example, risk and insurance could ensure that it was reviewing claims data from hospitals in the same state. That would eliminate the variable of differing tort systems from claims experience, Mr. Hinton noted.

Taking the process in house also would ensure that the same type of data was collected from each hospital in the benchmarking group and that it was collected in the same manner, Mr. Hinton said. With MMI, there were some differences in those areas that HCA physicians with whom risk and insurance had consulted did not like, he noted.

More-aggressive approach

By 2001, risk management was seeing claims experience improvements among the original 40 hospitals in the perinatal safety initiative, according to Mr. Hinton. Their claims frequency and claims costs had dropped between 2% and 3%

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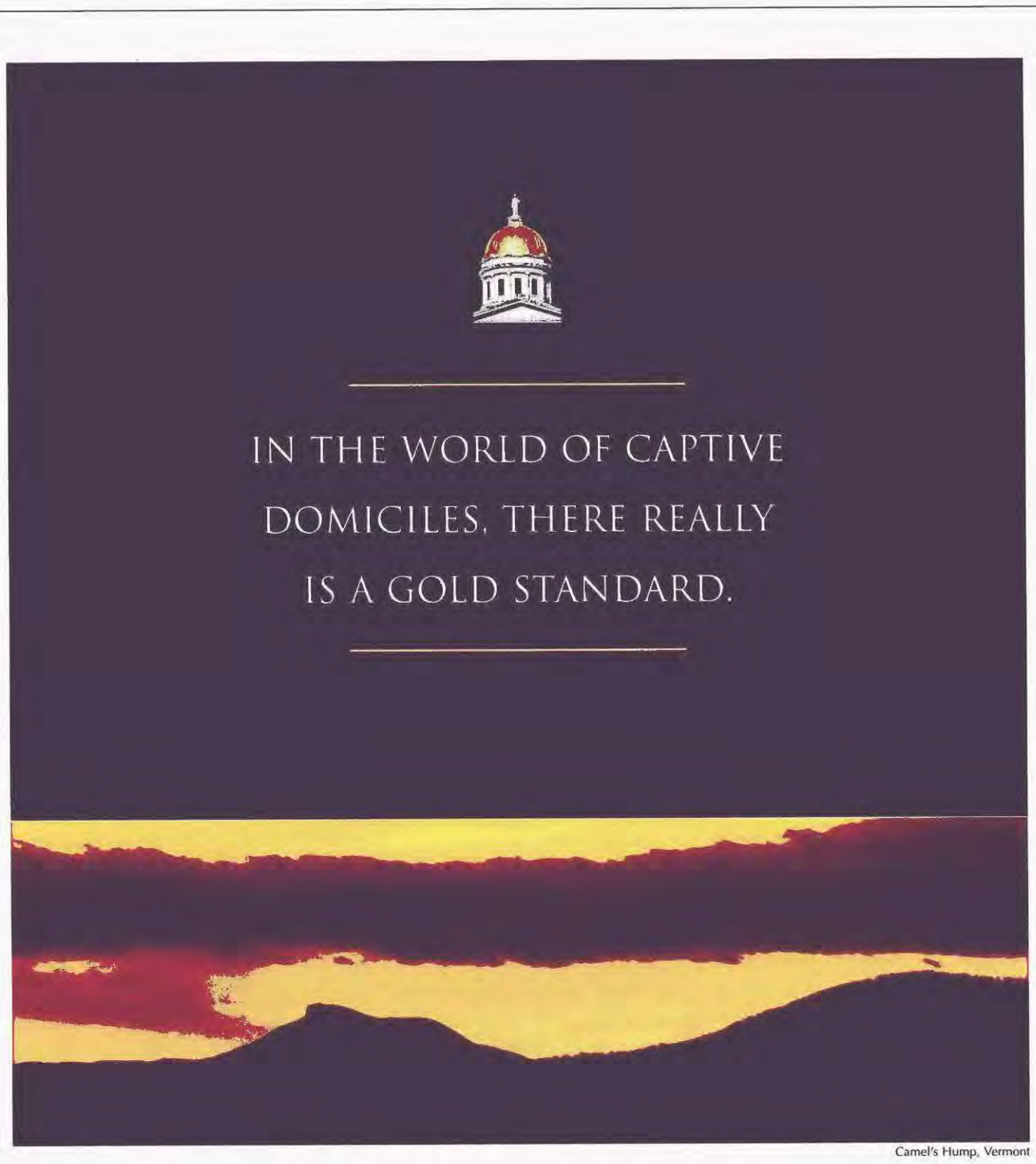

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HCA Inc.'s finance group. Front row, left to right: Jeff Barber, data coordinator; Suzanne Presa, senior insurance analyst; Teresa Ross, data coordinator; Tinna Catney, manager. Back row, left to right: Maggie Kuhlman, director; Lindsay Chance, senior insurance analyst; James D. Hinton, vp ; Rita Riley, insurance accounting analyst. Not shown: Ken Roth, assistant vp; Rita Carini, director; Lynn Richards, systems supervisor; Stuart Garber, director.

Initiatives: Delivering better perinatal care

Continued from page 16

annually, while other HCA hospitals' frequencies and costs were rising between 7% and 8% annually, he said.

"So that was pretty dramatic when you compare the two groups," Mr. Hinton observed.

Yet, Mr. Hinton envisioned a more wide-ranging effort to minimize claims. He wanted to eliminate variations in acceptable perinatal clinical practices in the approximately 220,000 births handled by all HCA hospitals.

"That's what was missing from our program in earlier years," he said.

Without a great deal of measurements on the perinatal program at that time, Mr. Hinton presented his idea to the HCA board and asked it to allow him to pull all of the organization's hospitals into the program.

The board approved his request in December 2001.

Early the following year, risk and insurance and HCA's quality management department began to address the variations that existed in clinical practices in HCA hospitals, but not by edict. Instead, while the impetus for change came out of those two departments, the changes themselves are largely physician-guided.

"Dictating to hospitals is not a good approach," Mr. Hinton said.

"We could only go so far by changing nursing practices," he said, referring to a fetal heart monitoring education program that risk and insurance and quality management engineered for obstetrics nurses in an effort to minimize claims (see story, page 24).

"We had to get physician buy-in" for modifying the clinical practices that claims data showed were contributing to losses, Mr. Hinton said. "So we got them involved in problem solving."

Other physicians then saw that their fellow physicians were a major driver in the changes in clinical practices, he said.

> "We had to get physician buy-in. ... So we got them involved in problem solving."
>
> **James D. Hinton**
> **HCA Inc.**

The process began with risk and insurance bringing its concerns about clinical practices—based on its claims data analysis—to a 26-member physician advisory board that Mr. Hinton's department pulled together in early 2002.

The advisory board agreed that the analysis did raise justifiable concerns, and it aided risk and insurance and quality management in focusing on "the right clinical indicators," said Jan Meyers, assistant vp/quality and director of HCA's perinatal safety initiative

At that time, claims data indicated that four HCA divisions were having more losses attributable to specific perinatal issues than the other nine HCA divisions were experiencing. Overall, those clinical issues were causing 85% of HCA's perinatal claims, Ms. Meyers noted.

Ms. Meyers asked the heads of each of those divisions to create a team of hospital chief executive officers and chief nurse officers, physicians and nurses that was assigned the task of creating a template for solving a specific problem.

The physician advisory board then reviewed each template to determine whether it could be implemented at all HCA hospitals or had to be modified.

When an initiative is ready for hospitals to adopt, each hospital establishes a team of physicians and nurses who develop that particular facility's strategic plan for implementing the initiative.

Although many of the initiatives are too new to measure their impact on claims, Mr. Hinton says the experience bears out his initial theory of how to induce change with minimal resistance.

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Policy helps cut risky delays in emergency C-sections

By DAVE LENCKUS

Risk and insurance has had a profound influence on the increasing number of emergency Caesarean section births performed at HCA Inc. hospitals within a critical time frame to ensure the health of mothers and newborns.

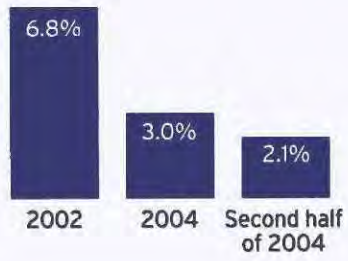
The percentage of procedures not completed within that time frame were slashed by more than half within the first year of a patient safety process developed James D. Hinton, vp-risk and insurance at Nashville, Tenn.-based HCA.

Under Mr. Hinton's direction, a 26-member physician advisory board was formed in 2002 to guide the development and implementation of clinical best practices throughout the HCA system.

With a foundation of claims data analyses provided by the risk and insurance department's risk management team, the advisory board and teams of hospital officials and top physicians and nurses from HCA's various divisions have crafted various patient safety improvement plans, beginning with a perinatal safety initiative.

Delivering results

Emergency C-sections performed at HCA hospitals after critical 30-minute period



The emergency C-section issue was among the top priorities in the perinatal initiative.

Of the approximately 220,000 births at HCA hospitals annually, 71,000 are C-section deliveries, and 2,600 of those are performed on an emergency basis.

In 2002, 6.8% of emergency C-section births at HCA hospitals were not completed within the critical 30-minute period that begins when an obstetrics nurse determines an emergency situation has developed and calls in the patient's obstetrician.

The risk of harm to the mother and fetus is much higher when an emergency C-section is performed after that 30-minute window closes.

A year later, the percentage of emergency C-sections completed after 30 minutes had dropped to 3%. For all of 2004, the rate remained flat, but it dropped to 2.1% during the last six months of the year, Mr. Hinton noted.

Reasons for delay

A couple of factors contributed to delays in performing the procedure, said Mr. Hinton and Jan Meyers, assistant vp/quality and director of the perinatal safety initiative.

Ms. Meyers noted that some physicians delayed performing the procedure because of their concern about holding C-section rates to 12% of deliveries, as suggested by some managed care guidelines.

They "got hung up on data that had no relevance on the outcome" of their patients, she said.

"It's better to perform a C-section rather than force a vaginal birth" when the baby's delivery is going badly, regardless of how that affects the C-section rate, she said.

To that end, HCA's board has adopted that philosophy on the physician advisory board's recommendation.

Another big factor that increased delays in performing the procedure was the preparation process.

From the time that an obstetrician receives a nurse's call that a patient could require an emergency C-section, the physician has 25 minutes to reach the hospital.

For physicians who need much or all of that time, there is virtually no way to examine the patient, decide that an immediate C-section is necessary, prepare the patient and the delivery room and complete the procedure.

That process changed in 2002 as a result of a recommendation from the physician advisory board. Now, before the patient's obstetrician arrives, the obstetrics nurse calls in a code team to assist the physician and prepares the patient and the room where the procedure would be performed.

As a result, there no longer is any preparation lag time that delays obstetricians from performing the procedure within 30 minutes from the time a nurse determines an emergency exists.

The change, though, does not override obstetricians' authority to decide whether to perform the procedure. If the obstetrician does not agree that an emergency C-section is warranted, the physician has the discretion to cancel the delivery preparations.

The majority of emergency C-sections now are completed within 20 minutes, Ms. Meyers said.

That means the hospital's and caregivers' roles are "highly defensible in court" if the outcome of an emergency C-section is bad even if it had been performed with the critical 30-minute period from "decision to incision," Mr. Hinton said.

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Claim findings prompt training in fetal monitoring

By DAVE LENCKUS

Even in an environment where process improvement is fostered but not dictated, some changes just have to be made.

While reluctant to impose clinical practice changes on physicians, HCA Inc.'s risk and insurance department saw no choice but to impose a professional development requirement on the hospital organization's 4,800 obstetrics nurses.

But the requirement—two days of training on how to read fetal heart monitoring strips—was one that both nurses and physicians have come to appreciate, said James D. Hinton, vp-risk and insurance at Nashville, Tenn.-based HCA.

In 2000 and 2001, risk management began to see that medical malpractice plaintiffs' attorneys were routinely building their cases on the ability of obstetrics nurses to detect when a pregnant woman's labor was deteriorating into a dangerous situation.

During depositions in those cases, obstetrics nurses often did not fare well in evaluating the monitoring strips, which are the readouts from equipment used during labor to track fetuses' heart rates. An abnormal readout suggests the fetus is in distress and needs immediate medical attention.

The nurses' performance during depositions lent support to plaintiffs' attorneys' charges that the nurses misinterpreted their clients' strips, according to Mr. Hinton and Dr. Frank Houser, the medical director and a senior vp at HCA. Dr. Houser also oversees the patient care quality management department.

Risk and insurance conducted what Mr. Hinton characterized as "a quick survey" of HCA hospitals and "found out what we kind of expected: Nurses were getting on-the-job training." Only a few hospitals responded that they assessed their obstetrics nurses' training on reading fetal heart monitor strips, he said.

Jan Meyers, assistant vp/quality and director of HCA's perinatal safety initiative, said the results would have been consistent with the findings from an industrywide survey.

Training was virtually "nonexistent in the hospital industry before" that time, Ms. Meyers said.

Further, noted Joseph S. Haase, vp of risk management and one of Mr. Hinton's top lieutenants, nurses and physicians do not learn to read fetal heart monitoring strips in school. As a result, "some had a couple hours of on-the-job training, and some had sophisticated training" that they picked up on their own, Mr. Haase said.

Test leads to training

Mr. Hinton next decided to quantify the nurses' knowledge curve by administering a basic knowledge test to the approximately 1,200 obstetrics nurses at HCA's hospitals in Texas and a division in South Florida. Altogether, the facilities represented about one-fourth of the HCA facilities with obstetrics departments but accounted for 70% of paid claims and reserves.

Ms. Meyers collaborated with a national nurse organization—the Washington-based Assn. of Women's Health, Obstetric and Neonatal Nursing—to develop the test, which was administered in 2002 to obstetrics nurses with at least six months of experience.

The results were not good: 30%

> Before HCA started its program, such training of obstetrics nurses was virtually "nonexistent in the hospital industry."
>
> **Jan Meyers**
> *HCA Inc.*

of the nurses failed.

At that juncture, Mr. Hinton approached HCA's board and recommended the organization immediately require its obstetrics nurses in the test areas to undergo formal two-day training sessions on how to read fetal heart monitoring strips.

"Obviously, it was a major commitment of the company to do that" for several reasons, Mr. Hinton said.

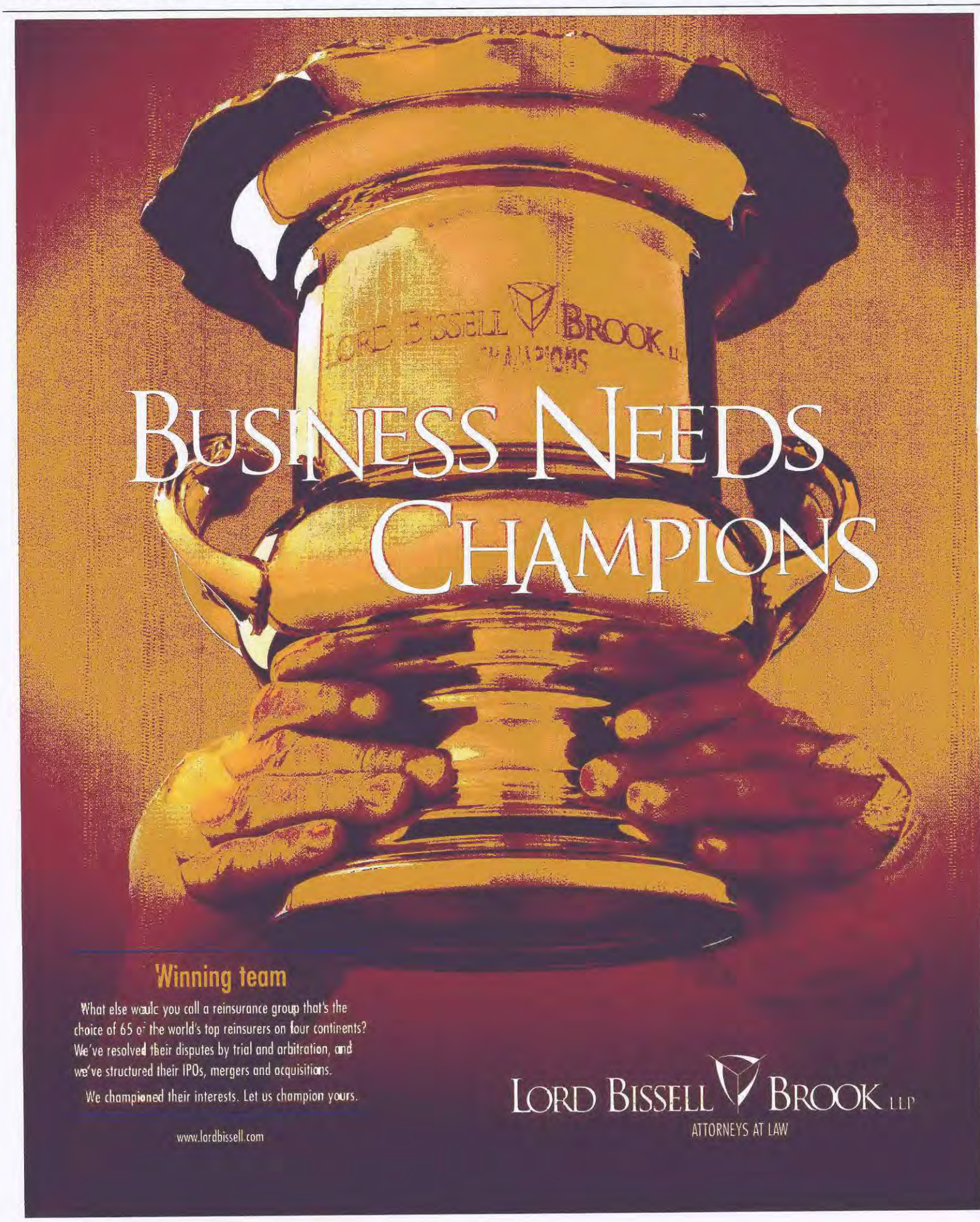
Although Mr. Hinton was confident in risk and insurance's assessment that the lack of training contributed to losses, there was no "hard data" on its exact impact on losses.

The training, conducted by AWHONN-certified instructors, meant that the nurses would be off their hospital shifts for two days. The hospitals—which, like others across the country, already were dealing with a nurse shortage—would have to staff those shifts with temporary nursing staff.

Risk and insurance did not plan on training obstetrics nurses throughout the HCA system at the same time. After those in Texas and South Florida were trained in 2002, the department had planned to train half of the remaining 3,600 nurses in 2003 and the other half in 2004, Mr. Hinton noted.

But because the projected training costs for the group of nurses who would have gone through the

See TRAINING / page 26



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Training: Claims analysis leads to obstetrics program

Continued from previous page

program in 2004 amounted to only $100,000, the board decided to complete all of the training in 2003.

The total investment, however, was more than the additional training costs. Overall, the training and temporary staffing cost HCA between $2.5 million and $3 million in 2002 and 2003, said Mr. Hinton.

The training also included about two dozen physicians, mostly in the Dallas area, who participated in a four-hour Saturday class.

Altogether, about 2,400 obstetricians have privileges at HCA hospitals, and Mr. Hinton would like all of them to be trained in reading the fetal heart monitoring strips.

To that end, Ms. Meyers retained Boston-based Advanced Practice Strategies L.L.C. to develop a Web-based fetal heart monitoring education program for obstetricians and labor and delivery nurses.

The key objective of the APS program is to ensure that physicians and nurses evaluate fetal heart monitoring strips in a consistent way, according to Ms. Meyers and John Harrington, chief executive officer of APS.

Based on HCA's claims analysis and the legal data analysis performed by APS, Ms. Meyers and Mr. Harrington say they believe claims arise because nurses and physicians evaluate the strips differently.

The program instructs participants how to read the strips, identifies what is a standard range of normal readings and outlines appropriate interventions and when they should be taken, Mr. Harrington said. Before this course was developed, there was no standard guideline on what constitutes a normal reading, Mr. Harrington said.

Meanwhile, Tulane University has signed up to offer the program on a pilot basis to obstetricians who practice at its medical center, and a few other universities with medical centers are considering offering the program, Mr. Harrington said.

Incentives

Mr. Hinton said his next effort will be to persuade obstetricians to go through the program. But that promises to be a bigger challenge than training obstetrics nurses.

HCA's captive insurer provides medical malpractice coverage to only about 50 of the obstetricians with privileges at HCA hospitals. Other insurers cover the remainder.

Besides the educational benefit the course promises, one incentive for physicians and nurses who complete it is that they can earn continuing education credits from the American College of Obstetricians & Gynecologists.

Another incentive is the time flexibility a Web-based course gives participants, who can complete the work at times most convenient to them, Mr. Harrington said.

Mr. Hinton said he plans to ask leading insurers to give premium credits to physicians who complete the program. He said HCA's captive would offer the same incentive.

Meanwhile, to backstop obstetrics nurses, HCA is conducting pilot programs in San Antonio and in Richmond, Va., that allow obstetricians to receive their patients' fetal heart monitoring strips at home.

Various issues surrounding the remote feeds have to be resolved. Those include ensuring patient privacy and that physicians have the equipment and training to read the strips, Mr. Hinton said.

But, those issues should be resolved within three years, which would allow all obstetricians in the HCA system to receive the strips at home, he said.

Strategy aids emergency rooms most in need of med mal help

By DAVE LENCKUS

Data analysis tells you that medical malpractice claims arising from treatment at HCA Inc.'s emergency rooms are in line with hospital industry norms.

James D. Hinton tells you that is not good enough.

Inherent in the concepts of averages and norms is the understanding that there are outlier numbers, or, in HCA's case, emergency rooms that generate a volume of claims that is considerably higher than the norm.

So while averages and norms indicate "we don't need to do anything," there are "hospitals that need help," said Mr. Hinton, vp-risk and insurance.

Mr. Hinton does not accept that medical malpractice claims are a price of doing business. To that end, he has attacked the outlier ER claim problem using the same strategy he has used successfully to reduce other malpractice as well as workers compensation claims at HCA: Identify the outliers, show them they have a problem, offer them claim-busting tools from respected professional sources and provide them with financial incentives to use the tools.

Claim figures indicate that the effort, which began in 2002, is working. ER claims in 2004 were 38%

Continued on next page

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Continued from previous page
lower than in 2001.

ER claims spiked in 2003 to their highest level in the 2001-2004 period, but an analysis of all types of claims filed against HCA suggests that the increase was an ironic aberration fostered by the medical malpractice liability tort reforms enacted in Texas that year, Mr. Hinton said. With little time to evaluate the merits of many claims before the deadline to file lawsuits under the expiring tort system, plaintiffs' attorneys filed a large number of claims that year that they otherwise would have turned away, he said.

Triage on ER claims

The first order of business in reducing ER claims was identifying the types of patients most often at the center of malpractice claims.

Data analysis by Mr. Hinton's department showed that physicians most often faced claims after providing treatment for chest pain, abdominal pain, abdominal pain in patients aged 50 or older, fractures and wounds. There are two abdominal pain claim categories because a misdiagnosis of that symptom typically leads to a different set of problems for older patients than for younger patients, Mr. Hinton said.

With that information in hand, Mr. Hinton retained hospital risk management consultant Dr. Daniel Sullivan, president and chief executive officer of The Sullivan Group of Oakbrook Terrace, Ill.

In his independent research of hospital industry claims, Dr. Sullivan already had identified the major drivers in the types of claims that Mr. Hinton's department found were most often plaguing HCA's emergency rooms.

Using that analysis, Mr. Hinton began asking HCA's emergency rooms to conduct semiannual audits of a sampling of ER physician charts. For each physician, HCA hospitals audit the charts of five patients in each category of high-risk symptoms. To compensate hospitals for the expense of conducting the audits on about 30,000 charts, Mr. Hinton has arranged a payment of $20 per record.

In the audits, the hospitals looked for specific diagnostic, care and documentation practices that Dr. Sullivan has determined are crucial to minimize treatment errors.

Reduced claims

The number of ER-related claims filed against HCA Inc. has dropped by 38% in the past four years.

For example, with a patient who had chest pains, an audit looks for how thoroughly the physician researched the patient's history, how fast the patient was moved to a bed and how quickly the patient underwent an electrocardiogram to detect potential heart abnormalities.

The audits also look at when the last abnormal vital sign was charted on an ER patient before the patient was discharged. If the last vital sign recorded before discharge was abnormal, "we have a totally indefensible claim" if that patient develops medical complications shortly after leaving the hospital, Mr. Hinton noted.

The last vital signs for that patient actually may have been normal but were not charted, he said.

Another high-risk factor the audits reveal are unresolved discordance between physicians' and nurses' documentation.

The data from those audits go to The Sullivan Group, which prepares reports on how HCA facilities compare to the hospital industry. The reports allow Mr. Hinton's department to identify the ER departments and physicians that are the greatest potential malpractice risks.

Assistance to outliers

Armed with the claims data and chart audit analyses, Mr. Hinton approaches the outliers with an offer designed to encourage them to minimize their malpractice risks.

A hospital can earn a 1% malpractice insurance premium credit if its ER's medical director fashions a plan to reduce the department's risk. An additional 1% credit is awarded if the ER department reaches its claim-reduction goals.

While Mr. Hinton's program focuses on outliers, it does not ignore the rest of HCA.

Dr. Sullivan has developed a two-hour Web-based education program on each of the five types of symptoms that are generating the most ER-related claims for HCA, and Mr. Hinton has taken several measures to encourage physicians to participate in the program.

In some cases, he has asked hospital management to stress that the physicians' group contracts with the facilities will not be renewed unless the physicians complete the program.

Some group contracts contain provisions that require physicians to complete the program.

And, the malpractice coverage that HCA's captive insurer writes for some of the groups requires physicians to complete the program.

About 1,600 physicians and 5,000 nurses work in HCA emergency rooms. Physicians and nurses typically sign up for two to four courses, said Mr. Hinton. In 2004, 1,053 physicians—or two thirds—and 2,403 nurses - almost half -took at least one course in the Web-based education program.

Once the current group of outliers has resolved its claims issues, Mr. Hinton plans to deal with the next tier of claim issues besetting HCA's emergency rooms—again using The Sullivan Group. Mr. Hinton said he decided to deal with claim problems on a piece-meal basis to avoid overwhelming hospitals with data collection requirements.

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Med mal crisis spawns innovative insurance coverage

By DAVE LENCKUS

Physicians did more than complain loudly as the medical malpractice liability insurance crisis crescendoed a few years ago.

Some responded in ways that threw patients' health care into turmoil.

At HCA Inc., the nation's largest multi-hospital organization, risk manager James D. Hinton was doing more than watching top management at company hospitals struggle with the opposing forces of keeping physicians happy and financially protecting their facilities.

Mr. Hinton, vp-risk and insurance at Nashville, Tenn.-based HCA, crafted an insurance program that provides the physicians more affordable coverage through HCA's captive insurer.

Because the hospitals receive Medicare payments, the insurance program needed to pass muster on federal rules designed to ensure that hospitals do not improperly curry favor with physicians. The program's terms and conditions not only allayed federal officials' concerns but also are designed to aid the risk and insurance department in handling claims and curbing losses.

Since the program's inception in 2003, about 600 physicians with staff privileges at 31 HCA hospitals in six states have purchased the coverage. And, the program may expand to a seventh state this spring.

As the soft market of the 1990s began to ebb, the medical malpractice insurance market constricted quickly and significantly. With a 136% market loss ratio in 2000 and annual loss costs growing 5% to 6% in combination with dwindling investment income, some insurers pulled out of the market, others retrenched and some underwriting facilities collapsed. Physicians faced spiked rates for the pinched market capacity.

Facing the prospect of paying exorbitant premiums, if coverage were even available, physicians in several hard-hit areas of the country made tough decisions.

Some retired early. Others—like obstetricians who stopped delivering babies and focused only on their gynecological practices—limited their practices to hold down their insurance premiums. Still others moved out of the hardest-hit states to areas where litigation trends and insurance costs were not quite as bad. And some just quit practicing medicine and turned to other professions.

At HCA-owned hospitals, physicians also began pressuring senior management to reduce or eliminate the malpractice insurance requirements on physicians with treatment privileges. But that would leave the hospitals as the deep pocket for plaintiffs' attorneys, Mr. Hinton noted.

The states where HCA staff physicians faced the greatest pressure were West Virginia—because of the large market share St. Paul Travelers Cos. Inc. had when it stopped underwriting malpractice coverage in late 2001—and Mississippi—where no insurer wanted to write, Mr. Hinton recalled.

Hospitals ask for help

HCA hospital chief executive officers asked risk and insurance to find the physicians coverage.

Initially, Mr. Hinton visited with about a half-dozen malpractice insurers in an effort to create an HCA-sponsored program. But none of the insurers was interested in writing in West Virginia or Florida, another state where HCA has numerous facilities. Those insurers "had all the business they wanted," Mr. Hinton recalled.

"We were willing to share risks with the underwriters," noted Shirley Fuller Cooper, assistant vp-insurance on Mr. Hinton's staff. "But we exhausted all the possibilities out there" without finding an underwriting partner.

HCA's captive insurer, Colorado-based Health Care Indemnity Inc., existed to write medical malpractice and other coverages for its parent company (see story, page 38).

"But we used it when we needed to for the hospitals and their constituents," Mr. Hinton said.

The captive, however, did not have claims-made rates and forms, because it writes medical malpractice coverage for HCA facilities on an occurrence basis.

"We really didn't have any in-house ability to underwrite in a large sense," Mr. Hinton said.

The solution: A fronting insurer was found to handle the backroom operation. The program is fronted by one of two units of Chicago-based CNA Financial Corp. units: Continental Casualty Co. and Columbia Casualty Co., CNA's surplus lines underwriter.

Resolving the problems with the mechanics of writing coverage for physicians, however, still left HCA with a high hurdle to clear before the federal government would approve the program.

Under Mr. Hinton's program, HCI would offer physicians malpractice coverage for 30% off market rates. The hospitals also would pay HCI a sum equal to 15% of the premium, so the captive, overall, would be receiving premiums equal to 85% of the market rate.

But under Medicare rules, hospitals are not allowed to monetarily

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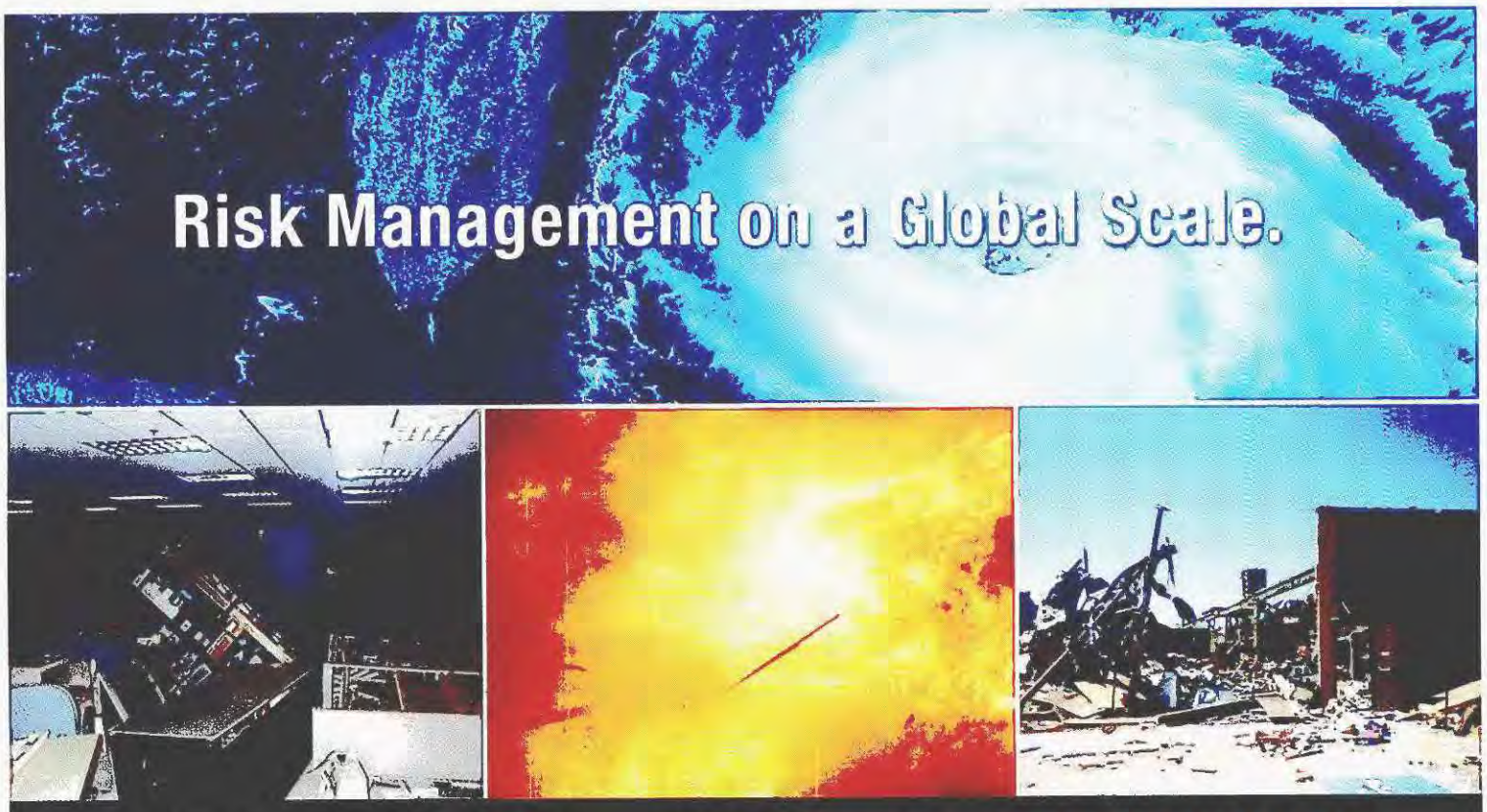

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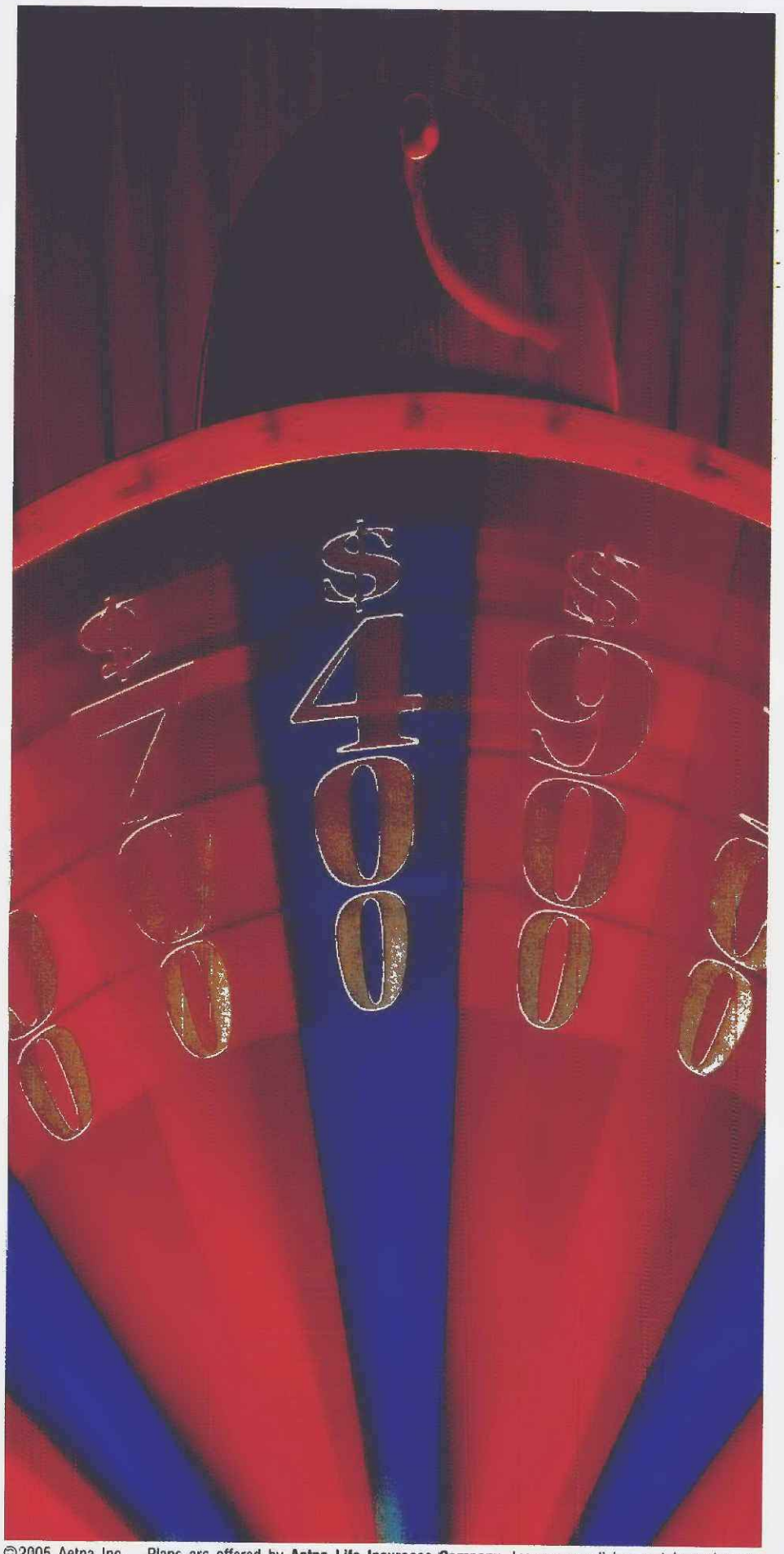

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Doctors' coverage embedded in HCA hospital program

Besides physicians with treatment privileges, HCA Inc.'s captive insurer covers some physician groups who contract exclusively with HCA hospitals.

Those physician groups include emergency room doctors, radiologists, anesthesiologists and pathologists. But, typically, not all physician groups at any particular HCA hospital purchase their medical malpractice liability coverage from the captive, Colorado-domiciled Health Care Indemnity Inc.

HCI provides the coverage to 300 physicians in the 23 states where HCA owns and operates hospitals.

The coverage is priced as though HCI writes $1 million of occurrence limits with a $3 million aggregate, because the physicians typically would not need coverage that exceeds those limits, according to Shirley Fuller Cooper, assistant vp-insurance and a top assistant to James D. Hinton, vp-risk and insurance. The physicians, however, have the same $350 million of malpractice coverage that HCA hospitals have, because the physicians' program is embedded in HCA's master program, she explained.

Malpractice trends

Average annual increase in malpractice liability claim settlements

A hardening malpractice market this year should drive up the number of physician groups that buy the coverage, Ms. Fuller Cooper said. HCI covered about 120 physicians in those groups just three or four years ago, she noted.

HCI discounts its premiums for those physicians between 15% and 20%, because a condition of coverage is that they agree to accept a joint defense with the hospital against any claim that arises.

Mr. Hinton, who also is president of HCI, insists on the joint defense stipulation, because it is "so valuable." With that coverage provision in place, hospitals and doctors are "not pointing to each other in a claim," Mr. Hinton said.

Unlike the physicians with treatment privileges, though, group physicians are not covered by Medicare rules that bar hospitals from monetarily compensating patient-referral sources. "These guys don't do referrals, Mr. Hinton said.

As a result, Mr. Hinton did not have to obtain federal approval of the physician group malpractice program.

—By Dave Lenckus

Med mal limits vary by state

HCA Inc.'s captive insurer writes standard claims-made physician medical malpractice liability insurance so the hundreds of physicians in six states who purchase the coverage do not have to find expensive tail coverage elsewhere.

But coverage varies by state.

Colorado-based Health Care Indemnity Inc. writes the coverage, which is fronted by one of two CNA Financial Corp. units.

In Mississippi and Missouri, physicians can purchase at least $500,000 of coverage per claim with a $1 million aggregate, but higher limits are available if physicians want them.

In Florida, physicians can purchase coverage that will provide up to $250,000/$750,000 of coverage.

In Virginia, physicians can purchase $2 million of limits with a $6 million aggregate.

In West Virginia and Kentucky, physicians can purchase $1 million/$3 million of coverage.

"We respond to what the doctors need," said James D. Hinton, vp-risk and insurance for Nashville, Tenn.-based HCA.

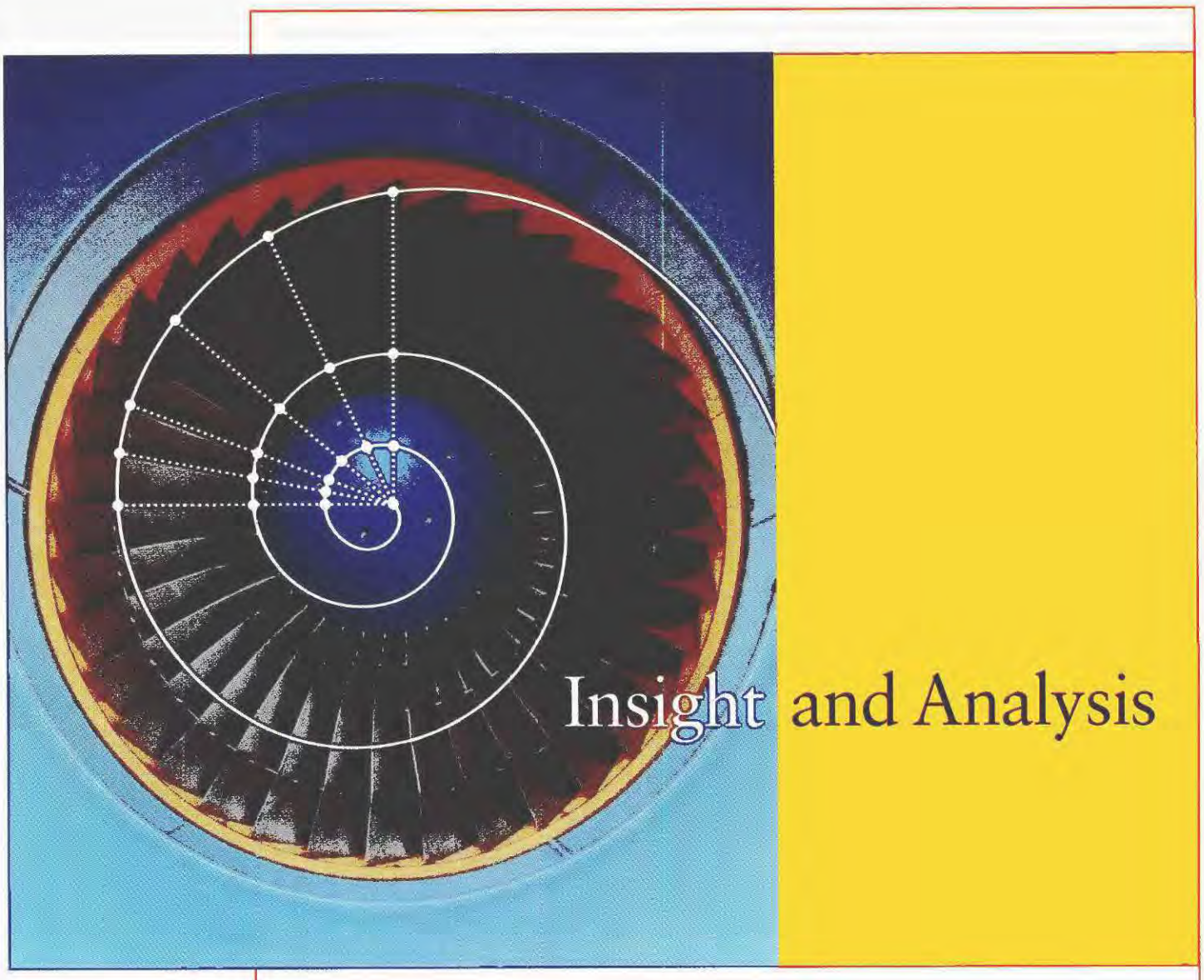
Toward that end, Mr. Hinton and his team have made the coverage available to its South Carolina hospitals, so that they can offer it to their employed physicians. HCA division executives in South Carolina had not decided in early April whether to offer the program, which would require the hospital to cover 15% of premium.

HCI fully reinsures the risk and does not cede any of the coverage. The captive generates about $15 million in volume annually on the business, according to Mr. Hinton, who is president of HCI.

Mr. Hinton decided not to purchase reinsurance because it was too expensive, given the nature of the risk and that HCI had inadequate claims experience with the physician medical malpractice program.

But Mr. Hinton said he will re-evaluate the situation later this year.

—By Dave Lenckus



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Laying claim to hospital med mal claims management

Captive gives HCA control to resolve claims with speed and savings

By DAVE LENCKUS

In covering HCA Inc.'s medical malpractice liability risks, a primary concern for the risk and insurance department is claims management.

Maintaining control of claims management is why HCA's Colorado-domiciled captive insurer, Health Care Indemnity Inc., writes the $25 million of primary and first-layer excess insurance for HCA's 189 hospitals and 92 outpatient surgery centers in about two dozen states.

Buying hospital medical malpractice coverage in the traditional commercial market would require Nashville, Tenn.-based HCA to give up control of claims management, explained James D. Hinton, vp-risk and insurance for HCA and president of HCI.

"How you handle claims can do more damage" to your reputation than the circumstances that generated the claim, Mr. Hinton said.

When a legitimate claim arises, Mr. Hinton wants it resolved quickly. "We come to settle," he said.

With the risk and insurance department's claims database on nearly 300 HCA hospitals and surgery centers, "we know the value of a claim," Mr. Hinton said.

"We're centralized and move in tune to what hospitals need. We don't want to do anything with HCI that could hurt HCA," he said. Insurers cannot guarantee that, he said.

HCA's average claim cost last year was down 7.3%, or about $14,300 per claim, said Lorraine Gerelick, vp-claims and one of Mr. Hinton's top assistants. Meanwhile, HCA is closing its claims in 22 months on average, 11 months sooner than the industry average, as calculated by the Physician Insurers Assn. of America of Rockville, Md.

And, over the long term, HCA's average cost per claim is growing at a much slower pace annually than the industry's. Since 1997, HCA's claim cost trend is 2.8%, compared with 7% to 10% for the industry.

The risk and insurance department's in-house claims-handling staff of 24, including two investigators, processes about 3,000 new claims every year, and the staff closes two-thirds of them without making a payment, according to Mr. Hinton.

But that finely tuned claims department did not always hum along so efficiently. As the claims management staff grew during HCA's acquisition spree in the mid-1990s, so did claims-handling consistency problems. Every organization brought along its own style of handling claims, Mr. Hinton said.

To establish a consistent style for HCA, the risk and insurance department identified what the claims department should strive for and developed a scorecard to measure how well claims handlers met the risk and insurance department's objectives.

The key objective was to have the ultimate value of a claim reserved within 12 months from the date the claim was reported.

See HOSPITALS / page 36

PHOTO: MICHAEL MARCOTTE

HCA Inc.'s risk management group. Front row, from left: Jerry Butler, director; Colleen Helm, consultant; Debra Stanley, administrative assistant; Gloria Merrimon, consultant; Lesa Franklin, risk analysis coordinator. Top row, from left: Joe Haase, assistant vp; Bill Laxton, director; James D. Hinton; Ches Alper, manager; Mike Bennett, consultant.

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Hospitals: Captive lets HCA manage medical malpractice liability claims

Continued from page 34

"We want to avoid spending a whole lot of money on discovery (in a litigated claim), only to conclude we've got to settle," Mr. Hinton said. Collecting claim information early "forces you to settle early and save money."

"If you don't have a prescribed timetable to get all of that done, it starts to lag," Ms. Gerelick said.

In 1996, when Mr. Hinton established the reserving objective, the value of 42% of claims were reserved within 12 months.

In 2004, 90% were reserved.

Indeed, for claims limited to $1 million or less—about 99% of the claim volume—101.4% of the claim value was reserved, Ms. Gerelick noted. For the remaining 1% of claims, which exceed $1 million, 83.3% was reserved in 2004, she said.

Over the past seven years, HCA's actuaries have recommended reserve reductions totaling $258 million, including $128 million in 2004. Last year's reserve reduction represented 8.5% of HCI's $1.5 billion of case reserves, $900 million of which is for incurred-but-not-reported claims.

Among the changes that were made to speed up the reserving process was requiring the claims staff to review and update every claim at least once every 90 days.

> "We want to avoid spending a whole lot of money on discovery (in a litigated claim) only to conclude we've got to settle."
>
> **James D. Hinton**
> **HCA Inc.**

The claim investigation process also was standardized. Investigations have to be made no later than 90 days after a claim is reported. Previously, there was no standard.

And, investigators' reports must be in a standard format. Investigators previously had filed only narrative reports.

In an effort to reduce the already low number of claims that go to trial, risk and insurance has implemented a pilot mediation project in Austin, Texas. In the project, HCA pays for the plaintiff's legal expense as well as its own if the plaintiff agrees to mediation.

For those claims that do go to trial, HCA now uses an "A list" of defense attorney firms that are not intimidated by plaintiffs' attorneys, Mr. Hinton said.

The captive also writes other risks, including medical malpractice coverage for physicians in several states where commercial capacity is scarce and cost-prohibitive (see story, page 28).

In addition, HCI writes medical malpractice insurance for doctor groups that practice only at HCA hospitals (see story, page 32).

HCI has been writing hospital medical malpractice insurance since 1976, when it was created by then-parent company Humana Inc. of Louisville, Ky. In 1993, Humana spun off its hospital operations, including HCI, and the spinoff later that year was acquired by Columbia Healthcare. Months later, in early 1994, HCA merged with Columbia Healthcare and folded its own captive, Tennessee-domiciled Par-thenon Insurance Co., into HCI.

Mr. Hinton held the top risk management post for Humana's hospital operations and remained with the entity as it was spun off and eventually acquired by HCA.

In the mid-1980s, Humana converted HCI's captive license to a commercial license.

Colorado statutes required captive owners to keep captive records in the state. That did not present a problem when Humana used a captive manager, but it became an administrative problem when Humana decided to manage the captive in house, Mr. Hinton explained.

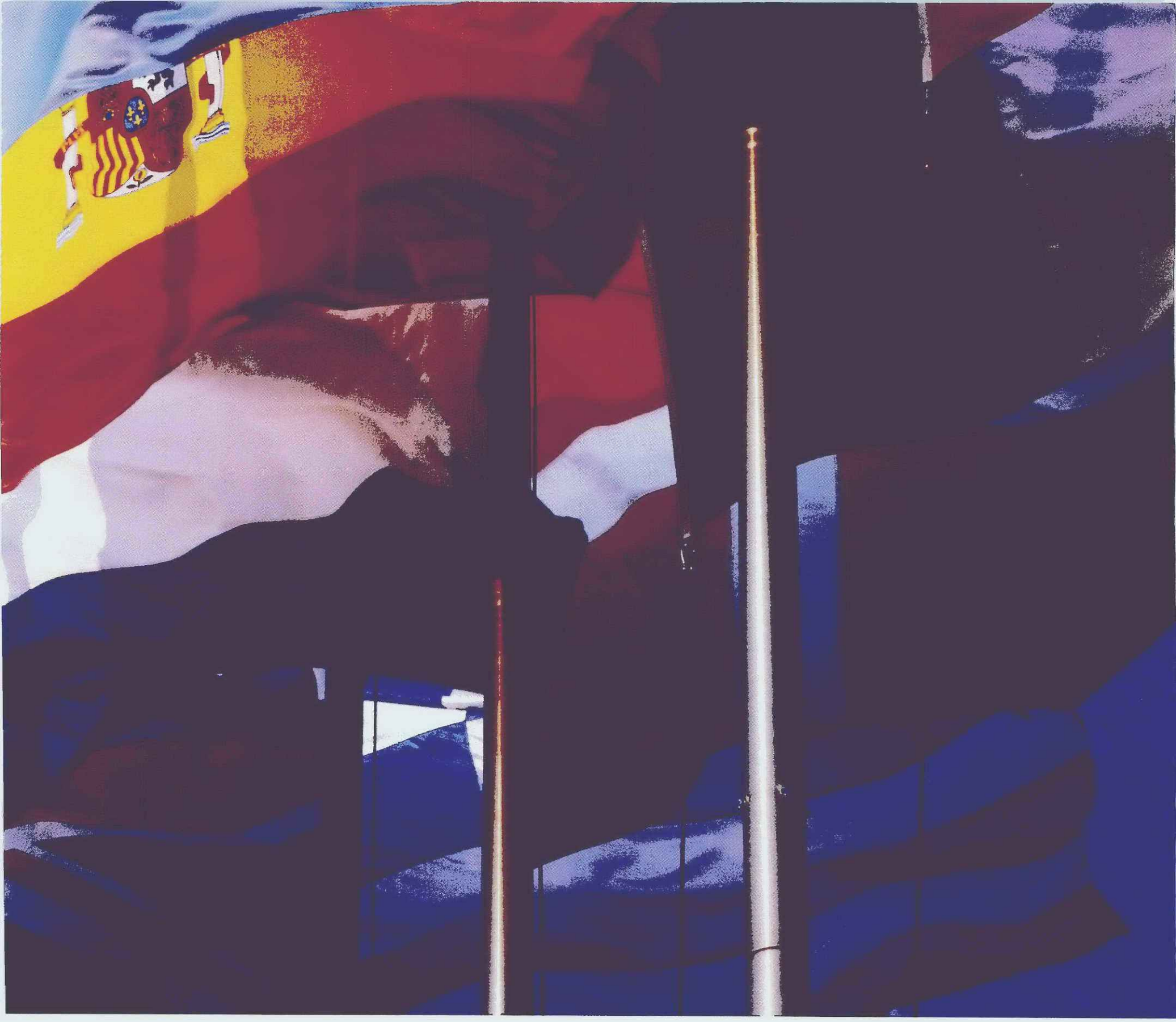
With a commercial license, the captive's home office could be anywhere.

And, with the hospital medical malpractice problem growing, HCI needed a commercial license to directly write Humana's hospital risks outside of Colorado either on an admitted basis or as an authorized surplus lines insurer.

The captive is admitted in 16 states and is an authorized surplus lines insurer in 11 more.

As of Dec. 31, 2004, HCI had $768 million of surplus. It carries an A.M Best Co. rating of A-, or excellent.

Malpractice reserving



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Captive provides $25 million of med mal, GL coverage

HCA Inc. captive insurer Health Care Indemnity Inc. writes a primary medical malpractice liability insurance policy that covers HCA's entire hospital and surgery center operation with $10 million of occurrence-based limits.

A second layer that HCI writes provides $15 million more of occurrence-based coverage excess of $10 million. Neither layer has an aggregate limit.

Above the HCI coverage, HCA purchases $325 million of limits excess of $25 million from the Bermuda market. XL Capital Ltd. of Hamilton leads that excess layer.

HCA's general liability insurance, with limited employment practices liability coverage, is included within the malpractice protection.

Covered risks include discrimination, but there is no coverage if the claim leads to a class action lawsuit.

HCA knows the ART of the deal

Captive has provided prior-acts coverage to aid hospital acquisitions

By DAVE LENCKUS

HCA Inc.'s risk manager has used the company's captive insurer to help HCA close a few acquisitions and divestitures.

Colorado-based captive Health Care Indemnity Inc. is "especially valuable when you're buying and selling hospitals every week," observed James D. Hinton, HCA's vp-risk and insurance and president of HCI.

Nashville, Tenn.-based HCA typically does not purchase prior-acts coverage for its single-hospital acquisitions, many of which have been nonprofit facilities. The coverage is unnecessary, because those types of hospitals typically self-insure their medical malpractice risks and have trust funds that are capitalized sufficiently to cover their liabilities.

That was not the case with the late-1990s acquisition of a West Virginia hospital, which had an undercapitalized trust fund that Mr. Hinton feared might go bankrupt.

In that deal, HCA received a discount on the purchase price. HCA then paid that difference to HCI as a premium to cover the acquired hospital's past liabilities, which was less expensive than purchasing prior-acts coverage from an insurer that would have wanted to profit on the deal, Mr. Hinton explained.

The arrangement also allowed HCA to close the deal on time, according to Mr. Hinton. The trust fund shortfall was discovered fairly late in the acquisition process, so HCA had little time to respond to the development, he said.

Mr. Hinton said he felt comfortable with the arrangement, because the acquired hospital had excess coverage above the risk that the trust fund was supposed to cover. That meant HCI was not taking on unlimited liability, he said.

The captive was used similarly in the early 1990s acquisition of a hospital in south Florida, he noted.

And, when HCA is selling hospitals, buyers do not have to be concerned about the warranties HCA management has made about the facilities' liabilities, Mr. Hinton said. HCI writes the first $25 million of medical malpractice and general liability coverage for HCA hospitals.

"That's taken care of" by the occurrence coverage HCA hospitals have, Mr. Hinton said. Buyers know that whenever a claim is filed for a pre-acquisition procedure, "it belongs to HCI," he said. That would not be the case with claims-made coverage, he said.

"So, in a few instances, it's benefited the deal getting done," Mr. Hinton said.

HCI also has written coverage for hospital organizations that HCA has spun off and, in one case, still does.

In 1999, HCA spun off about 75 hospitals into two separate organizations. Plano, Texas-based Triad Hospitals Inc. operates hospitals mostly in small cities. Brentwood, Tenn.-based LifePoint Hospitals Inc. owns facilities in nonurban areas.

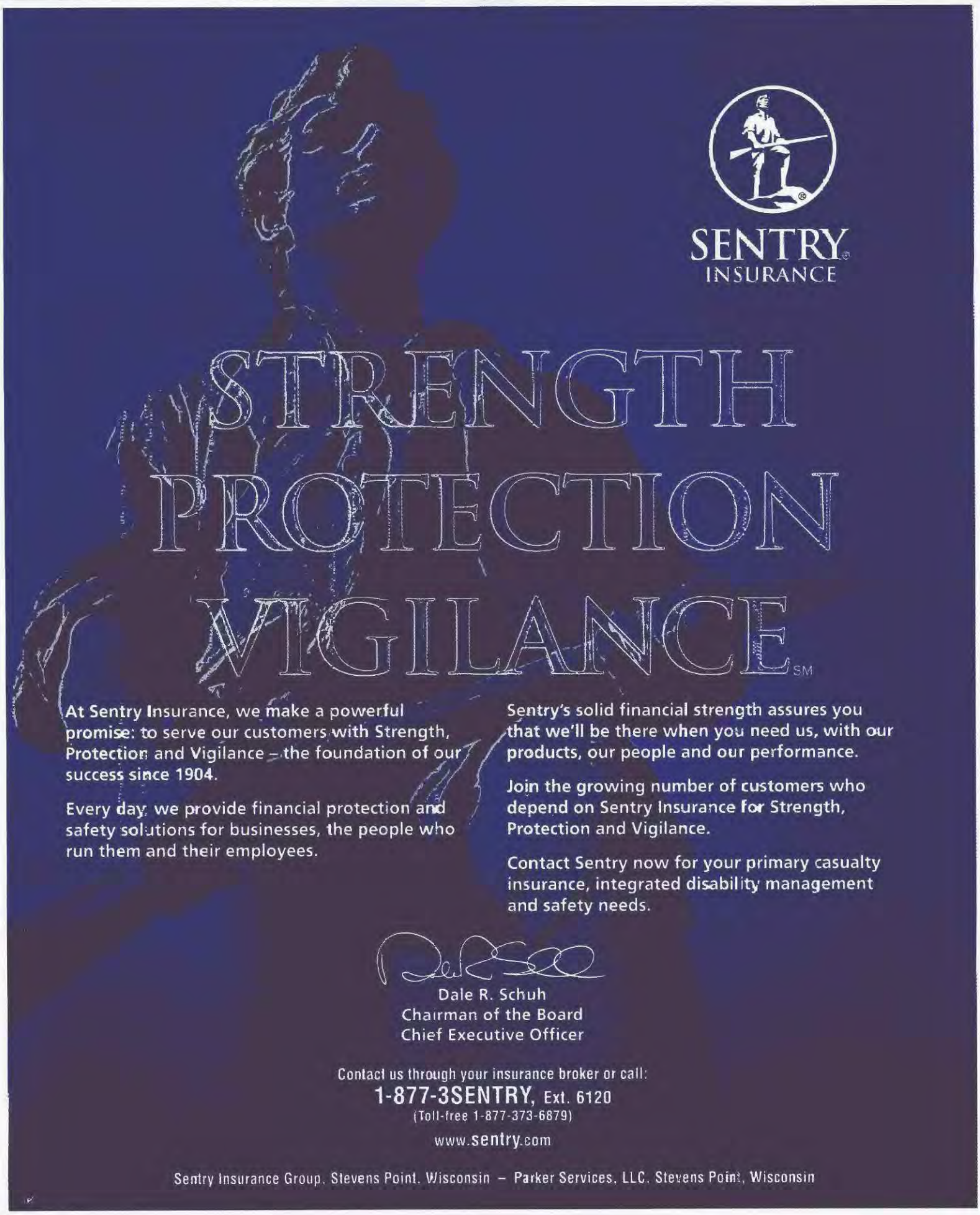
Both organizations received a package of coverages substantially like what their hospitals had when they were part of HCA, explained Shirley Fuller Cooper, assistant vp-insurance and one of Mr. Hinton's top assistants.

HCI provided medical malpractice and general liability coverage, and HCA's risk and insurance department purchased directors and officers liability, fiduciary liability, property and workers compensation coverage for the organizations. Triad and LifePoint paid for the coverage, though.

In 1999, both organizations had $25 million of per-occurrence hospital malpractice liability coverage, with a $500,000 deductible for Triad and a $1 million deductible for LifePoint.

But Triad and LifePoint purchased $50 million to $100 million of upper excess limits—much less than HCA purchased.

LifePoint no longer purchases coverage from HCI. Triad purchases $5 million of malpractice coverage from the captive.



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HCA Inc.'s risk and insurance department managers, from left: Tim Portale, assistant vp-environmental and employee safety; Larraine Gerelick, vp-claims, HCI; Joe Haase, vp-risk management; Shirley Fuller Cooper, assistant vp-insurance; James D. Hinton; Cookie Kimbrough, administrative assistant; and Kenneth E. Roth, HCI chief financial officer.

Suit led to landmark captive ruling

Hinton led effort that resulted in tax break

By DAVE LENCKUS

The litigation that would greatly improve the tax advantages of funding risk through captive insurance companies was nearly given up for dead until a future risk manager and a corporate attorney interceded.

After a defeat in U.S. Tax Court, Humana Inc. in 1989 convinced the 6th U.S. Circuit Court of Appeals that corporate brothers and sisters should be entitled to deduct premiums paid to a captive insurer that is wholly owned by the affiliates' parent company.

The appeals court found that the economic relationship between parent corporations and their captives bars tax deductions for the parent company's premiums, but the relationship between sister corporations and captives does not.

Following the Humana decision and other related court rulings the Internal Revenue Service in 2001 dropped its longstanding rule that premiums paid to captives are not deductible under its "economic family" principle.

Since the court rulings and IRS rule change, corporate subsidiaries have been able to deduct the cost of their coverage for the year they pay their premiums rather than waiting until after losses are paid.

At the time the Humana case was wending through the court system, James D. Hinton was the company's director of tax planning. Shortly before the 6th Circuit ruling, he became vp-risk and insurance and retained the same position when HCA in 1994 acquired the hospital operations Humana previously owned.

A fee structure Mr. Hinton helped negotiate limited Humana's legal costs enough to convince management the case was worth pursuing.

Humana's decision to pursue the case at the federal appellate court level after losing twice in tax court was not an automatic one for senior management, Mr. Hinton recalled. Indeed, management asked Mr. Hinton's department "to evaluate whether it was worth" the company resources that would have to be expended to press the case further.

Mr. Hinton and Arthur P. Hipwell, then an assistant general counsel for Humana, favored pursuing the case. But senior management was reluctant to throw more money at it, because they calculated that Humana's odds of prevailing were low, Mr. Hinton recalled.

Mr. Hinton and Mr. Hipwell, now Humana's general counsel and a senior vp, devised a plan to keep the case alive and allay senior management's cost concerns.

They negotiated a new fee structure that imposed some financial risk on the law firm representing Humana.

Under the agreement, the law firm would be entitled to contingency fees, up to a predetermined ceiling, if Humana won. But if the Internal Revenue Service prevailed, the law firm would be entitled only to its out-of-pocket costs and not its hourly fees, Mr. Hinton explained.

The new fee structure limited Humana's legal costs enough to convince management that the case was worth pursuing, he said.

Mr. Hinton credits the firm, Greenebaum, Doll & McDonald P.L.L.C. of Louisville, Ky., for being flexible enough to keep the case alive. He also said the firm has not received the attention it deserves.

Years later, HCA brought a similar case to the U.S. Tax Court. But, in 1997, the court ruled in favor of HCA. That case, though, involved HCA's Tennessee-domiciled captive, Parthenon Insurance Co., which had merged with HCI in 1994, when HCA acquired the former Humana hospital operations.

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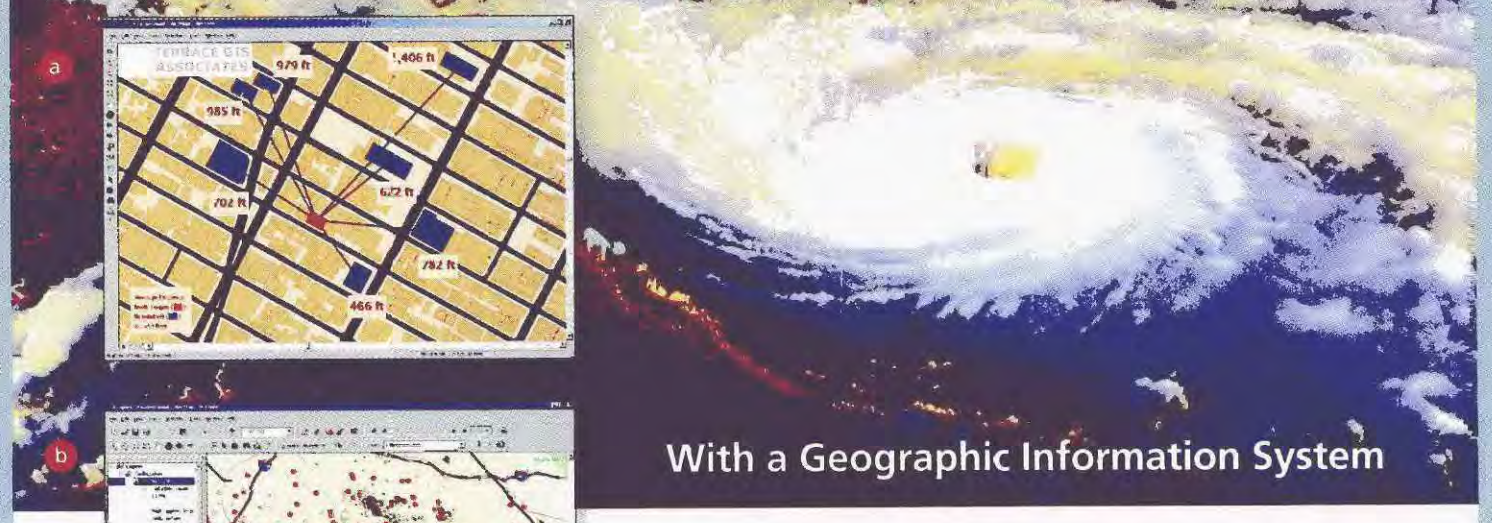

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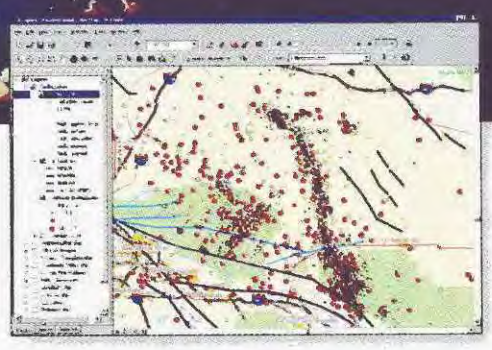

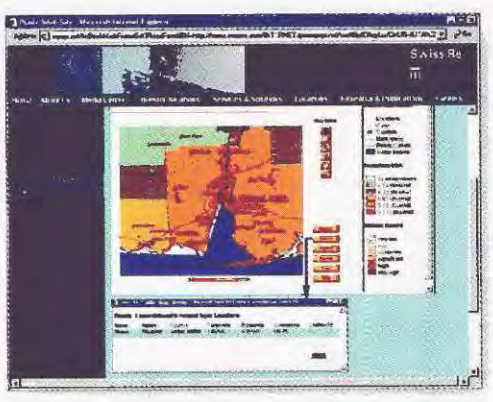

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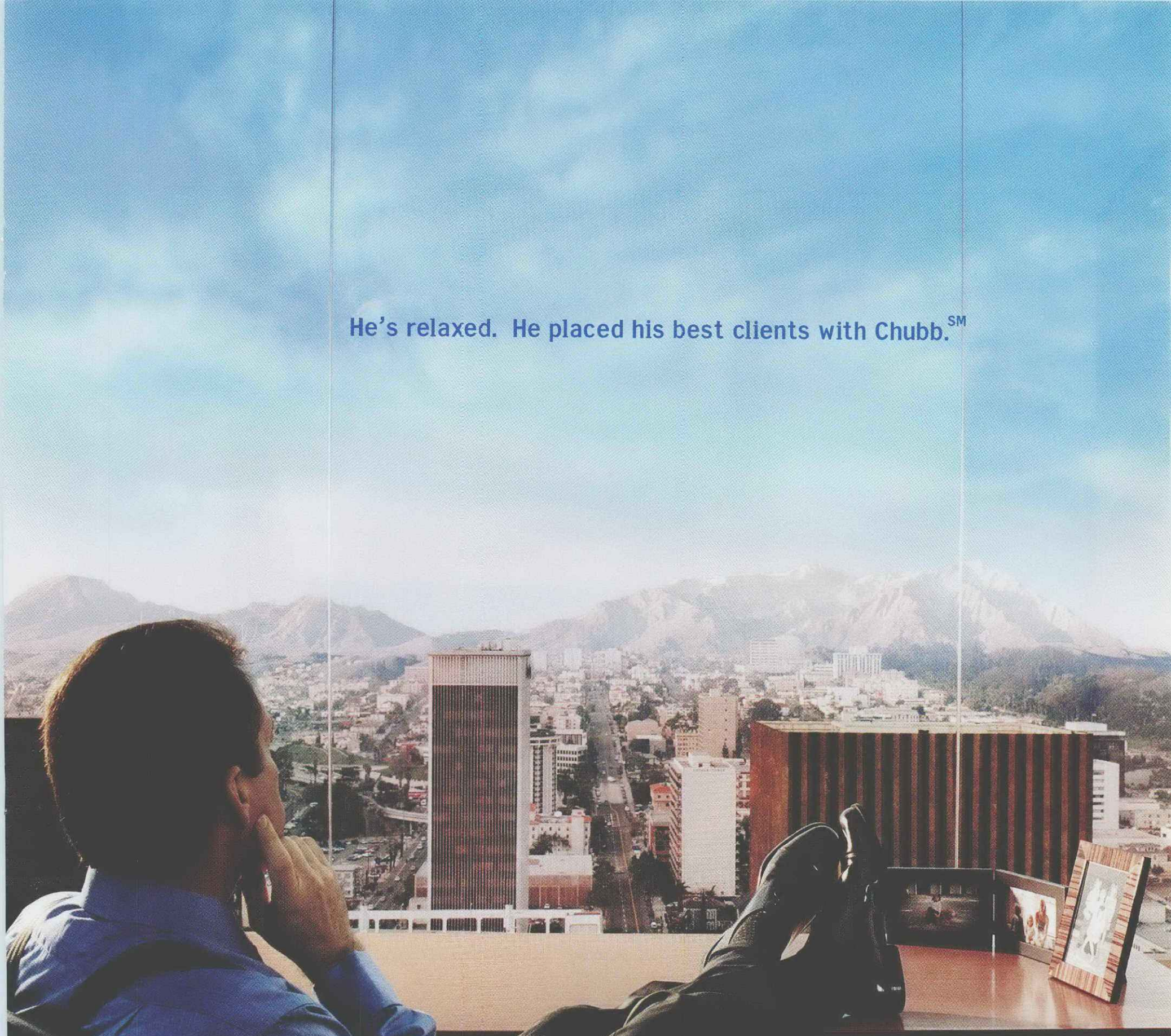

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Hinton spearheaded Texas med mal reform efforts

By DAVE LENCKUS

Behind the scenes of the 2003 Texas medical liability tort reforms, HCA Inc.'s risk manager helped shape the medical community's argument for reform and worked to keep the group focused.

While medical providers did not attain all of the reforms they sought, those that lawmakers enacted and were later cemented in a state constitutional amendment substantially limited medical providers' liability (see story, page 48).

HCA's monetary contribution to the lobbying effort was $860,000, according James D. Hinton, vp-risk and insurance for Nashville, Tenn.-based HCA, the nation's largest hospital corporation.

In comparison, the Austin-based Texas Alliance for Patient Access—the lobbying group formed by the state's medical community—contributed around $3 million toward the effort to enact the reforms and adopt them constitutionally, according to Mr. Hinton, who was treasurer of the organization.

"It's the best money we ever spent," said Larraine Gerelick, vp-claims and a top assistant to Mr. Hinton. "The return on that money is already huge."

As an example of what the reforms will mean for HCA, Ms. Gerelick noted that the company's largest-ever Texas claim of $10 million—which included less than $250,000 of economic damages—would have been $750,000 under the reforms.

The reforms also led to other benefits.

Texas' medical malpractice insurance market is beginning to improve, as insurers and the state's joint underwriting association have announced rate cuts in recent months.

The hard reinsurance market also has softened somewhat for HCA's captive insurer (see story, page 48).

For Texas residents, the reforms have resulted in greater access to health care professionals.

Over the past two years, the state has gained more than 3,000 physicians—a nearly 6% increase, according to the Texas State Board of Medical Examiners.

How HCA got involved

Mr. Hinton became involved in the tort reform effort in 2001, when he was invited to a meeting with a couple of the state's largest physician-owned malpractice insurers: the Texas Medical Liability Trust and the American Physicians Insurance Exchange. Both are Austin-based not-for-profit facilities.

The insurers wanted to form a coalition that would work toward achieving the same kinds of medical malpractice liability reforms that the California Legislature enacted in 1975 in the Medical Injury Compensation Reform Act.

Mr. Hinton then urged the medical community to frame its tort reform argument around the health care access issue and to focus on seeking the kinds of reforms that California had enacted.

"I said that, to battle the trial attorneys, we would have to make the debate about keeping doctors practicing and hospitals' doors open," Mr. Hinton recalled.

As physicians were leaving the state or restricting their practices to avoid high insurance premiums, hospitals were facing financial challenges under the existing system as well.

HCA's claim cost per risk-indexed bed in Texas from 1996 through 1999 was more than twice as much as it was in California during the same period, even though fewer claims were filed per 1,000 beds in Texas, Mr. Hinton noted. HCA's risk-indexed bed measure factors in not only medical/surgical floor beds but also high-risk areas, including the emergency room and labor and delivery.

"So, it was all about severity—what happens to you when you get to the courtroom," Mr. Hinton said.

With a nod toward the health care professional group Californians Allied for Patient Protection, which sprang up in an effort to protect the

See TEXAS / page 46

Texas reform

Claim cost per risk-indexed bed, 1996-1999

Texas	$5,340
California	$2,072

Number of claims per 1,000 RIBs

Texas	36.5
California	40.3

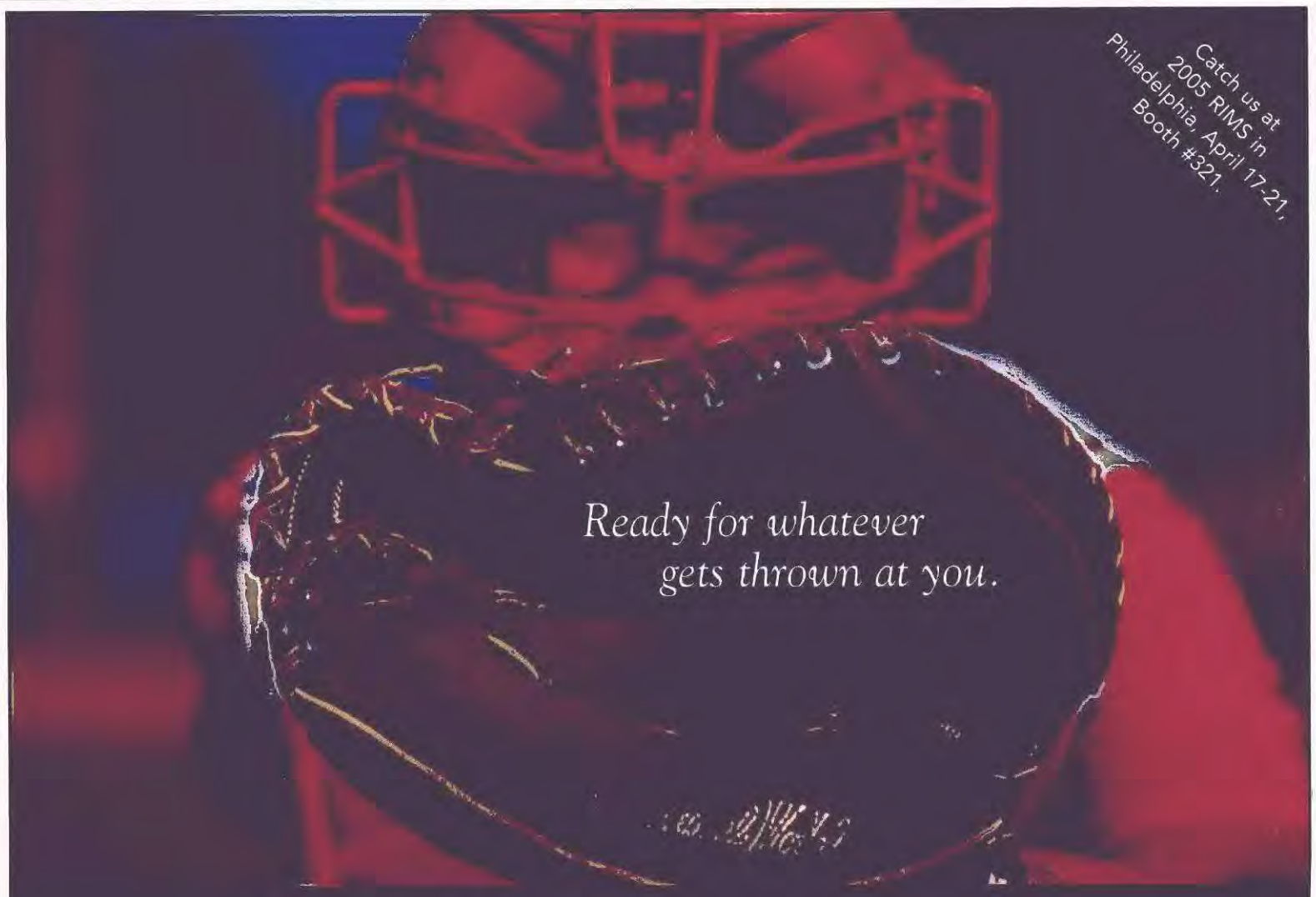
Practicing physicians in Texas

Jan. 2003	50,548
Jan. 2005	53,647

Premium Savings

$56 million HCA Texas hospitals premium savings in 2004 and 2005

Sources: HCA Inc.
Texas State Board of Medical Examiners



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Texas: Hinton helps shape med mal reform

Continued from page 46

"I knew how important this was" for hospitals, which plaintiffs' attorneys saw as the deep pockets, as well as for physicians, Mr. Hinton said.

He said he told the group: "Let's figure out what we need to succeed here and we'll get the money," even if hospitals have to contribute more than physicians do to appropriately fund a campaign for the right kinds of reforms.

In the reforms, Mr. Hinton also wanted to include a measure that was designed to discourage the kinds of constitutional challenges that the California reforms have faced.

The legal and claims group determined that courts might be more willing to uphold a law that caps health care providers' liability for noneconomic damages if the law also guaranteed that successful plaintiffs would be able to recover those damages.

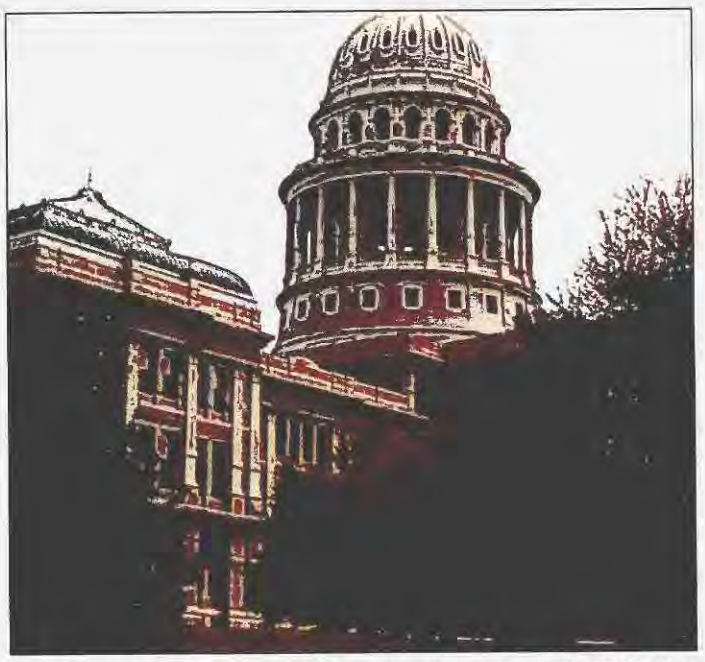
At the time, physicians typically purchased $200,000 of per-occurrence limits with a $600,000 aggregate. TAPA recommended requiring physicians to purchase $500,000/$1.5 million of coverage.

> "It was all about severity—what happens to you when you get to the courtroom."
>
> **James D. Hinton**
> **HCA Inc.**

Physicians, already complaining that they could not afford coverage and unsure how the reform measures would impact the malpractice liability insurance market, objected to the idea of a mandate that would force them to purchase more insurance than they currently could afford.

But, that issue became moot when voters in November 2002 re-elected Gov. Rick Perry, who campaigned for tort reform, and gave Republicans control of the Legislature. To prevent a constitutional challenge of the reforms enacted in June 2003, the governor supported constitutionally adopting the reforms.

The electorate narrowly approved a constitutional amendment adopting the reforms in September 2003.



Texas lawmakers passed medical malpractice reforms in 2003 that limit noneconomic damages and cap wrongful death awards.

Analysis of reforms' impact helps cut excess coverage costs

Reinsurers trim rates too, but not enough

By DAVE LENCKUS

Medical malpractice liability reforms in Texas and HCA Inc.'s actuarial analysis of the reforms' potential impact on claim costs has helped the company trim its excess insurance costs by millions of dollars.

But reinsurers have not lowered their rates enough to persuade the president of HCA's captive insurer to return to that market.

The reforms were enacted and adopted as part of the Texas constitution in 2003. Among other things, the reforms set caps on noneconomic damages.

James D. Hinton, vp-risk and insurance for HCA and president of its captive insurer, helped forge the reforms as a member of a lobbying group of medical providers.

HCA's Texas hospitals, as do the remainder of the company's facilities in 22 other states, purchase their first $25 million of medical malpractice insurance from HCA's captive insurer, Colorado-based Health Care Indemnity Inc. HCA then purchases $325 million of excess insurance above $25 million.

HCI had stopped purchasing any reinsurance in 2003 because of the cost.

Even after the reforms were adopted, malpractice liability insurers and reinsurers balked at reducing their rates significantly, noted Larraine Gerelick, vp-claims for HCI and a top assistant to Mr. Hinton. While the constitutional adoption of the reforms removed the threat that legal challenges could overturn the reforms, HCA's insurers and the reinsurance market maintained that they had to wait and see how the reforms impacted claims costs before they could cut their rates, she explained.

In response, Mr. Hinton's department pulled together some analyses that demonstrated the immediate impact the reforms would have on claims.

First, Mr. Hinton's department re-evaluated every loss HCA had in Texas over the previous 15 years and adjusted them to reflect inflation.

Adjusting for inflation provided a truer picture of what older claims would cost currently before being adjusted to reflect the new reforms.

PHOTO: MICHAEL MARCOTTE

Larraine Gerelick, vp-claims for Health Care Indemnity Inc.

For example, a $3 million claim in 1990 would have been worth $15 million when adjusted for inflation, Ms. Gerelick noted.

Risk management found that HCA had 32 claims that exceeded $3 million and four claims that exceeded $10 million in Texas during that 15-year period, according to Mr. Gerelick. Throughout all HCA, a total of five claims exceeded $10 million during that period, Ms. Gerelick noted.

After accumulating those claims files, Ms. Gerelick invited a claims specialist from Bermuda-based XL Capital Ltd. to fully review them and assess what they would be worth in current dollars under the new reforms. XL is the lead excess insurer on HCA's $325 million of coverage excess of $25 million.

Ms. Gerelick noted that only three or four of the claims went to trial, where a jury decided how much of the awards reflected economic damages—which were not capped under the reforms—and noneconomic damages. Therefore, the XL claims specialist had to estimate how much of the settlement amounts in the other cases reflected economic and noneconomic damages.

After a week of reviewing the claims and talking to HCA's claims personnel, XL's claim specialist reported that the $193 million HCA spent to close those claims would have been reduced to $83 million or less—including adjustments for inflation—under the Texas reforms.

HCA's largest-ever claim in Texas—$17 million—would have been $4 million under reforms, Mr. Hinton noted.

With that analysis in hand, risk and insurance approached its excess insurers and the reinsurance market.

Based on the analysis, HCA's excess insurers cut their rates 30%. The rate relief was welcome, but it fell shy of the 50% to 60% decrease that Mr. Hinton said he thought was warranted.

Reinsurers also offered reduced-rate quotes, but they were not attractive enough for HCI to begin purchasing reinsurance again, Mr. Hinton said.

Since the reforms were constitutionally adopted, HCA's actuaries have determined that the cost of Texas claims retained by HCI are 18% to 22% lower, Mr. Hinton said.

In response, risk management reduced the total malpractice premiums paid by HCA's Texas hospitals for their first $25 million of coverage through HCI by 20%, or $28 million, in 2004, he said.

Texas reforms cap providers' med mal liabilities

The medical malpractice liability reforms that Texas lawmakers adopted in June 2003 were not as broad as the medical community had wanted, but they did significantly cap health care providers' malpractice liability.

Under the reforms, plaintiffs' noneconomic damage awards were capped at $750,000. But, a plaintiff would be eligible to recover that amount only if one or more physicians and at least two unaffiliated health care institutions are liable for damages.

The reforms limit all physicians' liability to $250,000 in any single case. So, even if a plaintiff sues multiple physicians, the largest noneconomic damages award possible against that group of defendants is $250,000.

If the same plaintiff successfully sues a hospital or a group of hospitals that are economically affiliated, an additional noneconomic damages award of up to $250,000 is available.

If another unaffiliated health care facility is also named as a defendant, it could be held liable for $250,000 of noneconomic damages as well.

Other medical provider defendants could be named in the suit, but noneconomic damages would remain capped at $750,000.

Economic damages were not capped.

The reforms also significantly capped the damages that can be awarded for a wrongful death.

Before the reforms, death awards were capped at approximately $1.5 million per culpable defendant. The cap was based on a $500,000 cap first established in the mid-1970s and indexed annually thereafter to the consumer price index.

The reforms permit only a single death award, regardless of the number of defendants. In addition, under the reforms, a death award must be reduced by the noneconomic damages and punitive damages that a plaintiff is awarded.

The reforms did not modify punitive damages. They can equal twice the economic damages awarded plus a sum equal to the amount awarded for noneconomic damages, with a minimum of $200,000 and a maximum of $750,000.

In exigent cases, however, a trial judge now may allow higher punitive damages, said Larraine Gerelick, vp-claims for HCA Inc.

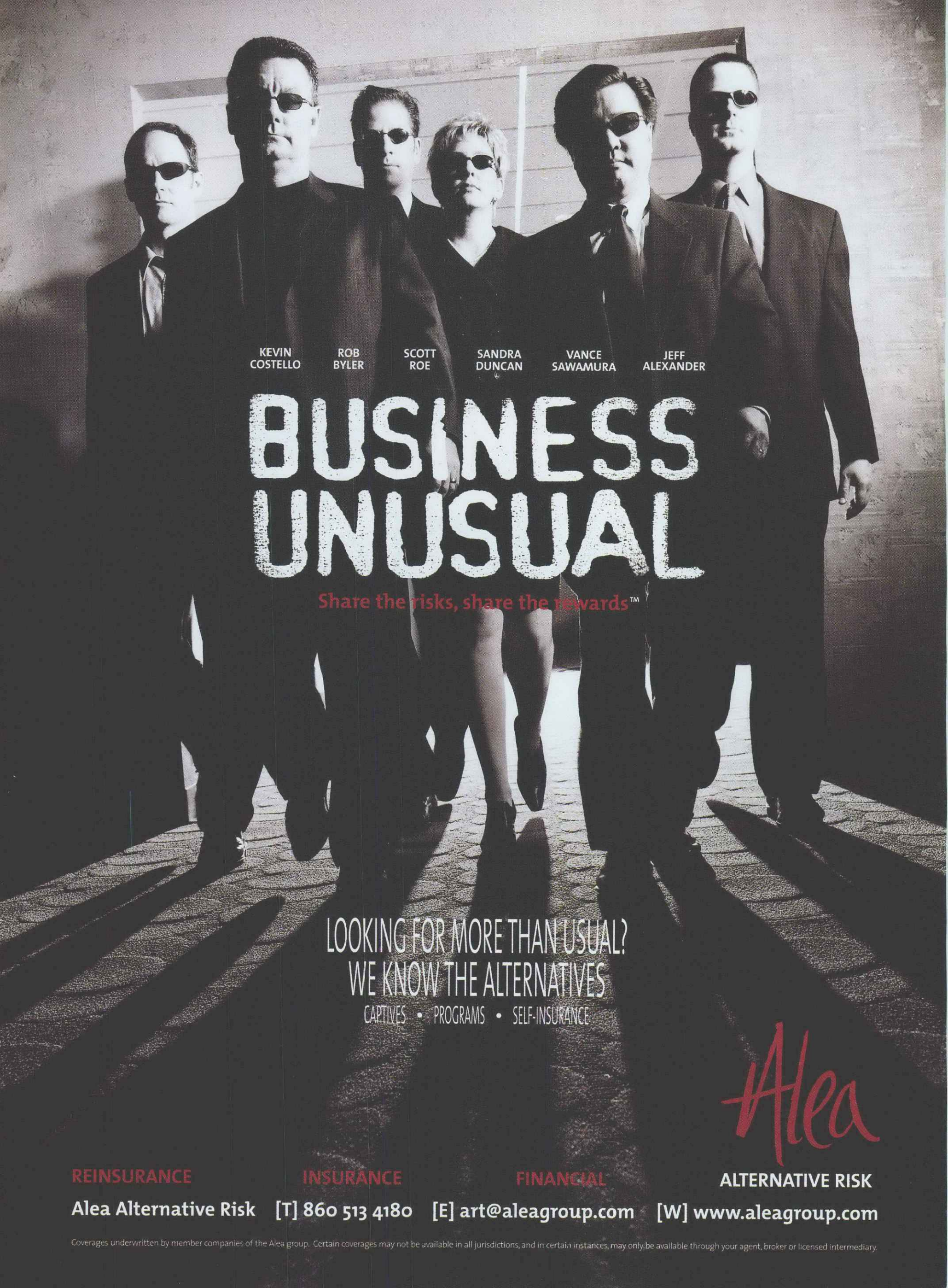
Another reform mandates that plaintiffs must accept periodic payments for future medical costs. That change allows defendants to purchase annuities to cover those damages, which is less expensive than paying all of those costs up front.

A trial judge also may allow a defendant to pay lost-wage damages in periodic payments.

The reforms, however, did not include several measures that the medical community had wanted in order to create a tort system nearly identical to California's. Texas lawmakers did not cap contingency fees for plaintiffs' attorneys or require that damages be offset by collateral source payments.

But, the Texas reforms will not face the constitutional challenges that the California reforms weathered. Texas voters approved the reforms as an amendment to the state constitution in September 2003.

—By Dave Lenckus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The Employee Safety Group, from left: Tim Portale, assistant vp; Lori Erickson, system supervisor; James D. Hinton; Darrell Urban, workers compensation supervisor; Melissa Burton, administrative assistant; Stan Cobb, manager. Not shown: David Vaughan, workers compensation supervisor.

Programs help cut comp costs

HCA slashes lost-time injury rates

By DAVE LENCKUS

Risk and insurance department programs founded on a combination of financial incentives and claims data analyses are driving down worker injury rates at HCA Inc.

From 1996 through last year, HCA's lost-time injury rate has been slashed 36.6%.

To that end, patient lifting-related injuries at a group of facilities with the organization's poorest experience were slashed by more than half over the last four years.

At a group of 50 hospitals that risk and insurance asked to focus on transitional duty, safety committee and other efforts to lower their workers comp costs, claim costs per 100 full-time employees have been pared by at least 25%. The first group of 10 hospitals far exceeded that goal and now report a lower cost ratio than the rest of the organization, which slashed its cost ratio 8.4% over the same period.

For 2005, HCA will spend about $100 million for workers compensation insurance premiums and self-insurance costs—1.6% of payroll, compared to an industry average of 2%—according to James D. Hinton, vp-risk and insurance.

HCA, which has 125,000 full-time employee equivalents among its 190,000 workers, insures its workers compensation risks in most of the 23 states where it operates facilities.

Under the workers comp cost allocation model that Mr. Hinton's department has developed, each HCA hospital's assessment is a function of its fixed costs, or payroll, and its variable costs, or medical costs and lost-time wages.

The fixed-cost charge comprises 25% of the allocation figure, and variable costs represent 75%, so keeping workers safe and returning them to work as soon as possible pays larger financial dividends for hospitals.

Workers comp

HCA lost-time injury rate per 100 full-time employees

1996	1.61
2004	1.02

Lifting-related lost-time injury rate per 100 FTEs

	23 hospitals in lifting program	All HCA
2000	.55	.30
2004	.24	.26

Claim costs per 100 FTEs

	Original focus group	Rest of HCA
2000	$83,276	$52,348
2004	$46,339	$47,933

Lowering lift injuries

For a group of 23 HCA hospitals, an analysis of their claims data by Mr. Hinton's risk management team showed that their employees—mostly nurses—were sustaining far more injuries lifting patients than were nurses at other HCA facilities.

With $2.7 million of capital from reserve funds that became available when HCA switched from a largely self-insured workers comp program years earlier, risk and insurance purchased patient-lifting equipment for the hospitals in 2002.

But before releasing the funds, risk and insurance's environmental and employee safety department, headed by Assistant Vp Tim Portale, required some commitments from the hospitals.

"Buying equipment is not going to solve your problem; it's only one piece of the puzzle," Mr. Portale said.

Other big pieces included training, which Mr. Portale's department handled, and working with the equipment vendor to evaluate each facility's layout and patient volume to determine what equipment was needed and where it should be located.

Hospital management also had to commit to encouraging routine use of the equipment during planned lifts. Environmental and employee safety evaluated hospitals' safety programs to ensure they established accountability for equipment usage.

The hospitals also kept track of injuries that occurred when lifting equipment should have been used but was not and when injuries occurred while workers were using the equipment. Mr. Hinton's risk management data analysis team tracked and compared pre- and post-equipment injury figures.

For an annual $10,000 fee from each facility, the equipment manufacturer evaluated the lifting programs for five hospitals. Each performed better than the 18 facilities that rejected the service, according to Mr. Hinton.

That analysis suggests that further safety improvements are attainable if additional program follow-up is provided, according to Mr. Hinton. Mr. Portale's staff is developing a program that will not be as extensive as the manufacturer's but will monitor equipment usage. Mr. Portale's staff will follow up with facilities where the equipment is underutilized, Mr. Hinton said.

While lost-time injury rates from lifting have been halved at the facilities that received the equipment, Mr. Hinton wants to evaluate one more year of claims data before expanding the program.

Mr. Hinton also is evaluating the benefit of making the equipment available throughout a hospital as opposed to limiting it to certain areas. Among the 23 hospitals that received the equipment, 22 make it available throughout their facilities.

A focused approach

Data analyses and financial incentives also underpin the Focus program, which environmental and employee safety created in 2000.

With a total of six staff, including Mr. Portale, to oversee safety for 190,000 employees in nearly 300 facilities, the head of safety decided to concentrate on a manageable number of facilities that had the highest workers comp cost allocation per $100 of payroll.

Some problems were common among the initial group of 10 facilities that were identified, while others were specific to those operations.

See WORKERS COMP / page 52

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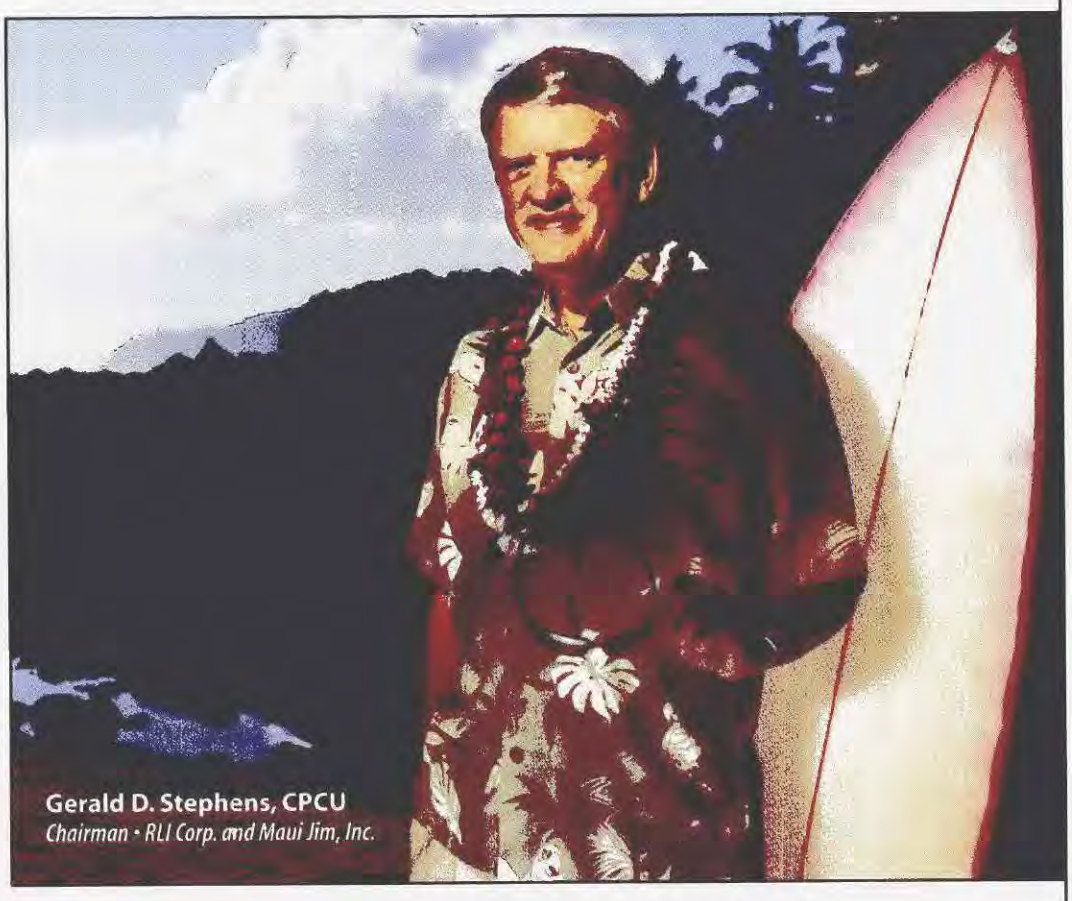

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Workers comp: Programs help reduce costs

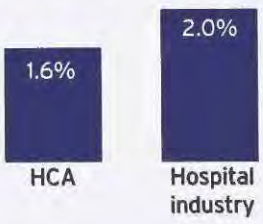
Continued from page 50

Mr. Portale's department first evaluated the hospitals' transitional duty programs and found that the facilities were not bringing injured workers back to work soon enough in alternative light-duty jobs.

"That's an easy problem to fix," because nurses can be productive in many areas—such as in medical records—besides patient care, Mr. Hinton said.

Smaller component of payroll at HCA

Workers comp costs as a percentage of payroll



But the hospitals had to learn to communicate better with injured employees' physicians about permitting their patients to return to work in transitional duties structured around the employees' medical restrictions, according to Mr. Portale.

Effective transitional duty programs immediately reduce hospitals' workers comp cost allocations, which are charged monthly, because the wage replacement element of the charge generally ranges from 2.5 to 3.5 times replacement wages.

That multiple is necessary to account for all lost-time wages within 36 months, no matter how long an injured employee is off work. The result is that the charge eventually drops off and does not haunt hospital management interminably, Mr Hinton explained.

"We don't want our model to be unresponsive to changes in hospitals' risk profiles," he said.

Some of the hospitals also needed to more effectively direct employees' medical care to HCA facilities in states that allow employers to direct care, Mr. Hinton said.

Another important measure that helped many hospitals prevent claims was strengthening their employee safety committees and loss prevention programs, according to Messrs. Hinton and Portale.

For example, not all of the hospitals' safety committees included department heads and nurses.

In addition, many committees focused on only reporting injuries. Many did not comb injury records to investigate how those incidents occurred and how they could be avoided in the future, Mr. Hinton said.

A properly functioning safety committee is valuable to any HCA facility. An active committee and a program that tests whether new hires can handle the physical demands of their jobs can earn facilities a premium credit.

Those original 10 hospitals exceeded Mr. Portale's goal of reducing their claim cost ratios 25% over two years and now report ratios nearly 21% lower than the rest of HCA.

Another premium credit is available to facilities with claim cost ratios that fall to state averages, or, if already there, below.

Each year, a new group of 10 hospitals are targeted. Of the 50 that Mr. Portale's group has worked with since 2000, only one has not met its goal.

Now, in the fifth year of the program, finding 10 hospitals that warrant participation because of their "cutlier" claim cost ratios has become difficult, Mr. Portale noted.

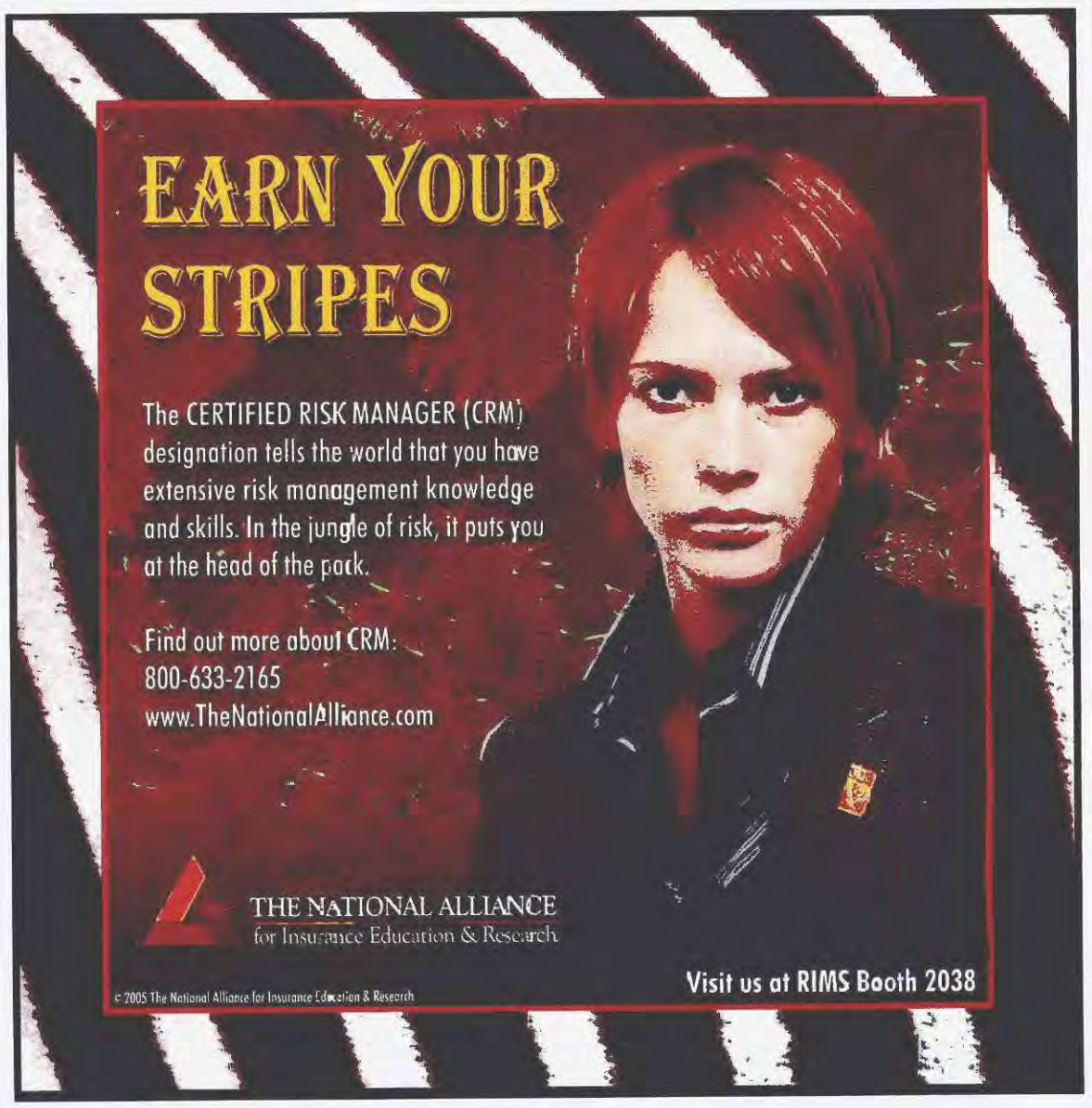
As a result, he is evaluating how to modify the program. One idea is to identify the best practices of the company's leading performers and share those with the remaining facilities.

Four facilities that likely would be role models are those that have earned the coveted Star designation in the Voluntary Protection Program sponsored by the U.S. Occupational Safety and Health Administration.

Among the 20 health care service facilities—only eight of which are hospitals—that have earned the Star designation, four are HCA hospitals. Those hospitals' claim rates per 100 full-time employees are 25% to 60% below the HCA average, and their lost-time frequency is 30% lower, Mr. Hinton said.

As a result, those four facilities' workers comp allocation charge is 33% less per $100 of payroll than the HCA average, he said.

Four to six more HCA hospitals are working toward VPP Star designations within the next 18 to 24 months, according to Mr. Hinton.



Broker incentives offer higher fees for adding value

By DAVE LENCKUS

Brokerages cannot count on HCA Inc. to generate additional commissions and fees for them during a hard market.

Indeed, under a fee structure that HCA's risk and insurance department has redesigned, brokerages' basic fees have been cut back to about the levels they were at before the Sept. 11, 2001, terrorist attacks further hardened market conditions.

And, they will stay there, unless the brokerages earn financial incentives that are available by delivering some meaningful cost, coverage and service enhancements for HCA.

That kind of performance could bring their total HCA-related revenues up to the levels they were at before the company's risk and insurance department restructured their fees.

"We'll let you earn that much, but we need you to accomplish some objectives to earn that," said James D. Hinton, vp-risk and insurance.

HCA's brokerages "have worked very hard to achieve their goals," though not all have been met, said Shirley Fuller Cooper, assistant vp-insurance and one of Mr. Hinton's top assistants, who negotiated the fee structure with the brokerages.

Overall, "I think it's been very effective," she said.

HCA implemented the redesigned fee structure in 2003 with its property insurance brokerage, Chicago-based Aon Corp. A new fee arrangement was instituted with Willis Holdings Group Ltd., the brokerage for HCA's medical malpractice and general liability excess insurance, last year.

Mr. Hinton characterized his department's focus on brokerage fees as an issue of fairness.

"Our view is that you're not doing that much more work for those higher fees in a hard market," he said.

And Mr. Hinton no longer wanted HCA to shoulder higher premiums to cover huge commissions paid to wholesalers for assisting HCA's retail brokerages.

Now, with HCA's property placement, for example, Aon must deliver a premium quote net of brokerage commissions. The only revenue that Aon and any wholesaler can generate from the account is the base fee and financial incentive awards that HCA has agreed to pay.

The base fee is about half of the commission Aon had generated on HCA's account, but the brokerage can get back to that level by earning financial rewards for meeting various goals.

For example, for every 5% reduction in property insurance premiums, Aon can earn a bonus that equals nearly 20% of its flat fee.

For the two-year period ending in 2004, HCA's property insurance premiums fell 40%.

In fee negotiations underway with Aon for HCA's May property renewal, Ms. Cooper has offered even more lucrative bonuses if HCA's deductibles for standard and catastrophe perils are reduced.

Similarly, HCA agreed to pay Willis a bonus for every 5% reduction in premiums for directors and officers liability insurance, subject

See BROKERS / page 54

Insurance coverage

■ Property

American Guarantee & Liability Insurance Co. writes the first $100 million layer.

■ Property difference in conditions

Continental Casualty Co., a subsidiary of CNA Financial Corp., writes the first $4.5 million layer.

■ Medical malpractice and general liability

HCA Inc. captive insurer Health Care Indemnity Inc. writes the first $25 million of coverage, which the captive fully retains. XL Capital Ltd. leads the excess coverage.

■ Directors and officers liability

Zurich-American Insurance Co. of Illinois, a subsidiary of Zurich Financial Services Group Inc., writes the first $15 million layer above a $25 million SIR

■ D&O liability A side only

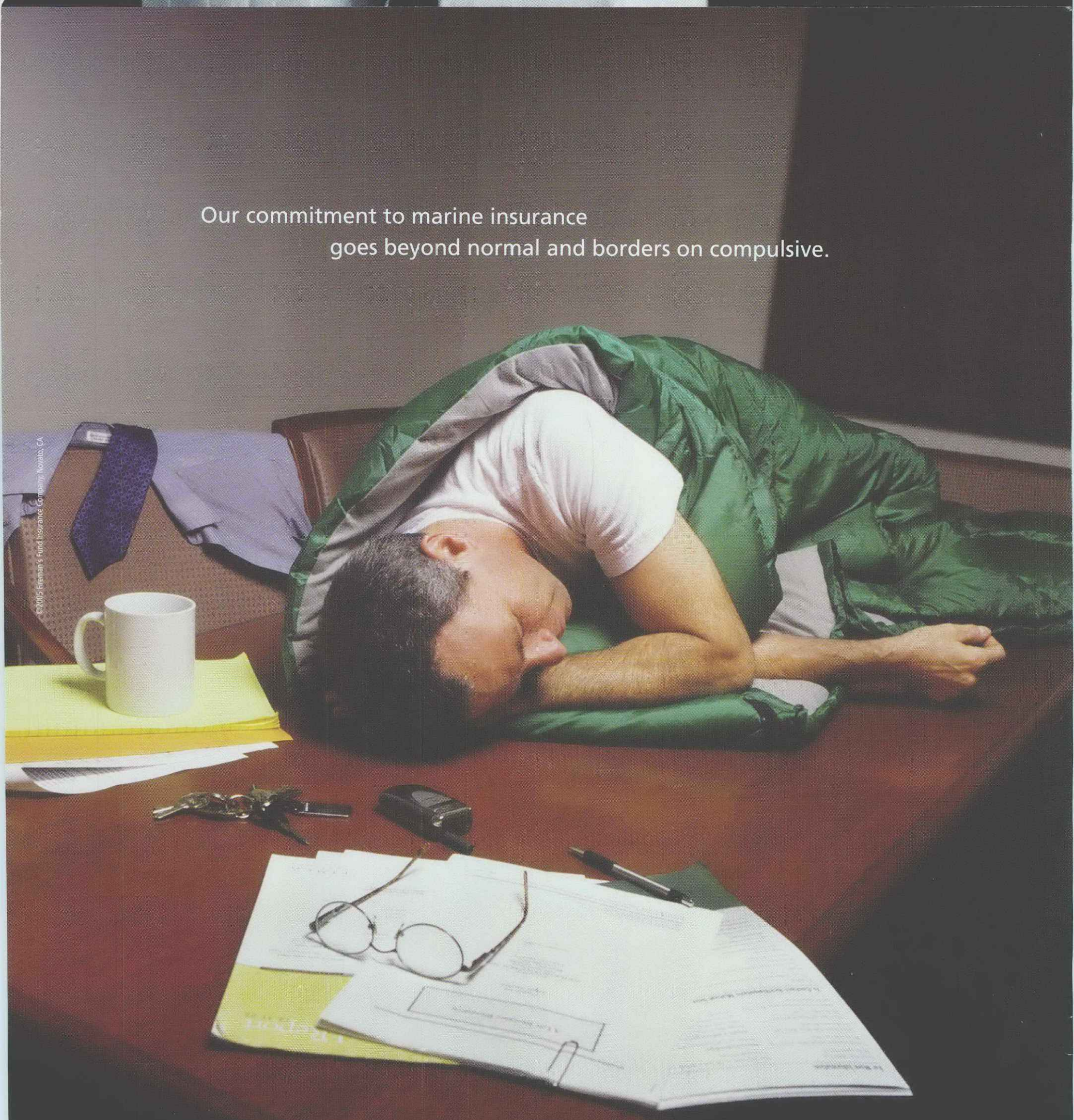
Corporate Officers & Directors Assurance Ltd., a subsidiary of ACE Ltd.

■ Fiduciary liability

National Union Fire Insurance Co. of Pittsburgh, Pa., a subsidiary of American International Group Inc., writes the first $20 million layer

■ Workers compensation

Zurich-American Insurance Co., a subsidiary of Zurich Financial Services Group Inc., writes statutory limits in most states where HCA Inc. operates. HCA participates in the monopolistic state plans in Washington and West Virginia. HCA has opted out of the Texas workers comp system.



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Luncheon: Hinton's low-key, effective approach praised by co-workers at HCA

Continued from page 54

"That's not true; he'd never miss it," she said.

Years later, the company faced a huge malpractice claim that Ms. Gerelick said was unwarranted. Still, she was concerned about the potential loss that HCA's captive insurer faced, because the litigation had been filed in a plaintiff-friendly jurisdiction.

After questioning whether settling the claim, rather than defending it, might be more prudent, Mr. Hinton asked her how she would handle the claim if the captive did not have reinsurance. She said that she would fight the claim, which HCA ultimately did and won.

Ms. Cooper compared Mr. Hinton's management style to a chess player's.

Ms. Cooper, while learning to play chess as a child, said her father often told her not to make a chess move "until you see it."

If a risk and insurance department staffer is not fully prepared in making a presentation to Mr. Hinton, "he'll listen to you, but he probably won't help you with it that day," she said.

"I certainly appreciate that type of leadership," she said.

In remarks that Ms. Kimbrough read for Mr. Roth, who could not attend due to illness, he recounted the time that he was a new staff auditor at HCA and questioned the accuracy of a financial document Mr. Hinton had prepared. Mr. Roth's supervisor suggested to the new auditor that he reconsider questioning Mr. Hinton's submission, because of the risk manager's sterling reputation for preparing flawless reports. He told Mr. Roth that if he insisted on questioning Mr. Hinton, he had better be well prepared.

With his file in top shape, Mr. Roth met with the risk manager.

Mr. Roth said that what he remembers from that first encounter with Mr. Hinton was not who was right but "how respectful he was" as he listened and then taking the time "to educate me."

"He told me, 'It may be complex, kid, but it's not complicated.' " Mr. Roth recalled.

Ms. Kimbrough noted that Mr. Hinton told her he developed his love for numbers as a boy while measuring land with his father on the family's Kentucky farm.

She also thanked him for many life lessons, including that one should look at the whole picture rather than sections of it, be comfortable in one's own skin, and give back to the community.

Mr. Portale noted that Mr. Hinton is not the type who stands back after motivating others to get involved in community work. "He's out there...with you."

Mr. Hinton's brother, Tony, and a few former colleagues and friends from Humana also offered their congratulations.

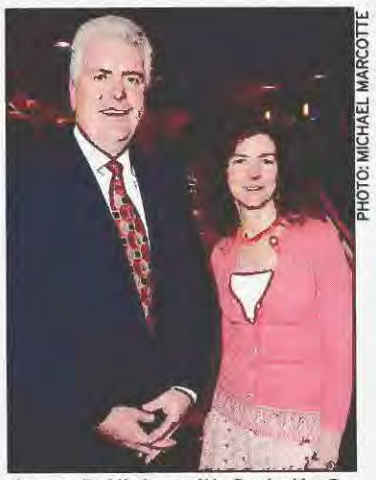

PHOTO: MICHAEL MARCOTTE

James D. Hinton with Corbette S. Doyle, chairman of Aon Corp.'s National Healthcare Practice.

Farmboy takes accountancy route to risk management

By DAVE LENCKUS

The big Kentucky farm kid's plan was to pilot military jets and maybe even spacecraft.

It certainly wasn't controlling the helm of a large corporate risk management department.

But for James D. Hinton, the numbers did not add up to a military career. They pointed him toward accounting, a discipline that eventually would lead him to his current position as vp-risk and insurance at Nashville, Tenn.-based HCA Inc.

It's a job he never sought, but he says it's the best one he has ever had.

Mr. Hinton, 55, grew up in a large farm family in a small town about 58 miles southwest of Louisville, Ky. He is the eldest of 11 children—seven boys and four girls

On the 200-acre Hinton farm in Hardinsburg—where the population has now boomed to 2,400—tobacco was the cash crop. But the farm, where Mr. Hinton's mother still lives, also produced corn, wheat and field hay. The Hintons also raised some cattle.

Mr. Hinton first left the farm to attend college at the University of Notre Dame in neighboring Indiana.

Influenced by the U.S. space race, his original goal was to major in aeronautical engineering while completing the Reserve Officer Training Corps program. He would then join the U.S. Air Force and, hopefully, train to be a pilot. He had thoughts of eventually competing for a spot in the space program.

"But I couldn't handle the engineering" coursework, Mr. Hinton said. He also discovered that he did not have the visual acuity required of pilots.

Because he also "liked numbers," Mr. Hinton switched his concentration of study after his freshman year to accounting and graduated with a bachelor's degree in business administration in 1971. In 1978, he earned a master's degree in the same area from the University of Louisville.

After Notre Dame, Mr. Hinton had a four-year commitment to the Air Force.

"I got lucky" when assigned duties, he said. Mr. Hinton, first stationed in Myrtle Beach, S.C., was able to use his education immediately in his assignment as a staff auditor in the service's audit agency.

After leaving the Air Force in 1975, Mr. Hinton took a staff accountant position for three years with the international accounting firm then known as Coopers & Lybrand.

One of Coopers' big accounts was Louisville, Ky.-based Humana Inc., a hospital organization that later would expand into health plans. In 1978, Humana offered Mr. Hinton a position as assistant corporate controller, and he accepted.

PHOTO: MICHAEL MARCOTTE

James D. Hinton and his wife, Linda, with their sons Brian and Mike.

Throughout the following decade, Mr. Hinton held positions as Humana's chief financial officer and the director of tax planning.

In that latter position, Mr. Hinton, along with a corporate counsel, negotiated a litigation cost arrangement that persuaded Humana senior management to keep alive a case that led to the 1989 landmark decision on the tax deductibility of premiums paid to captive insurers (see story, page 40).

A year before that ruling, Mr. Hinton thought that his career path would continue to run through Humana's tax department. But a former boss—Humana's risk manager—had other plans for him.

The former supervisor was retiring, and he wanted Mr. Hinton to take over risk management. Mr. Hinton had worked for him as the risk management department's director of finance during the early 1980s.

"I knew they were looking for a replacement, but I didn't apply," said Mr. Hinton, who was in line to be Humana's next tax vp.

But, with his former boss' support, Mr. Hinton was named vp-risk and insurance for Humana.

"I never really applied for the job, but it's the best job I ever had," he said.

He recalled that he "didn't know about claims, loss prevention or buying insurance" when he was named risk manager. "So I learned it on the job," he said.

When Humana decided to spin off its hospital operations in 1993 and focus on its health plans business, Mr. Hinton remained with the spinoff company. That company, Galen Health Care Inc., was acquired about six months later by Columbia HealthCare. About five months after that, in February 1994, Columbia merged with HCA.

At HCA, the nation's largest multihospital corporation, Mr. Hinton became the top risk manager and assumed the position as president of HCA's captive insurer, Health Care Indemnity Inc.

Mr. Hinton and his wife, Linda, were high school sweethearts and have been married nearly 36 years. They have two sons: Mike, 34, and Brian, 28.

In his leisure time, Mr. Hinton plays golf and likes to travel.

He also performs volunteer work for community organizations. For the United Way, most of his service over the past 20 has been in fund allocation.

Mr. Hinton, whose younger son has cerebral palsy, also devotes time to organizations dedicated to assisting the disabled. He currently is involved with helping BrightStone Inc., a Franklin, Tenn.-based nonprofit organization, in its efforts to create an educational, vocational and residential campus in central Tennessee for disabled adults.

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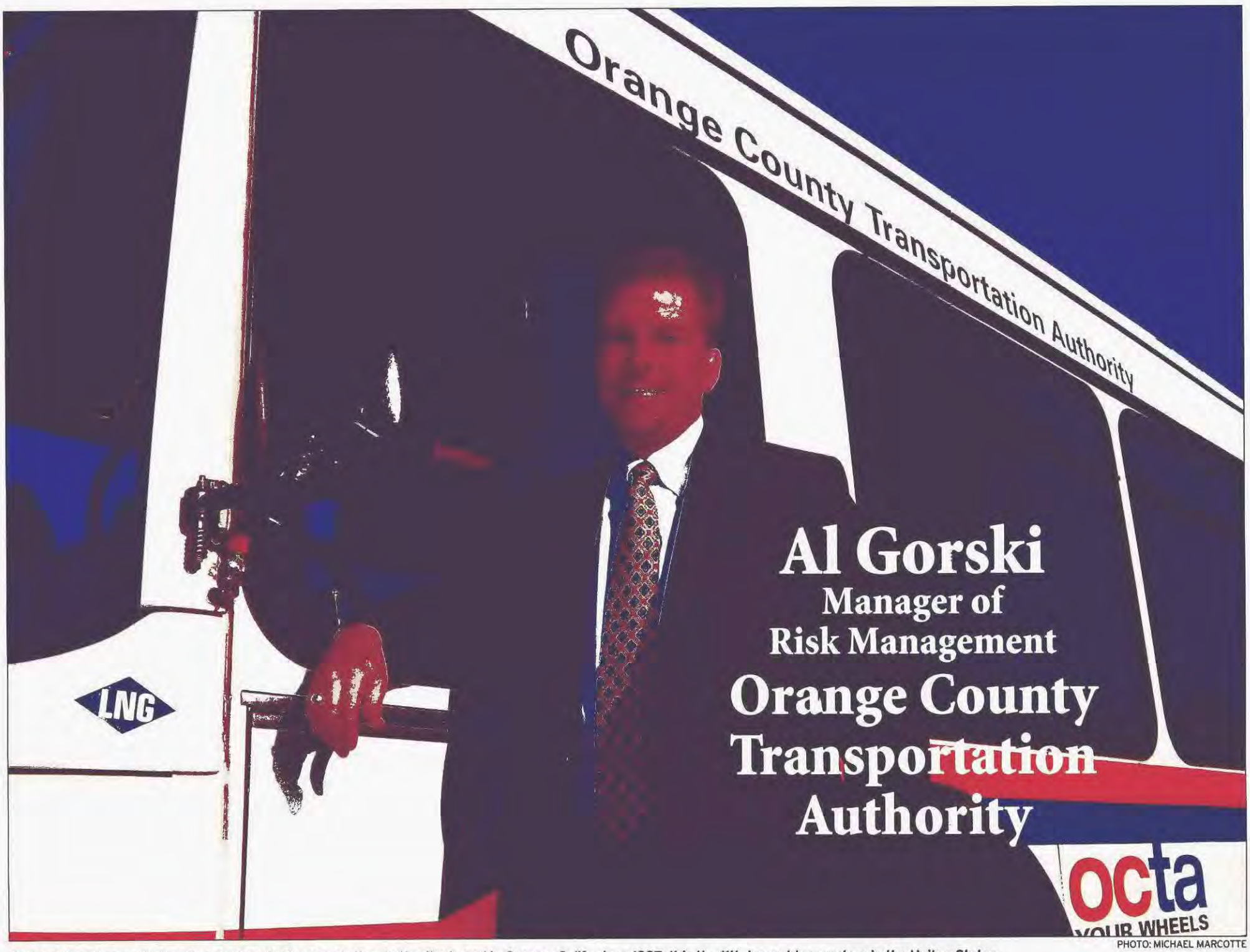

PHOTO: MICHAEL MARCOTTE

Al Gorski has been with the Orange County Transportation Authority, based in Orange, Calif., since 1997. It is the 11th-largest bus system in the Unitec States.

A man driven to manage public transit risks

By ROBERTO CENICEROS

Last year, passengers boarded Orange County Transportation Authority buses more than 68 million times, to traverse boulevards and freeways crowded with impatient drivers darting their cars around the lumbering motor coaches.

Such conditions could have provided numerous opportunities for the start of costly claims litigation stemming from riders who sustained falls on buses, from bus collisions with automobiles, and even from the occasional unruly passenger.

But, fortunately, the Orange, Calif.-based transportation agency has Al Gorski as its manager of risk management. His professional acumen includes a knack for stemming litigation by deftly maneuvering legal cases, according to a municipal risk manager in Orange County who is familiar with Mr. Gorski's work.

"He really has a good grasp and can look at a case and see where its strengths and weaknesses are and make decisions off of that," said Zachary Gifford, liability claims coordinator for Santa Ana, Orange County's largest city. "He can see the forest through the trees pretty early on."

As a public entity risk manager, Mr. Gifford said he has seen firsthand how a bus service-related claim can become a nightmare.

Public transit agencies typically experience high claims frequency, because they operate huge vehicles, transport large populations and serve the public at large.

But Mr. Gorski has an insatiable appetite for risk management techniques that help a highly visible public agency minimize its claim losses and avoid the adverse media publicity it would surely attract if it didn't adopt a sound risk management strategy, Mr. Gifford said.

Mr. Gorski's achievements and dedication to his profession have earned him a place on *Business Insurance*'s 2005 Risk Management Honor Roll. He was selected in the government entity category.

Mr. Gorski has established his reputation as a leading public entity risk manager since he joined OCTA in 1997. The entity, which is the nation's 11th-largest bus system, generates annual revenues exceeding $572 million; and its buses crisscross 797 square miles that include 34 cities and unincorporated county areas.

As OCTA keeps Orange County's three million residents on the move, Mr. Gorksi's seven-member risk management department self-administers about 340 general liability claims annually. During its 2003/04 fiscal year, the risk management department successfully resolved more than 220 liability claims with settlements that averaged $3,033 each. It settled 150 other claims with no payment.

Only one case reached the verdict stage last year, with a jury ruling in favor of the authority. During Mr. Gorski's tenure at OCTA, only six cases have made it to trial. The authority successfully defended against five of those, while the sixth resulted in a hung jury.

"Aggressive adjusting," such as acting on claims early, is part of Mr. Gorski's strategy for minimizing losses, he said.

Some of the most frequent liability claims submitted to OCTA stem from passengers falling as they board or exit buses. Other common claims arise from injuries related to the opening and closing of doors, from wheelchair passengers who slide off their seats and from bus collisions with other vehicles.

"Passenger falls mostly occur from buses starting and stopping, usually stopping to avoid accidents with vehicles that cut off the bus," Mr. Gorski noted.

In addition to general liability issues, the high level of public interaction that OCTA faces exposes the agency to some unusual workers compensation claims.

"When you are transporting the public, you meet all kinds of people and, strangely enough, there is a report at least a couple of times a month that someone spat on a driver," Mr. Gorski said. The drivers must then undergo a series of tests for hepatitis C, although no one to date has contracted the disease.

But mitigating and dealing with claim handling issues is only one aspect of his work. The wide range of Mr. Gorksi's accomplishments at OCTA include:

- Protecting property, including more than 500 buses and a revenue-generating tollway.
- Evaluating the coverage needs for a massive freeway construction project.
- Implementing a workers compensation strategy that includes incentives for union cooperation to reduce costs.
- Building a claims database for bus accidents.
- Saving premium dollars on an all-risk builders policy by directing that the coverage for a bus operation base construction project be purchased in stages, allowing OCTA to take advantage of a softening

See GORSKI / page 60

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Gorski: A dedicated man who's driven to manage public transportation risks

Continued from page 58

property insurance market.

In addition, the OCTA risk management department performs key functions that ensure that the agency is compliant with the requirements of its state and federal funding sources, in addition to ensuring that the agency is well protected.

For example, the U.S. Department of Transportation and the Federal Transit Administration both mandate the risk management department's monthly reporting of loss data for a national transportation database. They also require actuarial studies of OCTA's workers compensation and general liability programs and the drug and alcohol testing of drivers, whom OCTA refers to as "coach operators."

Under Mr. Gorski's direction, OCTA's risk management department has produced favorable results. In 2004, the American Public Transportation Assn.–which conducts peer reviews for compliance with federal standards–praised OCTA's reduction of liability claims costs by 36.5% over five years.

Claims costs dropped even while OCTA's exposures increased as it put more buses in operation to accommodate rising use. Ridership rose 4.2% in 2004, according to OCTA's annual report.

Mr. Gorski also handles a wide range of risk management responsibilities for OCTA's other operations.

In addition to the bus services, OCTA also funds and supervises a commuter rail service; administers Measure M, a sales tax voters approved in 1990 for freeway and roadway improvements (see related story); and maintains freeway emergency call boxes, among other driver services.

OCTA "literally touches everyone in the county, and Al is part of the management team that keeps it running smoothly," said Marybeth Hughes, corporate risk manager for Pacific Life Insurance Co. in Newport Beach, Calif. Ms. Hughes, who is herself a recipient of the 2002 Heart of RIMS award, nominated Mr. Gorski for the Risk Management Honor Roll.

OCTA operates a tollway comprised of four express lanes stretching 10 miles along a heavily traveled median of California's 91 Freeway. OCTA owns only the express lanes and not the adjoining freeway. Mr. Gorski buys property and business interruption coverage to protect the revenue stream flowing from the 91 Express Lanes Toll Road.

The toll lanes offer a glimpse into how Mr. Gorski helps OCTA reduce its liability expenses. He weighed the exposures that could result from the authority owning an automobile towing service necessary to help keep traffic flowing. Based on the estimated costs for workers comp, general liability and "on-hook" coverage for cars in tow, Mr. Gorski decided that it was better for OCTA to contract for towing services than to purchase its own towing service.

OCTA also regulates taxi companies operating in the county for compliance with regulations requiring them to purchase liability insurance. The Orange County Taxi Administration Program emerged after a city official complained in 1998 about how difficult it was to enforce requirements that cabs purchase insurance.

Mr. Gorski helped provide a solution by drafting insurance language that eventually would be adopted by all Orange County cities. Mr. Gorski now serves as insurance compliance consultant for OCTAP, which regulates 18 taxi companies with more than 650 vehicles.

Mr. Gorski said he loves his job because he is a problem solver by nature.

"What is nice about it for me is I can put a lot of innovation, I can put a lot of creativity, into it," he said of his work. "It's not the same thing every day. It's similar issues, but they have all different kinds of nuances that make (the work) more interesting. I come in every day and look at the job in slightly different ways because I have to. But I like that."

A mountaineer who has bagged several of the tallest peaks in the United States, including Washington state's treacherous Mount Rainier, Mr. Gorski is also known for his drive to advance risk management education in Orange County. He is an adjunct professor, teaching evening classes at the Center for Insurance at California State University, Fullerton, in Fullerton, Calif.

Mr. Gorski has also been instrumental in fund raising for the center and linking it to the Orange County chapter of the Risk & Insurance Management Society Inc. He serves on the chapter's board of directors, is chairman of its community outreach committee and has served as chairman of its education committee.

He is also a member of the Public Agency Risk Management Assn. and the American Public Transportation Assn.'s risk management committee. In 2003, he represented his employer as the host of the APTA risk management committee's annual conference. Mr. Gorski drew on risk management friends in the transit industry to help him develop the program, which attracted attendees from across the United States and Canada.

In Orange County, one of Mr. Gorski's most talked about instructional accomplishments stems from a half-day workshop he helped design and teach last fall for the Orange County RIMS chapter. The workshop's aim was to help risk managers by teaching risk management fundamentals to their staff members who had yet to learn of the profession's responsibilities.

Mr. Gorski was a prime force in organizing the workshop, said Ms. Hughes of Pacific Life. It proved so successful that participants asked the chapter to sponsor a more-advanced workshop so they could continue their education.

In addition to helping the general risk management community through educational efforts Mr. Gorski is also working to assist fellow risk managers by making some of OCTA's innovations available to other public entities.

For example, he has proposed making OCTA's homegrown Web-based accident reporting and tracking system available to other public transit agencies. He has presented the risk management information system before the American Public Transportation Assn., and several other public bus services have already expressed interest in using it.

Mr. Gorski said he hopes that if other bus authorities adopt his accident tracking system, a nationwide public transit risk management database will emerge. Transportation entities could then use it to benchmark accidents, giving risk managers a broader understanding of accident trends and patterns. It could also help them determine factors such as whether certain bus types are more likely to be involved in accidents.

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Policy speeds freeway project

By ROBERTO CENICEROS

The Orange County Transportation Authority's risk management department has responsibilities extending beyond handling insurance issues for a fleet of buses.

When OCTA obtained legislative approval to take control of a state freeway expansion project with $390 million in construction costs, for instance, its risk management department had to find the best way to insure the construction work.

The expansion of the Garden Grove Freeway, which currently handles 200,000 motorists a day, includes adding car pool lanes while expanding bridges, entrances, exits and other infrastructure.

The work is being funded with money from Measure M, a half-cent sales tax for transportation improvements that voters approved in 1990.

Under the mandatory guidelines for California-built freeway projects, the state would have had to contract for a project designer separately from its contract with the project builders. The designer and builders would each have had their own insurance policies.

That could mean that if a dispute were ever to arise over a construction defect, years of litigation likely would follow to determine whether it was the fault of the designer or the builders, said Al Gorski, OCTA's manager of risk management.

OCTA, though, wanted the project completed earlier than the state could complete it working under its mandatory guidelines for hiring designers and builders separately. So OCTA obtained the special legislation allowing it to take ownership and control of the state freeway for 26 months while it completed the expansion.

Because OCTA was not bound by the same requirements as the state to contract with the designers and builders separately, it was able to start the project more than three years earlier than the state would have. It did so by contracting with designers and builders who worked jointly under an agreement known as a "design/build approach," Mr. Gorski explained.

Mr. Gorski established the requirements for the designer/builder to purchase a single professional liability insurance policy covering all design and construction exposures. That eliminated the possibility of the project's designer and builders arguing over who would be at fault in the event of a construction defect claim.

"So the designer and the contractor are not pointing fingers at each other," Mr. Gorski said. "It's a covered loss and it gets resolved right there, so you don't have years and years of litigation."

Under Mr. Gorski's requirements, the designer/builder bought a builders risk policy from Zurich American with limits of $50 million per occurrence. The policy has a $100,000 deductible for property damage and a $250,000 flood or earthquake deductible.

In conducting the insurance feasibility study for the freeway construction project, Mr. Gorski determined that an owner-controlled insurance program would not be appropriate. OCIPs are frequently used for large construction projects. They are sometimes referred to as wrap-up programs, because a project owner provides bundled insurance coverage for all contractors working on the project.

If he could have predicted a better-than-average loss record, an OCIP would have made sense for OCTA, Mr. Gorski noted. But to be conservative, Mr. Gorski opted to consider the possibility of an average or below-average loss record.

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Professor Gorski shares real-life knowledge in class

Post at Cal State helps risk manager shape future business leaders

By ROBERTO CENICEROS

After attending several sessions of Al Gorksi's Principles of Insurance class at California State University, Fullerton, a student asked when Professor Gorski would finally start talking about insurance.

The student's confusion is understandable. Mr. Gorski—risk manager for the Orange County Transportation Authority during the day and an adjunct professor at the university's Center for Insurance Studies on Thursday evenings—spends the first six weeks of his semester-long class talking about risk management. It's a subject many of the business students arriving in his class for the first time have heard nothing about.

He is there to change that and has a passion for doing so.

Mr. Gorski is an energetic instructor, known for challenging his students while making risk management and insurance interesting subjects. But he does much more to spread risk management education.

He is a board member for the Orange County chapter of the Risk and Insurance Management Society Inc. and currently he is chairman of the chapter's community outreach committee. He has also served as chairman of the chapter's education committee.

Mr. Gorski uses his chapter involvement to promote California State University, Fullerton's six-year-old Center for Insurance Studies and raise scholarship money for its students.

Mr. Gorski's day job at the OCTA gives him real-life risk management experience that he shares with the 60 or so students who take his class each semester.

Mr. Gorski loves his job as a risk manager and the business creativity it takes to watch over the nation's 11th-largest transportation authority, but his risk management colleagues say that if he had a second go at life, there is a possibility he would teach full time.

Mr. Gorski has a desire "to teach and share his knowledge with the folks who are going to be the movers and shakers of the business world," said Marybeth Hughes, corporate risk manager for Pacific Life Insurance Co. in Newport Beach, Calif.

He has played a leading role shaping the Orange County RIMS chapter's increasing emphasis on education and professional development, Ms. Hughes said. Last year, for example, Mr. Gorski was a prime force in organizing a half-day workshop on risk management principles for risk managers' staff members.

The workshop was also a good primer for anyone recently thrown into the role of risk manager, Ms. Hughes said. It proved so successful that participants asked for another course this year to build on the themes they learned in the first workshop.

Mr. Gorski also taught the workshop, along with another university professor he recruited for the job. The Orange County chapter regularly helps the Center for Insurance Studies, so university participation in the workshop proved a good way to help the chapter in return, Mr. Gorski said.

"He has definitely been the impetus in our increasing involvement with California State, Fullerton's Center for Insurance Studies," Ms. Hughes said.

The center is part of the department of finance in the university's college of business and economics. It aims to bridge education and the insurance and financial services industry by helping to attract and teach the industry's future professionals. It provides one of six tracks that finance majors can pursue.

A number of insurers and business organizations contribute scholarship money, provide speakers for center-sponsored symposia and sponsor internships. The Orange County RIMS chapter, for example, donates about $5,000 annually in scholarship funds specifically to the center, in addition to its contributions to general risk management education through its donations to the Spencer Educational Foundation.

More than 731 students are currently enrolled in the center's program, said Weili Lu, the center's director. Over the past six years, the center has placed more than 400 students in insurance industry jobs. Brea, Calif.-based Mercury Insurance Group, for example, recently hired 59 graduates.

Mr. Gorski deserves a lot of credit for helping advance the center, Ms. Lu said. "He is always positive and just a fun guy to be with," she said.

His classes blend theory with practice, Ms. Lu added.

For instance, he shares with his students photograph blowups—the type used in court trials—of a fatal accident in which a car driver plowed through a red light, ramming a bicyclist into the side of an OCTA bus.

"I teach the students how real-life accidents go from start to finish," Mr. Gorski said. "I explain to them the whole process. I explain to them the coverage involved. I explain any unplanned retentions. In that case, the driver had to pay $200,000 above his primary auto policy and his excess liability coverage."

Students say his classes are recommended around campus.

"He is very animated in class," said Gerardo Santos, a finance senior. "He moves around; he is not just standing still. He is not monotone. He uses examples that apply to your personal life, so you can relate."

Insurance could be a boring subject, but Mr. Gorski is very knowledgeable and his teaching skills make it interesting, said Allyson Sera, another finance senior who is taking Mr. Gorski's Finance 360 class.

Ms. Sera noted that he is also the kind of professor who will call on people in back of the room to make sure everyone participates, though she stressed that he isn't intimidating.

"He wants you to be interactive, but in a comfortable way so you participate, where a lot of instructors can call on you and make you feel bad," Ms. Sera said. "He is very encouraging."

Mr. Gorski said his teaching style is akin to putting on a show that requires a lot of energy and preparation.

"It's a lot of work," he said, laughing. "When I come into class, I've done probably two hours of prep beforehand, and that's a class I've been teaching now for four years." Apart from preparing for his classroom delivery, there is plenty of administration work, such as grading exams and arranging for parking passes for the guest speakers that Mr. Gorski regularly invites.

He is constantly adding current events to the wide mix of topics, including real-world examples that illustrate issues involving employee benefits, workers compensation and property and liability losses. "When I get in front of class and say, 'Let's start,' then it's show time," Mr. Gorski said. "I'm trying to involve the students. I'm trying to involve the guest speakers. I'm

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PHOTO: MICHAEL MARCOTTE

Al Gorski with his class on principles of insurance.

Center for Insurance Studies

- The Center is part of the Department of Finance in the College of Business and Economics at California State University, Fullerton.
- Program started in the Fall of 1998.
- In the six years since the program began, the school has placed 400 students in insurance jobs.
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Teaching: Practical approach helps students

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trying to make sure that what I am giving them is relevant and it's consistent with the foundation I have laid down for them. That takes a lot of notes, and it takes a lot of mental focus to make sure we are in the game."

His teaching avocation began four years ago, after Ms. Lu was impressed with his style as a guest speaker at one of her classes and asked him to consider taking up the job permanently. Now his commitment goes beyond the classroom.

He is assisting the center in developing a graduate-level program in risk management and also helps students by inviting them to local RIMS meetings, where they can make contacts that might help launch their careers, Ms. Lu said. He donates a lot of personal time to the center too, for example, coordinating an insurance case contest the center sponsors each semester

The contest tests participants' research and writing skills by handing them a real-world scenario. One recent contest focused on the Indian Ocean tsunami that struck late last year. Working in groups of four, contestants explained what perils might be involved and what type of coverages might respond.

Depending on their performance, contestants can win scholarships, but Mr. Gorski stressed that responses must be well thought out. "We don't want a lot of hearts and flowers," he said. "We want a lot of substance."

The Los Angeles RIMS chapter and the Orange County RIMS chapter have both provided contest scenarios and questions. Mr. Gorski encourages participation by the students in his class by offering to drop a student's lowest quiz or project grade if he or she takes part.

According to Mr. Gorski, the Center for Insurance is like a second home. He doesn't teach for the pay, he said.

"For me, it's a way of giving back to the community, and the second thing is, I really enjoy interacting with the students," he said. "I really like to do it. I learn something, and they learn something. It helps me keep up with my craft."

PHOTO: MICHAEL MARCOTTE

Al Gorski uses real life examples to help students at his California State University, Fullerton, class learn about risk management and insurance.

Computer tracking helps county limit costly court trials

By ROBERTO CENICEROS

Tracking plaintiffs attorneys' litigation habits helps the Orange County Transportation Authority s risk manager maneuver cases and reduce costs.

By using a computer-based tracking system to monitor claims, settlements and awards, Al Gorski, OCTA's manager of risk management, said he can more easily decide which actions to take to avoid expensive litigation.

Mr. Gorski said the research enables him to categorize plaintiffs attorneys into three broad groups: those attorneys who always litigate; those that are willing to negotiate; and, finally, those that are lazy.

"Lazy plaintiffs attorneys are the worst kind, because you end up spending more money in litigation doing your due diligence when they are not doing theirs," Mr. Gorski said. "They never get to the point where they can sit down and tell you what the case is about. So, finally, on the courtroom steps... they come in and say, 'We will take $35,000,' when we have already spent more (on defense costs)."

Mr. Gorski's strategy to thwart those attorneys hinges on his automated bus accident tracking system. All the details of accidents involving OCTA buses–including photographs of the crashes, bus drivers' and plaintiffs' comments, and claims managers' actions–are logged in the system.

The risk management information systems tool also contains notes on plaintiffs attorneys and how they have handled prior cases against OCTA.

Mr. Gorski said he can tap that database of past attorney behavior to help him map out his settlement and litigation strategy for other cases in which those same attorneys represent claimants.

The practice is one reason why fellow risk managers familiar with Mr. Gorski say he excels at reducing OCTA's litigation liability.

For example, when his tracking system shows that a defense attorney hired by OCTA in the past has been successful against a particular plaintiffs attorney, OCTA will hire that same defense attorney to deal with claims represented by the plaintiffs attorney.

"We can make sure that, if we had a successful result from matching lawyer A and lawyer B, we line them up again and again," Mr. Gorski said. "If the plaintiffs attorney had a difficult time winning against us and we used a particular defense attorney, were going to use that same attorney."

With about 340 liability claims filed against OCTA each year, it would be difficult to monitor attorney behavior without an automated system.

The tracking system also helps Mr. Gorski gauge a plaintiff attorney's litigation style. If he figures an attorney is lazy, he might file motion after motion against him or her, Mr. Gorski said.

"If I need to litigate and it serves my purposes, I will litigate," Mr. Gorski said. After all, "the only good case is a closed one," he said.

But his preferred tactic is to avoid litigation, Mr. Gorski said. Whenever possible, OCTA seeks to contact plaintiffs attorneys early on with position letters in an effort to stay out of court.

The position letters basically state that "this is not the case you think

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PHOTO: MICHAEL MARCOTTE

Risk management staff at the Orange County Transit Authority. From left: Angelica Naranjo, office specialist; Ada Hanes, senior claims representative; Yolanda Lopez, claims representative; Debbie K. Christensen, section manager, benefits; Al Gorski; Marie Slocum, office specialist.

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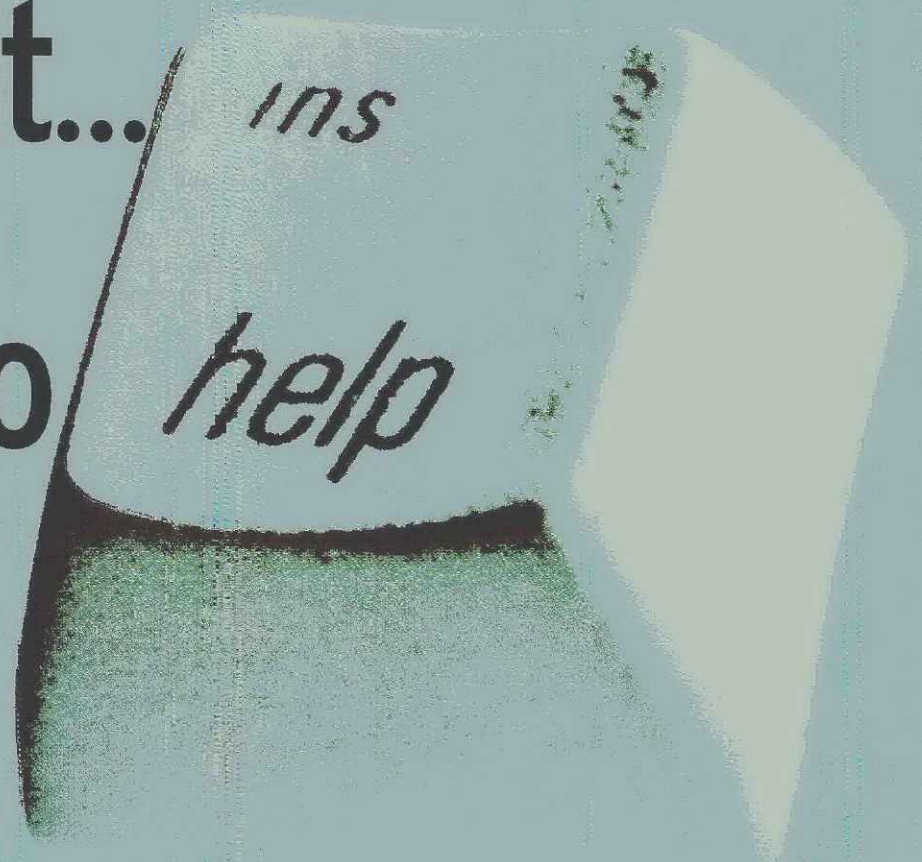

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Litigation: Computer tracking helps county limit costly court trials

Continued from page 64

it is," and explain why the case may not be as valuable as a plaintiff may have led his or her attorney to believe, Mr. Gorski said. This strategy can work because plaintiffs sometimes omit details when describing accident events to their attorneys or embellish details or provide details that differ from those that they entered in accident reports.

Mr. Gorski recalled one plaintiff who alleged she was injured by falling off a seat when the bus she was riding in made a turn. The woman convinced three successive

> "AI is good about understanding which cases have risk and which cases don't."
>
> **Craig Farrington**
> **Woodruff Spradlin & Smart**

attorneys to take her case before each one found fault with it and she finally represented herself in litigation. The position letters helped convince two of the attorneys that the case had no merit.

"That is just one example" of the cases OCTA occasionally faces, in which plaintiffs act as their own lawyers, added Craig Farrington, a partner at Woodruff Spradlin & Smart, an Orange, Calif., law firm and general counsel for the transportation authority. "We've got our share of crazy claims," he said.

But Mr. Farrington stressed that OCTA also faces its share of legitimate claims, in which it has to determine what constitutes a suitable liability payment and whether there is any shared liability.

When legitimate claims are represented by reputable plaintiffs attorneys who are prepared to negotiate, alternative dispute resolution is the preferred option, Mr. Gorski said.

"We take advantage of alternative dispute resolution if we have a legitimate case where we have liability and the only thing in dispute are the damages," Mr. Gorski said. "Why do a lot of extended and expensive discovery, when we know we can resolve the case? ADR costs less, and binding arbitration caps the exposure."

Mr. Gorski acknowledged that it can sometimes be difficult to convince plaintiffs attorneys to agree to ADR when they may otherwise be thinking, "Why not swing for the bleachers?"

But a plaintiffs attorney can also benefit from an ADR arrangement, he noted, because binding arbitration can cap his or her investment in a case while resulting in a judgment that is final and cannot be appealed. With the client agreeing to the process beforehand, it also frees the attorney from a potential legal malpractice claim if the client loses, and he or she cannot continue to pester the attorney to appeal.

"It's over in an afternoon, and we don't have to have all that many experts" and other factors that drive up trial costs, Mr. Gorski noted.

Some attorneys, though, always insist on taking their cases to trial, so "you just have to litigate," he said.

But Mr. Gorski has an advantage because of the generally conservative character of juries in Orange County, particularly in comparison to neighboring Los Angeles. The conservative bent means that an Orange County jury is much less likely to hand a plaintiff a large settlement, he explained.

A jury award for an injured knee, for example, is likely to be three times greater in Los Angeles County than an award for the same type of injury in Orange County, Mr. Gorski said.

"In Orange County, it's a different animal," he elaborated. "And, believe me, I'm very happy to be in this jurisdiction, and I take advantage of that."

Mr. Gorski has a "hands-on" approach to managing claims litigation, Mr. Farrington said. He regularly discusses defense strategy with his attorneys, such as whether to deliver a settlement offer, go to trial or try for ADR.

Mr. Farrington noted that whereas some defendants think they are always in the right, Mr. Gorski often has a sober assessment of potential case outcomes.

"Al is good about understanding which cases have risk and which cases don't," he said.

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Transportation authority uses risk transfer, retentions to remain in driver's seat

By ROBERTO CENICEROS

The Orange County Transportation Authority's insurance program blends risk retention and risk transfer.

To protect its high-value property and revenue-generating assets, the authority relies heavily on traditional risk transfer. Yet it retains a considerable amount of its liability risk.

Toll lanes are one of the more unusual risks dealt with by the transportation authority; property insurance policies for the 10-mile stretch include business interruption coverage.

While the insurance would respond to roadway damage caused by a flood, for example, the coverage more importantly protects a revenue stream and not just tangible property, said Al Gorski, OCTA's manager of risk management.

The tollway, named the 91 Express Lanes, consists of four lanes running along the median of California's 91 Freeway, connecting Riverside and Orange counties. In the mid-1990s, when California couldn't afford to expand the 91 Freeway, a congested commuter route linking the two sprawling counties, a group of developers proposed an idea.

They would build the express lanes and collect tolls in exchange for a 30-year property lease and a noncompete agreement restricting the expansion and certain repairs of the existing 91 Freeway, Mr. Gorski explained. But in order to meet Orange County's growing transportation needs and make necessary repairs to the 91 Freeway, OCTA purchased the rights to the 91 Express Lanes and took control of them in January 2003.

Currently, OCTA has $248 million in debt from that purchase, which means it needs to protect the revenue flowing from express lane tolls.

"So when we buy the property insurance, we really are not as concerned about the road," Mr. Gorski said. "We are worried more about the revenue loss from business interruption."

To protect that revenue, OCTA buys $100 million in primary property insurance limits from Axis Reinsurance Co., a unit of Hamilton, Bermuda-based AXIS Specialty Ltd. OCTA retains the first $50,000. The policy also has a $25 million sublimit for flood damage. Empire Indemnity Insurance Co., a unit of Zurich, Switzerland-based Zurich Financial Services Group, provides a difference in conditions policy with $25 million in limits for earthquake coverage. Both policies include business interruption coverage.

There are no toll collection booths on the 91 Express Lanes, so all drivers traveling them must obtain dash-mounted electronic transponders. The transponders debit their accounts as they drive the roadway. OCTA's property insurance protects the express lanes and OCTA equipment such as the system that reads the transponders and automatically debits drivers' accounts, Mr. Gorski explained.

The coverage also protects against the business interruption of toll collections if, for example, an earthquake were to disable the regular lanes of the 91 Freeway and California's governor were to order that the Express Lanes be opened to all traffic without a toll charge.

That would trigger the civil authority coverage clause, Mr. Gorski said.

OCTA renewed its property program March 1, paying $207,500 for both policies. That is nearly half the price it paid for its expiring coverage provided by six insurers. A more-competitive insurance environment helped reduce the price and simplify the program.

The hundreds of buses OCTA owns actually comprise its biggest property exposure. Each costs about $500,000, Mr. Gorski said. They are covered under a policy with $175 million in limits purchased from Novato, Calif.-based Fireman's Fund Insurance Co. and placed by Marsh Inc., OCTA's sole broker.

But the buses are covered only while at operation bases, which are the facilities at which they are stored and maintained. The bases are also covered by the Fireman's Fund property policy.

PHOTO: MICHAEL MARCOTTE

Marybeth Hughes, left, a risk manager for Pacific Life Insurance Co., and Zachary Gifford, right, a claims coordinator for the City of Santa Ana, Calif., nominated Al Gorski for risk management honors.

OCTA self-insures its buses for property loss when they are out on the road. The buses themselves are not likely to suffer much damage then. They are "built like tanks" and can withstand collisions with automobiles, Mr. Gorski said. Furthermore, he said, OCTA could withstand the financial loss of a few buses. But he stressed that the poli-

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Insurance: Covers unusual risks

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cy with Fireman's Fund protects OCTA against a catastrophic loss that could occur if, say, a fire were to sweep through a base and simultaneously destroy several buses.

Mr. Gorski said he was able to obtain a reduction in the per-vehicle deductible for the buses by pointing out to Fireman's Fund that they each have automated fire suppression systems in their engine compartments.

"There is nothing in the rest of the bus that will cause a fire," Mr. Gorski noted.

A crime policy purchased from Windsor, Conn.-based Great American Insurance Co. with $2 million in limits and a $10,000 deductible protects OCTA from the potential losses that could stem from handling cash and credit cards.

"It is a standard crime policy," Mr. Gorski said.

Under its liability program, OCTA retains $5 million per claim and transfers losses above that. Clarendon America Insurance Co., a unit of New York-based Clarendon Insurance Group Inc., provides $5 million in excess coverage above OCTA's retention. Arch Specialty Insurance Co., a unit of New York-based Arch Insurance Group, provides another $5 million in limits above the Clarendon layer.

Even though OCTA has never filed a property or general liability claim, maintains a high retention and has a risk management department with a reputation for mitigating claims, it still receives a number of quote rejections at policy renewal time. Few liability insurers write transit risks, Mr. Gorski explained.

One problem that OCTA faces is that insurers tend to lump together all transit risks, including those of charter buses and rail cars, Mr. Gorski said.

Insurers are also hesitant to underwrite bus operations because they expect frequent claims. There is also the potential for high claims severity, with large vehicles moving through densely populated areas and many pedestrians crossing the streets in front of them.

"Transit is always in movement," Mr. Gorski said. "You have different people on the road, you are dealing with traffic congestion, you are dealing with a lot of risks."

But OCTA's risk management practices help out, as do other factors, such as the wide, well-maintained Orange County streets the buses traverse, Mr. Gorski noted.

"We do pretty well in this transit agency because of our good experience, because of our good claims management, because of our training, because of the fact that we have good equipment and we have seasoned drivers," he said.

OCTA will apply for Marsh settlement funds

By ROBERTO CENICEROS

The Orange County Transportation Authority expects to collect funds stemming from a settlement Marsh & McLennan Cos. Inc. reached with New York Attorney General Eliot Spitzer over alleged fraud and bid-rigging charges.

In that settlement, MMC formally agreed in January that it would stop collecting contingent commissions and create an $850 million fund to compensate U.S. policyholders. Marsh Inc. is OCTA's sole insurance broker, explained Al Gorski, the authority's manager of risk management.

"We have been very satisfied with Marsh," Mr. Gorski said.

But OCTA's contract with Marsh calls for the broker to disclose all fees, including contingent commissions, that it obtains while procuring policies for the authority.

Following the nationwide controversy that began last year when Mr. Spitzer sued Marsh & McLennan, alleging that the brokerage rigged bids to favor certain insurers and steered business to those insurers that paid it the highest contingent commissions, OCTA's board of directors inquired whether the broker engaged in such practices while placing authority business.

Marsh then agreed to include OCTA in an internal audit conducted by its Marsh Kroll consulting unit, Mr. Gorski said.

"We are very pleased that they were very responsive," Mr. Gorski said.

Fees on OCTA business

The audit uncovered that Marsh generated approximately $100,000 in contingent fees over four years through its placement of OCTA policies, Mr. Gorski said. OCTA, therefore, will apply for settlement funds, but how much it might receive still has to be worked out.

Contracting with only one broker helps create a cohesive insurance program and allows OCTA to obtain more brokerage services at a lower cost than would be possible if it worked with several brokers, Mr. Gorski said.

OCTA pays Marsh a flat fee to place all its insurance needs, with the exception of excess workers compensation coverage. The authority pays Marsh a 10% commission to place that insurance.

Partnership of OCTA, Teamsters aims to lower workers comp costs

Union will share savings if claims payouts fall

By ROBERTO CENICEROS

An agreement with a labor union that allows the worker organization to share in potential workers compensation savings has helped the Orange County Transportation Authority limit premium increases and could lower bus driver liability costs.

OCTA's partnership with the International Brotherhood of Teamsters Local 952, which represents its 1,200 bus drivers, is necessary for real change in lowering claims costs, said Al Gorski, the transportation authority's manager of risk management.

In an effort to formalize a partnership, OCTA entered into a three-year collective bargaining agreement with the union in 2004, under which labor will receive a share of the savings if OCTA's payout of workers comp benefits for existing claims falls by a set amount, Mr. Gorski explained.

As part of the effort to reduce benefits costs, the union has agreed to encourage members with outstanding claims to participate in alternative dispute resolution, Mr. Gorski said.

With ADR, disputes over thorny issues such as the amount of future indemnity payments and future medical expenses can be settled much quicker, and thus at a lower cost, than through litigation, he said.

PHOTO: MICHAEL MARCOTTE

Orange County Transportation Authority CEO Art Leahy, left, Al Gorski and Jim Kenan, executive director finance, administration and human resources.

Setting a baseline

Under the agreement, OCTA and the union will use $4.67 million as a baseline for annual claims costs. That amount is based on OCTA's average benefit payout for its 2003 and 2004 fiscal years. If benefit costs for outstanding claims fall below the baseline by a certain margin, the union will receive a percentage of the savings. Mr. Gorski declined to reveal the percentage the union stands to receive or the amount of cost reduction that must occur before the union receives any of the savings.

But the union can also increase the percentage of any savings it stands to receive if the number of new claims filed each year also decreases by a certain percent. To gauge a decrease in new claims, the union and OCTA agreed to use 262 as a baseline, which is the average number of workers comp claims filed annually during the prior two years.

The agreement emerged during efforts to end a contract negotiation stalemate over wages. The union can use the workers comp claims savings in any way it chooses, including using it to bolster member pay, Mr. Gorski said.

The Teamsters suggested using ADR to settle claims because its members can benefit from quicker resolutions. But precisely how the union will help ensure savings occur must still be worked out, Mr. Gorski noted. It could help, for example, by endorsing work-site communication efforts to discourage fraud or extol the financial benefits workers stand to gain by helping reduce claims costs.

> Placing workers comp under risk management, where it is viewed as a liability, represents a change in claims handling philosophy.

Even before the union and OCTA officially agreed to share in potential work comp savings, Mr. Gorski said the concept helped him win favorable rate consideration when he renewed OCTA's excess workers compensation coverage that took effect in October 2004. He was able to negotiate for a premium increase of just 1.4%, instead of the 15% increase his broker had warned was possible. The difference amounts to $95,000.

ACE American Insurance Co., a unit of Bermuda-based ACE Ltd., provides the excess coverage with statutory limits. OCTA retains $1 million per claim. Mr. Gorski also contracts with Chino, Calif.-based Hazelrigg Risk Management Services Inc. for the third-party administration of workers comp claims.

Change in philosophy

The union agreement was not the only factor that helped Mr. Gorski wrangle a favorable premium.

Mr. Gorski said he took charge of the transportation authority's workers compensation program last summer. Previously, OCTA's human resource department oversaw workers compensation, which, he said, made workers comp seem like a benefit or entitlement program. Placing workers comp under risk management, where it is viewed as a liability, represents a change in claims handling philosophy, he said.

That change helped also contributed to the lower-than-expected premium increase.

In addition to the agreement with the union, Mr. Gorski plans to reduce OCTA's workers comp liability through several other strategies, including conducting an audit of all outstanding claims to ascertain

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Workers comp: OCTA, union will share potential premium savings

Continued from previous page

whether they can be resolved quickly. He also plans to take advantage of recent workers compensation reforms adopted by California in 2003 and 2004, and he will be hiring a new claims manager.

In addition, Mr. Gorski said he is taking advantage of the camaraderie among transit risk managers nationwide to develop "best practices" for claims handling and injury reduction.

Direct discussions with ACE also helped his renewal.

"Don't just rely on the broker," Mr. Gorski advised. "Rely on human contact with the insurer, and let them know what your business is about."

OCTA is also working to reduce the incidence of injuries, he said.

Most workers comp injuries suffered by OCTA workers are similar to those sustained by employees in other industries. There are a number of sprains and strains that can occur as mechanics squat over engines or bus drivers reach for something after sitting for long periods.

OCTA has taken several measures to prevent such injuries. For example, to prevent strains from drivers reaching up high after sitting for long periods, they have mirror-adjusting stands the drivers can step up on to help them with the task. OCTA also has a safety department that helps with ergonomics concerns and provides training for wellness programs such as smoking cessation and weight loss programs. The safety department does not fall under Mr. Gorski's purview, but he works closely with that department.

> "Don't just rely on the broker. Rely on human contact with the insurer, and let them know what your business is about."
>
> **Al Gorski**
> **Orange County Transportation Authority**

While most of OCTA work-related injuries are similar to those suffered elsewhere, bus drivers are also exposed to large numbers of members of the public, some of whom can become violent.

"Unfortunately, bus drivers are exposed to passengers that may become violent," Mr. Gorski said. About twice a month, on average, someone spits on a bus driver. That drives up medical expenses, because OCTA has to fund a battery of tests for hepatitis C, even though no OCTA bus driver has ever contracted the disease under those circumstances, Mr. Gorski said.

The union has also acted to help bus drivers who may become victims of crime. Since the mid-1990s the union has demanded that OCTA purchase a policy covering "felonious assault," Mr. Gorski noted. The policy supplements workers comp coverage by paying an additional $75,000 should an operator die on the job. Los Angeles-based Transamerica Occidental Insurance Co. provides the coverage, which costs about $3,500 annually for all OCTA drivers. But no claim has ever been filed.

The union is just one of many workers comp stakeholders that Mr. Gorski said he must partner with to solve complex claims and coverage issues–a challenge he enjoys.

"It's getting a bunch of people together to solve all these problems that are interrelated, and that is cool," Mr. Gorski said. "What's nice about it for me is I can put a lot of creativity into it."

Risk taker makes 'interesting climb' of Rainier, career

By ROBERTO CENICEROS

Jamming his ice ax and the metal points of his crampon-covered boots into a steep, icy slope helped Al Gorski break his fall and keep from sliding further down the mountainside.

The two companions he was roped to similarly dug in, forming an anchor that allowed Mr. Gorski to right himself and climb back up to them. The trio had left their base camp at midnight, reached the 14,410-foot peak of Washington state's Mount Rainier around 10 a.m. and were traversing down the most heavily glaciated mountain in the contiguous United States when they had to employ the life-saving technique.

"It was a close call there," Mr. Gorsksi said.

The 1994 mountaineering feat shows that Mr. Gorski doesn't just manage risks, he also takes them.

PHOTO: MICHAEL MARCOTTE

Mr. Gorski, with two companions, employed a life-saving technique while descending Mount Ranier.

"There is a side of him that I joke about," says Jim Kenan, Mr. Gorski's boss at the Orange County Transportation Authority. "He clearly does things that I wouldn't anticipate a risk manager doing. He tends to push the envelope a little bit with respect to some of his personal activities. I guess that is the daring side of Al."

When at work as OCTA's manager of risk management, Mr. Gorski is known for guarding the authority's assets as if they were his own. But he doesn't do it by obstructing others who have tasks to accomplish.

"He is always looking to provide solutions," said Mr. Kenan, executive director of finance, administration and human resources for OCTA. "He is not a guy that just says no."

Mr. Gorski started his risk management career in 1976 as a 19-year-old security and safety manager for Kmart Corp. The job required him to collect reports on slip and fall accidents and product liability complaints. Meanwhile, he earned a bachelor's degree in political science from California State University, Northridge.

Mr. Gorski worked nearly 20 years at Kmart, eventually supervising liability adjusters who handled the claims for 14 Western states, Puerto Rico and Guam. Then he worked another two years as a risk manager for a company that located underground pipelines prior to excavation.

In 1997 he joined OCTA. To help acquaint himself with public agency risk, he completed a master's degree in public administration in 1999 from California State University, Long Beach.

Some risk managers may see increasing the visibility of their work as risky, Mr. Kenan noted, but Mr. Gorski has applied an outgoing personality, leadership skills and the ability to gain others' trust to increase the profile of his risk management department.

That has led to his involvement in more of OCTA's operations, Mr. Kenan added. Mr. Kenan, for example, handed Mr. Gorksi responsibility for workers compensation about seven months ago.

In his off hours, Mr. Gorski's hobbies include shooting pool and riding around on his two late-1970s Yamaha motorcycles. "I'm sort of a weekend warrior," he said of the rides he takes on them.

He also hikes regularly, although not likely with the same intensity as when he trained for his ascent of Mount Rainier. To prepare back then, he hiked strenuous mountain trails and rode a bicycle often.

Climbing Mount Rainier was one of those things that you do because it's there and it's a chance to get away, Mr. Gorksi said.

"You think about Mount Rainier, and you think, 'That might be an interesting climb,' " Mr. Gorski said. "And then you do it, and you say, 'Oh my, I was wrong, that was just a lot of work.' But then you would do it again."

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Bradley R. Wood in the hotel lobby of the Bethesda North Marriott Hotel & Conference Center in Bethesda, Md.

PHOTO: MICHAEL MARCOTTE

Wood serves as concierge of loss prevention

Marriott's risk manager works to 'avoid the losses before they happen'

By MARK A. HOFMANN

The easiest loss to adjust is the one that never happens.

At Bethesda, Md.-based Marriott International Inc., the safety of guests and employees is paramount. Loss transfer isn't enough—loss prevention comes first.

The ways in which Bradley R. Wood, Marriott's senior vp-risk management, has carried out that mission has earned him a place on *Business Insurance*'s 2005 Risk Management Honor Roll.

Mr. Wood currently oversees a risk management department with more than 260 employees. During his 19 years at Marriott, the 48-year-old Mr. Wood has:

- Developed a business continuity plan in advance of the Sept. 11, 2001, terrorist attacks (see story, page 71).
- Played a key role in pushing for the enactment of the Terrorism Risk Insurance Act of 2002 and continues to work for its extension through the end of 2007 (see story, page 71).
- Instituted changes that reduced losses at Marriott's Senior Living Services unit, which has since been sold (see story, page 74).

Mr. Wood also has addressed worker safety issues arising from Marriott's aging workforce (see story, page 73) and has overseen the continued development of the company's fire safety program, long regarded as among the best in the industry (see story, page 72).

"He's a tremendous asset to Marriott," said Carl T. Berquist, Marriott's executive vp-financial information and risk management, noting that Mr. Wood "does a great job of leading" loss prevention efforts at the company's properties. Mr. Berquist added that Mr. Wood was "solely responsible" for developing the idea of establishing a business continuity program and is vigilant about working "to avoid the losses before they happen."

Mr. Wood brings "forethought and innovation to the table," said Richard Montminy, managing director at Marsh USA Inc. in Washington, Marriott's property insurance broker.

"The programs and best practices that they developed at Marriott have really set the standard in the industry. Brad has certainly helped develop a lot of those programs," Mr. Montminy said.

"They always put their guests and their (employees) first and foremost in Marriott. The safety and security of those guests and associates is the foundation of Marriott's risk management," he said.

"One of their pillars is loss prevention vs. just risk transfer. They've developed programs and practices throughout the organization that are focused on preventing something from happening. They're very focused on loss prevention," Mr. Montminy said.

Striking a balance

The Sept. 11, 2001, terrorist attacks have resulted in new kinds of challenges in loss prevention and other areas of risk management, Mr. Wood said.

"In the post 9/11 environment, it's finding the right balance between safety and security. When I say that, the whole world flipped upside down in the loss prevention world on 9/11.

"All the emphasis went toward security and how do you secure your premises and how far do you go with that? That was a big change for Americans to come to grips with," Mr. Wood said.

"The flip side is, you can't lose sight of the importance of workers compensation costs, the importance of mainstream liability claims, protecting your property—all those elements that are out there and related to nonsecurity aspects of the world," he said.

"When you're starting to put all of those resources into security, suddenly you find yourself needing also to pay attention to the things that you've done for the past two decades. That's been a real difficult challenge—not only for us, but for American business to get their hands around."

"The balance is one of the keys. Workers compensation costs are not going down. As we all know, medical inflation drives about 50% of the workers compensation cost.

Continued on next page

Y2K spurred continuity plan that was put to test by 9/11

Marriott's preparation helped company respond quickly to crisis

By MARK A. HOFMANN

Like most corporations, Marriott International Inc. didn't have a formal, enterprisewide business continuity plan five years ago.

But unlike many, it did have one in place before the Sept. 11, 2001, terrorist attacks broadly raised awareness of the need for such preparations.

When Bradley R. Wood, Marriott's senior vp-risk management, in 2000 began working on a business continuity plan, it "wasn't the most popular of disciplines," he said. In fact, only some governmental entities and financial institutions had a formal office devoted to coordinating efforts in an emergency. But preparations surrounding the Y2K computer issue led planners to think beyond just crisis response.

"We were talking about four cornerstones around business continuity. The first one being emergency response, what do you do in the first 24 hours," said Mr. Wood. "The next would be the crisis management side—controlling the crisis as it occurred within the first 72 hours." After crisis management would come disaster recovery and systems recovery, and finally, business resumption, he said.

Chad Callaghan, Marriott's vp-enterprise loss prevention, said that as the company developed different crisis plans, "we found that when you open one door, you end up opening others" as well.

"You really don't know what you don't know until" you begin that exercise. "Now, we all of the sudden we have to deal with things like: how do we communicate with potential victims? How do we deal with employees? How do we deal with systems?" he said.

"We really couldn't create a crisis plan in a vacuum," he said. "A part-time person in each division cannot do this on their own."

"We really weren't thinking broadly in the planning area," said Mr. Wood. Business continuity was generally limited to crisis management and emergency response, with each unit acting independently. There was no enterprise-wide plan, he said.

Little did Marriott realize that the new approach would be put to the test a little more than a year after the company created its Business Continuity Office in July 2000, with Penny Turnbull as senior director-business continuity.

"We were fortunate to have a jump start on that for about a year prior to the 9/11 event," said Mr. Wood.

"When 9/11 happened, everyone knew what we were talking about," said Ms. Turnbull.

Marriott's planning allowed the company to quickly get people on the ground who could represent the crisis team near the incident. "We were able to get people—human resources, loss prevention, casualty claims, public relations—into Manhattan."

For example, Marriott set up its employee assistance team at one of its hotels that had not been damaged in the attack. There, the team talked to displaced employees about a variety of issues, including concerns about benefits, pay and what would become of their jobs.

"The response proved the value of having a strong team with the right people on it. We hadn't planned for the particular incidents," said Ms. Turnbull. "We have an all-risks approach to planning."

Ms. Turnbull said that one of the lessons learned quickly in the wake of the terrorist attacks was that not having technology personnel represented on the crisis teams was a mistake. "They were critical."

Marriott's business continuity plan worked not only on Sept. 11 but also during the anthrax contamination at Washington Brentwood postal facility, which processed Marriott's mail.

PHOTO: MICHAEL MARCOTTE

Carl T. Berquist, left, Marriott's executive vp-financial information and risk management, with Bradley R. Wood.

"We were one stop down from that. We had to look at our own internal mail system and see whether we were also impacted," said Mr. Wood.

Business continuity has only two full-time staff members, so Marriott relies "very heavily on other people in the company," said Ms. Turnbull. There are several crisis-response teams at the corporate level, which include both primary and ac hoc members, she said.

"There are alternates for the primary members and even alternates for the alternates," said Mr. Wood.

Ms. Turnbull says that one of the aims of the policy is to ensure consistency.

"This is a bottom-line baseline standard for Marriott," she said. Senior executives at every site and every department must certify compliance annually, all the way up to the executive vp level. Compliance is reported to the board.

"It gets to the roots of the culture of our organization," said Mr. Wood.

From root beer stand to global corporation

It all started with a nine-stool root beer stand in Washington in 1927.

From that modest beginning, the company that is now Marriott International Inc. grew into a globally known corporation. Marriott operates in nearly 70 countries, has well over 100,000 employees and consists of 18 brands, including the Ritz-Carlton and Ramada International as well as Marriott Hotels & Resorts.

Starting with their one root beer stand, J.W. Marriott Sr. and his wife, Alice, eventually opened a chain of Washington-area restaurants called Hot Shoppes. After incorporating Hot Shoppes Inc. in 1929, they later pioneered airline food catering in 1937, setting up "In-Flite Catering" at Washington's Hoover Field, where the Pentagon now stands.

The company entered the hotel business in 1957 with the opening of the Twin Bridges Motor Hotel in Arlington, Va. Twelve years later, Marriott opened its first international hotel in Acapulco, Mexico. Marriott currently operates or franchises about 2,800 hotel, resort and timeshare properties worldwide.

—By Mark A. Hofmann

Continued from previous page

Those costs are continuing to be almost double-digit increases," he said. "We got to keep a focus equally upon preventing the injuries out there and controlling that side of the ledger."

Because Marriott operates in about 70 countries, "we have had to adjust from a risk management perspective to be able to service those."

This leads to numerous ongoing challenges both domestically and internationaliy, said Mr. Wood. Maintaining consistency and effectiveness from everything from loss prevention to claims management is key, he said.

Looking ahead, Mr. Wood also cited concerns about the ongoing investigation of insurance industry practices.

"I worry a little bit about the strength of the insurance industry, what's occurred with the various investigations. Policyholders need to have strong insurers. This is a real wake-up call for many out there as to some of the issues that underlie the relationships between policyholders and insurers. Ultimately, I hope this plays out so that the strength of the insurers is not compromised. Policyholders find themselves with fewer and fewer choices as consolidations and acquisitions have gone on throughout the insurance industry. We certainly need strong healthy insurers at the end of the day and reinsurers to support them."

Terrorist attacks led Wood to push for TRIA passage

By MARK A. HOFMANN

A tragedy that rocked the nation ultimately propelled Bradley R. Wood into the political arena.

The terrorist attacks of Sept. 11, 2001, hit home for Marriott International Inc., said Mr. Wood, senior vp-risk management for the Bethesda, Md.-based hospitality giant, which had two hotels near the World Trade Center. One of the properties was destroyed by the attack on the twin towers, while the other was significantly damaged.

Sept. 11 and its impact on the insurance market led Mr. Wood to become involved in efforts to enact the Terrorism Risk Insurance Act, which provides a government financial backstop for insurers facing losses from future catastrophic terrorist attacks.

The drive to enact TRIA proved successful, and President Bush signed it into law in November 2002. But the act will expire on Dec. 31 unless it is extended. Not surprisingly, Mr. Wood is active in the push for extension as well.

As part of that effort, he serves on the steering committee of the Coalition to Insure Against Terrorism, a Washington-based policyholder coalition. Mr. Wood describes his role "as kind of the risk management representative for CIAT." He said that he is "able to bring some risk management expertise that is beyond the lobbying effort" to extend TRIA through the end of 2007.

Mr. Wood says that his initial role was one educating the lobbyists in insurance and risk management concepts that are "foreign to non-risk management professionals." Although he did not testify, he helped take lobbying strategy and match "it up to the practical aspects of risk management," he said. The act had to be workable for both policyholders and the insurance industry.

He served as the business community's representative who could talk with congressional and Treasury staffs about the terrorism insurance issue, said Mr. Wood. In addition, he acted as "a bridge" linking CIAT with the Risk & Insurance Management Society Inc., and the American Insurance Assn.

Mr. Wood's involvement began because the issue was "important to our company. On 9/11, we lost the World Trade Center Marriott Hotel. That was destroyed after the towers fell. It became very personal to our company.

"While we safely evacuated 2,000 guests and employees that day, we did lose two employees, and we have 11 hotel guests to this day that are still unaccounted for. When you're in a hotel, you don't sign in and sign out. We don't know whether they were caught up in the towers or where they were."

For Marriott, TRIA is important from several perspectives, Mr. Wood said, noting that enacting

See TRIA / next page

TRIA: Advocacy role puts Wood in national spotlight

Continued from previous page

the federal backstop was "the No. 1 legislative item for the Marriott organization."

TRIA is important "not only from property insurance, which initially was what people thought about—protecting the buildings and the resultant business interruption—but it's also important to a company that has 100,000 employees throughout the United States," he said.

Marriott, like other employers, must ensure it has appropriate workers comp coverage, he said. "This is an issue that is beyond just one employer—it's about the aggregation risk that all employers have of physically cohabiting one particular region that could be impacted by one regional terrorism event." .

"I had a real opportunity to step forward, representing our industry and policyholders as it relates to getting the message out about the importance of TRIA."

Bradley R. Wood
Marriott International Inc.

Mr. Wood said that the nature of Marriott's operations make him a good TRIA advocate.

"Marriott has a national presence out there where we have hotels that are not only in downtown Manhattan high-rises but we also have hotels that are smaller—for example suburban and rural hotels in Iowa.

"We're able to bring a legitimate view of the entire United States and answer the question of whether this is a big-city urban issue or whether this was an issue for all of America," he said. "Marriott as an organization had the breadth to be able to discuss these issues."

As the company's risk manager, "I had a real opportunity to step forward, representing our industry and policyholders as it relates to getting the message out about the importance of TRIA," said Mr. Wood.

"Unfortunately, the policyholder community has not been individually vocal on these issues and often stood behind their associations," he said. Marriott, however, saw an opportunity to "lead the way."

Noting that the company's efforts contributed to the initial enactment of TRIA in 2002, Mr. Wood said they appear to be bearing fruit in the drive for a two-year extension of the act. "It appears right now that we're likely to have an extension of the act—at least we're hopeful of that," said Mr. Wood.

Policyholders in general, he said, "have gotten more engaged in the last six months," he said. "We've seen a real turn from...the summer of 2004, where this looked like it would be going nowhere again."

Marriott sets the standard in fire safety

In-house inspection staff provides insight to on-site engineers

By MARK A. HOFMANN

PHOTO: CREDIT IS NOW 6 PTS

Front row, from left: Bradley R. Wood; John "Sonny" Scarff, senior director-fire protection; Penny Turnbull, senior director-business continuity. Back row, from left: Hector A. Mastrapa, vp-insurance; Chad Callaghan, vp-enterprise loss prevention; Robert B. Steggert, vp-casualty claims. Not pictured: Michael S. Owens, senior director-finance and accounting.

A consistent approach to life-safety issues is one of the hallmarks of Marriott International Inc.'s risk management philosophy.

"What's absolutely critical for us is to ensure that we've got consistent approaches to life safety throughout the world," said Bradley R. Wood, senior vp-risk management for the Bethesda, Md.-based hospitality company.

"We have guests that are traveling, that are Americans, throughout the world, and they expect the same level of standards of care outside the United States that are in the U.S." he said.

"We're very fortunate that in our organization, the entire executive leadership is behind life safety. It's not inexpensive," said Mr. Wood. "The cost of retrofitting hotels that we acquire, older hotels that don't have sprinkler systems, is significant. The cost to include life-safety standards outside the U.S.—where it may not be required by local custom or law—to have it to Marriott standards, that difference is significant. It takes executive support from the company to ultimately have that consistent product out there."

The emphasis on fire safety has a long history at Marriott, noted Mr. Wood. Two particular initiatives from more than 20 years ago exemplify that commitment, he said, adding that John "Sonny" Scarff, senior director-corporate fire protection, and his team "continue to push the envelope as it relates to the life-safety area."

Milestone operations

The two events were known as Operation Fort Lauderdale, and Operation San Francisco, which Mr. Wood characterized as "major milestones, well chronicled in the fire protection world."

Mr. Scarff explained that a series of hotel fires—not involving Marriott properties—caused Marriott to consider retrofitting all properties with sprinkler systems. But there was a catch: using the iron pipe accepted in the early 1980s meant taking rooms out of service for days as well as destroying carpet during installation. Plastic pipe, on the other hand, could be installed quickly, he said.

Mr. Wood said that the "naysayers" of 1982 said that plastic pipe could not work, arguing that fire would destroy it and render it useless.

Mr. Scarff set out to prove them wrong. In 1982's Operation Fort Lauderdale, named for the Florida city in which it took place, Mr. Scarff brought 40 fire marshals to see how plastic piping performed in hotel room fires. A year later, he oversaw a more extensive test dubbed Operation San Francisco, in which Marriott used a property slated for demolition to show how plastic piping would perform in fire in a series of different rooms and conditions.

Marriott set the standard for the use of plastic pipe; previously, there was no building code covering its use. And despite initial resistance from building code enforcers and insurers, the use of plastic pipe won acceptance. Mr. Wood said that acceptance was part of a evolution throughout the 1980s, as localities adopted building codes that permitted the use of plastic pipe.

Marriott is continuing its research into improving fire safety through a partnership with the University of Maryland Fire and Rescue Institute in College Park. For example, the company has developed a mist system that uses much less water—and thus cuts down on the possibility of damage to furnishings—to protect some of its historic properties.

"We're doing more testing with products we think will work than the sprinkler industry," Mr. Scarff said.

The university has "done a terrific job of driving the documentation," said Mr. Wood.

Marriott has five full-time life-safety engineers on staff dedicated to corporate fire protection, he said. The team is based in Bethesda.

"These folks are out there looking at the individual plans of every hotel and ensuring that the life-safety systems are in compliance with the Marriott standards as it relates to any new build or conversion of an existing hotel into a Marriott brand," said Mr. Wood.

If life-safety systems aren't completely in place, a hotel's opening will be delayed despite the wishes of its local managers, said Mr. Scarff. "That's the bottom line," he said. While such delays cost money, they're not expensive "when you look at the big picture. If you lose a person or two people at a hotel, that's where the expense comes in."

"We're very fortunate that in our organization, the entire executive leadership is behind life safety."

Bradley R. Wood
Marriott International Inc.

"Beyond the key issue of the loss of life that we're trying to prevent, it's also protection of the brand and the image of the corporation and the reputation," said Mr. Wood.

Marriott "made considerable investment in this area to protect all of those different elements that are significant to the success of our company," he said. "I think the message here as it relates to life safety is, Marriott has been not only an innovator in our industry, but outside the industry, in helping bring advanced life safety throughout the world," he said.

"Sonny and his team have brought sprinkler systems and smoke exhaust systems and the like into countries that just didn't have them before," he said. In some cases, that means bringing in the piping, too.

Using its own personnel pays numerous dividends for Marriott, according to Mr. Wood.

"Generally, building owners will rely upon outside vendors to do annual inspections of their systems," said Mr. Wood. But Marriott found that this was expensive and that the services provided were substandard in some cases. So about nine years ago, the company began its own inspection program that continues to this day.

An inside job

The program uses "in-house staff that are credentialed to do these inspections. We get the benefit not only of that expertise but also the training that these individuals can provide to our onsite hotel engineers, to spend time with them. We found vendors were not supplying an appropriate level of training," said Mr. Wood.

"Fast-forwarding to today, we have the vast majority of our hotels under this inspection program delivered by Marriott personnel; and through that training and the investment that we've made over the course of time, the hotel engineers wholly understand their system. Six or seven years ago, we did not have that high level of competence because they were not getting that training from outside vendors."

"Everyplace we go we use our standards, the American set of standards," said Mr. Scarff.

Philosophy promotes 'safety first for first-class service'

Giving hotels incentives to keep safe a workforce of changing demographics

By MARK A. HOFMANN

Bradley R. Wood likes to note what Marriott founder J. Willard Marriott Sr. said about employee safety: "Take care of your employees, and they'll take care of your customers."

"We see common types of challenges throughout all of our operations," said Mr. Wood. "It all starts with preventing the loss."

But even the best program cannot prevent all losses at a company the size of Marriott, which has more than 100,000 employees. As a result, Marriott has developed an innovative workers compensation program to deal with worker injuries and changing workforce demographics, relying on in-house nursing expertise and multilingual staff.

The emphasis on employee safety goes back to the earliest days of Bethesda, Md.-based Marriott, noted Chad Callaghan, vp-enterprise loss prevention. The company's founder "had identified a safety policy for (Marriott predecessor company) Hot Shoppes workers. The slogan they used back then was, 'Safety first for first-class service.' So it's been a tenet of Marriott philosophy to take care of associates," he said.

"Really, what's important is that the properties see this as an effort that they want to take ownership of," said Mr. Callaghan. "We have a saying that safety is all about three things: awareness, focus and accountability. Awareness we can do for them, but really focus and accountability to a large extent has to come from the property itself. They have to choose to make it a priority."

As the company seeks to carry out its safety-first mission, it faces some key challenges.

"The aging workforce brings on new dilemmas," Mr. Wood said, noting that growing number of older workers will no doubt increase workers compensation costs. "It will take longer for those individuals to be rehabilitated and brought back to the job. We're got to find ways in which we can continue to manage that successfully for these individuals that we value tremendously," he said.

"We want to retain the older workers where we can," Mr. Callaghan said. An internal task force—including risk management—is focusing on the aging workforce issue. Questions include which jobs are appropriate for individuals and what sort of ergonomically appropriate equipment needs to be put in place, he said.

"The second big challenge is on the other extreme—that's the new worker coming onto the job. There is such a challenge to get people into a job and productive as soon as possible, it presents a challenge for us to make sure people are trained properly," said Mr. Callaghan. "Many, many injuries occur to people on their first six months on the job."

"We're focusing on job safety analysis and job-safety training," he said. The company is tracking new employees to make sure they've have been properly trained for the job and is using measurements to see how well that's working. As part of that effort, the company is working to determine how such measurements can be used to promote accountability among managers. Giving properties a financial stake in their losses also is part of that process.

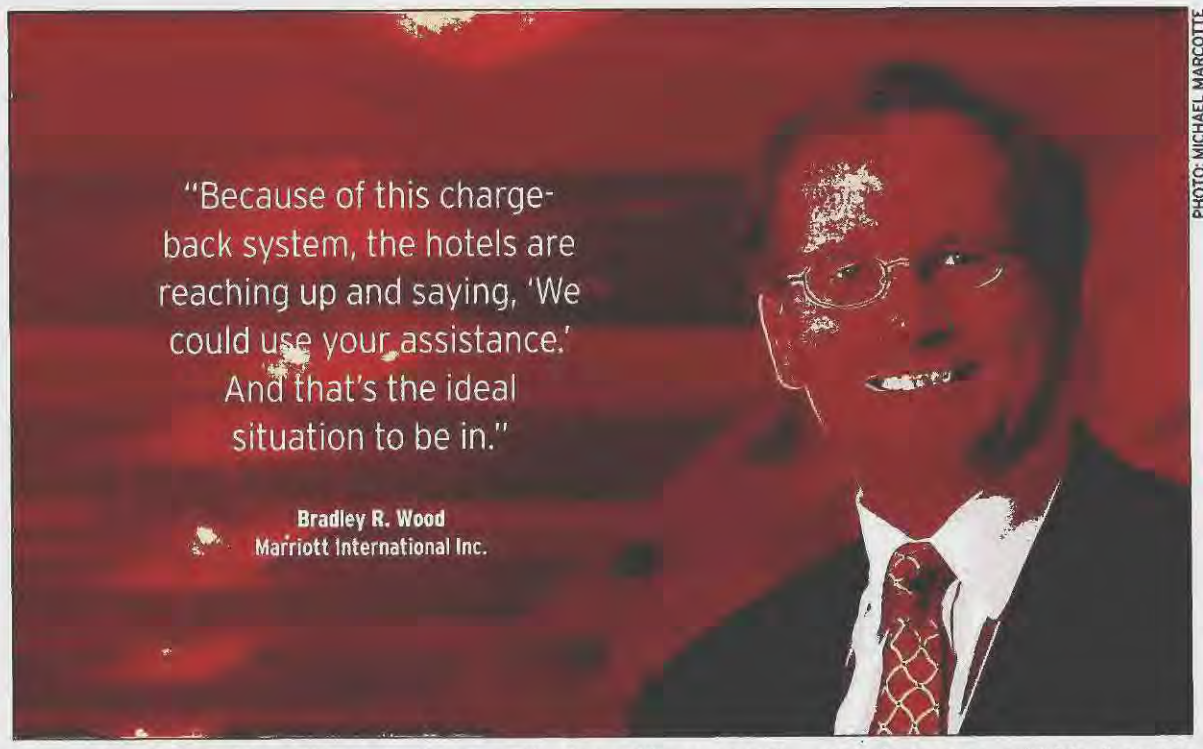

PHOTO: MICHAEL MARCOTTE

"Accountability is often driven by us giving the hotels incentives to prevent loss," said Mr. Wood. "Through the charge-back system we have, the hotels will treat losses like any other quality control item. The key for Chad's organization, you'd much prefer an environment where the hotels are knocking on his and his team's organization for help as opposed to them going in and pushing down," he said.

"Because of this charge-back system, the hotels are reaching up and saying, 'We could use your assistance.' And that's the ideal situation to be in," he said. Under the charge-back system, hotels are responsible for reserves of up to $50,000 that are established to cover liability or workers comp claims, said Mr. Wood.

"I think all the programmatic things we develop at (the corporate) level are useless if we don't have the desire at the lowest level to actually implement them," said Mr. Callaghan.

Marriott handles about 18,000 workers comp claims a year and 7,000 auto and general liability claims, said Robert Steggert, vp-casualty claims. Among workers comp claims, the "vast majority are slip/trip, falls or lifting injuries," he said. "It's difficult to make a banquet waiter's or waitress's job light—they've got to lift trays, move large volumes of food and we've housekeepers who've got to attend to room issues," he said.

Once again, Marriott turns to loss prevention first. For example, the company has examined ways to reduce the physical demands of bedmaking. "In terms of making beds, we've looked at ways to minimize that in terms of teams," said Mr. Steggert. Such an approach is particularly critical given the aging workforce, he said. "One of the things we're doing is when an associate's capabilities diminish, we will look at partner agreements, have teams of people making rooms vs. individuals."

"We look at mattresses that don't require turning. For example, most of our new mattresses are large layers of foam that don't require turning like traditional spring mattresses. So we're looking at it from a design standpoint, ergonomics and human resources capabilities standpoint," he said.

Given Marriott's global scope, communicating safe practices can be particularly challenging, said Mr. Callaghan.

"A lot of our safety training is nonverbal," he said. Using visual aids—such as showing the proper way to clean a bathtub—as well as translations can help people do their jobs properly and safely, he said.

"It presents challenges, but it's not something we can't overcome," he said.

Sometimes, dealing with a workers comp claim involves using multiple languages, said Mr. Steggert, vp-casualty claims. Wherever possible, Marriott uses bilingual associates to communicate with injured workers, he said.

This reflects a deep-seated management philosophy, he said. "We fundamentally believe that empathetic contact in their native tongue is important," he said. It's important "not only to communicating what we need to under the law but to give them a comfort level that we're really trying to do the right thing for them in terms of getting them the highest quality and most appropriate level of medical care as soon as possible."

"In a typical urban hotel, there are typically 35 to 40 different cultures represented," and many of those employees are not native English speakers, Mr. Steggert said.

Marriott currently has an in-house, self-insured, self-administered claims program, said Mr. Steggert. This includes in-house nursing expertise.

"We deal directly with our employees in all circumstances," he said. "We're quite different; when our adjusters contact an injured worker, they do it in a genuine, caring fashion. They tell them that they are co-employees. They try to take the mystery out of workers compensation. They try to take the friction out of workers compensation."

Reducing such friction has paid off, too. Over the last decade, the rates of both attorney representation by claimants and of litigation "have dropped to low single digits," Mr. Steggert said.

"From every benchmark that I've seen, we've got, if not the lowest in the lodging industry, among the lowest of all corporate America in those two areas. That's critically important when you get to managing particularly difficult challenging cases where you've got serious injuries, and you get into dueling doctor situations and litigation and the friction costs that are attendant to a lot of comp systems in the country," said Mr. Steggert.

Idea from unusual source pays off

Bradley R. Wood sometimes finds inspiration for Marriott International Inc.'s risk management program from some unusual sources.

Take the genesis of Marriott's innovative "shelter in place" program as an example. As Mr. Wood, Marriott's senior vp-risk management, recalls, the idea sprang from a December 2002 letter he received from the Fairfax County, Va., public school system—which his children attend—explaining how schools would respond to a chemical release. The school system planned to implement a shelter-in-place plan, under which no one would be allowed to enter or exit a school building until authorities received an all-clear signal.

After reading the letter, Mr. Wood began wondering whether such a shelter-in-place approach had any utility for hotels. He called Chad Callaghan, Marriott's vp-enterprise loss prevention, into his office and handed him the letter.

"I actually thought this would not work in a hotel environment," Mr. Callaghan said. Whereas schools act in loco parentis, in hotels, people can come and go as they please, he said. "You don't have control over their movements," he noted.

Penny Turnbull, Marriott's Atlanta-based senior director-business continuity, said that the challenge was to draft a plan as generic and all-encompassing as possible.

This meant establishing ways for hotels to respond to diverse situations—such as a tornado, a gunman in a parking lot or, as a worst case, the release of a biological agent—that eliminated evacuation as a possibility.

"It's simply, what do we do when it's not safe to evacuate one of our buildings?" she said.

"Our shelter-in-place plan includes a centralized gathering point for assessment and information, food and drink for up to 24 hours and a place to isolate guests and employees from the outside environment," said Mr. Wood.

The idea met with some initial skepticism but eventually won the backing of management, he said. "It was a new idea for corporate America. It required resources in both time and cost," he said.

But the resistance receded when managers "realized the cost associated with it was fairly minimal and the goals of shelter in place were consistent with our culture of taking care of our employees and guests," he said.

And the plan soon paid off. Stocking up on basic food supplies, water and blankets as required under the shelter-in-place plan helped Marriott take care of its guests and employees in the 2003 Northeast blackout, recalled Mr. Wood.

"We got a few more believers that time," said Ms. Turnbull.

—By Mark A. Hofmann

Entering the broad market to stitch 'a quilt of coverage'

By MARK A. HOFMANN

The Sept. 11, 2001, terrorist attacks changed the nature of Marriott International Inc.'s insurance program profoundly.

Where the Bethesda, Md.-based hotel and hospitality company had bought property insurance from a single insurer for nearly half a century, it now had to enter the brokerage marketplace. And this change created new challenges for Bradley R. Wood, Marriott's senior vp-risk management, and his team.

Mr. Wood points out that Marriott had two properties in the immediate vicinity of the World Trade Center, the World Trade Center Marriott and, a block away, the Financial Center Marriott. The first was destroyed in the terrorist attack; the second was significantly damaged and reopened in about four months, said Mr. Wood.

Until the attacks, Marriott purchased its property insurance directly from Allendale Mutual Insurance Co., which became part of Factory Mutual Insurance Co. in the late 1990s. The relationship went back about 45 years.

The attacks led to a claim that was ultimately settled for more than $430 million, including business interruption, said Hector A. Mastrapa, vp-insurance. That was the largest single claim in FM Global's history, he said.

As Marriott's May 1 renewal approached, its longtime insurer said that it could not continue to approach the risk in the way it traditionally had, said Mr. Mastrapa.

"They pretty much said, 'We want to remain partners with Marriott but not at the same level as in the past because of capacity restrictions and so forth,'" he said. Marriott had never before used a broker to place its property program and, after interviewing four, chose Marsh Inc.'s Washington office to do so. Mr. Wood had a small relationship with Marsh before the property issue emerged.

"FM Global gave us notice several months in advance of our renewal that they would no longer be able to provide blanket capacity as done in prior years," said Mr. Wood. That notice came in early 2002, he said.

"FM Global continued on the program in an excess position for the next year, which provided us time to develop relationships with the new markets," he said.

The 'quilt'

"We had a significant challenge. Marriott as a hotel was very well known, but the risk had never been in the broader marketplace," said Mr. Mastrapa. To find coverage, Marriott risk management personnel had to travel to all of the major insurance markets to explain how the company worked during one of the tightest markets in history.

"What we had going in our favor was that Marriott has a very good story to tell in terms of risk management, life safety, loss prevention and crisis management," he said. The company was able to place a broad program. "I think the pricing was fair, given the terms that were available," he said, adding that "overall, (the process) delivered a program that owners and we were quite satisfied with."

"We affectionately call it the quilt, because if you look at it, it looks like a quilt. We have a patchwork of carriers, layers and quota shares," that involves 15 to 20 insurers.

Mr. Mastrapa pointed out that "Marriott buys its property insurance on behalf of most of its owners," and the risk management department must make sure that Marriott's interests are protected.

He said that most of the insurers that began participating in Marriott's property program after it first went to market have remained in the program. Marriott has added a self-insurance component, in part to show that market "that we were very confident" in Marriott's approach to risk management.

Marriott's Hawaii-domiciled captive—Marquis Insurance Corp.—is part of the self-insured program, taking on what Mr. Mastrapa called "predictable" losses. The captive participates in the primary level. Insurers were "very, very careful" about writing business interruption, and "putting our captive in the mix helped us."

"We're kind of targeting the A list of carriers," said Mr. Mastrapa. These include ACE Ltd., Zurich Financial Services Group, Lexington Insurance Co. and several Bermuda insurers, he said.

When the "quilt" was first sewn together in 2002, it covered properties with a total insured value of about $26 billion. During the past couple of years, some of the larger real estate owners have decided to create their own risk management programs to handle the placement of their property insurance.

"We've actually helped them along with that process—we view it as a positive thing," said Mr. Mastrapa. The main program now insures about 700 locations with a total insured value of $16 billion.

"Big is not necessarily good as it relates to insurance programs in this era. It's been in the best interests to have multiple large programs, as opposed to one mega-program," said Mr. Wood. "The objective was to minimize the catastrophic risk that was in a large singular program," explained Mr. Wood.

Both Mr. Wood and Mr. Mastrapa noted that the insurance marketplace struggled to differentiate risks within specific industry groups such as lodging and hospitality.

"We really challenged" the insurers to not only say that they were differentiating Marriott from

Continued on next page

Early exposure to insurance world

By MARK A. HOFMANN

Bradley R. Wood learned about insurance early in life.

The Valparaiso, Ind., native's father was an independent insurance agent. "I kind of grew up" hearing insurance terms and concepts being discussed around the kitchen table, Mr. Wood recalled.

In fact, after graduating from Ball State University in Muncie, Ind., with a bachelor's degree in business administration, Mr. Wood worked in the family business before entering the graduate business program at the University of Wisconsin at Madison. There, he earned a master's degree in business administration with a concentration in risk management in 1986, in what he characterizes as "an outstanding program."

His work at the university brought Mr. Wood to the 1986 Risk & Insurance Management Society Inc. annual conference in Toronto as part of the RIMS student involvement program.

At the conference, one of Mr. Wood's professors was on a panel discussion with Arnold Davenport, then vp-risk management at Marriott. Mr. Davenport mentioned to the University of Wisconsin professor that Marriott had been looking for an insurance manager for some time, and the professor recommended Mr. Wood.

Mr. Davenport in 1991 was named Risk Manager of the Year.

"Marriott's insurance management at that time was handled through our accounting group, so it was an opportunity to grow that side of the risk management business," said Mr. Wood. "So I took on immediately the property and casualty insurance programs."

"I remember walking into my first day at Marriott five days prior to a major casualty insurance renewal, and terms were being bantered around that I had no idea what they were. I had no idea what the concept of captives and fronting and what all that meant. I struggled and quickly learned that I needed to get myself up to speed and educated myself on what that was," he said.

He had to hit the ground running, too.

"Two months after I started, they put me on a plane and shipped me over to Vienna, Austria, to negotiate the Warsaw Poland Marriott Hotel," said Mr. Wood.

"I had to negotiate the management agreement, the development agreement of that hotel that had yet to be built. I was struggling with a lot of concepts of how I was going to be able to sell this to an Eastern Bloc that really couldn't understand the United States' tort system and that we were going to have U.S. patrons at the hotel" who would bring claims back into the U.S. tort system, he said.

Help came from an unexpected source, Mr. Wood said.

"The only thing that saved me that particular day when I was a young lad trying to negotiate that deal was that one of the partners that was going to own the hotel that we were going to manage was LOT Polish Airlines," he said. "Their risk manager was all too familiar with the United States tort system from plane crashes that involved Americans. So he was real sympathetic to my desire to pass through costs that were protecting everybody's interests."

Mr. Wood rose through a variety of positions at Marriott over the succeeding years, assuming his current post as senior vp-risk management in 2003. He has also earned both the Associate in Risk Management designation and the Chartered Property Casualty Underwriter designation and is a past president of the Potomac RIMS chapter.

He and his wife, Linda, have three children: 14-year-old son Tyler and twin 7-year-old daughters, Sophia and Sarah. Mr. Wood and his family live in Vienna, Va.

Managing risk at senior centers

Litigation costs spur program investment

The name alone of "Marriott Senior Living Services" made it a tempting target for attorneys filing patient injury lawsuits, according to Bradley R. Wood, Marriott International Inc.'s senior vp-risk management.

Marriott has a "large name," Mr. Wood acknowledged, and that posed a challenge for a risk management operation seeking to minimize its losses.

He explained that Marriott had developed its assisted living retirement business through years of acquiring retirement communities and, ultimately, also built its own communities.

"Marriott built its retirement community business from scratch in 1984 through acquisitions and new build construction. At the time we exited the business in 2003, we had over 150 locations with more than 20,000 beds," Mr. Wood said.

"Through acquisitions, you have a melding of different management teams. To ensure that you have a consistent approach, you have to have consistency," said Mr. Wood. "It takes time to build that."

Mr. Wood noted that, beginning in the late 1990s, the volume of lawsuits alleging patient injuries was skyrocketing throughout the long-term care retirement industry. And Marriott was by no means immune to such lawsuits, he said.

"We realized that, to survive in this business, we had to take significant efforts to advance the risk management discipline in the senior living services arena," he said.

To reduce the company's exposure to litigation, Marriott's risk management department targeted the underlying issues associated with assisted living lawsuits, he said.

For example, "one of the challenges that industry has was pressure sores that developed on people who were bedridden," said Mr. Wood. To address that problem, "we invested a considerable amount of money, from a risk management perspective, in putting in pressure-reducing mattresses," he said.

Marriott tackled another exposure by instituting a national pharmaceutical program to better document of delivery of prescription drugs throughout the entire organization.

"It became paramount as a company to have uniform documentation to be able to appropriately defend ourselves in the event there were allegations against us," said Mr. Wood.

"We saw, to survive, that we needed to adjust how we delivered our business out there. We worked toward getting counsel that was expert in the defense of these types of claims," he said. In keeping with Marriott's policies, Mr. Wood declined to detail how much litigation the company faced related to its assisted living business.

In addition, Marriott consolidated all of patient injury claims into two regional offices with expertise in this area, working in harmony with defense counsel, he said.

Marriott was able to stabilize costs in 2002. But it sold the business to McLean, Va.-based Sunrise Assisted Living Inc., which does business as Sunrise Senior Living, a year a later.

"We were beginning to see the real fruits of all the work about the time we sold the business," said Mr Wood.

—By Mark A. Hofmann

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some of its competitors but also to show how they were doing so, Mr. Mastrapa said. "If a company offers a certain amount of protection, they should have a certain amount of differentiation within its peer group."

As Marriott has grown from a primarily North American operation to an international one with hotels in almost 70 countries, the company's appetite for political risk coverage has grown considerably, said Mr. Mastrapa. Marriott began by procuring coverage on a transaction basis through the Overseas Private Investment Corp. and the World Bank but soon sought to create a more-global network, he said.

"We wanted a comprehensive global approach to political risk, one that afforded coverage for Marriott's financial exposure—fees, loans, equity—and one that offered a long-term horizon of coverage that was typical in OPIC but not typical in the insurance market," he said.

Ironically, Marriott was ready to sign a contract with Zurich Financial Services Group's Emerging Markets Solution unit to create such a global program on the morning of Sept. 11, 2001. "There was a certain amount of concern whether the deal would be in place, but Zurich thought it was still a fair deal" and the program went forward, said Mr. Mastrapa. The program operates on a global basis, covering the nearly 70 countries in which Marriott has operations, said Mr. Wood.

The resultant political risk program has achieved both cost savings and reduced administrative burdens, while giving Marriott flexibility, said Mr. Mastrapa. "The more hotels you have, the greater spread of risk you have."

Casualty covers

On the traditional casualty side, "we take a large casualty program—being liability, primary, excess, workers comp—and we build it into one program that is then allocated out to the hotels," said Mr. Mastrapa.

"We self-insure the primary limits," he said. "We can achieve certain coverage enhancements that are important to hospitality companies. This includes limited mold coverage. We can underwrite a certain amount within our captive. We're able to underwrite childcare exposures within our primary self-insured program." Marriott uses Atlanta-based Beecher Carlson Holdings Inc. to manage its captive and self-insurance programs. Beecher Carlson is Marriott's broker for domestic casualty programs, while Willis Group Holdings Ltd. manages the global casualty program outside the United States, said Mr. Wood.

Marriott has a separate international program, because businesses outside the United States in general have "far less appetite" for retained risks than do their domestic counterparts. American International Group Inc. unit American International Underwriters insures the international casualty program.

Excess of both casualty programs is a global excess liability program. The primary umbrella is written by AIG's National Union Fire Insurance Co. of Pittsburgh, Pa., unit, with the rest of the program involving "the A list" of domestic and Bermuda underwriters, said Mr. Wood.

In terms of professional liability coverage, some of that "is built into the captive," said Mr. Wood. Marriott's directors and officers liability program is a fully insured layered program with National Union in the lead.

Michael S. Owens, senior director-finance/accounting, said that individual hotels are responsible for the first $50,000 of any casualty or workers compensation claim. Mr. Wood said that responsibility is part of the accountability the risk management department requires and helps focus attention on loss control.

In addition, hotels have to pay insurance cost based on brand level, said Mr. Owens. "It's a pooling of all the similar brand hotels, and they're cost-sharing their losses. The first $50,000 is controlled at the hotel; the amounts above that are pooled together by all of the hotels taking all their loss experience collectively by brand," said Mr. Wood. This permits some matching of exposures, said Mr. Owens.

On workers compensation, the risk management department looks at what's "financially best for Marriott and our owners," said Mr. Mastrapa. The means self-insurance in 31 states, with excess comp purchased from AIG.

In Texas, Marriott is a nonsubscriber, said Mr. Wood. Marriott fully insures—with large deductibles—its workers comp program in the remaining states.

Risk Management Honor Roll members

2004: **Joan Conner**, Maine Municipal Assn.

2003: **Roger L. Andrews**, E.D. Bullard Co.
William G. Chapin, Diocese of Rockville Centre, N.Y.
Johanna M. Zschomler, State of North Dakota

2002: **Lauren M. Gregory**, Metropolitan Transportation Authority

2001: **Gary Baxter**, Weyerhaeuser Co.
Peggy Nakamura, Adventist Health System/West

2000: **Theodore G. Jeske**, Historic Tours of America Inc.

1999: **David A. Holcombe**, International Speedway Corp./ NASCAR
Lewis Leigh, Washington Cities Insurance Authority
Sheryl Pixler, Storage Technology Corp.

1998: **James E. Green**, Justin Industries
Mark L. Hubbard, Loma Linda University/Adventist Health Science Center
Edward Molloy, Aetna Inc.

1997: **John J. Carney**, National Freight Industries Inc.
Betsy Kutska,Park District Risk Management Agency
William R. Powell, Salt River Project
Russell Opferkuch, Bankers Trust Co.
Jeannie Sedwick, AHA-Insurance Resource Inc.

1996: **Craig S. Macdonald**, Bi-State Development Agency
Michael Tawney, Loomis Armored Inc.

1995: **Lee D. Holland**, Tennessee Municipal League Risk Management Pool
K.C. Kidder, Norwest Corp.
Judith Payne, South Dakota
Bruce Zaccanti, Jupiter Mechanical Industries Inc.

1994: **Sal M. Bianchi**, Intergovernmental Risk Management Agency
Judith Moses McDonald, Comerica Inc.
Ronald J. Guilfoile, City of St. Paul, Minn.
Thomas J. Hickey, Malcolm Pirnie Inc.

1993: **David G. Adler**, The Portman Cos.
Thomas E. Bell Sr., Middle Cities Risk Management Trust
June Dickinson, SunTrust Banks Inc.
C. David White, State of Oregon

1992: **Marc Darby**, Bombardier Inc.
Jerry Newsom, State of Georgia
Judith Tornese, Transamerica Corp.

1991: **Donald D. Batchelor**, Union Planters Corp.
Mary L. DeCampli-Stewart, Metropolitan Washington Airports Authority
Rod Umscheid, University of California

1990: **Josephine Goode Johnson**, University of Maryland Medical Service System
Roger D. Oaks, Tennessee Farmers Cooperative
M. Michael Zuckerman, Thomas Jefferson University

1989: **John A. Lindquist**, Browning-Ferris Industries Inc.
J. Douglas Higley, State of Louisiana

1988: **Gregory L. Daniels**, American National Red Cross
Timothy G. Galarnyk, Lunda Construction Co./ Phoenix Steel Inc.
Stephen A. Finley, City of Lakewood, Colo.
Edward G. Weiss, First of America Bank Corp.

1987: **Susan M. Werner**, Hardee's Food Systems Inc.
Mark F. Wilson, First Mississippi Corp.

1986: **Delmer Ison**, Washington Metropolitan Area Transit Authority
William E. Rogers, Conemaugh Valley Memorial Hospital

1985: **Susan N. Weiner**, Dade County Public Schools
Eva F. Goodrich, Cincinnati Electronics Corp.

1984: **Sidney D. Blatt**, Holloway Cos.
Gene Snyder, State of Oregon

1983: **Jerri Nelson MacMillian**, Aetna Life & Casualty Cos.' Real Estate Investment Department
Robert Sinclair, Metropolitan Government of Nashville and Davidson County

1982: **Spencer J. Traver**, BF Goodrich Co.
Paul B. Harvey, Ponderosa Homes
Gene M. Marsh, General Conference of Seventh-Day Adventists
George N. Pierce, Orange County, Fla.

1981: **Robert Bieber**, Westchester County
William Ryan, University of Michigan

Risk Managers of the Year 1978-2004

2004: Christopher E. Mandel, United Services Automobile Assn.

2003: Sheila Small, Verizon Communications Inc.

2002: Daniel H. Kugler, Snap-on Inc.

2001: Dan Hartman, State of Oregon

2000: Paul F. Buckley, Lucent Technologies Inc.

1999: Merritt W. Fabel, American International Group Inc.

1998: Philip J. Grewar, Government of British Columbia

1997: Judy Lindenmayer, FMR Corp.

1996: Brian D. Casey, Corning Inc.

1995: Scott K. Lange, Microsoft Corp.

1994: Lucille A. Gallagher, ConAgra Red MeatCos./Monfort Inc.

1993: Richard C. Heydinger, Hallmark Cards Inc.

1992: Millicent W. Workman, Belz Enterprises

1991: Arnold L. Davenport, Marriott Corp.

1990: Stephen M. Wilder, The Walt Disney Co.

1989: Jeffrey W. Pettegrew, Contra Costa County Municipal Risk Management Insurance Authority

1988: William L. Mather, The Gillette Co.

1987: Edith F. Lichota, Irving Trust Co.

1986: Donald Nelson, ARA Services Inc.

1985: Harold C. Lang, Leaseway Transportation Corp.

1984: Richard M. Inserra, American Can Co.

1983: John A. O'Connell, Holy Cross Shared Services Inc.

1982: Eckart Russell, Alcan Aluminium Ltd.

1981: Duane E. Allen, Hanna Mining Co.

1980: Thomas V. Hallett, General Motors Corp.

1979: Edward L. Erickson, American Broadcasting Cos. Inc.

1978: Howard T. Weber, Minnesota Mining & Manufacturing Co.

Risk management honorees chosen by independent judges

Nine independent judges from all sectors of the risk management and insurance profession selected the 2005 Risk Manager of the Year and Risk Management Honor Roll.

Nominations for the 2006 awards, which will be announced next April, are being accepted until Nov. 21, 2005. Risk managers anywhere in the world are eligible to enter the competition. A nominee need not handle risk management responsibilities full time, but he or she must be a full-time employee of the organization whose program he or she directs.

The 2006 Risk Manager of the Year will be the 29th person to receive this honor. *Business Insurance* created the Risk Manager of the Year competition in 1977, on its 10th anniversary of publication, to recognize outstanding risk management practices. The first award was presented in 1978. *BI* created the Risk Management Honor Roll in 1981 to recognize outstanding achievements in risk management in employment categories not represented by the Risk Manager of the Year.

Winners of the awards are profiled each year in *Business Insurance* and are formally recognized at an event during the Risk & Insurance Management Society Inc. annual conference and exhibition.

Nine independent professionals judged this year's entries. Honorees were chosen based on the judges' opinions of each nominee's program as detailed in the nomination form. This year's panel comprised the 2004 and 2003 Risk Manager of the Year recipients, the 2004 Risk Management Honor Roll member, two insurer executives, two brokerage executives, a risk management consultant and an insurance educator.

Judges for the 2005 awards were:

- Joan Conner, director of Risk Management Services for the Maine Municipal Assn. in Augusta, Maine, and a member of the 2004 Risk Management Honor Roll.
- Steven A. Coombs, president of Risk Resources Inc., a consulting firm based in Elmhurst, Ill., representing risk management consultants.
- Frederick de Grosz, president and CEO of ABD Insurance & Financial Services Inc. in Redwood City, Calif., representing regional brokerages.
- Alan J. Maguire, president and CEO of AEGIS Insurance Services Inc. in Jersey City, N.J., representing mutual insurers.
- Christopher E. Mandel, assistant vp-enterprise risk management for United Services Automobile Assn. in San Antonio, and the 2004 Risk Manager of the Year.
- John J. O'Connell, the C.V. Starr Professor of International Risk Management at Thunderbird, The American Graduate School of International Management in Glendale, Ariz., representing educators.
- Brian O'Hara, president and CEO of XL Capital Ltd. of Hamilton, Bermuda, representing stock insurers.
- Sheila Small, assistant treasurer for risk management and insurance for Verizon Communications Inc. in New York, and the 2003 Risk Manager of the Year.
- Mario Vitale, chairman and CEO of Willis North America in New York, representing international brokers.

Judges evaluate each entry based on 10 criteria (see related story). The nominee with the highest total score is named Risk Manager of the Year; the remaining individuals typically are placed into one of four categories not represented by the RMOY:

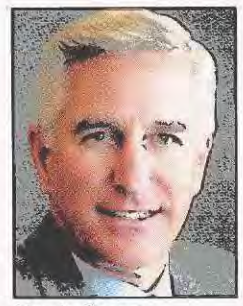
- Corporations with sales exceeding $300 million.
- Corporations with sales of less than $300 million.
- Government entities, including public entity pools.
- Tax-exempt or nonprofit entities.

The highest-scoring individual in each field not represented by the RMOY normally is considered for the Risk Management Honor Roll, though candidates with exceptional scores in the same field may be included.

To obtain a nomination form for or for more information, please contact Karen Tucker, executive assistant of *Business Insurance* at *ktucker@businessinsurance.com* or 312-649-5319. Forms and instructions also are available at *www.businessinsurance.com.*

Ms. Conner

Mr. Coombs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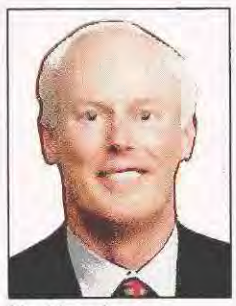
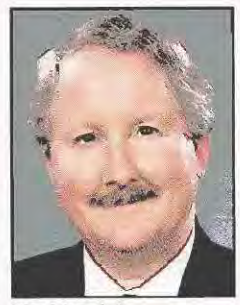
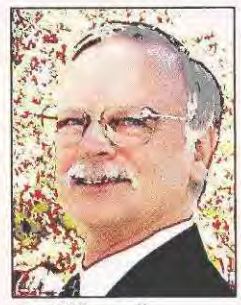
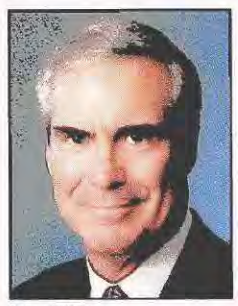

Mr. Maguire


Mr. Mandel


Mr. O'Connell


Mr. O'Hara

Ms. Small

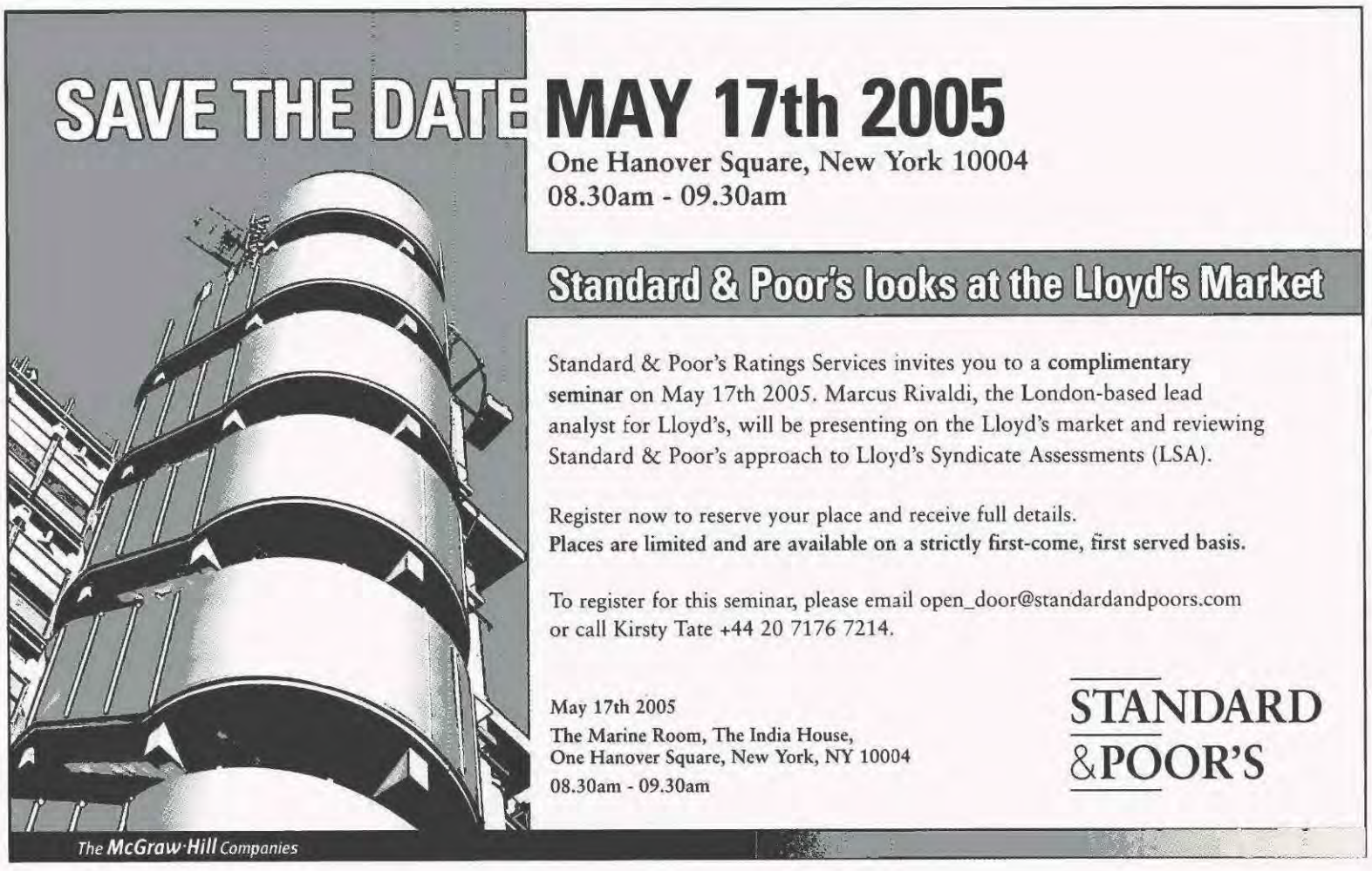
Mr. Vitale

Criteria for the RMOY judging

Ten criteria are used to score the nominations for the annual Risk Manager of the Year Award and the Risk Management Honor Roll.

The panel of independent judges scores each nominated candidate on a scale of one to 10, according to how well he or she:

- Established and implemented an effective risk management program within the organization.
- Tackled and solved one or more major problems for his or her organization.
- Innovatively applies the diverse tools of risk management and insurance.
- Creatively and effectively uses the insurance markets to structure an insurance program that serves the needs of the organization (specifically addressing the types of policies purchased and manuscripted policies, if any).
- Established a workable intelligence system inside and outside the organization, culminating in a flow of information about events and activities that affect the organization's risk management and insurance (how the risk manager secures information from other departments in his or her organization and the use of risk management information systems are addressed in this criterion).
- Skillfully performs the functions of management in the overall organization and within the risk management/insurance department. The functions include planning, organizing, directing and controlling.
- Achieves the most effective risk management program at the optimum cost over the long term.
- Developed technical expertise in any or all of the broad categories included within risk management, leading to a better managerial grasp of the operational aspects of the job.
- Exhibits an attitude and performs activities fostering the advancement of the risk management profession (such as professional activities, speaking engagements, teaching and related activities).
- Develops in his or her career (as exhibited by job history, including current job description, education, honors and memberships).



Insurers bristle at Marsh plans to levy charge

Broker says insurers should pay for services to the London market

By SARAH VEYSEY

LONDON—Marsh Inc.'s plan to negotiate premium reductions from U.K. insurers, apply a charge to insurers on some specialty business and negotiate higher fees with some policyholders will likely be resisted in the London market.

Insurers and other observers contend that, in light of the ongoing scandal surrounding contingent commissions and other broker compensation issues, brokers should only be compensated by their clients. And the 1% to 2% premium discounts that Marsh plans to negotiate likely are insufficient to warrant fee increases, they say.

Marsh revealed its plans last week as part its new business model for the United Kingdom. In addition to changes in its business model, Marsh said it may layoff up to 750 employees in a bid to cut costs. Marsh currently employs about 6,000 staff in 24 locations around the United Kingdom.

The announcement follows the brokerage's decision last October that it would cease accepting volume-and profit-linked contingent commissions, in the wake of New York Attorney General Eliot Spitzer's fraud and antitrust charges against Marsh & McLennan Cos. Inc.

Marsh earlier this year agreed to settle that suit by paying $850 million in client restitution and agreeing to business changes designed to ensure greater transparency in its compensation arrangements, among other things (*BI*, Feb. 7).

Bruce Carnegie-Brown, chief executive officer of Marsh's European operations, said that a large part of the contingent compensation payments that Marsh received from insurers was in recognition of Marsh's large network and distribution capabilities.

Since the broker stopped charging contingent commissions, insur-

See LONDON / next page

Marsh's model

- Obtain a 1% to 2% discount on premiums to reflect the benefit Marsh says insurers receive from its network.
- Charge insurers a 0.75% commission on specialty business for services it provides to insurers.
- Provide clients with an annual statement of Marsh's remuneration in respect of their account.

Quebec pension ruling favors employers

Court makes plan changes easier

By GLORIA GONZALEZ

MONTREAL—A recent Quebec Court of Appeal ruling in a pension dispute involving Montreal-based Hydro-Quebec is seen as a boon for Canadian employers because it expands their control over ongoing pension plans.

Pension experts say the decision was extremely favorable to Canadian employers, reaffirming their rights to make key decisions about their ongoing plans without consulting retirees and establishing legal principles that could benefit employers involved in other pension disputes.

In *Provincial Assn. of Hydro-Quebec Retirees vs. Hydro-Quebec*, the Quebec Court of Appeal ruled last month that retirees do not have to be consulted on the use of a surplus in an ongoing pension plan. The court also confirmed that Quebec employers are entitled to take contribution holidays, unless prevented by the provisions of the pension plan or other agreements.

The case began in 1997, after Hydro-Quebec and the unions representing its employees agreed to several amendments to the utility company's pension plan, including more-generous early retirement provisions and employer and employee contribution holidays. A group of retirees then filed a class action lawsuit, claiming that the company and the unions were not entitled to agree to the amendments, which would affect the pension plan's surplus, without their consent, unless they were granted a fair share of the benefit improvements, then valued at $377 million Canadian ($260.1 million).

The Court of Appeal ruled, that the employer did not have a legal obligation to consult the retirees—a key issue because it has been standard practice for employers not to involve them in these decisions, said Michel St-Germain, an actuary with Mercer Human Resource Consulting based in Montreal.

"That is why it's a very important decision," he said. "Now employers are a lot more comfortable when they make a decision to take a contribution holiday and a lot more comfortable when they plan to improve benefits for active members."

In addition, the Court of Appeal ruled, upholding a lower court ruling, that the use of the surplus in an ongoing pension plan to improve the benefits of active employees and to take contribution holidays did not infringe on any contingent right to the surplus the retirees may have if the plan is terminated. The judges dismissed the argument that the retirees' contingent right to the surplus upon termination entitled

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Pension ruling

Key highlights of Provincial Assn. of Hydro-Quebec Retirees vs. Hydro-Quebec ruling:

- Employers do not have to consult retirees on the use of a surplus of an ongoing pension plan.
- Employers are entitled to take contribution holidays.
- The use of a surplus in an ongoing pension plan to improve benefits for active employees or to take contribution holidays does not infringe on the rights of retirees, even if they have a contingent right to surplus upon termination of the plan.
- The right to a surplus can only be decided upon termination of the pension plan.
- Employers act as plan sponsors, not plan fiduciaries, when amending pension plans.

Former HIH directors sentenced to jail terms

By SARAH VEYSEY

SYDNEY, Australia—Two former executives of failed Australian insurer HIH Insurance Ltd. last week were sentenced to jail terms for their roles in the company's 2001 collapse.

Rodney Adler, a former HIH director, on Thursday received a four-and-a-half-year sentence after previously pleading guilty to four charges of making false statements and failing in his duties as a director. His sentence, handed down by the New South Wales Supreme Court, carries with it a nonparole period of two-and-a-half years.

PHOTO: NEWSPIX/GARY RAMAGE

Rodney Adler, former director of HIH Insurance Ltd., on his way to jail after his sentencing to 4-1/2 years last week.

On Friday, the court sentenced former HIH Chief Executive Officer Ray Williams to a four-and-a-half year term with a nonparole period of two years and nine months. Mr. Williams had pleaded guilty to three criminal charges relating to his management of HIH between 1998 and 2000, including a charge that he made or authorized a statement in the company's 1998-1999 annual report that he knew to be misleading.

Mr. Williams' lawyer said he plans to appeal the sentence.

HIH's $5.3 billion Australian ($2.72 billion) insolvency was Australia's largest corporate failure.

Meanwhile, a reinsurer that investigators have linked to HIH's collapse is facing a regulatory probe into its financial and finite reinsurance transactions.

The Australian Prudential Regulatory Authority announced last week that it investigating certain financial and finite reinsurance transactions at General Reinsurance Australia Ltd., the Australian arm of General Reinsurance Corp.

APRA said in a statement that Estelle Pearson, a founding principal of Sydney-based Finity Consulting Pty. Ltd., has been appointed "to investigate General Re's complex financial products in relation to financial and finite reinsurance and the marketing and promotion of those products."

APRA said it would make no further comment during the investigation.

Three General Re Australia executives last year stepped down from their positions, following an APRA investigation into reinsurance deals the company made with FAI Insurance Ltd. prior to FAI's acquisition by HIH Insurance Ltd. (*BI*, Oct. 18, 2004). Investigators determined that the deals masked the true financial condition of FAI, whose acquisition by HIH contributed to HIH's unraveling.

Updates

U.K. employers increase pension contributions

U.K. employers paid almost five times as much into pension plans during 2004 as did employees, according to figures from the Office for National Statistics. In 2004, employers with self-administered pension funds–occupational pension plans not managed by insurance companies–made pension contributions of £25.64 billion ($49.13 billion), while employees contributed £5.41 billion ($10.37 billion). In 2003, employers contributed £20.87 billion ($37.24 billion) to self-administered funds, while employees contributed £5.26 billion ($9.38 billion), according to the London-based ONS. In 2004, employers made special contributions–such as one-off payments to address funding deficits–of £7.98 billion ($15.29 billion) to pension plans, compared with £5.80 billion ($10.35 billion) in 2003.

Equitable Life trial begins in London

A £4 billion ($7.54 billion) negligence claim brought by Equitable Life Assurance Society against its former auditors and 15 former directors of the company began in the High Court in London last week. London-based Equitable Life was forced to close itself to new business in five years ago after a court ruled that the insurers must pay out about £1.50 billion ($2.82 billion) to policyholders with guaranteed annuity rate policies. The company is seeking about £2 billion ($3.77 billion) from its former auditor.

Generali reports 30% net profit jump

Italian insurer Assicurazioni Generali S.p.A. announced a net profit of 1.32 billion euros ($1.79 billion) for 2004, a 30% increase over 2003. Generali said it would target a profit of 1.51 billion euros ($1.95 billion) for 2005. The Trieste, Italy-based insurer said gross written premiums increased in 2004 to 56.34 billion euros ($76.27 billion), up 14% over 2003. It said it hopes to write gross premiums of about 56.40 billion euros ($72.89 billion) in 2005.

Glacier Re names marine underwriter

Oliver Wirtzfeld has been appointed senior underwriter for marine and energy underwriting at Glacier Reinsurance A.G. Mr. Wirtzfeld joins Pfäffikon, Switzerland-based Glacier Re from GE Insurance Solutions in Munich, Germany, where he was senior underwriter in the marine whole-account unit. Glacier was established as a specialty reinsurer late last year.

Between the Lines

Compiled by Joanne Wojcik

Connecting the healing of body and soul

There may be some substance to the concept of "faith healing," according to university researchers who are launching a comprehensive study of the relationship between religious attitudes and health.

The University of Chicago received a $1.8 million grant from the West Conshohocken, Pa.-based John Templeton Foundation to finance the study, which will include, among other things, using functional magnetic resonance imaging to explore differences in the brains of believers and nonbelievers.

Among the initial findings of the study is that a strong belief in God can reduce depression, especially among African-Americans.

Spitzer sets sights on big pharma

Prescription drug wholesalers may be running for cover as New York Attorney General Eliot Spitzer trains his sights on their industry. Mr. Spitzer announced during a national television talk show that he was looking into possible drug tampering and mislabeling by drug wholesalers.

PHOTO: GETTY PHOTO

Eliot Spitzer is taking on drug wholesalers.

Appearing on ABC's "This Week with George Stephanopoulos," Mr. Spitzer said investigators were looking at "pricing and the integrity of the drugs, whether or not there are drugs that are being adulterated, that are being tampered with...."

The comments came just days after three leading drug wholesalers—McKesson Corp., Cardinal Health Inc. and AmerisourceBergen Corp.—disclosed they had received subpoenas in a probe of wholesalers' use of secondary sources of drugs for resale.

When asked whether he had reason to believe there were "fake" or "diluted" drugs on the market, Mr. Spitzer replied: "There certainly are some. The question is what magnitude."

Zagnut, we hardly knew ye

There will be a lot less junk food in the worksite vending machines at 10 California health care organizations that have decided to set an example for patients and plan members.

"Obesity is a major health concern for us, and we need to focus on our environment in the workplace as well as on programs for our members," said Dr. Jeff Kamil, vp and corporate medical director at Blue Cross of California. Blue Cross of California is a member of Walnut Creek, Calif.-based Integrated Healthcare Assn., which is spearheading the program.

Other companies that will be promoting healthier snacking among their own employees are PacifiCare Health System, Health Net, HealthCare Partners Medical Group, Hill Physicians, Camino Medical Group, L.A. Care Health Plan, Keenan Associates, Monarch Medical Group and Sutter Health Systems.

Under the program, alongside the usual sodas and candy bars, these companies' worksite vending machines will be stocked with water, fruit and foods low in saturated fat, sugar and sodium and free of trans fats.

Golden years will leave some uninsured

Early retirement may be a dream for some, but it could turn into a nightmare for those without health insurance.

At least 25% of older U.S. adults will be uninsured at some point during the years preceding their Medicare eligibility, according to research published in the Archives of Internal Medicine, one of the leading journals of the American Medical Assn.

Because they are uninsured, many of these adults are less likely to obtain preventive health care services or timely care for acute medical problems, leading to disability and, in some cases, early death, the study found.

Women, African-Americans, Hispanics and those with low family incomes and/or low educational attainment were more likely to be uninsured at least once. Older, uninsured men with poor overall health and having one or more chronic illnesses had a higher risk of death, researchers found.

Tips and feedback from readers are welcome. Please send information to jwojcik@businessinsurance.com.

London: Marsh unveils new business model

Continued from previous page

ers have continued to benefit from the value of that network but have not been paying for it, he said.

Marsh now plans to negotiate with insurers to obtain a 1% to 2% discount on premiums to reflect the benefit they receive from Marsh's network, said Mr. Carnegie-Brown. And if the broker can demonstrate these savings to buyers, it will seek to negotiate higher fees to reflect the benefit they receive from the network, he said.

Marsh previously earned about $200 million per year from contingent commissions on business placed in the United Kingdom, Mr. Carnegie-Brown noted. That represents around one-quarter of Marsh's previous worldwide income from such commissions.

Charging underwriters

In addition, for some specialty business placed at Lloyd's and in the London company market, Marsh will charge underwriters a commission of 0.75% of premium for services it provides.

Mr. Carnegie-Brown said this charge reflected mainly the services the broker provides to underwriters on subscription business, such as policy production and claims processing.

He said Marsh viewed such services as of benefit to the market rather than of direct benefit to the client, therefore insurers should pay those commissions.

A spokesman for Marsh said he was unable to say what percentage of Marsh's U.K. business would be affected by the 0.75% commission arrangement.

Marsh also will increase transparency to allow clients to know how much Marsh is earning on their accounts and the services brokers are performing to earn those payments, Mr. Carnegie-Brown said.

All clients will be provided with an annual statement of Marsh's remuneration in respect of their account, he said.

The announcement by Marsh follows changes by the London operations of other major brokers.

In December, Aon Ltd., the U.K. arm of Aon Corp., announced that from Jan. 14, 2005, on specialty business placed in London it would charge insurers a fixed percentage of premium for services such as policy issuance and claims handling. Aon said the charge would vary according to lines of business but would be subject to an upper limit. The charge would likely be between 2.5% and 3.75%, it said.

Several underwriting sources in the London market said many underwriters had rejected this model. A spokeswoman for Aon said the company was currently in discussions with insurers about a remuneration model for other areas of its business.

And in March, Heath Lambert Group announced it would charge insurers a flat-fee of 1% of premium to pay for services. When Heath announced its new plan, it noted that several insurers already had indicated their intention to accept the new model.

But some underwriters in London said they had not agreed to the plan.

David Gamble, executive director of the Assn. of Insurance and Risk Managers, said that risk managers welcomed "any move towards transparency," but said AIRMIC was still studying the Marsh proposal.

Clients have reservations

One risk manager, a client of Marsh who asked not to be named, said he was unsure of how the model would benefit him.

He said that a 1% to 2% reduction in premium would represent a small monetary decrease and he was not sure whether he, or other buyers, would be willing to pay an increased fee in light of such a small premium reduction.

He also expressed concerns about the effect that the 750 planned staff layoffs at Marsh would have on client service.

Underwriters and their representatives also expressed reservations about the Marsh model.

A spokesman for the London-based International Underwriting Assn., which represents company market insurers, declined to comment specifically on Marsh's proposed model, but said that the joint working party set up by the Lloyd's Market Assn. and the IUA had identified certain core principles that it believes should underpin any new broker business models. "The most important of these is that the broker is the agent of the insured and should therefore be paid by the insured," he said.

He said that until a consensus model is reached between the working party and brokers, underwriters "are advised to consider carefully the implications of subscribing to slips that include the principle of insurers paying fees to brokers."

Bill Rendall, head of underwriting and claims at the LMA, which represents Lloyd's underwriters, said the association took the position that brokers are the agents of insurance buyers, rather than insurers. Therefore, he said, insurance buyers rather than underwriters should pay for all the services provided by the broker.

One London-based director of underwriting, who asked not to be identified, said his company would reject the 0.75% fee model for subscription market business.

He said that he believed any fee taken by the broker for services provided to an insurer should be subtracted from the gross premium rather than the net premium, he added. This would help to avoid contravening the principle that the broker is the agent of the buyer because any deductions for services provided by brokers would be included in the underwriter's gross premium quotation.

Business Resources

To place your ad, contact **Tina Vasilakis** at (312) 649-5340 / fax: (312) 649-7937 / E-mail: tvasilakis@BusinessInsurance.com
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Catlin Insurance Company Ltd and Catlin Insurance Company (UK) Ltd

Notice is hereby given that an application was on 14 April 2005 made in the High Court of Justice of England by Catlin Insurance Company Ltd (**CICL**) and Catlin Insurance Company (UK) Ltd (**CICL(UK)**) for an Order under Section 111(1) of the Financial Services and Markets Act 2000 (the **Act**) sanctioning a scheme (the **Scheme**) providing for the transfer to CICL(UK) of the rights and obligations attaching to certain contracts of insurance comprising the entire general insurance business underwritten by CICL through its branch in the United Kingdom (the **Catlin Branch**) and for an Order making provision under Section 112(1) of the Act.

A copy of a report on the terms of the Scheme prepared by an independent expert in accordance with Section 109 of the Act and a statement setting out the terms of the Scheme and containing a summary of that report may be obtained free of charge:

- from the offices of the Catlin Branch and CICL(UK) at 6th Floor, Minster Court, 3 Mincing Lane, London EC3R 7DD;
- from the offices of Kendall Freeman at 43 Fetter Lane, London EC4A 1JU; or
- online at **www.catlin.com.**

The application is directed to be heard before the Applications Judge at the Royal Courts of Justice, Strand, London WC2A 2LL on [2 June 2005]. Any person (including any employee of CICL or CICL(UK)) who alleges that he would be adversely affected by the carrying out of the Scheme may appear at the time of the hearing in person or by Counsel. Any person who intends so to appear and any policyholder of CICL or CICL(UK) who dissents from the Scheme but does not intend so to appear should give written notice, not less than two clear days prior to the date of the hearing, of such intention to dissent to the solicitors named below.

Dated: 14 April 2005.

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Canada: Court ruling expands employers' control over ongoing pension plans

Continued from page 77

them to benefit enhancements equal to those provided to the active workers.

The court also said the right to the surplus could be decided only upon the termination of the pension plan, not while the plan is still ongoing. That is because the plan's funding position is fluid while it is ongoing, said Natalie Bussiere, an attorney with the pensions and benefits practice of Blake, Cassels & Graydon L.L.P. based in Montreal, who was not directly involved in the case.

"While the plan is ongoing, you cannot claim you have a right to a certain amount," she said. "If you look at the life of a pension plan, sometimes it will be in surplus, sometimes it will be in deficit."

The decision confirmed that an employer is acting as a plan sponsor rather than a plan fiduciary when it amends a pension plan and, therefore, has no fiduciary obligation to ensure that all beneficiaries are treated equally. "That's also favorable to the employers, because they don't have to make sure they look out for everyone's best interests," said Roxanne Poulin, senior consultant and a lawyer with Watson Wyatt Worldwide in Montreal.

The ruling, which can be appealed to the Supreme Court of Canada until May 10, will have no impact on Hydro-Quebec employees or the way the utility manages its pension plans in the future, a spokesman for the company said. Hydro-Quebec's lawyer, Michel Benoit, said the disputed plan changes have already been implemented and the contribution holidays were taken many years ago.

Pension experts say the decision is a boon for Canadian employers.

"It's very good news," said Mr. Benoit, co-chair of the pensions and benefits department of Toronto-based Osler, Hoskin & Harcourt L.L.P. "All of that has now been settled in the employer's favor. It's a pretty pro-employer decision."

"I would say it's probably 95% favorable to employers," Ms. Poulin said.

The few aspects that are unfavorable to employers in the case are considered minor. For example, the Court of Appeal decided the participants would have a right to the surplus if the plan were eventually to be terminated, because the plan was silent on the issue. It is unlikely, though, that a provincial entity such as Hydro-Quebec would terminate its pension plans, she said.

In addition, the judges said that if a plan were about to terminate, participants could take measures to protect the plan's assets, such as seeking an injunction to prevent administrators from spending money out of the plan.

The Hydro-Quebec decision is different from the Supreme Court's decision in the Monsanto pension case last year that required the distribution of surpluses for partially wound-up plans, pension experts say (*BI*, Aug. 9, 2004). Unlike the Monsanto case, the Hydro-Quebec dispute involved an ongoing pension plan rather than a partially terminated one.

The immediate impact of the Hydro-Quebec case is limited, because most pension surpluses have vanished over the past five years, Mercer's Mr. St-Germain said. "All of this is quite artificial in the current environment, where there are no surpluses," he said. "If we ever go back to an environment where there are surpluses, they won't have to negotiate with the pensioners."

The case could have far-reaching implications outside of Quebec because of the principles established by the Court of Appeal's dismissal of the need for consent for decisions over a plan's surplus and the alleged breach of fiduciary duty, Mr. Benoit said.

"That certainly extends beyond the borders of Quebec, because there weren't that many precedents out there," he said.

Provincial Assn. of Hydro-Quebec Retirees vs. Hydro-Quebec; Quebec Court of Appeal, No. 1644.

Finite: Slowdown of deals from regulatory scrutiny likely to be temporary

Continued from page 1

reinsurance industry has the creativity and flexibility to deal with this challenge, he said.

"As long as transactions are consistent with accounting and disclosure rules," there will still be a market for "creative forms of reinsurance that try to address legitimate business needs," said Mr. Kroll.

Among the needs finite risk products can meet are to: stabilize unforeseen fluctuations in earnings; lower costs in exchange for the client's increased participation in ultimate losses; improve reserve adequacy and address the issue of discontinued operations.

And such tools are not limited to insurers and reinsurers, observers say, noting that corporate buyers sometimes use finite products either directly on a primary basis or through reinsurance for their captives.

And while finite insurance and reinsurance deals may provide financial benefits, they are not always primarily—or even partially—driven by the desire to smooth income statements through creative accounting, say many observers.

"There are real economic reasons why companies would look for alternatives" to traditional insurance, said Dan Malloy, executive vp in reinsurance brokerage Benfield Inc.'s alternative risk solutions group in New York.

For example, applications for finite insurance include environmental programs, where, as part of a package of environmental risks policies, the coverage is used as a funding mechanism to pay for cleanup costs, said Dave Dybdahl, founder of Middleton, Wis.-based Environmental Risk Resources Assn. He estimates that, each year, fewer than 50 deals are written in this area, representing about $500 million in premium. Finite insurance has also been applied to product liability risks.

Mark Knaack, president of Peoria, Ill.-based ELM, an environmental liability management services firm that purchases several finite environmental risk policies annually that provide about $5 million to $15 million in coverage, said regulatory scrutiny "might make it more difficult to do these deals."

Mr. Knaack said he is not concerned about his own policies. "I think there's plenty of risk transfer in the deals we've been doing," he said.

Market sources say that finite reinsurance may account for about 5% of reinsurers' premium volume, which totaled $28.76 billion last year among U.S. reinsurers, according to the Washington-based Reinsurance Assn. of America. Major non-U.S. markets include ACE Ltd. and XL Capital Ltd. of Bermuda; Munich Reinsurance Co. in Munich, Germany; Hannover Reinsurance Co. in Hannover, Germany; and Swiss Reinsurance Co. in Zurich, Switzerland.

Deals in doubt

A key focus of the current investigation into finite coverage, which is being led by the U.S. Securities and Exchange Commission and New York Attorney General Eliot Spitzer, has been a four-year-old, $500 million loss portfolio deal between American International Group Inc. and General Reinsurance Corp.

That deal, which AIG recently admitted should not have been accounted for as insurance, apparently led to the resignation last month of AIG Chairman and Chief Executive Officer Maurice R. Greenberg. Mr. Greenberg last week declined to answer investigators' questions about the extent of his knowledge of the deal (see story, page 3).

In another deal that drew regulatory scrutiny, AIG last year agreed to pay $126 million in penalties and disgorgement payments to the U.S. Department of Justice and the SEC to settle charges over certain structured financial transactions among AIG units and Pittsburgh-based PNC Financial Services and Plainfield, Ind.-based Brightpoint Inc., a mobile telephone distributor (*BI*, Nov. 29, 2004).

Investigators are also seeking information related to General Re's finite reinsurance business, including its involvement with the defunct Sydney, Australia-based insurer HIH Insurance Ltd. (see story, page 77).

Finite risk defined

Contract under which the ultimate liability of the reinsurer is capped and on which anticipated investment income is expressly acknowledged as an underwriting component.

Source: Insurance Information Institute

One early casualty of the current environment may be Hamilton, Bermuda-based Inter-Ocean Holdings Ltd., a finite risk reinsurer that said earlier this month it will run off the business of reinsurance units in Bermuda and Ireland. Analysts have cited the mounting regulatory scrutiny of finite reinsurance as a potential roadblock to Inter-Ocean's future business prospects (*BI*, April 11).

Although the recent investigations have highlighted the use of finite risk deals, the issue of how much risk transfer needs to be included in the deals for them to be legitimately accounted for as insurance has been a concern for several years.

End of 10/10?

In 1993, the Financial Accounting Standards Board introduced FAS 113, which allows a ceding U.S. company to account for a contract as reinsurance only if it transfers significant underwriting risk. Observers note, though, that there remains a gray area in terms of determining when adequate risk transfer has occurred. The general, informal rule of thumb that has developed is to categorize a contract as eligible for reinsurance accounting if the reinsurer has at least a 10% probability of a 10% loss of the premium paid.

To reach that 10% level, "the typical finite transaction is engineered by people...who look at what risks are represented, the funds available to pay for those risks, the timing that may be involved in payment and other contingencies," said Mr. Kroll.

But in trying to evaluate finite transactions, accountants, regulators and rating agencies have encountered problems, in that such deals are all customized.

"There is no silver bullet," said Steve Ader, associate director at Standard & Poor's Corp. in New York. "We would like a nice big checklist to run each contract through," but no such guidelines exist, he said. "A lot of it depends on judgment." Two experts could look at the same contract and reach opposite conclusions as to whether there is adequate risk transfer, noted Mr. Ader.

Kate Westover, vp-alternative risk financing, for Colchester, Vt.-based Innovative Captive Strategies Inc., a captive consultant, said captives that use finite insurance do so to transfer risk, not to "window-dress their balance sheets and misrepresent the financial position of the ceding company." Ms. Westover estimates that about 20% of captives have either a retro-rated or finite risk feature in their reinsurance.

Providers of the coverage also stand by finite deals.

Munich Re said in a statement that, "when properly structured," finite risk products "are legitimate solutions for the comprehensive risk management purposes of insurance companies and noninsurance companies." Munich Re said it "will continue to apply our selective and prudent approach to such reinsurance concepts in compliance with regulatory, accounting and other requirements."

The statement also notes, though, that because of the ongoing investigations, "currently, there is no strong demand for alternative risk transfer solutions."

Hannover Re said in a statement that it began entering into financial reinsurance contracts more than 25 years ago and, as in traditional reinsurance, "we have long-established internal rules and implemented procedures" to protect against their misuse.

Shirley Beglinger, a former managing director of Swiss Re's London office whose work included finite reinsurance, said: "The effect of the brouhaha surrounding finite reinsurance will mean companies will stop doing finite reinsurance transactions until they are certain what accounting treatment they will receive.

"Meanwhile, accountants will be crouching in front of Spitzer and will be unwilling to express an opinion about finite transactions," said Ms. Beglinger, now an independent consultant.

In the short term, "companies that may otherwise be solvent will be obliged to go into bankruptcy, while others will be presenting increasingly volatile results which investors do not like," she said, noting that "investors increasingly will regard insurance as a short-term and opportunistic investment."

Ms. Beglinger predicted in the long term, though, that the finite reinsurance market will "strengthen again, because it serves a real commercial need."

"There's probably some innate conservatism right now," but finite reinsurance will continue in some form, said Mr. Malloy. After the implementation of FAS 113, "I think a lot of people said the business was dead, but it came back in a different fashion," he said.

"If people are given a set of rules to live by, they will adapt their life to accommodate those rules," said Mr. Malloy.

Many captives "are dealing with risks that are not commercially insurable," and thus need alternatives such as finite products, said Ms. Westover.

Michael P. Goldman, an insurer attorney with Sidley Austin Brown & Wood in Chicago, said transactions that have been undertaken to transfer risk and have economic merit "will continue notwithstanding the accounting treatment that may be imposed on the transaction."

Regulators weigh rule changes on finite contracts

By JUDY GREENWALD

State, federal and international regulatory authorities are increasingly scrutinizing finite insurance and reinsurance deals with an eye toward introducing stricter risk transfer and disclosure requirements.

One lingering question, though, is the degree to which increased regulation risks discourage legitimate deals.

Regulatory efforts underway in the statutory arena include plans by the casualty actuarial task force of the National Assn. of Insurance Commissioners to "identify what risk transfer tests are being used in the industry today" and then to "provide guidance on what the minimum transfer of risk standard should be," said Nancy Watkins, chair of the Washington-based American Academy of Actuaries' Committee on Property and Liability Financial Reporting.

The committee has presented a work plan on the issue to the NAIC group, and they plan to work jointly on the project. Ms. Watkins is a principal and consulting actuary in the San Francisco office of Milliman Inc.

The NAIC reinsurance task force, which is chaired by Massachusetts Insurance Commissioner Julie Bowler, is examining the issue as well.

Florida insurance regulators last week announced plans to require domestic insurers to make additional disclosures about their finite reinsurance arrangements.

The New York Insurance Department has already issued finite-related requirements, including one calling for insurer executives to attest under oath that all finite reinsurance contracts used by their companies constitute valid reinsurance (*BI*, April 4).

New York regulators said that they expect that any increased disclosures or changes in accounting rules would be adopted by the NAIC by year-end. The NAIC is also working on the issue with the Basel, Switzerland-based International Assn. of Insurance Supervisors.

On other fronts, the office of the chief account of the U.S. Securities and Exchange Commission is considering issuing guidance as well, said an SEC spokesman in Washington.

In addition, the Norwalk, Conn.-based Financial Accounting Standards Board, the body that determines generally accepted accounting principles, plans to strengthen the criteria for determining what is adequate risk transfer in finite insurance and reinsurance contracts. It appears "there is some need for a tightening of the definition of when risk is transferred," said FASB board member Michael Crooch.

FAS 113, which was introduced in 1993, says a U.S. cedent can account for a contract as reinsurance only if it transfers significant underwriting risk. But there is ambiguity as to exactly how much risk must be transferred.

The FASB staff has recommended as a starting point to strengthening the risk transfer criteria that FASB compile guidance from various sources, then structure a definition of an insurance contract and insurance risk from what is already in the record.

Possible approaches suggested by the FASB staff include providing limited guidance in a question-and-answer format, making simple modifications to FAS 113, or broadly reconsidering FAS 113 risk transfer criteria.

The London-based International Accounting Standards Board has also established a working group to analyze accounting issues related to insurance contracts. FASB plans to coordinate with the IASB on this issue, said Mr. Crooch.

Dublin insurance regulatory authorities are also studying this issue (see related story).

Regulatory action will probably not discourage legitimate finite deals, but "if that is so, then so be it," said Georgia Insurance Commissioner John Oxendine, who is vice chair of the NAIC regulatory task force. "There has got to be broader oversight of the finite transactions, and that is a given," he said.

"Let's not overreact," said Joseph B. Sieverling, senior vp of the Reinsurance Assn. of America, though. Financial reinsurance "serves a valuable purpose in the marketplace, and we don't want to see that eliminated through too heavy-handed regulatory change," he said.

Mr. Sieverling said the RAA supports improving disclosure and facilitating regulators' ability "to identify reinsurance transactions that may deserve closer regulatory scrutiny." But significant change to FAS 113, or its statutory equivalent, Statement of Standard Accounting Practice 62, is not needed, he said.

"We feel that existing accounting guidance is appropriately designed" and based on principle-based standards "that allow the accounting to reflect the true economic substance of the transaction," said Mr. Sieverling. "Just because someone isn't following the accounting rules, doesn't mean you should change the accounting rules."

Meg Fletcher contributed to this report.

Ireland reacts to inquiry into domicile's finite transactions

By CAROLYN ALDRED

DUBLIN, Ireland–International probes into finite reinsurance are leading investigators to Ireland, now one of the leading centers for financial reinsurance.

Several contracts under investigation—including the loss portfolio transaction at the center of the investigation of American International Group Inc.—were written in Dublin, and one high-profile scandal involving a finite transaction written in the late 1990s resulted in sanctions against reinsurance executives there (see box).

Ireland's insurance regulator says it is committed to ensuring appropriate transactions and is assisting investigators from the United States and elsewhere. "We are working closely with our international regulatory colleagues in their investigations," said a spokeswoman for the Irish Financial Services Regulatory Authority. IFSRA was set up in 2003 to establish a single regulator for Ireland's financial services sector.

In addition, Irish regulators and market participants are lobbying the European Union to ensure that finite reinsurance will be treated separately from traditional reinsurance in proposed European reinsurance regulations.

Ireland's regulatory authority and the Dublin International Insurance & Management Assn. remain upbeat that, despite the current investigations, the domicile's reputation will remain intact, saying that Ireland will not tolerate disreputable behavior by any of its insurers.

"It is sound business practices and strong ethics which will sustain the continuing development of a thriving international reinsurance sector in Ireland," said Sarah Goddard, chief executive of DIMA, a trade group representing insurance industry companies, in a statement.

"The (investigations into AIG) are a matter of deep concern to (IFSRA). Transactions having the effect of deliberately obscuring the transfer of risk are unacceptable," said IFSRA CEO Liam O'Reilly, adding that "there is no tolerance in this jurisdiction for such activity," according to the text of a speech that he gave at a recent conference.

> "Ethical behavior, including transparency in business dealings, are key values expected of boards and senior management of all financial entities operating in Ireland."
>
> **Liam O'Reilly**
> **Irish Financial Services Regulatory Authority**

"Ethical behavior, including transparency in business dealings, are key values expected of boards and senior management of all financial entities operating in Ireland," he said.

During the 1990s, Ireland built itself into a key center for finite reinsurance underwriting, with major U.S. and European reinsurers setting up finite reinsurance subsidiaries in the country.

IFSRA estimates that its finite reinsurance sector—which includes General Re subsidiary Cologne Re Insurance Dublin Ltd.; Swiss Re Ireland Ltd.; Hannover Re (Ireland) Ltd. and sister company E&S Re (Ireland) Ltd.; and GE ERC Strategic Reinsurance Ltd.—now writes total premiums of about 2 billion euros ($2.6 billion) in premiums each year.

IFSRA has not commenced any regulatory enforcement actions against finite reinsurers since it was established, the IFSRA spokeswoman said.

Tax advantages and favorable accounting treatment encouraged the growth of the financial services sector in Ireland, including the finite risk sector.

Ireland generally has a less-prescriptive approach to accounting regulation than U.S. authorities. And when the Irish government issued new regulations intended to attract financial services business in the late 1980s, it offered new companies a corporate tax rate of 10%.

Finite reinsurance companies in Ireland have been innovators in structured finance transactions, bank reinsurance financings and other financing arrangements, according to Liam Flynn, a partner with law firm Matheson Ormsby Prentice in Dublin, who has worked on structuring financial reinsurance transactions.

These include the creation of special-purpose vehicles to help secure financing from the capital markets to support finite reinsurance transactions, he said.

Mr. Flynn does not believe that the current probes will adversely impact Ireland's position as a growing financial insurance center.

"Cedents and reinsurers have not been comfortable with the concept of side letters for some time," he said referring to secret agreements that have been used in some transactions to remove any actual risk transfer.

And in the wake of accounting scandals such as that at Enron Corp., the "focus has been on making sure all transactions are fully documented and public." In addition the demand for finite products is "now being driven by legitimate business needs."

Meanwhile, Ireland's financial regulator and its finite reinsurance industry are working to make sure changes in European reinsurance regulation allow for latitude for finite reinsurance.

An E.U. directive, currently being reviewed by the European Council and Parliament, seeks to harmonize reinsurance regulation across Europe by creating a single, comprehensive system. But an amendment added in recent months would allow each E.U. member state to establish its own provisions on finite reinsurance and special-purpose vehicles. Such provisions could include lower solvency margin requirements for finite reinsurers than for traditional reinsurers

The directive is undergoing further revisions, and if the special exemption for finite reinsurance is amended, some finite reinsurers may be tempted to move to other locations, such as Bermuda, Mr. Flynn said.

Dublin dealings questioned

Some finite reinsurance transactions written in Dublin have drawn the attention of regulators and investigators.

- A $500 million retrocessional loss portfolio transfer deal between American International Group Inc. and General Reinsurance Corp., which is a focus of an investigation by New York Attorney General Eliot Spitzer and the U.S. Securities and Exchange Commission, originated in Gen Re's Dublin office.

- The Australian Prudential Regulation Authority last year barred several executives–three from General Re Australia Ltd. and two from sister company Cologne Reinsurance Co. Dublin Ltd.–from holding senior positions in property/casualty companies because of finite reinsurance deals Gen Re Australia struck with FAI Insurance Ltd. in the late 1990s. Regulators determined that the transactions were not legitimate reinsurance and were used to mask the true financial condition of FAI, whose acquisition by HIH Insurance Ltd. played a role in HIH's subsequent collapse.

- The United Kingdom's Financial Services Authority in 2001 probed an £800 million ($1.16 billion) finite reinsurance policy written between Equitable Life Assurance Society and Irish European Reinsurance Co. Ltd., a Dublin-based company that is now part of GE ERC Strategic Reinsurance Ltd. The FSA eventually banned former Equitable Life Chief Executive Christopher Headdon from holding any management position at an FSA-regulated company until 2010, after finding that he had failed to disclose to the FSA details of a so-called "side letter" that raised questions about the legitimacy of the contract.

Funding: Pension plan levels still below mark a few years ago

Continued from page 4

maining 99 employers contributed $40.7 billion to their plans last year, up 7.7% from $37.8 billion in 2003.

Despite two consecutive years of improved plan funding levels, those levels are far below what they were a few years ago, when the bull equities market led to spectacular investment gains. For example, in 1999, just before the stock market began to decline, surveyed employers' plans were, on average, 130.1% funded.

Still, plan funding levels, on average, are up 10% from their low point of 82.6% in 2002.

"It is a slow recovery," said John Ehrhardt, a Milliman consulting actuary in New York.

The findings are based on the 100 largest pension programs sponsored by U.S. employers.

Pension programs include both qualified U.S. plans, as well as nonqualified and foreign plans, both of which often are often subject to much lower funding rules than for qualified U.S. plans. The information was gathered for companies with a fiscal year ending on or before Dec. 31, 2004, and whose annual reports were released by April 6, 2005.

Despite last year's 12.4% gain on investments and a nearly 20% gain in 2003, plan investments have had an average annual return of 3.4% since the end of 1999, reflecting how badly plans were battered by the slide in the equities' market in the early part of the decade.

Still, plan assets crossed over the $1 trillion mark in 2004, rising 10% to $1.02 trillion.

However, plan liabilities also rose, as the continuing slide in interest rates boosted the value of obligations. At the end of 2004, the plans' projected benefit obligations were $1.13 trillion dollars, up 8.7% compared with the prior-year period.

In addition, 22 in employers in 2004 reported overfunded pension programs, compared with 20 in 2003.

The five biggest employer-sponsored pension programs—as measured by plan assets—and their changes in funding levels are:

- General Motors, whose plans, on average, were 93.0% funded in 2004, an increase from 91.6% in 2003.
- IBM Corp., whose plans were 91.1% funded last year, down from 92.2% in 2003. IBM now is phasing out its defined benefit plan—which has a cash balance plan design—covering U.S. employees. Employees hired as of Jan. 1, 2005, are covered in an enriched 401(k) plan.
- Ford Motor Co., whose plans are 83.0% funded, up from 82.1% in 2003.
- General Electric Co., whose plans were 117.6% funded last year, up from 116.0% in 2003.
- Verizon Communications Inc., whose plans were 104.6% funded in 2004, up from 104.4% in 2003.

Copies of "2005 Survey of 100 Large U.S. Companies with Pension Plans" are available at www.milliman.com.

COMINGS & GOINGS - INDUSTRY

Ms. Makagon

Ms. Williams

Mr. Kekula

Insurers:

Chattanooga, Tenn.-based UnumProvident Corp. has named **Joseph M. Zubretsky** senior executive vp of finance, investments and corporate development. Previously, Mr. Zubretsky was president and chief operating officer of GAB Robins Group.

HCC Insurance Holdings Inc. has named **Cory L. Moulton** president and chief executive officer of Professional Indemnity Agency in Mount Kisco, N.Y. Previously, Mr. Moulton was executive vp of U.S. Risk Insurance Group.

Managed care:

David R. Fusco has been named president of New Haven, Conn.-based Anthem Blue Cross & Blue Shield's Connecticut market, replacing Linda A. Masci, who has retired. Before his promotion, Mr. Fusco was vp, commercial accounts.

Shelton, Conn.-based Health Net of the Northeast has made two senior-level appointments:

William Lamoreaux has been promoted to COO from health care delivery officer.

Paul Lambdin is the new chief commercial officer. Previously, he was chief sales officer.

Other providers:

Michael L. Close, formerly chief sales and marketing officer, has been promoted to president of CONEXIS, an Orange, Calif.-based benefits administration company.

Chicago-based Mullin Consulting Inc. has appointed **Matthew P. Andersen** senior managing consultant. Previously, Mr. Andersen was a senior consultant at Clark Consulting.

Exigen Group, a San Francisco-based provider of business process software and services, has appointed **Kira Makagon**, formerly executive vp of marketing at the company, president of ventures and alliances.

Agents/Brokers:

Dena Williams has been promoted to director of sales and marketing at San Diego-based John Burnham Insurance Services. Previously, Ms. Williams was senior vp.

London-based R.K. Carvill & Co. Ltd. has appointed **David Thomas** managing director. Before his promotion, Mr. Thomas headed the company's specialty, program and medical malpractice divisions.

Rick Kekula, executive vp of Madison, Wis.-based Mortenson, Matzelle & Meldum Inc. has been elected president of Menlo Park, Calif.-based RiskProNet International.

Chicago-based Noodle Specialty Brokers has promoted **Tom Neeley** to senior vp. Previously, he was a product manager of NSB's directors and officers underwriting unit.

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers. Please send news and photos of recently promoted, hired or appointed senior-level executives to: Joe Walker, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; jwalker@businessinsurance.com.

Pollution: Policyholders, insurers battling over cleanup liability

Continued from page 4

proach to allocating loss payments. While a policyholder can choose which one insurer would pay up to policy limits, that insurer would then be able to sue the policyholder's other insurers for their share, they say.

The major opponents of the bill are insurers belonging to the American Insurance Assn. and the Wisconsin Assn. of Mutual Insurance Cos., as well as two state agents' associations and a few Madison-based general business groups, including the Wisconsin Federation of Cooperatives and the Wisconsin Merchants Assn.

"This is really, really bad public policy for the Legislature to insert itself into a contract dispute," said Sean McManamy, the AIA's assistant-vp for the Midwest region in Chicago.

Requiring a policyholder to designate a single insurer to pay losses is "unfair" and "unconstitutional" and will lead to additional litigation that could slow down the cleanup, stressed Laura Foggan, a partner with the Washington-based firm of Wiley, Rein & Fielding L.L.P. who has advised bill opponents. She is also counsel for the insurer-backed Complex Insurance Claims Litigation Assn.

The 39-mile stretch of the Fox River from Neenah, Wis., north to Green Bay became polluted with PCBs in about 1954 when paper companies using the chemical to make carbonless copy paper began discharging it, sometimes through municipal treatment plants.

It wasn't until the 1970s that the health hazards—including cancer in animals, an acne-like rashes in adults as well as neurobehavioral and immunological changes in children—were known, experts say. A federal ban on the long-lived PCBs was imposed in 1976, and the area is now a candidate to become a Superfund site, according to the Wisconsin Department of Natural Resources.

The debate in Wisconsin has national implications because states have taken varying approaches to resolving similar issues.

"With the exception of the untested legislation passed last year in Oregon, the legal standards governing allocation have been developed almost exclusively through case law," Ms. Foggan noted.

"The weight of judicial authority, including 10 state high courts and numerous federal and state intermediate appellate courts has ruled in favor of (proportional or pro-rata) allocation" she said, noting that such allocations more closely reflects a policy's terms and conditions. Those high courts are in Alabama, Colorado, Connecticut, Kansas, Maryland, Minnesota, New Jersey, New York, Utah and Vermont.

Meanwhile, six states—Delaware, Indiana, Ohio, Pennsylvania, South Carolina and Washington—have imposed all-sums liability on insurers in cases in which policyholders sued insurers, Ms. Foggan said.

A 2003 Wisconsin Supreme Court decision laid important groundwork for the bill by deciding that government-related enforcement actions to clean up contaminated sites could be considered damages for which policyholders' insurers could be required to pay, attorneys say.

Such a decision is important to municipalities, because "foot dragging" by insurers in paying claims could mean paper companies would sue municipalities for their role, said Rich Eggleston, a spokesman for the Madison-based Wisconsin Alliance of Cities, which supports the measure along with other individual municipalities and related groups.

To preserve their rights, the paper companies already have entered into "tolling" agreements with some municipalities to extend the statute of limitations for companies to file claims against them, said Paul Kent of the Madison-based firm of Anderson & Kent S.C., which is special counsel to Georgia-Pacific.

Also supporting the legislation is Bob Horkovich, a policyholder plaintiffs attorney who is not involved in the Fox River cleanup controversy.

"It's a shame that the failure of the insurance industry to deliver on its product requires that the Legislature becomes involved," said Mr. Horkovich, a New York-based attorney with Anderson Kill & Olick P.C. "This situation is particularly perverse, because policyholders purchased 100% protection from multiple insurance companies and instead are getting no protection from any insurance company."

Opponents of the bills have "a strong concern" that a final version of the measure could be "slipped into the state's budget and be passed this summer without open discussion," another AIA spokesman said. That is because the Assembly bill's chief sponsor is State Rep. Dean Kaufert, R-Neenah, who is co-chair of the Joint Finance Committee, the spokesman explained.

When asked to comment on this possibility, Mr. Kent said, "Wisconsin historically has used its budget for a number of items."

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Terror coverage: Doubling of take-up rate seen

Continued from page 3

by their proximity to the high-profile cities of Washington and New York, and Boston was the departure point for some of the Sept. 11 hijackers, the report notes.

"Why are companies choosing to buy or not to buy? A lot say they don't 'because we don't think that we have any perceived risk,'" said Mr. Lundin. But he added that the survey found that "the median 2004 terrorism premium rate quoted to nonbuyers was 35% higher than for those that actually bought the coverage."

The survey said "there appears to be a mismatch between some companies' perception of risk and some insurers' perception of risk, resulting in the declination of coverage by those companies."

Generally, terrorism insurance prices remained stable. The survey found that there was a "slight rise in the median percentage of a company's annual property program costs attributable to terrorism premiums—from 4.4% in 2003 to 4.7% in 2004. This occurred because terrorism rates did not decline as dramatically as other property rates in 2004, meaning that terrorism coverage represented a slightly larger percentage of overall property insurance budgets."

The survey also found that "most companies with TIV (total insured values) under $500 million that bought terrorism insurance purchased the equivalent of their full fire limits. Companies with TIV over $500 million that purchased terrorism insurance—especially those with layered programs—tended to purchase TRIA-only coverage on the lower layers. In some quota share programs, the limits purchased for the largest companies tended to be skewed by the prevalence of captives, which often provide higher TRIA limits than does the commercial insurance marketplace."

But the survey cautioned that the private market alone cannot meet terrorism insurance needs, at least not right now.

"Without a continuation of some form of government reinsurance support, the insurance market will not be able to respond fully in the event of a catastrophic terrorism loss," according to the report. "Scarce capacity will likely cause rates to rise dramatically, and organizations in perceived high-risk locations in large metropolitan areas will be challenged to find affordable coverage—if they will be able to find it at all."

After calling TRIA a "valuable component of the U.S. administration's war on terror," the survey says that TRIA "should be continued in some form for the next few years to allow more time for the development of a permanent solution."

"In partnership with the government, it should be the duty of clients, brokers, insurers, and reinsurers to investigate all potential options," the report says, "and develop a robust, long-term terrorism risk management and risk-transfer solution."

The survey "Marketwatch: Terrorism Insurance 2005" will be available in early May through the local offices of Marsh Inc.

Integro: Ex-Marsh executives form brokerage

Continued from page 1

Some observers were skeptical about the prospects for a new large-account broker.

Although Mr. Clements clearly has a good track record and credibility, his latest venture "is easier said than done," said Timothy J. Cunningham, a partner with brokerage consulting group OPTIS Partners L.L.C. in Chicago.

Mr. Clements

Notwithstanding concerns some risk managers may have about their brokers, "it's a hard process to move an account because of all the institutional knowledge of the infrastructure of the account that resides with the account team," Mr. Cunningham said.

MMC agreed in January to pay $850 million and reform its business practices to settle fraud and bid-rigging charges brought by Mr. Spitzer, who charged that the brokerage steered business to insurers paying the highest contingent commissions. The investigation centered on Marsh's Global Placement units, which Mr. Clements helped develop when he headed MMC's brokerage operations in the early 1990s.

Shortly after Mr. Spitzer filed his civil suit in October, MMC asked Mr. Egan and Christopher M. Treanor, Marsh's chairman and chief executive officer of Global Placement, to step down from their positions. Neither Mr. Egan nor Mr. Treanor were charged with any wrongdoing.

Mr. Garvey replaced Mr. Egan as co-president of Marsh in November—a position he held until his March 22 resignation.

Shortly after MMC's settlement with Mr. Spitzer, Aon Corp. agreed to pay $190 million and change its practices to settle fraud and anti-competitive charges brought by officials in three states. And Willis Group Holdings Ltd. agreed earlier this month to pay $51 million and change its practices to resolve concerns about fraud and anti-competitive practices raised by state officials.

BI Stock Index [4/11 - 4/15]

Up-to-the-minute data for all 87 companies that comprise the *BI* Stock Index can be found at *www.businessinsurance.com*.

Percentage change of *BI* Stock Index vs. key indicators

***BI* Stock Index**	2295.96	-3.84
Dow Jones	10087.51	-3.57
S&P 500	1142.62	-3.27

Largest gains

NYMagic Inc	1.94%
RLI Corp.	1.28%
Aspen Insurance Holdings	1.21%
Citigroup	0.77%
SCPIE Holdings Inc.	0.27%

Largest losses

Argonaut Group	-9.14%
EMC Insurance Group Inc.	-9.04%
UnumProvident Corp.	-6.60%
Marsh & McLennan Cos. Inc.	-5.85%
Aetna Inc.	-5.81%

Weekly change by market segment

Brokers	-3.83%
Insurers/Reinsurers	-2.08%
Managed Care Organizations	-4.08%

Source: FinancialContent Inc. *(http://financialcontent.com)*

Late News

Continued from page 1

falsified company financial statements. As part of the agreement, pending approval in U.S. district court in Topeka, Kan., Westar and the individual defendants named in the suit admitted to no wrongdoing. A spokeswoman for Westar declined to name the insurers.

Comp rate panel proposal advances in California

California's Senate Labor and Industrial Relations Committee approved legislation that would create a commission to set workers compensation insurance rates. Sen. Richard Alarcon, D-Van Nuys, authored Senate Bill 46, which is opposed by insurers.

Segal lowers projection of Rx price inflation

The Segal Co. lowered its projected outlook for 2005 prescription drug rate increases to between 12% and 14%, down from between 15% and 17%. The decreased rate of inflation is expected to persist into 2006 and beyond, said Vp Sean Brandle. Several factors are contributing to a dampening cost trend for prescription drugs, including growth of mail-order dispensing, safety concerns about some drugs and the current lack of blockbuster drugs in manufacturers' pipelines, Segal said.

PBGC restructures, adds department

The Pension Benefit Guaranty Corp. has reorganized its corporate structure, creating a new Insurance Program Department, among other changes. The agency said the moves are designed to improve customer service and its ability to respond to developments in the current business environment. The head of the new department will be Terrence Deneen, who previously served as the PBGC's principal deputy general counsel. Plan administrators filing for standard terminations will continue to contact the Standard Termination and Compliance Division, now a part of the IPD.

Ruling clarifies HSA eligibility

An individual can contribute to a health savings account even if his or her spouse has so-called "nonqualifying" family coverage, as long as the individual is not covered by that insurance, the Internal Revenue Service and Treasury Department say in a new ruling. Under federal law, HSAs, which are tax-favored accounts used to fund out-of-pocket health care expenses, must be linked to high-deductible health insurance plans. In 2005, the minimum annual deductibles for such plans are $1,000 for single coverage and $2,000 for family coverage.

Gallagher sells two claims units

Arthur J. Gallagher & Co. has sold Gallagher Benefit Administrators Inc. and Northshore International Insurance Services. Gallagher Benefit Administration, an employee benefits third-party administrator, was sold to The Parker Group Inc., a health care management company in Lubbock, Texas. Northshore, a medical claims management and auditing services provider based in Danvers, Mass., was purchased by its management group. Terms of the deals were not disclosed. The operations generated 2004 revenues of $27.1 million for Gallagher's risk management segment and $6.2 million for its brokerage operations.

UnitedHealth earnings rise 41% in quarter

UnitedHealth Group Inc. posted a 41% gain in net income for the first quarter of 2005, attributing its profits of $779 million to growth across its operations. First-quarter revenues at the Minneapolis-based managed care company rose 34% to $10.9 billion. Medical membership as of March 31, 2005, was 23.1 million, up 12.5% from the prior-year period. The total includes members acquired through the company's purchases of Oxford Health Plans Inc. and Definity Health Corp.

Briefly noted

Willis Group Holdings Ltd. completed the sale of its New York-based wholesale unit, Stewart Smith Group, to Charlotte, N.C.-based American Wholesale Insurance Group. Terms of the deal, announced in February, were not disclosed....California Treasurer Phil Angelides urged the California Public Employees' Retirement System and the California State Teachers Retirement System to take legal action against **American International Group Inc.** to recoup around $400 million in stock losses stemming from the drop in AIG's share price amid investigations into the insurer's practices. Mr. Angelides, a candidate for California governor in 2006, also urged the retirement funds to examine whether auditor PricewaterhouseCoopers played any role in alleged wrongdoing at AIG....**XL Capital Ltd.** is changing the way it reports the results of credit default swap transactions and other elements of its Financial Products & Services sector, resulting in a $90 million decrease in projected 2005 investment income from general operations and a $40 million increase in projected income from financial and life annuity operations, the insurer reported.

At *BusinessInsurance.com*

New Online Poll: When are brokers justified in charging insurers for services they provide in the course of placing business?

Items in the Late News column originally appeared in BI's Daily News feature on *www.businessinsurance.com*. Visit the BI Web site to sign up to receive BI's Daily News by e-mail.

Insurers: Companies so far avoid fate of brokers

Continued from page 3

investigation is continuing.

Insurers as victims?

For their part, insurers uniformly say they are continuing to cooperate with the regulatory investigations and refuse further comment. Some privately complain, though, that they were victims themselves, coerced in Marsh's case into providing inflated bids to channel business to favored insurers, industry participants and observers note.

"The insurance companies position themselves as semi-innocent victims," said Donald Light, a San Francisco-based senior analyst with Celent Communications, a business and technology research and consulting firm.

This leaves them arguing that they shouldn't be held responsible for the alleged wrongdoing while at the same time they are terminating employees who were involved, Mr. Light noted. He characterized this line of defense as "'We only did what we had to do, but anyone caught doing it will be fired.'"

"I think that will probably be a successful tactic" in heading off litigation with regulators, Mr. Light predicted.

Even if they avoid regulators' charges, insurers cited in the broker complaints will still be busy in court: Several have been named as defendants in policyholder and shareholder class action lawsuits over the alleged anticompetitive practices, including consolidated policyholder litigation now pending in U.S. District Court in Newark, N.J.

Mr. Spitzer's October 2004 lawsuit against Marsh and the nine criminal complaints filed since then paint a picture of insurers cooperating, sometimes unwillingly, in rigging bids and steering business to benefit Marsh and themselves at the expense of policyholders.

Without actually leveling charges against them, the Marsh suit cites four insurers for providing inflated quotes at Marsh's insistence: AIG, ACE, The Hartford Financial Services Group Inc. and Munich-American RiskPartners, a Munich Re unit.

Insurers sometimes resisted. One Munich-American official complained about sending a representative to a client presentation to create an appearance of competition when Marsh had already decided to place the business with another insurer; another Munich-American executive said in an internal memo that he found the bid rigging "repugnant."

Munich-American management was aware of the practices, though, and Munich and the other three insurers largely complied with Marsh's demands, according to the suit.

The suits against Marsh and Aon and a settlement agreement with Willis also charge that the brokers steered business to certain insurers that agreed to lucrative contingent commission arrangements. In the cases of Aon and Willis, insurers benefiting from these deals included Chubb Corp., Crum & Forster Corp., Fireman's Fund Insurance Co., Hartford and The St. Paul Cos., the documents say.

10 execs out

Executives who have pleaded guilty to criminal charges in the Spitzer investigation

Marsh & McLennan Cos. Inc.
- Robert Stearns, senior vp
- Joshua Bewlay, managing director, Global Broking
- Cathryn Winter, managing director

American Home Assurance Co. (American International Group Inc.)
- Karen Radke, senior vp
- Jean-Baptist Tateossian, manager, national accounts
- Carlos Coello, underwriter
- John Mohs, manager

ACE USA Insurance Co.
- Patricia Abrams, assistant vp

Zurich American Insurance Co.
- Edward Coughlin, senior underwriter, excess casualty
- John Keenan, senior underwriter, excess casualty

Insurer execs not ousted

While the charges forced the resignations of several high-level Marsh officers—including former Chairman Jeffrey Greenberg and former Marsh Inc. President Roger E. Egan—top managers at the insurance companies have generally not suffered similar fates.

Susan Rivera, former president of ACE INA Holdings Inc., the holding company for ACE's U.S. operations, resigned in January. She has not been accused of wrongdoing, and both ACE and Ms. Rivera declined to comment on the reasons for her resignation, Ms. Rivera saying only that she looked forward to spending more time with her family.

ACE also fired Geoffrey Gregory, former president of ACE Casualty Risk, and Patricia Abrams, an ACE Casualty Risk assistant vp who pleaded guilty to a misdemeanor restraint of trade charge brought by Mr. Spitzer.

Insurers have generally maintained, though, that any wrongdoing was confined to a handful of lower-level employees. Mr. Spitzer's criminal charges against insurer employees have so far centered on underwriters and middle managers, not senior officials (see box).

And while Mr. Spitzer has publicly downplayed the possibility of criminal charges against corporations, it is also unclear whether he will bring civil charges against any of the insurers implicated in the broker complaints.

Industry observers express reluctance to speculate on what Mr. Spitzer may do and offer differing opinions on whether charges against insurers over the alleged bid rigging and client steering are likely, and on which of the practices is more pernicious.

Eugene Anderson, lead partner of the policyholder law firm Anderson, Kill & Olick, said his hunch is that the insurers are "out of the woods." "In a sense, they didn't initiate it," he said of the brokers' alleged wrongdoing.

A source with long experience in the industry, though, said, "I can't believe anybody would take comfort in believing that...if there is any suggestion of wrongdoing by the (insurance) companies that (Mr. Spitzer) would just close the file."

Celent's Mr. Light, meanwhile, said that his "personal moral sense" is more offended by bid-rigging charges than by contingent commission practices, which he said could fall into a "gray area."

Another industry source, though, said client steering resulting from contingent agreements caused more damage to policyholders because it was more widespread.

Thus far, only Connecticut's Mr. Blumenthal has brought charges against a property/casualty insurer, suing an ACE unit for allegedly paying Marsh a secret commission to steer state workers compensation business to the insurer.

California Insurance Commissioner John Garamendi earlier this year sued four life/health insurers and a broker, Universal Life Resources Inc., over client steering allegations.

Greenberg: Ex-AIG chief cites Fifth Amendment

Continued from page 3

in a loss portfolio transaction with a unit of AIG. AIG has conceded that it accounted improperly for the transaction as insurance.

Mr. Spitzer, meanwhile, promised more civil and criminal charges are coming in his wide-ranging industry probe. He offered no further details during remarks last week at a conference hosted by the Investor-side Research Assn. in New York.

He had earlier suggested that he would not bring criminal charges against AIG itself and said at last week's conference that he considered indictments of corporations a "nuclear option" that he would avoid wherever possible.

In other related developments:

- An AIG SEC filing last week disclosed that Mr. Greenberg gave his wife, Corinne P. Greenberg, 41.4 million shares of AIG three days before he resigned as CEO last month. The stock closed down 1.5% Friday to $51.11, making the gift worth around $2.12 billion. Mr. Greenberg continues to hold 1.9 million AIG shares after the transaction, according to the SEC filing.
- AXA Re, a unit of Paris-based AXA S.A., reported that Mr. Spitzer and the SEC have requested information about transactions with Armonk, N.Y.-based bond insurer MBIA Inc. The transactions relate to the 1998 bankruptcy of Allegheny Health, Education and Research Foundation of Pittsburgh, Pa., as well as to nontraditional reinsurance products, AXA said.

TRIA: Skepticism and support expressed at extension hearing

Continued from page 1

as was evident last week as the Senate Banking, Housing and Urban Affairs Committee held its first hearing of the year on TRIA's future. The committee's chairman, Sen. Richard Shelby, R-Ala., made no effort to hide his skepticism over the need to extend TRIA, saying that he intends to approach the question of extending a federal terrorism insurance program with "a critical but, I hope, open mind."

Sen. Shelby was one of only 11 senators to vote against enactment of TRIA when it passed the Senate in late 2002. In his remarks last week as his committee began its first hearing on possibly extending TRIA beyond its slated Dec. 31 expiration, the senator indicated he remains skeptical of the need for the program.

"The stated purpose of this law was 'to establish a temporary'—and I'll say it again, 'temporary'—federal program that provides for a transparent system of shared public and private compensation for insured losses resulting from acts of terrorism. Now, two and one-half years later, the program's scheduled termination date draws near. I think we are at a point where we can determine what, if anything more, is required of this temporary program," he said.

> "The message that we're getting from the House and Senate is that it has to be a long-term solution."
>
> **Ernie Csiszar**
> **Property Casualty Insurers Assn. of America**

Not all members of the committee, though, shared Sen. Shelby's skepticism.

"I would make a pitch that we do this permanently," said Sen. Charles Schumer, D-N.Y. Sen. Schumer predicted that, otherwise, construction and insurance markets would be disrupted every two years as Congress considers whether to extend the program. Sen. Schumer is a co-sponsor of the Terrorism Risk Insurance Extension Act of 2005, a bipartisan bill that would extend TRIA through the end of 2007 (*BI*, Feb. 28). The bill would also require a presidential working group to offer Congress suggestions on long-term solutions regarding terrorism insurance availability and affordability no later than June 30, 2006.

"Let's make it permanent, or at least do it for a much longer period of time," said Sen. Schumer.

Support for extending TRIA reached across both sides of the committee.

"I think we're still in a period of sufficient uncertainty," and the federal government has a role to play in calming that uncertainty, said Sen. Robert Bennett, R-Utah, who, with Sen. Chris Dodd, D-Conn., drafted the extension bill. "It is important that the federal government steps up to it," Sen. Bennett said.

Most, though not all, of the witnesses at the April 14 hearing agreed.

"Insurance regulators strongly urge Congress to act immediately" on TRIA extension, Howard Mills, the acting New York superintendent of insurance, told the committee.

Ernie Csiszar, president of the Property Casualty Insurers Assn. of America, told the committee point blank that "fundamentally, a terrorist event is uninsurable."

ACE Ltd. Chairman Brian Duperreault also called the risk "uninsurable," scoffing at industry critics who point to insurers' profitability as a reason to let TRIA die. "Frankly, you can have this risk. I don't want this risk. It's uninsurable," he said.

The third industry witness, Reinsurance Assn. of America President Frank Nutter, called for a long-term public-private solution. He called the possibility that the private reinsurance market could replace TRIA's capacity "improbable."

Although no risk managers spoke, Robert J. Lowe, chairman and CEO of Los Angeles-based real estate developer Lowe Enterprises, presented a policyholder view that TRIA should be extended, and extended "swiftly." TRIA is "vital" to the real estate industry, he said.

But Bob Hunter, director of insurance for the Consumer Federation of America, said that TRIA is not necessary. The insurance industry "is no longer in need of a handout," said Mr. Hunter.

The remaining witness, Congressional Budget Office Director Douglas Holtz-Eakin didn't call for an end to TRIA, but he stressed that "TRIA is explicitly a temporary program." Mr. Holtz-Eakin also said the CBO considers financial insurance to be in much better shape than it was at the time of the World Trade Center attack.

In interviews after the hearing, two of the industry witnesses said they believe Congress has become more receptive to the idea of a long-term approach to terrorism insurance.

"I think it's going to be necessary," said Mr. Csiszar. "The message we're getting from the House and Senate is that it has to be a long-term solution."

Mr. Duperreault agreed. "I think there's a growing appetite" for a long-term approach, he said. "As the Senate and House begin to realize it's not an insurable risk," he said, they are acknowledging that "they must do something else."

Ron Robinson, chairman of the Chicago-based Defense Research Institute's TRIA subcommittee, said after the hearing that he thinks that there is a realization that "a public-private infrastructure" is needed to insure against terrorism. Mr. Robinson, an executive partner in the Los Angeles law firm of Berkes Crane Robinson L.L.P., outlined how such a partnership might work in a recent *Business Insurance* Perspective (*BI*, Jan. 17).

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- Internet security and cyber-risk insurance
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