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UPDATES

Willis plans redomestication to Bermuda, IPO in U.S.

LONDON—Willis Group Ltd. is planning to redomesticate to Bermuda from the United Kingdom and launch an initial public offering of a new holding company's stock in the United States.

Willis has formed Willis Group Holdings Ltd. in Bermuda to act as the ultimate parent company of Willis' worldwide operations, the company announced last Thurs-

See **Updates** *on next page*

E-mail access rights expanded

By JUDY GREENWALD

A recent federal district court ruling expands employers' ability to monitor workers' electronic communications, attorneys say.

But even some employer attorneys believe Judge Anita B. Brody of the U.S. District Court in Philadelphia may have proposed too narrow an interpretation of federal law in her March 27 decision in *Richard Fraser vs. Nationwide Mutual Insurance Co.*

Judge Brody, granting summary judgment, ruled that employers may retrieve employee e-mails without incurring liability so long as the communication has already been read by the addressee.

The decision is significant, if only because it is one of the few so far to deal with the issue of electronic communication, attorneys say. Some attorneys believe it conflicts, though, with the decision by the influential 9th U.S. Circuit Court of Appeals in *Konop vs. Hawaiian Airlines.*

Judge Brody's decision is helpful to employers, said Gerald L. Maatman Jr., a partner and chairman of the global employment law practice group at Baker & McKenzie in Chicago. "The practical implications are it gives a green light to employers to safeguard their workplace and their property through broad e-mail and Internet access policies that virtually guarantee an employer can't be sued over snooping or retrieval of e-mails inside their computer systems after they've been sent," he said.

"An employer, according to this case, has the ability at all times" to read e-mail messages, "so it impacts very broadly on an employer's ability to conduct workplace investigations," he said. This is particularly significant in instances involving trade secrets, policing noncompete covenants and conducting internal investigations in sexual harassment cases, he said.

The decision involves Richard Fraser, an agent who began working as an independent contractor for Nationwide in 1986. He subsequently leased computer hardware and software from Nationwide for his office and insurance business. In 1996, he helped form the Pennsylvania chapter of the Nationwide Insurance Independent Contractors Assn., which opposed the insurer on a number of issues.

In July 1998, to express opposition to a Nationwide plan to establish multiple distribution channels, Mr. Fraser prepared a letter to Nationwide competitors to solicit interest in acquiring the policyholders of the approximately 200 Pennsylvania NICA members.

The following month, Nation-

See **E-mail** *on page 22*

Bill would extend COBRA coverage

By JERRY GEISEL

WASHINGTON—Employers terminating their retiree health care plans would face new liabilities under legislation recently introduced in Congress.

The bills—sponsored by Sen. John D. Rockefeller IV, D-W.Va., and Rep. Fortney Stark, D-Calif.—would require employers terminating retiree health plans or cutting benefits by at least 50% to extend COBRA coverage to retirees as young as 55. In addition, the measures introduced in both the Senate and House of Representatives would allow retirees to continue COBRA until age 65. COBRA, short for Consolidated Omnibus Budget Reconciliation Act, is a 1986 federal law that allows an individual and his or her dependents to continue coverage under a former employer's group health care plan for a limited time.

Sen. Rockefeller

Rep. Stark

Under the proposals, employers could charge retirees electing COBRA coverage a premium equal to 125% of the company's group health plan rate,

See **COBRA** *on page 21*

Battle lines drawn in Michigan

RRG fights state fee

By JERRY GEISEL

LANSING, Mich.—Another legal battle over fees is unfolding between a risk retention group and state insurance department regulators.

Attorneys' Liability Assurance Society Inc., a Risk Retention Group, is asking a U.S. District Court in Michigan to bar the Michigan Office of Financial and Insurance Services from imposing a regulatory fee that it charges the group. Michigan charges ALAS, and other RRGs that are licensed in other states and write coverage for policyholders in Michigan, a fee of 0.5% on premiums paid for coverage provided to policyholders in Michigan.

In its lawsuit, ALAS, which is chartered in Vermont, says the federal Risk Retention Act bars states from imposing any requirements on nondomiciliary RRGs not specified in the federal law. Because the regulatory fee is neither specified nor authorized by the Risk Retention Act, it is pre-empted by the federal statute, according to the ALAS complaint.

"We think the law is very clear and unambiguous" on this point, said Donald Breakstone, senior vp and general counsel in the Chicago office of ALAS.

In its answer to the complaint, the Michigan Department of the Attorney General says the pre-emption provisions in the Risk Retention Act were intended to protect RRGs from state charges that discriminate against the group. According to the reply, the regulatory fee set in Michigan does not discriminate against RRGs, because the same fee is imposed on "sales of insurance by unauthorized insurance companies."

The controversy in Michigan is only the latest in a long-running series of tussles involving fees and other points of dispute between the groups and state insurance regulators.

First passed in 1981 and later expand-

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WAFFLE HOUSE

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- **A proposal by a group of congressional Democrats to give early retirees more health care coverage options isn't much better the second time around, this week's editorial says.** **PAGE 8**

- **Recent agreements reached by the Risk & Insurance Management Society Inc., a standards-making organization and insurance industry officials have accelerated the development of a risk management data standard.** **PAGE 14**

- **At the "New World, Old World: Risks Have Changed" conference in Dublin, Ireland, attendees learned about the risks involved in doing business online.** **PAGE 15**

- **All employers would be allowed to offer tax-favored medical savings accounts under legislation introduced last week in the House of Representatives.** **PAGE 22**

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UPDATES

Continued from previous page

day in a two-paragraph press release. The broker also said it will file a registration statement with the U.S. Securities and Exchange Commission for an initial offering of the Bermuda holding company's stock. Willis' announcement did not address any potential changes to existing operations.

Willis, the world's third-largest insurance broker, has been owned since 1998 by an investment consortium led by buyout firm Kohlberg Kravis Roberts & Co. L.P. Consortium members also include insurers Guardian Royal Exchange P.L.C., Royal & SunAlliance Insurance Group P.L.C., Chubb Corp., the Hartford Financial Services Group Inc. and Travelers Property Casualty Corp.

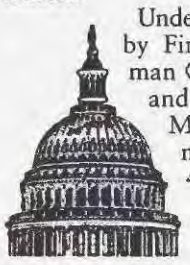
KKR has said that its KKR 1996 Fund (Overseas) L.P.—Willis' majority shareholder—has "no intention to sell shares in the proposed offering," Willis announced. KKR has maintained that it views its stake in Willis as a long-term investment.

A Willis spokesman declined to comment on the proposed offering or Willis' reasons for moving to Bermuda.

About 50 Bermuda-based companies have issued stock on U.S. exchanges, according to Bermuda law firm Conyers, Dill & Pearman. Reasons incorporating in Bermuda include lighter regulation and absence of taxes on income, profit and capital gains.

In addition, the SEC imposes lighter regulations on Bermuda companies listed on U.S. exchanges than on listed U.S.-based companies, according to Bermuda-based law firm Appleby, Spurling & Kempe.

▶ PENSION REFORM BILL Bipartisan pension reform legislation introduced last week in the Senate would allow employees to contribute more to their 401(k) and other retirement plans and would reduce administrative hassles.



Under the measure, introduced by Finance Committee Chairman Charles Grassley, R-Iowa, and Sen. Max Baucus, D-Mont., the current $10,500 maximum limit on annual 401(k) plan deferrals would be gradually raised to $15,000. In addition, employees age 50 and older could make additional "catch-up" contributions—eventually as much as $5,000 per year—to the plans.

The measure also would raise to $200,000 from $170,000 the amount of employee salary that can be considered in calculating pension benefits. Additionally, certain plan nondiscrimination tests would be simplified, while Pension Benefit Guaranty Corp. premiums would be cut for small employers starting new defined benefit plans. The bill also would eliminate fees the Internal Revenue Service charges employers setting up new plans for determination letters.

A similar bill, backed by a broad array of business and labor groups, was earlier introduced in the House by Reps. Rob Portman, R-Ohio, and Ben Cardin, D-Md. (*BI*, March 19).

▶ AIG ENTERS BIDDING American International Group Inc. last week made a bid to buy American General Corp., topping an all-stock offer by U.K. insurer Prudential P.L.C. that has dropped in value in the weeks since it was made.

The original offer from Prudential—a London-based multiline insurer that is not affiliated with the Prudential Insurance Co. of America—was valued at $25.85 billion (*BI*, March 19). But Prudential's share price has declined more than 12% since it announced the merger with American General, reducing the value of its offer to about $22.6 billion overall. AIG last Tuesday offered to buy American General in a stock transaction valued at $46 per share, or about $23.2 billion overall, and Prudential said last week that it would not increase its offer.

Houston-based American General has a large life insurance operation, along with a sizable retirement and annuity business. Although it writes some group life and health business, most of American General's book is tailored to individuals.

Moody's Investors Service Inc. noted that American General's retirement savings operation would fit nicely with New York-based AIG's SunAmerica unit to "substantially raise AIG's profile in the retirement savings segment."

AIG purchased SunAmerica in 1998 after it lost a bidding war for American Bankers Insurance Group to Cendant Corp. earlier that year.

Lehman Brothers noted that the combined enterprise would create "the U.S. life insurance industry's first King Kong" in terms of capital as well as create an industry leader in the retirement savings business. But Lehman also noted that the AIG bid reflects poorly on the property/casualty industry, as the insurer prefers to invest in companies in other fields.

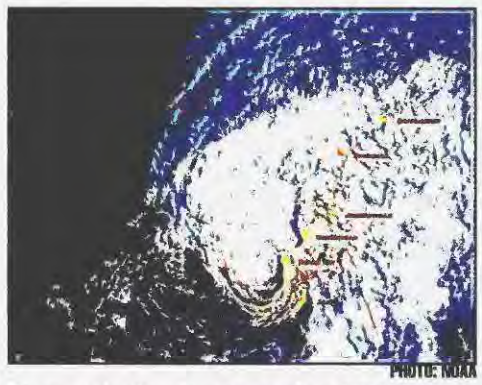


PHOTO: NOAA

Three major hurricanes, such as 2000's Hurricane Gordon, are forecast to form this year.

▶ HURRICANE FORECAST The Atlantic and Gulf coasts should expect a normal hurricane season in 2001, says William Gray, a Colorado State University professor and nationally renowned hurricane forecaster.

Mr. Gray updated his forecast last Friday after predicting a light hurricane season in December 2000.

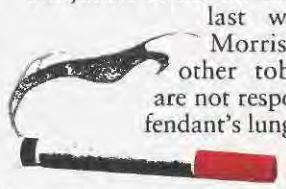
For this year's hurricane season from June 1 to Oct. 30, Mr. Gray and his team at Colorado State in Fort Collins, Colo., are now predicting 10 named storms, six of which will become hurricanes and two that will become major hurricanes of category 3 or higher. That is one tropical storm and one hurricane more than Mr. Gray predicted in December.

There is a 65% chance of one or more major hurricanes making landfall in the United States in 2001, Mr. Gray said. The probability of one hitting the East Coast and the Florida peninsula is 46%, and the probability of a landfall between the Florida panhandle west to Brownsville, Texas, is 37%.

"What we believe is that 2001 will prove to be less active than the very busy seasons of 1995, 1996, 1998, 1999 and 2000 but definitely more active than the average of the 25-year period of relatively low activity we saw beginning in 1970," Mr. Gray said in a statement.

In their final forecast for 2000 hurricanes, issued in August, Mr. Gray and his team predicted seven hurricanes, only one fewer than occurred. Their prediction of three major hurricanes last year proved correct.

▶ SECONDHAND SMOKE SUIT Cigarette makers have won the first of about 3,200 individual lawsuits filed by flight attendants claiming injuries from secondhand smoke.



Six jurors in Miami Circuit Court ruled last week that Philip Morris Cos. Inc. and other tobacco companies are not responsible for the defendant's lung problems. Marie Fontana, who relies on oxygen tanks to breathe, blamed her sarcoidosis on cigarette smoke she inhaled while working as a Trans World Airlines Inc. flight attendant.

The case was the first to come to trial after the cigarette companies in 1997 paid $349 million to settle the so-called *Broin* case. That settlement called for the establishment of a health foundation and allowed the class of flight attendants to bring individual suits only for compensatory damages.

"The plaintiff is suffering from a terrible disease, but it is a disease that is not associated with exposure to tobacco smoke," William S. Ohlemeyer, Philip Morris vp and associate general counsel, said in a statement.

No decision has been made on whether to appeal the verdict, said plaintiffs attorney Philip Gerson of the Miami law firm of Gerson & Davis. He represents about 600 flight attendants in individual suits and plans to continue with those cases despite the recent verdict.

▶ SCOR ACQUISITION SCOR S.A. is in negotiations to buy Sorema S.A. and Sorema North America Reinsurance Co., the reinsurance subsidiaries of French mutual Groupama-GAN.

Paris-based SCOR said in a statement that an agreement could be reached "within the next few weeks" but would not provide any additional details. SCOR, France's largest reinsurer, recorded premium volume of 3.5 billion euros ($3.24 billion) in 2000.

SCOR

Sorema and Sorema North America generated total gross written premiums of 521.6 million euros in 1999 ($525.1 million), which are the most recent figures available. Last year, Sorema set up a syndicate at Lloyd's of London.

In January, Alexis Russet resigned as chairman of Sorema, citing personal reasons. He was replaced by Paris-based Groupama's chief operating officer, Jacques Giraud (*BI*, Feb. 12).

▶ BRIEFLY NOTED Financial guarantee insurer MBIA Inc. said it is closely monitoring bankruptcy proceedings filed last Friday by Pacific Gas & Electric. MBIA has a net par exposure to PG&E of $590 million. The utility had been unable to resolve its financial problems in talks with California utility regulators....Senate Small Business Committee Chairman Kit Bond, R-Mo., urged Labor Secretary Elaine Chao to convene "some form of blue-ribbon commission" to find the best ways to reduce ergonomic-related workplace hazards. He said the complexity of the ergonomics issue should lead the Labor Department to bring together a commission to "allow the various sides to participate" in a dialogue about what the Occupational Safety and Health Administration should do regarding ergonomics. BI

▶ To get breaking news as it occurs, visit Business Insurance's free online Updates at www.businessinsurance.com. All of the material in the For The Record column, as well as other content in this week's issue, is generated from daily news postings that appeared on the Web site in the previous week.

California bill promotes continuity of care

By ROBERTO CENICEROS

SACRAMENTO, Calif.—Recently introduced legislation in California would protect health plan members from treatment disruptions caused by standoffs in contract negotiations between health care providers and insurers.

The measure would allow health plan members to continue to receive care from a doctor or hospital for a limited time after providers sever relations with a health plan.

Health care purchasers in the state say the legislation would prevent plan members from being used as pawns in negotiation battles between providers and health plans, as has occurred in some recent disputes.

The increasing number of contract disputes between providers and health plans is driving the Sacramento-based California Public Employees' Retirement System to seek similar protections for plan members in its health plan contracts for 2002, said Allen Freezor, CalPERS health plan administrator. CalPERS provides benefits to 1.2 million public employees and their families, making it the state's largest health care purchaser.

The legislation and CalPERS' efforts were spurred by a dispute earlier this year between Blue Cross of California and Sutter Health, a Sacramento-based provider organization that owns physician groups and 26 hospitals in Northern California. Medical care for tens of thousands of Blue Cross plan members was disrupted in January after negotiations between the two organizations reached an impasse.

Members in Blue Cross' health maintenance organization were transferred en masse to non-Sutter doctors, and many members of Blue Cross' preferred provider organization found that their doctors were no longer in the network.

One corporate benefits manager said her San Francisco-based company had just moved employees to a Blue Cross plan with Sutter providers when the contract talks fell through. The employer learned of the resulting problems when employees called to complain that Sutter providers would not accept their Blue Cross coverage.

Blue Cross eventually improved its communication with the employer, according to the benefits manager, who asked not to be identified. The insurer also helped employees move to new providers in the Blues plan's network and agreed to pay a higher, nonnegotiated fee with some nonnetwork providers so others could continue to receive care from their chosen physicians.

The legislation could help avoid similar disruptions for other employers and employees in the state, the benefits manager said.

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Obstacles hinder headway of new health plan approach

By MICHAEL PRINCE

ATLANTA—Defined contribution health care plans must overcome numerous obstacles before they can gain widespread acceptance, two speakers told attendees at the National Managed Health Care Congress last month in Atlanta.

Interest in a defined contribution health care system is growing as employers develop an increasingly consumerist approach to their health care plans, said Brad Benton, a partner specializing in health care at the consulting firm KPMG L.L.P. in Atlanta. Under such a system, the employee, and not the employer, directs how health care dollars are spent.

But that shift requires that more health plan options be made available to employees. Furthermore, the change means that employees must realize that they have more of a stake in paying for health care than simply sharing the cost of premiums, Mr. Benton said.

The National Managed Health Care Congress NMHCC

Converting to a defined contribution plan may lower administrative costs, but employers should not view it as a way to eliminate their responsibility to provide health care for their employees, he said. "Rather, it's an opportunity for employers to get control of key issues they are struggling with today," Mr. Benton said.

Getting control means relieving at least some of the administrative burden of providing health care, holding down costs and giving employees both more choices and more responsibility, he said.

A model defined contribution plan would offer employees more options. While not all defined contribution plans are alike, a typical setup consists of a catastrophic care medical plan and some variant of a medical savings account that lets an employee determine where his or her health care dollars are spent. Ideally, such a plan should permit the employee to

See **Plan** *on page 12*

Cat bond participants anticipate market growth

By RODD ZOLKOS

AVENTURA, Fla.—While the market for risk-linked securities continues to develop, and tightening reinsurance markets suggest 2001 might show significant growth, the market is still small in comparison with those for other capital markets asset classes, as well as with the traditional insurance and reinsurance markets.

THE BOND MARKET ASSOCIATION

Still, a gathering last month of the various players in the market—investment bankers, insurance and reinsurance executives, investors and various other participants in the cat bond process—demonstrated that the market might be poised to enter its next phase.

The first Risk-Linked Securities Conference—sponsored by the New York-based Bond Market Assn. and held March 21-23 in Aventura, Fla.—showed interest among both issuers and investors in increasing the size of the market.

Moderating a session examining case studies from two major market players—United Services Automobile Assn. and Munich Re Group—Christopher McGhee of Marsh & McLennan Securities Corp. noted that since the first risk-linked securities deal was done in 1994, there have been 47 transactions by 31 different issuers.

Those deals represent $6 billion in risk transferred to capital markets investors. "Most of these have been insurance and reinsurance companies, but we've also seen a handful of issues by insureds," said Mr. McGhee, who is managing director of Marsh & McLennan Securities in New York.

It's notable that, in each of the past three years, five new issuers have entered the market, Mr. McGhee said. In addition, he said, there has been steady growth in the number of investors in risk-linked securities.

Yet "while we have seen steady growth, this market is still relatively small," Mr. McGhee said.

The $6 billion in risk-linked securities issued to date "is still very marginal compared with the insurance and reinsurance industry," said Manfred Seitz, a member of the executive management at Munich, Germany-based Munich Reinsurance Co.

Although the risk-linked securities market is growing, it's doing so more slowly than Munich Re had hoped, Mr. Seitz said. He added that the

See **Risk** *on page 19*

PROFILE

Cat model pioneer honored as APIW's Woman of the Year

By LEE FLETCHER

What makes Karen M. Clark worthy of the honor of being named Woman of the Year for 2001 by the Assn. of Professional Insurance Women?

It could be that she founded a business without any outside financial backing after recognizing a need in the insurance industry for a catastrophe model to estimate losses.

Or perhaps it is that this business, Applied Insurance Research Inc. of Boston, has grown from one staff member in 1987 to 100 in 2001, with technology that covers all major natural perils—including earthquakes, fires following earthquakes, floods, hurricanes, tornadoes and other severe windstorms—in more than 30 countries in North America, the Caribbean, South America, Europe, Australasia and Asia. AIR's models have become standard tools in the industry for making pricing, underwriting and reinsurance decisions.

Or maybe it's because she is a strong proponent of professional education, for herself and for her employees, within the company and outside its walls.

Perhaps for all these reasons, Ms. Clark will be the 25th recipient of the prestigious industry award at a June 5 cocktail reception at the Marriott World Trade Center in New York.

"One of the main reasons I think we chose Karen is because we were looking for a quality that she certainly possesses—she's an industry innovator," said Catherine A. Kalaydjian, the president of the APIW and vp-claims for QBE Reinsurance and QBE Insurance Corp. in New York.

Ms. Kalaydjian said that another important quality the APIW looks for in those it honors with its Woman of the Year award is "a commitment to supporting women and advancing women's careers within the industry." Ms. Kalaydjian said that

See **Clark** *on page 20*

Court to review federal litigation of arbitrated cases

By MARK A. HOFMANN

WASHINGTON—How the Supreme Court decides an employment arbitration case that the justices recently accepted for review could mean that an employer might end up having to both arbitrate and litigate the same dispute.

In fact, both employers and the federal government have a considerable stake in the outcome of *Equal Employment Opportunity Commission vs. Waffle House Inc.*, employment law experts say. A decision allowing government enforcement agencies to collect monetary damages on behalf of victims of discrimination, regardless of any arbitration provisions in an employment agreement, could increase employer costs and discourage the use of alternative dispute resolution mechanisms. But a decision banning such damages could cut into the EEOC's effectiveness in enforcing anti-discrimination law.

At issue is whether the EEOC can seek monetary damages on behalf of an individual who had signed an employment agreement requiring that job-related disputes be settled through binding arbitration (*BI*, April 2). The justices decided to hear the case in the aftermath of their split decision in *Circuit City Stores Inc. vs. Saint Clair Adams*. In that March 21 decision, the justices ruled 5-4 that the Federal Arbitration Act of 1925 could apply to most forms of employment and, thus, allow employers to require employees who had signed arbitration agreements to resolve employment-related grievances through arbitration rather than litigation (*BI*, March 26).

Employers had feared the high court would follow the lead of the 9th U.S. Circuit Court of Appeals and, for all practical intent, ban the use of binding arbitration through a broad reading of the arbitration act's exemption from the arbitration requirements of workers involved in interstate or international commerce. Following the March 21 decision, employers breathed a collective sigh of relief and declared victory.

But the *Circuit City* decision left unanswered some questions concerning the use of arbitration agreements that the high court's review of *EEOC vs. Waffle House* should help to answer.

The case began in 1994, when Eric Scott Baker filled out an employment application that included an arbitration agreement at a Waffle House restaurant in Columbia, S.C.; Mr. Baker then accepted a job at a restaurant in neighboring West Columbia, S.C., without filling out a new application.

Mr. Baker suffered from seizures and was eventually fired. He did not seek arbitration but filed a complaint with the EEOC, holding that his dismissal violated the Americans with Disabilities Act.

A U.S. district court agreed that the arbitration agreement did not block the EEOC's pursuit of monetary damages on Mr. Baker's behalf. But a three-judge panel of the 4th U.S. Circuit Court of Appeals ruled 2-1 on Oct. 6, 1999, that, while it could seek injunctive relief for Mr. Baker, the EEOC could not seek monetary compensation, including punitive damages. The EEOC appealed to the Supreme Court, which agreed late last month to hear the case.

The high court's decision will help determine exactly how valuable employment arbitration agreements are when the federal government gets involved.

"I'm not surprised at all by the decision of the appeals court in *Waffle House* or the Supreme Court taking the case. It's an area that does need clarification," said Chuck Freeman, a partner in the Chicago law firm of Gardner Carton & Douglas.

"There's a split in the circuits, but the prevailing view is that the employee waives his individual rights but the federal government retains the right to bring enforcement actions seeking either classwide or other forms of equitable relief," Mr. Freeman said.

"The reality is arbitration, both before or after this *Waffle House* decision, was never a complete insulator from employment-related litigation. What you have here is a situation where an employee, by signing an arbitration agreement, has given up his or her claims against an employer, but, clearly, that employee was never in a position to effectively waive whatever other enforcement rights that an agency like the EEOC or National Labor Relations Board or even the Department of Labor enforcing the Fair Labor Standards Act might otherwise retain," Mr. Freeman said.

"Can the EEOC do for the charging party that which the charging party cannot do for him- or herself? A charging party may be an employee, may be a former employee, may be an applicant for employment," said Charles Edwards, partner and head of the labor and employment practice in the Raleigh, N.C., office of the Winston-Salem, N.C.-based law firm of Womble Carlyle Sandridge &

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NAIC urged to keep focus on modernization

By MEG FLETCHER

NASHVILLE, Tenn.—State insurance regulators must "change the dynamics" of their discussions about modernizing insurance regulation and emphasize playing offense—rather than defense—if they are to successfully advance their agenda, urges Kathleen Sebelius, president of the National Assn. of Insurance Commissioners.

Ms. Sebelius

She made that recommendation during the organization's recent spring quarterly meeting in Nashville, after using some Oscar-nominated movie titles to describe her personal view of the challenges that state insurance regulators face today.

"'Crouching Tiger, Hidden Dragon' reminds me of some federal agency that is lying in wait for us to make a false step," said Ms. Sebelius, who serves as commissioner of the Kansas Department of Insurance. Also, "I think many times as state regulators we can identify with Tom Hanks in 'Castaway'...It often seems that we're by ourselves on some desert island," she said.

"But I think the real movie theme that strikes a chord with me is the role Russell Crowe played in 'Gladiator'...I know exactly how he felt in the middle of that arena, with his leg chained to the ground and doors popping open with lions behind every door," she said.

"Often, the people who are observing or participating in the process are really just curious about what the outcome is going to be—they're not terribly engaged in the process. They're there for the sport," she added.

State insurance regulators need to dramatically change the focus of discussions to emphasize the positive steps they have made in recognizing flaws in the state regulatory process and working to overcome them, while preserving consumer protections, she said.

During the past year, the NAIC has made "absolutely remarkable" progress in achieving or working toward financial modernization goals outlined in its "Statement of Intent," she said. These include developing a more market-based approach to speed insurance products to market, as well as creating a streamlined and uniform process for licensing and overseeing insurers and agents.

Supporters of state regulation agree that there is more work to be done by regulators.

Boston-based Liberty Mutual Insurance Co. said in a recent "white paper" that state insurance regulators still must strive to eliminate the "significant weaknesses" of the state regulatory system—including unnecessary distinctions and inconsistencies among states—that reduce predictability and increase costs. In addition, the insurer stated, regulators should eliminate outdated rules and practices that mask the strengths of a state-based system—which Liberty Mutual cited as diversity, innovation and responsiveness—in a modern financial services environment.

At the meeting, NAIC regulators themselves acknowledged the need to scale back a pilot program designed to help achieve a "national treatment" approach for regulating insurers, reportedly due to a lack of consensus among states. The subgroup charged with that project will now focus on more modest goals, including developing uniform processes for company admissions and corporate changes.

For state insurance regulators to remain a viable part of the functional regulatory system, some state insurance departments also must make a strategic change in culture "that moves the process toward greater responsiveness to and support for the insurance industry, together with greater administrative accountability," according to a paper by the Alliance of American Insurers.

That includes eliminating so-called "desk drawer rules," which are regulatory practices not authorized by law, the Alliance stated.

These and other suggestions for state regulatory reform were made in response to increasing calls for optional federal chartering of insurers, which was promoted most recently by the Washington-based American Insurance Assn. (*BI*, Feb. 19).

However, "if it ever comes, federal regulation will not be optional for many companies," because "few will want to be left holding the bag in the state guaranty funds and other residual market mechanisms," said Lenore Marema, vp-legal and regulatory affairs for the Alliance.

"What we still need to do is get the whole NAIC modernization agenda out of the NAIC task forces, out of the NAIC quarterly meeting schedules and into the state insurance departments and into the state legislatures for action in real time," she said. *BI*

Comp market sees signs of firming

By MEG FLETCHER

NASHVILLE, Tenn.—Several factors, particularly an increase in business written in workers compensation residual markets, signal a firming in the workers comp marketplace.

"There is definitely a market tightening," especially in the residual market, said Peter Burton, senior division executive-state relations with the Boca Raton, Fla.-based National Council on Compensation Insurance. His comments were made during a presentation at the recent spring quarterly meeting of the National Assn. of Insurance Commissioners' Workers' Compensation Task Force, held March 24-27 in Nashville.

What remains uncertain is the extent to which insurers—which in many states have already increased rates—will try to recoup their higher costs by raising rates further or by refusing risk-prone or inexperienced business. When such risks can't find coverage in the voluntary market, they must turn to state residual markets, which generally charge a higher premium.

Residual market activity during 2000 compared with 1999 shows a 21.6% increase in the number of business "assignments" to insurers writing such business, as well as a 112.7% increase in assigned premium, Mr. Burton said.

In addition, the NCCI is starting to see residual market insurers writing a lot of larger risks, which Mr. Burton defines as those paying at least $200,000 annually in premium. The NCCI is particularly concerned, he said, because those risks represent a broad mix of industries, not just those traditionally considered to be risk-prone, such as mining or construction.

Additional evidence of firming in the workers comp market is NCCI data indicating that many states need to take into consideration increases in loss costs in setting advisory rates. The NCCI factors the cost of prior losses into the rate requests it files with state regulators.

There has been "a notable shift" over the last few years toward state filings that reflect the increases in loss costs, Mr. Burton said. Most recently, changes in loss costs ranged from an increase of 10.2% in Vermont to a decrease of 15.3% in Georgia. Also, 20 of 30 states had filings that ranged between an increase of 4% and a decrease of 4%, he said.

Some of the loss-cost increases are due to what the NCCI describes as "law filings," which typically stem from legal mandates by state or federal lawmakers. Such mandates include increasing benefits for injured workers and the fees paid to medical providers.

In other action at the meeting, NAIC regulators:

- Changed the site of the NAIC's summer national meeting to New Orleans from San Francisco because of a labor dispute at the San Francisco Marriott Hotel. Plans now call for the meeting to be held at the New Orleans Marriott on the same dates, June 9-12.
- Advanced the NAIC's Special Purpose Reinsurance Vehicle Model Act. The Insurance Securitization Working Group adopted the measure and sent it on to the Financial Condition Committee, which received it and plans to study it further.

The model allows the creation of an SPRV to facilitate the securitization of one or more ceding insurers' risk within the boundaries of the United States. Currently, such vehicles typically are available only offshore.

Major insurer trade associations generally support the measure, but the Reinsurance Assn. of America opposes the creation of such vehicles except for use with catastrophic risks.

- Hosted the first meeting of a new Consumer Protections Working Group, which was established to focus on consumer concerns.

"Our ultimate goal with this new working group is protecting consumers while keeping insurance companies accountable," said NAIC President Kathleen Sebelius, the insurance commissioner from Kansas.

The group discussed several matters, including the possible use of the NAIC's Web site as a "consumer portal" to provide both consumer complaint and insurer financial information.

Working group members are working on other consumer-focused projects, including the development of a list of the best consumer guides available on state insurance departments' Web sites.

- Recognized the North Carolina, Utah and Wyoming insurance departments for successful implementation of all 11 technology-based initiatives in the Uniform Regulation Through Technology program, formerly known as State Regulation 2000.

Currently, 26 jurisdictions have completed these initiatives, which are designed to streamline and strengthen state regulation.

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OPINIONS

A proposal worth retiring

LIKE MANY RECYCLED IDEAS, a proposal by a group of congressional Democrats to give early retirees more health care coverage options isn't much better the second time around.

As we report on page 1, the proposed measure is geared to individuals between 55 and 64 who are too young to be eligible for Medicare but, depending on their health, may find health coverage too costly in the personal lines market.

While this proposal is well intentioned, we fear it could have a host of unintended consequences, not least of which would be eliminating much of the flexibility that employers now have in offering benefits voluntarily to early retirees.

The legislation would allow laid-off employees as young as age 55 to purchase Medicare coverage for a monthly premium of about $460. Individuals who choose to retire at age 62 could purchase Medicare coverage for about $325 a month, plus an additional small surcharge when they turn 65.

In addition, in cases where an employer has terminated health care coverage for retirees 55 and older, the employer would have to extend COBRA coverage to those retirees until they turn 65. The employer could charge retirees a premium of up to 125% of the group rate to cover the extra administrative burdens such a provision would impose. For some early retirees, though, that could create a 10-year commitment by their former employers to provide COBRA coverage.

The legislation draws heavily on a proposal first advanced by the Clinton administration but not acted upon by Congress. The most significant difference between that proposal and the latest bill, which was introduced by Sen. John D. Rockefeller IV, D-W.Va., and Rep. Fortney Stark, D-Calif., is the proposed tax credit.

To be sure, the measure would provide some financial relief to employers with retiree health care plans. An employer, at least in the case of retirees 62 through 64, could cut costs by terminating its retiree health care plan and then reimbursing retirees—such as through higher pension benefits—for at least a portion of their Medicare premiums. That would be a lot less costly, in many cases, than paying for those early retirees to be covered under a retiree health care plan. And retirees, through employer payments and the federal tax credits, could end up paying less for health care coverage than they currently do. That is because regardless of the coverage purchased—Medicare or COBRA—retirees would be eligible under the proposal for a federal tax credit equal to 50% of their premium costs.

That said, however, would it really be in the public interest to encourage workers to retire at 62? With life spans growing, we don't believe it makes much sense to encourage—through tax breaks—retirement at earlier and earlier ages. We also question whether it would be a good use of federal tax dollars to subsidize the health care premiums of those early retirees who, because of financial wealth, are able to retire early.

We also have questions about how COBRA continuation coverage would be applied.

Sen. Rockefeller justifies what could be a 10-year employer commitment to provide COBRA—far longer than the 18-month duration of typical COBRA coverage—as only fair if an employer "reneges" on its commitment to provide retiree health care coverage. We don't think—and courts across the country have concurred on this point—that an employer is reneging if it terminates a plan that it not only voluntarily agreed to provide but also reserved the right to amend or terminate.

By requiring employers that cancel coverage for early retirees to offer COBRA coverage for such a potentially lengthy period, the measure could discourage many employers from choosing to offer such health coverage in the first place.

Certainly, good health policy dictates that as many people as possible be covered in group or public plans. But we believe that this measure, while well intentioned, does not achieve that goal in a way that is cost-effective.

Business Insurance creates new look for magazine

This week's issue of *Business Insurance* introduces several changes in the design and layout of the magazine to make it easier to read, better organized and—we hope—more attractive.

One of the main changes you'll notice is an increase in the size of the type we use.

Another big change is a redesign of page 2 to contain an expanded index of each issue's contents, as well as an expanded Updates column. Updates also now encompasses the For the Record column.

Pages 1 and 3 remain devoted to our top stories each week, but we will be running fewer stories on each page to accommodate more and larger photographs and illustrations with these articles. The change also means that more major articles will appear throughout each magazine, not just on the front pages.

BI's periodic Spotlight report sections will now begin on page 10 instead of page 3. On non-Spotlight weeks, the Perspective section will appear on page 10.

Other design changes can be found on this page, where the editorial Opinions and Letters to the Editor appear, and on the Ticker page, where the *BI* Stock Index has been reformatted.

These changes are not intended to be a major overhaul of *Business Insurance*'s design but instead small improvements featuring a more updated style to make the magazine easier to read and better organized.

Feedback on the changes is welcomed. Send your comments to Editor Paul Winston at *pwinston@crain.com*.

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PERSPECTIVES

Get used to, and prepare for, power outages

By Charles S. Macaulay

It appears that rolling blackouts and brownouts in California—and perhaps other states—will be with us for years to come.

And, as power shortages continue, there also is an increased risk of first-party and third-party losses for businesses in affected areas. As a result, risk managers should make sure their organizations' contingency and recovery plans are current and as effective as possible.

The primary reason that power shortages are likely to continue is because there is no immediately available supply of new power to supplement existing demand, much less meet the projected growth in demand over the next several years.

While power conservation efforts may slightly reduce the extent of outages in the short term, they are unlikely to have a significant long-term effect. Indeed, it is unreasonable to expect that overall usage reductions can be achieved over a protracted period with a growing economy and population base.

New sources of power will take years to come on line. Even without the environmental and land use regulations currently in place throughout the Western United States, it simply takes several years to design and build a large-scale power generating facility.

There also is a possibility that the outages California now is experiencing will spread to other Western states as a result of a federally mandated cap on most wholesale power pricing. This step by the government could have the effect of increasing demand, though there are plans to offset this potential effect with new power usage legislation that would limit consumption at the retail level.

As long as the gap between supply and demand continues, the risk of outages will remain. With this risk comes an increased potential for casualty and property losses throughout the region. Several types of losses can be expected, but there are ways to mitigate the effects of the outages.

The greatest impact obviously will be business interruption. While for most office-type facilities, these impacts will be relatively light—in part because most of the blackouts are controlled to last only about one hour—manufacturing facilities are exposed to more significant losses. These losses may or may not be insured. A one-hour outage in an office may mean nothing more than an extended lunch break or early quitting time for some employees, but it often takes hours for production operations to recover from a power outage.

Here are some steps that should be considered by all organizations that are exposed to blackouts:

- Test the information technology contingency plans to ensure they are up to date and effective. An effective test includes actually restoring data from back-up media to active media.
- Ensure a plant's restart plan is up to date, including lists of critical personnel and contact information.
- Maintain a good testing program for emergency power equipment. Generators should be tested weekly, including the automatic start feature. Generators should be run under load at least monthly, and a generator's automatic transfer switch should be included in the load test. In addition, top off fuel tanks for emergency generators whenever the level drops below three-quarters of a tank. Be sure to check emergency lighting at least quarterly.
- Develop procedures to minimize the impact on a company's operations when warned by utilities of an imminent power outage. Most large electric power consumers are warned at least several hours before an outage.

The procedures to follow after receiving such warnings should at least address the following:

- Facilities that are subject to significant damage to work in process in a power outage may find it advantageous to take the precaution of shutting down in a controlled manner before there is an actual outage.
- When the power does go out, assign personnel to shut off the main power switches on all equipment. This will ensure the equipment is not damaged during power fluctuations that are likely during the period initially following power restoration. It will also minimize the chance of employee injury should equipment start suddenly, surprising someone nearby.
- Immediately back up all electronic data.
- Check fuel levels for emergency equipment, such as generators and fire pumps.
- Check air-pressure levels in dry pipe fire sprinkler systems to prevent false trips during the outage. There is a potential risk, for example, that dry pipe sprinklers could be triggered in the event of a fire if they don't have compressor power for a couple of hours.
- Consider whether to send employees home for the day. Having employees wandering around in a darkened facility could result in avoidable injuries.
- Review security precautions. Test the electronic access system on back-up power—if provided—to ensure it will work properly in a power outage. Could critical security breaches result if the system is out of service? Can personnel be trapped in secure areas during an outage? Some older systems are designed to fail "shut."

Power outages during summer months—when demand and the risk of shortages are at their peak—can result in overheating of sensitive equipment if emergency cooling is not available. This is especially true of equipment that must be heated to function properly. When it is shut down normally, a cooling circuit continues to operate to prevent a build-up of residual heat. Special considerations may be appropriate to provide emergency cooling for these machines.

While power outages now last approximately one hour, consideration should be given to the possible effects of much longer outages in the future. Issues to be considered in the event of longer outages include:

- Procurement of more emergency generating capability.
- Fuel supplies for emergency generators.
- Alternative operating hours, such as transferring maintenance to day shifts and peak production to graveyard shifts.
- Transferring critical functions to facilities outside the area.
- Mirroring/duplicating critical functions at widely separated facilities.

These actions will not be appropriate at all facilities, and additional precautions not mentioned may be prudent. It is clear that those who don't consider the long-term ramifications of repeated power outages in the Western United States over the next several years will probably experience avoidable losses. BI

Charles S. Macaulay is the managing consultant for the West Region of North America for Global Risk Consultants in Issaquah, Wash.

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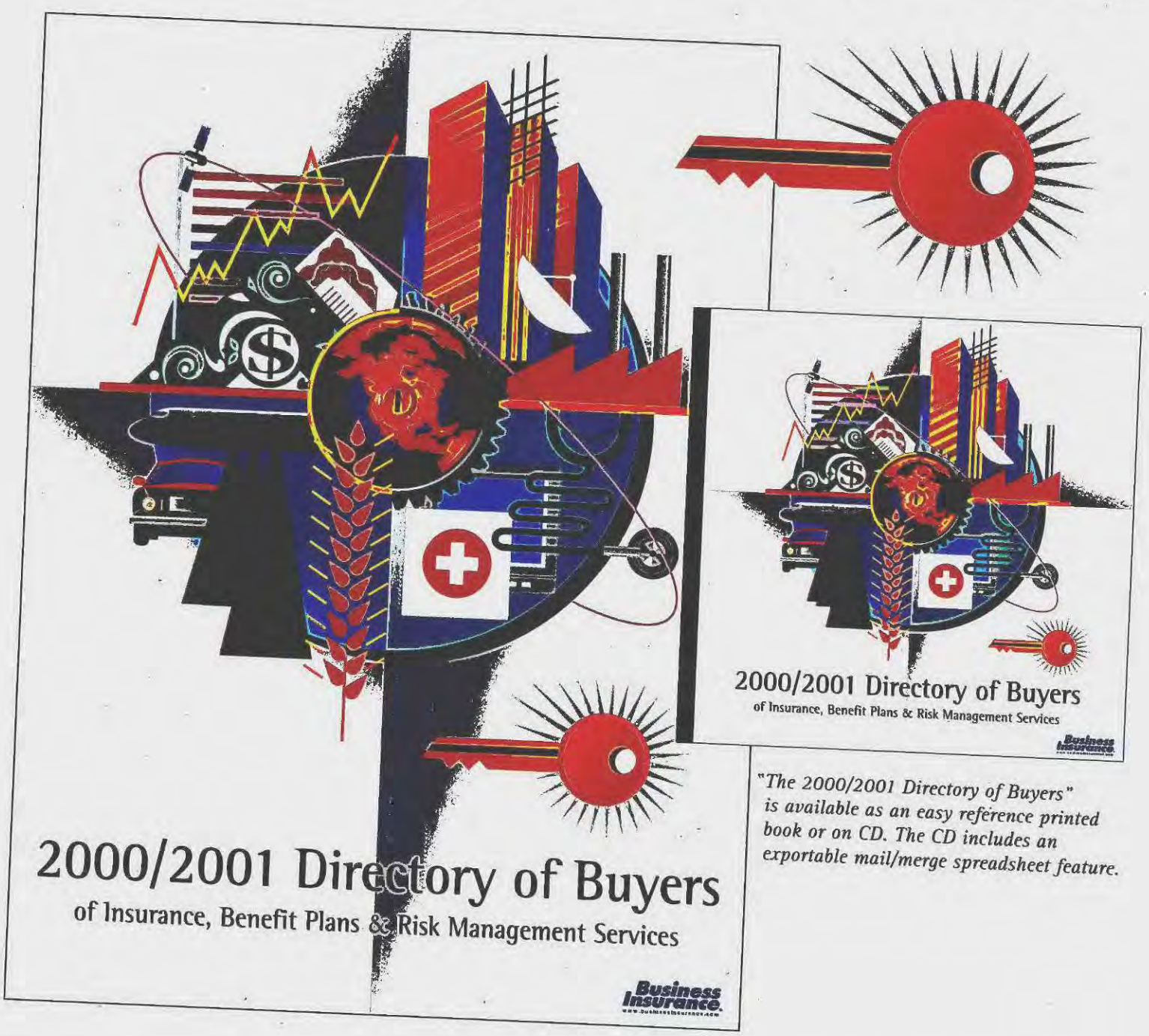

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Plan

Continued from page 3

customize the health plan, such as adding coverage for so-called lifestyle drugs or alternative medical care. Furthermore, the plan should make an employee financially accountable for his or her health care, leading to the adoption of healthier habits.

"There is the opportunity to reinvigorate the debate around health behavior," Mr. Benton said.

Despite their advantages, though, not many employers will soon switch to defined contribution health care plans, said Charles Montreuil, vp of corporate human resources for Carlson Cos. Inc. in Minneapolis.

Employees have come to view health care as an entitlement provided by employers, not as a valued and optional benefit, Mr. Montreuil said. "We, as an employer, get absolutely no credit with employees for providing health care coverage," he said.

And with continuing tight labor markets, employers are discouraged from passing rising health care costs on to their employees. And employees become upset when their employers switch health plans, which often forces workers to change doctors.

One obstacle to the increased adoption of defined contribution plans is concern about their potential to improve the quality of health care. Currently, with little competition among health plans, there is not much incentive to boost quality, Mr. Benton said.

With a widespread defined contribution system, though, there would be lots of competition among plans, Mr. Montreuil said. Such a system would result in "a consumer that has competition for his health care dollars, and competition will drive quality," he said.

In addition, health plans would have to make themselves stand out from the crowd, Mr. Montreuil said. One way to do so, he said, would be to offer higher-quality care.

Other barriers also exist. It is widely believed that employees would be reluctant to switch to defined contribution health plans. But Mr. Benton noted that a recent survey by his company shows that employees may be more willing to change than had previously been thought.

An employee's openness to change depends on his or her current level of satisfaction, the survey found. An employee who is satisfied with his or her current health care plan is less likely to accept a defined contribution plan. Conversely, an individual who is unhappy with the current system will more readily agree to a change, Mr. Benton said.

Any conversion will require a significant education effort on the part of the employer, in the same way that education was needed when employees were switched to defined contribution pension plans.

Still another barrier is the current tax system, which does not provide the same tax benefits for a defined contribution plan as it does for an employer-sponsored plan. But Mr. Benton said that while the current tax system does not promote switching, conversion is still economically feasible under current tax laws.

What may prove more important than the current tax code, however, is the potential liability that may be created by the enactment of a patients' bill of rights, Mr. Montreuil said. If a new law imposes liability on employers, it could spur employers to adopt a defined contribution system, he said.

Yet another problem with a defined contribution system is that a plan that offers quality care for a particular illness may disproportionately attract patients with that illness. This may flood that plan with sick patients. To avoid this problem, Mr. Montreuil recommends that patients in poorer-than-average health receive risk-adjusted health care premiums from their employers. That way, health plans whose patients tend to require more care will also receive more money to treat them, he said.

Mr. Benton anticipates that, in three to five years, many employers will have switched to some sort of a defined contribution system.

While Mr. Montreuil would make no forecasts about conversions to the new system, he did say that once a few employers make the switch, many others that are now reluctant will quickly follow suit.

Sally Whitney, managing editor of Best's Review in Oldwick, N.J., moderated the session. BI

Cost tops list of concerns for U.S. health care system

By MICHAEL PRINCE

ATLANTA—The U.S. health care system faces a number of crises that must be addressed in the near future, three health care experts say.

While all three generally agree on what the problems are, they differ about how to fix them.

Uwe Reinhardt, a professor of economics at Princeton University in Princeton, N.J., said that three crises afflict the U.S. health care system. The first is the return of sharp cost increases.

Second, Mr. Reinhardt said, a huge sector of the U.S. population—perhaps 42 million people—lack any health care coverage whatsoever. And the problem of the uninsured, he said, has not improved with the strong economy.

"A booming economy is no cure to the uninsured," Mr. Reinhardt told attendees at the National Managed Health Care Congress last month in Atlanta.

The third crisis, he said, is the lack of quality and the large amount of waste in the health care system.

Mr. Reinhardt said the crisis could be attributed to the lack of a guiding social ethic in the United States concerning health care.

A society can adopt any of a number of perspectives on health care, Mr. Reinhardt said. For example, he said, in Canada, health care is regarded as a social good to be made available to all people.

The National Managed Health Care Congress NMHCC

Another approach, commonly found in Europe, holds that while health care is a social good, individuals have the option to purchase their own care, which, presumably, would be of higher quality.

The approach in the United States regards health care as a service like any other that is available for private consumption; that perspective assumes that the rich will be able to afford more and better care than the poor, Mr. Reinhardt said.

Mr. Reinhardt said that much of the criticism directed at managed care in recent years has been unwarranted.

Current health care spending is $350 billion less than was projected a few years ago, he said. Those savings stem from the ability of managed care to save money, he said, yet "no one thanked the managed care companies."

Mr. Reinhardt described three principles that he said govern health care around the world. First, everyone complains about the health care system in his or her country. Second, these complaints lead to health care reform. Third, he said, such reform will always fail.

Nevertheless, Mr. Reinhardt recommended that some immediate improvements be made in the current U.S. system by using a portion of the federal budget surplus to cover those who are now uninsured; simultaneously, he said, the government should require every individual to purchase at least a basic package of health insurance. Furthermore, he said, the government should spend at least an additional $1 billion on medical research to determine which medical treatments produce the best outcomes.

Dr. David Eddy, senior adviser for health policy and management at Kaiser Permanente in Aspen, Colo., said that three main problems plague the U.S. health care system: cost, quality and access.

Dr. Eddy said that problems in regard to costs have developed because patients want medical services but want someone else to pay for them. "Everyone wants to have their cake and eat

See **Cost** *on page 14*

Managed care's value debated

By MICHAEL PRINCE

ATLANTA—Two health care experts offered sharply divergent views of the value of managed health care during a lively session of the National Managed Health Care Congress last month.

The National Managed Health Care Congress NMHCC

Managed care's record is not one that should make health plans proud, said Dr. David Himmelstein, professor of medicine at Harvard Medical School in Cambridge, Mass. The number of uninsured individuals is at its highest level in 30 years and has continued to rise during the past decade, despite the booming economy, Dr. Himmelstein noted. Health care costs are also increasing, and there is a surplus of medical resources, including an excess number of doctors and hospital beds, he said.

"We have done a poor job of matching those resources to needs," Dr. Himmelstein told attendees at the NMHCC in Atlanta.

In addition, he said, the number of administrators with managed care companies is growing six times faster than the number of doctors.

Dr. Himmelstein said that studies have found that although managed care provides good care to health plan members who are generally healthy, sick patients generally get better care in fee-for-service plans. In addition, managed care organizations seek out healthy patients and try to squeeze out sicker members, he said.

The past decade has also seen a sharp movement away from nonprofit managed care organizations toward for-profit, publicly held companies. He added that for-profit organizations, despite generally providing worse care than nonprofits, "are coming to dominate the market."

Furthermore, Dr. Himmelstein said, managed care plans are not lean organizations. Managed care companies, he explained, consume about 20% of their premiums in administrative costs and profits. In contrast, in the Medicare system, that figure is closer to 2%, he said.

Dr. Himmelstein favors a shift to another approach to health care in the United States. "There are better alternatives," he said.

He noted that surveys support his view, showing a growing disenchantment with managed care on the part of patients and physicians alike. "The popularity of our system has gone through the floor," he said.

"We are headed to health care reform by a system that is dysfunctional," he added.

Dr. Himmelstein said he prefers a nationalized health care system that would cover everyone, such as the system used in Canada. But, he said, such a system would require a greater level of government funding than currently exists in Canada. He contended that many of the problems with the Canadian system, such as long waits to see providers or have tests conducted, result from sharp funding cuts made by the Canadian government. He added that in the United States, the wealthy pay a smaller percentage of their income for health care than do the poor—a disparity that a Canadian-style system would correct.

Dr. Himmelstein was quick to point out, however, that he's still open to a system that does not involve the government. "I have no love of government—it's just the alternatives I like less," he said.

> *'Managed care has put on the national agenda' that resources are limited.'*
>
> *— Dr. David Nash*
> *Thomas Jefferson University Hospital*

On the other hand, managed care has not done such a bad job, counters Dr. David Nash, professor of health policy at Thomas Jefferson University Hospital in Philadelphia.

Managed care has made a commitment to measure clinical quality and hold physicians accountable for the care they provide, he said.

"It's certainly not perfect, but we have seen the growth of a system to promote quality that we had not seen before," he said.

In addition, managed care has changed the debate over health care by introducing the notion that health care resources are limited. "Managed care has put on the national agenda that we cannot do everything for everyone all the time," he said.

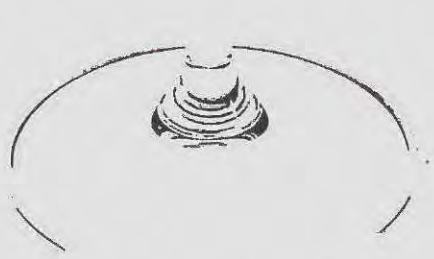
Dr. Nash also maintains that managed care has promoted public health, created the disease-management industry and helped encourage preventive care.

In addition, Dr. Nash dismissed Dr. Himmelstein's call for a nationalized health care system, calling such an approach contrary to the nature of Americans, who prefer choice to a single system.

The two doctors were able to reach common ground on one item: Both acknowledged that the U.S. system is full of waste that must be eliminated. "There is no evidence that the U.S. is more efficient than any other country," Dr. Himmelstein said.

"On that we can agree," Dr. Nash replied.

Ian Morrison, an author and speaker on health care topics, moderated the discussion. BI



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Cost

Continued from page 12

it too," he said.

For this, Dr. Eddy said, blame falls on all participants in the health care system—patients, employers, health plans and even healthy people. But he reserves his most severe rebuke for physicians and politicians. While the other groups are merely being selfish, Dr. Eddy said, physicians and politicians bear special responsibility for the health care system. Doctors could take cost into account when they make medical decisions, but they don't, he said.

Dr. Eddy also places much of the blame for low-quality medical treatment on physicians. "We, as a profession, don't know what we're doing," he said.

Too often, he said, doctors do the wrong things or they do the right things in the wrong ways. And the problem is prevalent throughout the profession, he said. "It's not just a small problem of some bad-apple physicians," he said.

The first step toward a solution of all these problems, Dr. Eddy said, is determination. "First, we need to decide that we want to solve the problem," he said.

Costs must be held in check so that they increase only at the same rate as overall inflation, he said. Also, everyone has to accept that health care resources have limits. Furthermore, he said, clinical waste has to be cut.

As for quality, Dr. Eddy said, better research is needed that ties clinical decisions to outcomes, and clinical care has to be more effectively managed.

He acknowledged that, under such a plan, physicians would have to give up some autonomy, but that's preferable to the current system in which doctors are allowed to do whatever they want.

Dr. Eddy said managed care companies should be given more authority to raise quality and rein in costs.

"Let managed care really manage care," he said.

As a first step, Dr. Eddy proposed publicizing the message "that it's important to take cost into account when making medical decisions." Such a message, he said, would inform the public that cost is part of the U.S. health care system.

A different concern was voiced by E. Haavi Morreim, a professor of ethics at the University of Tennessee College of Medicine in Memphis, Tenn. She said that a major problem with the health care system is the current arrangement between health plans and patients.

Health plans have promised patients they will receive whatever care is "medically necessary," Ms. Morreim said. As a result, she said, patients have come to believe that all care will be covered by their health plans.

"They expect the sun, the moon and the stars," Ms. Morreim said.

In reality, health plans don't tell patients that treatments are not covered because of their costs, she said. Instead, they typically say that they are not medically necessary.

"We're not willing to say it's great but it's not worth the money," Ms. Morreim said.

Many people believe that money is no object when it comes to health care; consequently, when coverage for a treatment is denied, they tend to believe that the denial must be for reasons other than cost. But when someone says it's not about the money, that's a ruse, she said.

"Of course it's about money," Ms. Morreim said.

The solution, she said, is to remove medical-necessity language from health plan contracts. In its place, health plans should delineate exactly which treatments are covered. Then, she said, the contract language would be "if you buy this health plan, here is what you get."

The session was moderated by Barry Scheur, president of the Scheur Management Group Inc. of Newton, Mass. BI

NMHCC draws 7,500

ATLANTA—More than 7,500 attendees and exhibitors journeyed to Atlanta for the 13th annual National Managed Health Care Congress.

The National Managed Health Care Congress NMHCC

This year's conference featured more than 400 exhibitors and nearly 100 educational sessions. Next year's conference will be held April 15 through 17 in Baltimore.

For more information, call the NMHCC at 888-882-2500.

First draft possible in six months

Data standard seen

By DAVE LENCKUS

CHICAGO—Recent agreements reached by the Risk & Insurance Management Society Inc., a standards-making organization and insurance industry officials have accelerated the development of a risk management data standard, according to risk management officials involved in the project.

As a result of the agreements, reached late last month, the insurance and financial industry standards developer may have the first draft of a standard for transmitting an extensible markup language—or XML—data stream for monthly loss runs over the Internet within six months, said Elizabeth M. Morrell, who chairs the Data Standard Task Force of the RIMS Technology Advisory Council subcommittee. The subcommittee put the data standard development project on the fast track last year by bringing in the standards developer, the Assn. for Cooperative Operations Research & Development of Pearl River, N.Y. (*BI*, Dec. 4, 2000).

The lack of a claims data standard presents many problems for risk managers. Insurers and third-party administrators define data in various ways in their proprietary claims-handling systems. As a result, risk managers face a difficult, time-consuming and expensive task of converting supposedly identical data elements that they receive from various claims-handling sources into data that truly match up on an apples-to-apples basis.

A data standard that is available in the XML format would both eliminate those headaches for risk managers and facilitate the transmission of the data over the Internet. The XML format allows those who want to exchange Web-based data over the Internet to tag data and define it in specific ways.

At year-end 2000, the effort by RIMS, ACORD, the Insurance Data Management Assn. and the Insurance Services Office Inc. had resulted in a draft standard for how risk managers seeking policy quotes would submit information about their exposures to insurers over the Internet.

At a meeting of 38 representatives from those groups in Chicago March 27-28, risk managers agreed to accept ACORD's existing first-notice-of-loss XML data stream standard and move on to the more important and potentially trickier loss-run standard, according to Ms. Morrell, the risk management information systems administrator at Atlanta-based Southern Co., an electric utility holding company.

To that end, the group agreed to largely adopt a data dictionary that the IDMA has written and to incorporate the XML tags that ACORD has developed for that data. The dictionary provides a standard data definition that all risk managers, brokers, TPAs and insurers would use in developing and exchanging various insurance and loss reports.

In addition, the group agreed to harmonize dictionary definitions that are inconsistent with several other sources. Those sources include some data definitions that risk managers developed at the meeting and a RIMS glossary of risk management terms.

"Considerable progress was made exploring the semantics and definitional barriers that might otherwise separate the parties," said Christopher Mandel, RIMS vp-member and chapter services and assistant vp-enterprise risk management at USAA Group in San Antonio.

A draft loss-run standard would be developed for one or two lines of coverage initially, but loss-run standards for other lines would follow, Ms. Morrell said. BI

Kelly takes post at Willis

William J. Kelly has joined Willis North America Inc. as executive vp and practice leader of financial institutions. Mr. Kelly will be responsible for developing business with financial services entities for the brokerage from his New York base.

Mr. Kelly left J.P. Morgan & Co. late last year after its acquisition by Chase Manhattan Corp. He spent 15 years at the investment bank and established himself as a leading figure in risk management (*BI*, Dec. 18, 2000). He held the position of managing director at the time of his resignation.

Mr. Kelly

Mr. Kelly's responsibilities at J.P. Morgan included global risk and insurance management with respect to all corporate property/casualty exposures, as well as $8 billion in real estate investment assets and all trust and estate assets.

He has held a number of industry leadership positions, including chairman of the International Federation of Risk & Insurance Management Assns. and president of the Risk & Insurance Management Society Inc. He also has served as a director of the Spencer Educational Foundation and chairman of the American Bankers Assn.'s insurance committee.

He holds a bachelor of arts degree in English literature from Fordham College and a master of business administration degree from Fordham University Graduate School of Business.

* * *

Christopher E. Mandel has joined USAA Group in San Antonio as assistant vp-enterprise risk management.

COMINGS & GOINGS: BUYERS

Mr. Mandel will oversee all property/casualty and operational risks for the financial services company. He reports to Joe Robles, executive vp and chief financial officer.

Mr. Mandel has assumed the newly created position after serving as director-global risk management at Tricon Global Restaurants Inc. in Louisville, Ky. His replacement at Tricon has not been announced.

Mr. Mandel earned a bachelor of science degree in business administration from Virginia Tech in Blacksburg, Va., and a master of business administration degree from George Mason University in Fairfax, Va.

Mr. Mandel

He holds the Chartered Property Casualty Underwriter, Associate in Risk Management and Associate in Claims designations. Mr. Mandel serves as vp, member and chapter services, on the executive council of the Risk & Insurance Management Society Inc.

He has been nominated to serve as first vp of RIMS, the traditional steppingstone to the society's presidency.

* * *

Steve DiGiacinto has been promoted to director-risk management services at Hallmark Cards Inc.

Mr. DiGiacinto replaces **Richard Heydinger**, who retired at the end of last year.

In his new role, Mr. DiGiacinto will be responsible for the corporate risk management services team that works with operating unit management on insurance, claims, loss prevention, health and safety compliance and environmental conservation.

He reports to **Bruce McKinney**, treasurer of Kansas City, Mo.-based Hallmark.

Mr. DiGiacinto joined Hallmark in 1993 as an environmental issues administrator and has held positions that include senior environmental, health and safety administrator; principal risk control administrator; and risk control services manager.

He earned a bachelor of science degree in chemistry from the University of Nebraska and a master in business administration degree from the University of Kansas.

Mr. DiGiacinto is a registered environmental engineer.

* * *

Alison Gregg has been named executive director of human resources at HNC Insurance Solutions, an Irvine, Calif.-based division of HNC Software Inc.

Ms. Gregg replaces **Marlene Maher**, who was promoted to senior vp of human resources for HNC Software.

In her new position, Ms. Gregg is responsible for HNC Insurance Solutions' recruiting, retention, employee relations and other human resources functions.

She reports to **Sean Downs**, president of the parent company.

Before joining HNC, Ms. Gregg was vp of human resources at Embion Inc. in Irvine.

Ms. Gregg has a bachelor of arts degree in psychology from the University of Redlands and a master's degree in counseling psychology from Loyola Marymount University. She holds a certificate in business management from the University of California at Los Angeles.

GLOBAL BRIEFS

The Polish state treasury has granted approval for pan-European financial group **Eureko** to take control of Polish insurer PZU. The treasury announced that Eureko would increase its stake in Warsaw-based PZU to 51% from 30% during a public offering expected to take place this year....Sydney, Australia-based **QBE Insurance Group** has announced a management restructuring for its European operations. Under the change, Paul Glen, currently deputy general manager of European operations, will become general manager of the group's European operations. This move will bring all of QBE's European operations under Mr. Glen's direction, except for the group's Lloyd's operation, which will continue to be managed by Steven Burns....New York-based **Ambac Financial Group Inc.** has appointed Nancy Fox to head the group's new office in Sydney, Australia. Ms. Fox was previously managing director and head of asset securitization in the structured finance division of Dutch bank ABN AMRO in Sydney. In her new role, Ms. Fox will report to Douglas Renfield-Miller, managing director of Ambac's operations in Asia, Australia and the emerging markets....**The Salvage Assn.**, the London-based marine casualty surveying organization, has been purchased by Middlesex, England-based British Maritime Technology Ltd. BMT is a technology consultant that specializes in design, design support and risk management....Moody's Investors Service Ltd. in London has downgraded the performance rating of **Lloyd's of London syndicate 227**, managed by St. Paul Syndicate Management Ltd., to B- below-average from B average. Moody's said the downgrade was based on the short-term outlook for the non-marine property-casualty syndicate, which recently announced that it expected to post a loss for the 2000 year of account....Moody's has placed its B+ above-average performance rating of **Lloyd's of London syndicate 1009**, managed by Markel Syndicate Management Ltd., under review for a possible downgrade. The move follows the announcement that the energy and aviation syndicate's underwriter, David Hope, has resigned....Moody's has assigned an A1 insurance financial strength rating to Tokyo-based **Aioi Insurance Co. Ltd.**, the product of the merger earlier this month of Dai-Tokyo Fire & Marine Insurance Co. Ltd. and Chiyoda Fire & Marine Insurance Co. Ltd. Moody's said the rating action reflected the improved competitive position of the company, which now has a 12% share of the Japanese market....Moody's has also assigned an A1 rating to another recently merged Japanese insurer. **Nipponkoa Insurance Co. Ltd.** was created by the April 1 merger of Nippon Fire & Marine Insurance Co. and Koa Fire & Marine Insurance Co. Moody's said the rating action reflected the company's "more defensible market position."...Daniel Schante has been appointed secretary general and chief executive of the **Comite Europeen des Assurances**. Mr. Schante was formerly a board member of Winterthur Europe and senior adviser to the chief executive officer of Winterthur Swiss Insurance Co. in Switzerland....Standard & Poor's Corp. has affirmed its AAA rating of **Munich Reinsurance Co.** S&P said the rating affirmation was made in response to Munich Re's April 1 announcement that it will continue to sell off its shareholding in Allianz A.G. Holding. By the end of 2003, Allianz and Munich Re's cross-holdings will have been reduced to about 20%, S&P said (see related story).

Bank deal would boost Allianz in Germany

MUNICH, Germany—Allianz A.G. Holding is on its way to becoming Germany's first bancassurance group and the world's fourth-largest insurance group, following the agreement of Dresdner Bank A.G. late last month to a 23.4 billion euro ($20.9 billion) takeover.

In an April 1 statement, Munich, Germany-based Allianz said the new entity would concentrate "on the three core business activities of insurance, asset management and banking."

With its combined sales and consulting capacities and expansive product range, the new group also expects to participate in the anticipated high growth rates in German private and corporate pensions, the Allianz statement said.

According to the statement, Allianz has approximately 2 million corporate customers, while Dresdner Bank has about 165,000 corporate clients.

Allianz's offer is worth 53.13 euros ($47.48) per share of Dresdner, representing a 15% increase over the bank's closing share price of 45.99 euros ($41.10) on March 27, the day before the proposed takeover was first reported.

Allianz already holds 21.4% of Dresdner's shares, and Dresdner has a 10% stake in Allianz.

The deal is also linked to Allianz's acquisition of Munich Reinsurance Co.'s 40.6% stake in Allianz Lebensversicherungs A.G., Allianz's main German life insurance unit. Munich Re will acquire from Allianz and Dresdner Bank all of their shares in HypoVereinsbank Group next year.

Allianz Chairman Henning Schulte-Noelle said: "By reducing cross-holdings, Allianz and Munich Re are laying the foundation for a crucial realignment of the structures within the German financial services sector. This entails strengthening the competitive position of the companies and, thus, Germany's position as a financial center."

—By Edwin Unsworth

Claims may face fund shortfall

Asset adequacy in question at HIH

By DAMIEN TOMLINSON and KATE TILLEY

SYDNEY, Australia—The provisional liquidator who has taken charge of the financial affairs of HIH Insurance Ltd. says it will be at least nine months before there is any distribution of assets.

The liquidation covers Sydney, Australia-based HIH and 17 of its subsidiaries, including FAI Insurances Ltd., World Marine & General Ltd., and CIC Insurance Ltd., all based in Sydney.

"There is a very real possibility, in relation to some classes of insurance for which the HIH Group is responsible, there will not be sufficient available funds to meet the full amount, or even a significant portion, of any claim that may be made," said Tony McGrath, corporate recovery partner with the Sydney-based liquidator KPMG Australia.

Reinsurers would not comment on their potential liabilities. Bruce Ford, senior vp of Sydney-based St. Paul Re, a unit of the St. Paul Cos. Inc. of St. Paul, Minn., said his company had reinsured some HIH treaties. Mr. Ford would not comment on the possibility of the liquidator seeking funds from reinsurers, saying that

See **HIH** *on next page*

Lloyd's agency Beazley Furlonge undergoes MBO

By SARAH VEYSEY

LONDON—Lloyd's of London managing agency Beazley Furlonge Ltd. has been purchased by its management.

Under the new structure, the directors and staff of Beazley now own 100% of the Lloyd's managing agency, while a variety of sources will continue to provide capacity for syndicate 623, the group announced last week.

Andrew Beazley, the syndicate's underwriter and one of its founders, explained that the group opted for the buyout after its strategic partner hesitated to boost the syndicate's risk capital. He declined to identify the partner.

Syndicate 623, a composite, or multiline, syndicate, has a 2001 underwriting capacity of £216 million ($322.5 million), and Mr. Beazley said the syndicate intends to increase its capacity for 2002.

In 1997, Beazley Furlonge joined forces with a strategic partner that was granted a 49% share in the managing agency on the condition that the partner contribute risk capital to the

See **Beazley** *on next page*

A recent conference in Dublin on changes in risk management attracted attendees from around the world.

E-commerce risks abound for companies

By SARAH VEYSEY

DUBLIN, Ireland—The Internet and e-commerce are still a "work in progress," said Joe Wojdula, manager of corporate insurance at Motorola Inc. in Chicago. But the risks faced by a company with an Internet presence are manifold.

"Ninety percent of large corporations and government agencies reported (Internet) security breaches in 2000," Mr. Wojdula said. Such breaches can lead to a loss of data integrity, sabotage, intellectual property damage, reputational risk, denial of service, confidentiality problems, extortion, libel and slander, data availability litigation, copyright violation and financial loss, Mr. Wojdula said.

"Even Microsoft lost (some) core source code to hackers," he pointed out, speaking at the "New World, Old World: Risks Have Changed" conference, held last month Dublin, Ireland.

"Managing e-risk is partly about people's perception of where risks are going to be," said Andrew Horrocks, a partner in the professional litigation and commercial litigation team at the London-based law firm of Barlow Lyde & Gilbert. Mr. Horrocks outlined several liability risks faced by any company with a Web presence.

Mr. Horrocks pointed out that, when doing business online, a company may be entering into transactions with other organizations with which it has no track record. This can create contractual risks involving the terms and conditions of the deal, as well as its legal jurisdiction, Mr. Horrocks said. Companies "need to try to take control of this process," he said.

Doing business online also involves regulatory

See **Internet** *on page 17*

HIH

Continued from previous page
reinsurers were awaiting a meeting with Mr. McGrath and representatives of the regulator, the Australian Prudential Regulatory Authority.

The meeting was held in Sydney on March 30, but served only to discuss the liquidator's course of investigation into HIH. Ross Middleton, the Sydney-based Australian agent for several reinsurers, including Hannover Ruckversich-erungs A.G., Le Mans Re, NRG London Reinsurance Co. Ltd., NRG Victory Australia Ltd., and Swiss Re Italia S.p.A., said no indication of likely increased exposures for reinsurers was discussed.

"This is a disappointing issue for all involved, but it is something that we just have to deal with," Mr. Middleton said.

While insurers have been offering to replace HIH coverages upon payment of additional premium, Mr. Ford warned that some could be hit with lawsuits. "If a clever plaintiff attorney knows the person they are going to act against is insured by HIH, they will not take action until a solvent insurer is found," he said.

Mr. Ford said that while insurers were marketing new policies at rates higher than HIH had charged, the markup would "hardly" cover potential claims.

Mr. McGrath said policyholders with corporate coverages that include professional indemnity; directors and officers; public and products liability; marine; group salary continuance; and property and special risks—such as jewelers' block, group personal accident, contingencies, trade credit and builders' warranty—should seek alternative coverage.

He said that some lines, such as personal, domestic and some travel policies, would be covered under deals entered into by HIH before it went into liquidation.

A spokesman for KPMG said it could be 12 months before details about other classes of business are known.

Sydney-based QBE Insurance Group Ltd. has abandoned a joint venture announced with HIH on March 6, nine days before HIH's collapse. The deal was, effectively, a purchase of HIH's corporate insurance lines in exchange for a 40% stake in a new company, QBE Corporate Insurance Ltd. The new company was to have written the Australian and New Zealand corporate lines for QBE and HIH.

> *"It may take two years before the final position of HIH's unsecured creditors can be established."*
>
> *— Ruth McColl*
>
> *NSW Bar Assn.*

Frank O'Halloran, QBE Insurance Group Ltd. managing director and chief executive officer, said that QBE would underwrite all corporate and travel insurance for HIH policyholders in Australia and New Zealand and all professional liability lines for HIH Asia policyholders. Policyholders would be required to pay additional premium for the coverage.

Sydney-based NRMA Insurance Group Ltd. had announced March 14, a day before the liquidator was appointed, that it would take over HIH's workers compensation business.

NRMA and HIH originally agreed to a purchase price of $130 million Australian ($62.2 million), which comprised $100 million Australian ($47.9 million) in cash and two other payments of $15 million Australian each ($7.2 million), based on renewal rates on the portfolios.

Eric Dodd, CEO and managing director of NRMA, said the cash component had been reduced to $90 million Australian ($43.1 million). NRMA would assume responsibility for claims under HIH policies incurred on or after March 15 in the total of four states and territories in Australia in which insurers can underwrite workers compensation. HIH would assign all unpaid premium and premiums payable after March 15 to NRMA. But Mr. Dodd said NRMA would not assume liability for existing claims or claims incurred before March 15. Those would be dealt with by the liquidator, he said.

HIH's domestic insurance policies will be covered by Sydney-based Allianz Australia Insurance Group, which bought HIH's retail operations last year.

Allianz is also covering small business, rural and small commercial policies, including for those for motor fleets of fewer than 150 vehicles, property with assets up to $20 million Australian ($9.6 million), public and products liability policies for companies with less than $5 million Australian ($2.4 million) in revenues and small marine policies.

HIH was a major player in the professional indemnity market, and insurance brokers are scrambling to place alternative coverage. Some professional associations have had difficulty placing their risks, though.

The Sydney-based New South Wales Bar Assn., which represents New South Wales attorneys, has met the liquidator to determine whether outstanding claims against attorneys with HIH indemnity coverage will be honored.

But Ruth McColl, president of the NSW Bar Assn., said the meeting "provided little comfort" for attorneys with outstanding claims and law firms waiting for fee payments for work performed for HIH. One insurer, who requested anonymity, estimated outstanding fees payable to attorneys at $30 million Australian ($14.4 million) to $50 million Australian ($23.9 million).

"It may take two years before the final position of HIH's unsecured creditors can be established," Ms. McColl said. Policyholders will be considered unsecured creditors.

The Sydney-based Institute of Chartered Accountants of Australia has advised its members to assume that claims will not be paid and urged members to seek alternative coverage immediately. But Lesley Simmons, ICAA consultant-professional standards, said some members were having trouble obtaining coverage due to outstanding claims that had been forwarded to HIH. While many had obtained retrospective coverage, "some are still negotiating with insurers."

Brokers withholding HIH premiums until the announcement of the outcome of the provisional liquidator's report have been warned not to risk contravening the Insurance (Brokers & Agents) Act 1984. David Muir, the head of Deacons Lawyers' Brisbane-based national insurance business unit, said that while the "moral incentive" was to withhold premiums, brokers were legally required to do so, despite the fact that full refunds might not be possible. But Mr. Muir told brokers to use the full 90-day maximum period allowed for passing on premium to attempt to determine whether coverage would be provided.

David Kearney, a partner in insurance and financial services at the Sydney-based law firm of Phillips Fox, warned brokers and policyholders to check for policies in which HIH may have had a percentage of coverage, because holders of such policies may be left exposed in the event of claims.

Mr. Kearney said policyholders might not be aware that HIH is a coinsurer on their policies. "In existing contracts, it may not be obvious that HIH is coinsuring a risk," he said. Other coinsurers are "highly unlikely" to take on the rest of the risk themselves, Mr. Kearney said.

The Australian Prudential Regulation Authority has been criticized by insurance brokers and risk managers for not acting sooner to take control of the company (*BI*, March 26). But APRA has defended its actions in the leadup to HIH's collapse.

Graeme Thompson, the CEO of APRA, said, "It is a big step for a prudential supervisor to appoint an inspector to a public company, and it needs to have solid grounds to take such a step."

"In APRA's judgment, it did not have those grounds until very recently," Mr. Thompson said.

APRA appointed an inspector to investigate HIH only hours before the company went to the New South Wales Supreme Court to seek the appointment of a liquidator.

Con Abbott, an insurance specialist with the Sydney-based Institute of Chartered Accountants of Australia, one of the professional bodies seeking alternative coverages, said: "Insurance regulators play a vital role in protecting the public interest. To say they could do nothing begs the question 'why are they there?'" he said. "This is very serious. Insurers are there to protect financial risks."

Mr. Abbott said that APRA should to "be more proactive" and interventionist. "The legislation must be changed, and as a matter of urgency," he said.

The plaintiff law firm of Maurice Blackburn Cashman, of Melbourne, Victoria, may launch a class-action suit against HIH on behalf of its shareholders and insurance policyholders, depending on the outcome of the liquidation, said Stephen Walsh, a major projects partner at MBC. He said "hundreds" of shareholders and policyholders had contacted the firm. HIH had 33,000 shareholders.

He said MBC was exploring potential claims for misleading and deceptive conduct under Australia's Trade Practices Act and negligence claims against directors.

Hong Kong's Commissioner of Insurance has ordered HIH's Asian subsidiaries—HIH Insurance (Asia) Ltd., HIH Casualty & General Insurance (Asia) Ltd., Asian Area Reinsurance Co. Ltd. and FAI First Pacific Insurance Co. Ltd.—to cease writing new contracts and renewing existing business until the companies receive written authorization to do so. BI

Beazley

Continued from previous page
group, Mr. Beazley said.

But as Beazley Furlonge upped syndicate capacity to take advantage of the upturn in the insurance cycle, it became clear that the strategic partner would be unwilling to increase risk capital, he said.

The strategic partner agreed amicably to splitting with Beazley Furlonge and relinquishing its stake in the managing agency, he said.

Beazley Furlonge examined other options, including selling the managing agency or attracting venture capital, said Nick Furlonge, the syndicate's deputy underwriter and another of its founders.

But, after talks with potential purchasers, management decided on a buyout.

Under the new structure, syndicate capacity will continue to come from traditional names, corporate names and Beazley's capital investment vehicles, Beazley Dedicated and Beazley Dedicated II.

"Our structure is almost unique in the current Lloyd's market, and it is our strongly held belief that this will ensure we are able to retain and attract underwriting talent to help expand Beazley and secure our future as a flexible and profitable underwriter-driven business," Mr. Beazley said.

"The independent structure also enhances our ability to deliver on the promise of building long-term relationships with brokers and clients," he said. "Buyers like the owner-operator concept where business is direct." BI

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Internet

Continued from page 15

risks, Mr. Horrocks said. He pointed out that European Union legislation and insurance and computer industry legislation must be taken into account. Tension exists between the international regulation of the Internet and the national nature of much e-commerce law.

There are also a host of third-party liability risks faced by companies doing business on the Internet, Mr. Horrocks said. Computer viruses can be passed on during the transfer of files or data between companies, leaving the company from which the virus came open to claims, he said. There is also a potential for intellectual property infringements to arise over such matters as domain name disputes, he added. And defamation is a potential problem for companies that allow third parties to put content or links on their Web sites, Mr. Horrocks said. "You need to control what third parties are putting on your site," he warned delegates.

Care must also be taken to protect confidential information, Mr. Horrocks added. "If you are putting it on the Internet, you are broadcasting to the world," he said.

Furthermore, a company with a Web presence can also suffer first-party losses, Mr. Horrocks said. "This is not just about claims exposure," he said. Other potential costs include those for the cleanup of corrupted data, replacement of data, and for revenues lost through business interruption, he said.

Mr. Horrocks cited reputational damage as yet another first-party loss; it is a loss, he said, that is extremely difficult to quantify. He gave the example of a U.K.-based supermarket that found itself the target of a hacker. The hacker sent an e-mail to all of the supermarket's Internet customers, informing them, falsely, that the supermarket was about to raise all its prices; the e-mail said that if the customers did not like the price hikes, they could shop at other stores. The reputational cost of such an incident is very difficult to put a price on, Mr. Horrocks said.

> *'There is no substitute for looking very carefully at the individual wordings of key coverages.'*
> — *Andrew Horrocks*
> *Barlow Lyde & Gilbert*

Some traditional insurance coverages do apply to cyber risks, he said. Business interruption coverage, property all-risk coverage and fidelity insurance can all be used for first-party risks, he said. Errors and omissions, general liability and legal expenses coverage are among those that are appropriate for third-party risks.

"There is no substitute for looking very carefully at the individual wordings of key coverages," Mr. Horrocks said. For example, he pointed out that while the Internet is a global medium, many insurance coverages are limited to certain geographic areas. It is also often difficult to determine where an event or act actually occurred.

Another important aspect of policy wording that insurance buyers should examine carefully concerns the definition of "computer software," Mr. Horrocks said. It is vital to determine whether software is defined in a policy as a product or a service. "This is very important in definition terms," he said. "Insurance often talks about services (not being covered)."

Another important definition is that of "property," Mr. Horrocks said. "Does information held on a computer amount to property? If it doesn't, you may not be covered for the loss," he said. While the cases that have been heard to date seem to suggest that the courts do consider such information to be property, Mr. Horrocks said, the legal position on this may well change.

Mr. Horrocks also noted that, just as damage to a reputation is very difficult to define and quantify, it is also very difficult to insure.

Insurance buyers should look carefully at their existing insurance coverages to determine their applicability to cyber risks and determine what gaps in coverage exist, Mr. Horrocks advised.

"Does traditional insurance necessarily respond?" he asked.

The conference, which took place March 15-16 at the Berkeley Court Hotel in Dublin, attracted more than 120 attendees from all over the world. The conference was organized by Tillinghast-Towers Perrin, sponsored by Aon Corp. and XL Europe, and supported by the Dublin International Insurance & Management Assn. and IDA Ireland, the country's industrial development agency. BI

Companies should evaluate potential risks to brands

By SARAH VEYSEY

DUBLIN, Ireland—Companies need more help evaluating the potential financial impact of brand risk, according to Matthew Frost, head of risk financing at London-based Diageo P.L.C.

Food and beverage manufacturer Diageo, which owns perhaps Ireland's best-known brand in Guinness, last year undertook a brand-damage project to identify risks the company faced.

Mr. Frost said that a series of internal workshops revealed that Diageo employees had radically differing views about the company's potential brand risks. Following a workshop, one business unit concluded that the company faced many potential brand risks but that those risks were neither serious nor capable of developing in that particular unit, he said. But another business unit concluded that there were many risks, some of which were serious, though not catastrophic, and quite likely to occur. Yet another business unit concluded that there were many risks, all serious and all likely to develop within that particular unit. "Internally within the company, there are people with diverse ideas of brand risks," Mr. Frost said.

Diageo's brand-damage exercise identified some 139 potential risks to brand, Mr. Frost. But, he said, "we discovered that traditional insurance solutions were invalid for more than 60% of these risks."

Mr. Frost bemoaned the fact that traditional insurance responses to brand risk are still 'silo-driven." In regard to this lack of coordination, he said that 'nothing yet approaches all risks of loss of value to brand cover."

Mr. Frost said that one reason for the lack of comprehensive insurance coverage for brand risk is that it is so difficult to place a value on a brand. "Valuations are usually only made when a merger or acquisition looms. Consequently, risk financing remains within traditional boundaries," he said.

> *'Does the insurance industry have enough capacity? Perhaps the answer is capital market securitization.'*
> — *Matthew Frost*
> *Diageo P.L.C.*

Mr. Frost added that he is not sure if insurers have sufficient resources to offer coverage for brand risks. "My challenge to the insurance industry is—does the insurance industry have enough capacity? Perhaps the answer is capital market securitization," he said.

Gus Reyes, director of risk management at Bacardi-Martini Inc. in Miami, said that, for companies such as his, their brands are their greatest assets. "If our brands were damaged in any way, we could be very quickly in trouble," Mr. Reyes said.

A manufacturer of alcoholic beverages, Bacardi-Martini has established a product recall protocol that classifies recalls into three categories, he said. The categories are brand integrity recall, health issues recall and malicious product tampering recall.

Brand integrity concerns include such developments as poor presentation of products; slight impairments in product quality that are not harmful to health, such as abnormalities in the density of the drink; and, most seriously, improper tastes or odors that, while not harmful to human health, prompt consumer complaints.

Health concerns include the presence of glass, molds, bacteria or other contaminants and the use of improper ingredients in the products.

The third, and most serious, category of recall for a beverage company is malicious product tampering, Mr. Reyes said. This category covers the threat of extortion—tampering with products for financial reward, for political or religious reasons, or for revenge by a disgruntled employee.

The key players in a product recall are the plant manager, the marketing director, the production director and the quality control director, Mr. Reyes said. He explained that while recalls are often completed before the products reach consumers, Bacardi-Martini has a crisis management strategy to handle a recall should the product already have reached store shelves. In such a case, Mr. Reyes said, the risk management director becomes heavily involved, as does a locally based crisis management team and the company's public relations director. He said that his company uses the services of both a crisis management consulting team and a communications and public relations specialist.

Mr. Reyes pointed out that not many insurers offer brand-risk coverages. He said that while Bacardi-Martini is very willing to retain a portion of its brand risk exposure, it would like to find a way to finance a little more of the risk than it currently does. "This is an area of our business that is pretty much on a trial basis," he said. BI

Cyber coverage is found lacking in conference poll

By SARAH VEYSEY

DUBLIN, Ireland—Insurance e-commerce will offer significant benefits to risk managers as buyers of insurance, but current insurance coverage for cyber risks needs improvement, according to a recent poll.

The survey of attendees during the "New World, Old World: Risks Have Changed" conference, held March 15-16 in Dublin, Ireland, found that 68% of attendees, who included agents, brokers, consultants and risk managers, agreed or strongly agreed that insurance e-commerce would significantly benefit risk managers.

While 12% said they neither agreed nor disagreed with that statement, 9% said they disagreed and 2% said they strongly disagreed. The remaining 9% did not respond.

The same question was then asked only of risk manager attendees. About 55% said they agreed with the statement, and 15% said they strongly agreed. While 15% of risk managers said they neither agreed nor disagreed with the statement, 15% said they disagreed with it. No risk manager said they strongly disagreed.

At the end of the conference's first day, attendees were allowed to respond to the same statement again. This time, 52% of respondents said they agreed that insurance e-commerce would offer significant benefits to risk managers and 18% strongly agreed. Another 18% said they neither agreed nor disagreed, 10% said they disagreed, and 2% said they strongly disagreed.

Responding to the statement that insurance currently available offers good protection against cyber risks, only 8% agreed. Forty-four percent disagreed with the statement, and 17% strongly disagreed. The remaining 30% said they neither agreed nor disagreed.

Attendees were asked whether they believed e-commerce would bring significant cost reductions for insurers. More than one-third of the attendees—37%—said they agreed with the statement, and 16% strongly agreed. Only 1% of respondents strongly disagreed, while the remaining 20% said they neither agreed nor disagreed with the statement.

Conference attendees were also asked if they thought that brokers were strongly positioned to meet the future strategic and transactional needs arising from e-business. Almost half of the respondents—46%—said they disagreed with the statement, while 20% agreed with it. Just 7% said they strongly agreed, and 9% that they strongly disagreed, with the remaining 18% of respondents saying they neither agreed nor disagreed with the statement.

The survey was conducted by Hugh Rosenbaum, principal at Tillinghast-Towers Perrin and conference chairman.

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LEGAL NOTICES

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION)
OF AGORA SYNDICATE, INC.) NO: 00 CH 13471

NOTICE OF CLAIM FILING DEADLINE AND PROCEDURES

PLEASE TAKE NOTICE, that on November 15, 2000, the Circuit Court of Cook County, Illinois, entered an Order of Liquidation With a Finding of Insolvency against Agora Syndicate, Inc. ("Agora Syndicate"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of Agora Syndicate ("Liquidator").

TAKE FURTHER NOTICE, that on March 20, 2001 the Circuit Court of Cook County, Illinois, entered an Order Fixing Rights and Liabilities and Providing for the Filing of Claims and the Setting of Claim Filing Deadlines ("Fixing Order"). Pursuant to the Fixing Order, all rights and liabilities of Agora Syndicate and its policyholders, creditors and stockholders, and all other persons interested in its property or assets, are fixed as of November 15, 2000, unless otherwise provided in prior or subsequent orders of the Court.

TAKE FURTHER NOTICE, that all persons, companies or entities who have, or may have claims, against Agora Syndicate, its property or assets, or against an Agora Syndicate insured or policyholder, shall have the right to present and file with the Liquidator proper proofs of claim on or before November 15, 2001 at 4:30 p.m. (C.S.T.).

TAKE FURTHER NOTICE, that any insured under an insurance policy issued by Agora Syndicate shall have the right to present and file with the Liquidator a proper proof of claim setting forth a contingent claim on or before November 15, 2001 at 4:30 p.m. (C.S.T.). No contingent claim shall be allowed for purposes of participating in any distribution of estate assets that may be made at the fourth priority level [215 ILCS 5/205(1)(d)] unless such claim has been liquidated and the insured claimant has presented and filed evidence of payment of such claim to the Liquidator on or before November 15, 2002 at 4:30 p.m. (C.S.T.). Any contingent claim for which a proper proof of claim is filed on or before November 15, 2001 at 4:30 p.m. (C.S.T.), but which is not liquidated on or before November 15, 2002 at 4:30 p.m. (C.S.T.), may be estimated pursuant to 215 ILCS 5/209(4)(b) for purposes of participating in any distribution of estate assets that may be made at the fifth priority level [215 ILCS 5/205(1)(e)] unless otherwise directed by the court.

TAKE FURTHER NOTICE, that the form and required content of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with, and may be obtained from, the Liquidator of Agora Syndicate, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to Agora Syndicate relating to all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST AGORA SYNDICATE, ITS PROPERTY OR ASSETS, OR AGAINST AN AGORA SYNDICATE POLICYHOLDER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE NOVEMBER 15, 2001 AT 4:30 P.M. (C.S.T.)

Cathleen Travis
Special Deputy Receiver

LEGAL NOTICES

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

IN RE PETITION OF DAN YORAM SCHWARZMANN AND COLIN GRAHAM BIRD, AS JOINT PROVISIONAL LIQUIDATORS OF BLACK SEA AND BALTIC GENERAL INSURANCE COMPANY LIMITED, CASE NO. 98-B-46759 (CB)

NOTICE IS HEREBY GIVEN THAT ON MARCH 21, 2001, THE BANKRUPTCY COURT ENTERED AN ORDER (THE "ORDER") CONTINUING THE PRELIMINARY INJUNCTION ORDER PURSUANT TO 11 U.S.C. § 304 ORIGINALLY ENTERED IN THIS CASE ON OCTOBER 5, 1998. THE ORDER SHALL REMAIN IN EFFECT UNTIL SEPTEMBER 21, 2001. A HEARING TO CONSIDER WHETHER THE ORDER SHALL BE CONTINUED IS SCHEDULED TO BE HELD ON SEPTEMBER 20, 2001 AT 2:00 P.M. (THE "RETURN DATE") BEFORE THE HONORABLE CORNELIUS BLACKSHEAR, IN ROOM 601 OF THE ALEXANDER HAMILTON CUSTOM HOUSE, ONE BOWLING GREEN, NEW YORK, NEW YORK. AL_ PAPERS SUBMITTED FOR THE PURPOSE OF OPPOSING CONTINUATION OF THE ORDER AFTER THE RETURN DATE SHALL BE FILED WITH THE COURT, WITH A COPY TO THE CHAMBERS OF THE HONORABLE CORNELIUS BLACKSHEAR AND SERVED ON COUNSEL FOR THE PETITIONERS LISTED BELOW, SO AS TO BE RECEIVED AT LEAST FOURTEEN (14) DAYS PRIOR TO THE RETURN DATE. ANY PERSON WISHING TO OBTAIN A COPY OF THE ORDER SHOULD CONTACT COUNSEL TO THE PETITIONERS.

CHADBOURNE & PARKE LLP
ATTORNEYS FOR THE PETITIONERS
30 ROCKEFELLER PLAZA
NEW YORK, NEW YORK 10112
(212) 408-5100

ATTN: HOWARD SEIFE, ESQ.
FRANCISCO VAZQUEZ, ESQ.

REQUEST FOR PROPOSALS

LOS ANGELES COUNTY METROPOLITAN TRANSPORTATION AUTHORITY (MTA)

REQUEST FOR PROPOSALS

The Los Angeles County Metropolitan Transportation Authority (MTA) will receive proposals for **PS-5312-1052, Workers' Compensation Claims Administration** per specifications on file at the LACMTA Office of Procurement, One Gateway Plaza, Los Angeles, CA 90012 (12th Floor).

All proposals must be received on or before **4:00 p.m., Friday, April 20, 2001**, at the address listed above, sent to the attention of **Jo Ann Johnson, Senior Contract Administrator.** Proposals received later than the above date and time will be rejected and returned to the proposer unopened. A Pre-Proposal conference will be held on **Tuesday, April 10, 2001 at 10:00 a.m., Imperial Conference Room, 12th Floor** located at the address above.

You may obtain a copy of the RFP, or further information, by faxing **Jo Ann Johnson** at **(213) 922-1005**, or by visiting the MTA website at **www.mta.net.**

REQUEST FOR PROPOSALS

LOS ANGELES COUNTY METROPOLITAN TRANSPORTATION AUTHORITY (MTA)
REQUEST FOR PROPOSALS

The Los Angeles County Metropolitan Transportation Authority (MTA) will receive proposals for **PS-5310-1057, Public Liability/Property Damage Third-Party Claims Administration** per specifications on file at the LACMTA Office of Procurement, One Gateway Plaza, Los Angeles, CA 90012 (12th Floor).

All proposals must be received on or before **4:00 p.m., Friday, April 20, 2001**, at the address listed above, sent to the attention of **Deborah Spottsville, Senior Contract Administrator.** Proposals received later than the above date and time will be rejected and returned to the proposer unopened. A Pre-Proposal conference will be held. **Please contact Deborah Spottsville at spottsville@mta.net for more information.**

You may obtain a copy of the RFP, or further information, by faxing **Deborah Spottsville** at **(213) 922-1005**, or by visiting the MTA website at **www.mta.net.**

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LEGAL NOTICES

THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION
OF BACK OF THE YARDS NEIGHBORHOOD
COUNCIL RISK MANAGEMENT ASSOCIATION, INC.
99 CH 06024

NOTICE OF CLAIM FILING DEADLINE AND PROCEDURES

PLEASE TAKE NOTICE, that on January 22, 2001, the Circuit Court of Cook County, Illinois, entered an Agreed Order of Liquidation With a Finding of Insolvency and Injunctive Relief against Back of the Yards Neighborhood Council Risk Management Association, Inc. ("BYRMA"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of BYRMA ("Liquidator").

TAKE FURTHER NOTICE, that on March 7, 2001, the Circuit Court of Cook County, Illinois, entered an Order Fixing Rights and Liabilities and Providing for the Filing of Claims and the Setting of Claim Filing Deadlines (Fixing Order). Pursuant to the Fixing Order, all rights and liabilities of BYRMA and its policyholders, members, creditors and all other persons interested in its property or assets, are fixed as of January 22, 2001, unless otherwise provided in prior or subsequent orders of the Court.

TAKE FURTHER NOTICE, that all persons, companies or entities who have, or may have claims against BYRMA, its property or assets, or against a BYRMA policyholder or member, shall have the right to present and file with the Liquidator proper proofs of claim on or before January 22, 2002 at 4:30 p.m., Central Standard Time ("C.S.T.").

TAKE FURTHER NOTICE, that pursuant to Section 209(4) of the Illinois Insurance Code, 215 ILCS 5/209(4), any insured under an insurance policy issued by BYRMA shall have the right to present the Liquidator with a proof of claim setting forth a contingent claim, subject to the claim filing deadline of January 22, 2002 at 4:30 p.m. (C.S.T.). The final date by which evidence supporting the liquidation of any such contingent claim may be received by the Liquidator shall be January 22, 2003 at 4:30 p.m. (C.S.T.). No such contingent claim shall be allowed for purposes of participating in any distribution of estate assets that may be made at the class"d" priority level, 215 ILCS 5/205(1)(d), unless such claim has been liquidated and the insured claimant has presented evidence of payment of such claim to the Liquidator on or before January 22, 2003 at 4:30 p.m. (C.S.T.).

TAKE FURTHER NOTICE, that the form and required contents of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with, and may be obtained from, the Liquidator of BYRMA, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to BYRMA upon all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIM AGAINST BYRMA, ITS PROPERTY OR ASSETS, OR AGAINST A BYRMA POLICYHOLDER OR MEMBER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE JANUARY 22, 2002 AT 4:30 P.M. (C.S.T.)

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Risk

Continued from page 3

market needs to expand both in supply and demand. "We realize, from Munich Re's perspective, that the market has not developed enough," he said.

At present, about 100 investors are active in the cat bond market, of which about 30 are core investors, Mr. Seitz said. "That number of core investors is still too small to support large transactions."

Steven F. Goldberg, senior vp-property and casualty underwriting and pricing at San Antonio-based USAA, suggested the risk-linked securities market would grow in 2001 due to tighter reinsurance capacity, particularly for retrocessional coverage. Growth also would be fueled by increased interest in the asset class by a variety of investors around the world and the gradual maturation of the market, he suggested.

There are issues that are limiting the market that must be addressed, however, Mr. Goldberg said. They include the need for investor information; the high cost of risk-linked securities transactions, particularly when the deals are structured on an indemnity rather than an index basis; and tax consideration and the deals' present offshore focus, he said.

But, as was the case at Munich Re, USAA's examination of the exposures it faces and the ways it might address them convinced the company of a need for increased risk-transfer capacity. That led USAA, like Munich Re, to seek to help develop a market for risk-linked securities.

USAA made its first foray into the risk-linked securities market in 1997, and it has come back to the market each year since to secure coverage for its hurricane exposure.

"The question we had to ask ourselves after Hurricane Andrew was, how would USAA insulate itself from the next mega-hurricane?" Mr. Goldberg said.

For USAA, 1992's Hurricane Andrew represented a $600 million loss. "But there are other areas of the U.S. that are exposed to major disaster from mega-hurricanes," Mr. Goldberg said.

He noted that, since 1989, a series of natural disasters has resulted in variability in insurance losses. Before Hurricane Hugo in 1989, the industry had never suffered losses of more than $1 billion from a single disaster, Mr. Goldberg said. Since then, losses from 11 natural disasters have exceeded that amount.

"Traditionally, hedging had been done in a somewhat closed society of global reinsurers," Mr. Goldberg said. But, faced with the loss potential of a large hurricane, it's apparent that traditional reinsurance mechanisms are limited in capacity, Mr. Goldberg said.

> *'Traditionally, hedging had been done in a somewhat closed society of global reinsurers.'*
>
> *— Stephen Goldberg*
> *USAA*

In light of that, he said, the insurance industry has reconsidered its approach to addressing low-frequency/high-severity occurrences, with the questions asked focusing on how to reduce losses from future disasters and how to reduce variability in insurer results from disasters.

From USAA's perspective, the challenge centered on the notion that serving members who live in catastrophe-prone areas requires maintaining high levels of capitalization and liquidity. "If such exposures could be mitigated, then transferred or separately securitized, USAA could more efficiently deploy its capital resources," Mr. Goldberg said.

"We looked at a variety of options for us to address this problem," Mr. Goldberg said. Among them were expanded use of traditional reinsurance, catastrophe bonds, catastrophe options, surplus notes and contingent surplus notes, contingent equity and catastrophe swaps.

"Ultimately, what we selected was to expand our traditional reinsurance program, as well as participating in the development of the catastrophe bond market," the USAA senior vp said.

Mr. Goldberg noted that the catastrophe bonds serve as a supplement to traditional reinsurance and are a complement to, rather than a replacement for, traditional markets, a view Munich Re's Mr. Seitz shared.

Discussing his company's experience, Mr. Seitz noted that, to date, Munich Re has not built a large capital markets group but has a small, highly skilled dedicated team that is growing as the risk-linked securities market develops.

Munich Re Capital Markets participates in the risk-linked securities market in three ways, Mr. Seitz noted. The company can serve as a facilitator of third-party transactions, as a sponsor of its own transactions or as an investor in risk-linked securities through a fund it established in London in 1996, the Munich London Insurance Securitization Fund.

Mr. Seitz discussed his company's own recent PRIME Capital Hurricane Ltd. and PRIME Capital CalQuake & EuroWind Ltd. deals, which together provided $300 million in reinsurance capacity for U.S. hurricanes, California earthquakes and European windstorms (*BI*, Jan. 29).

He said Munich Re saw several reasons for tapping the capital markets for risk transfer capacity. The capital market deals diversify Munich Re's sources of retrocessional capacity, Mr. Seitz said, while providing fully collateralized protection against significant low-frequency/high-severity events. In addition, the amount of coverage is large enough to provide meaningful protection for Munich Re. And,

See **Risk** *on next page*

Risk

Continued from previous page
he said, the deals balance the impact of appreciation of the dollar for Munich Re's U.S. exposures, and they establish a platform for capital markets hedging.

"We wanted to see to what extent can we use the capital markets as a capacity provider," Mr. Seitz said.

Munich Re's expectations in looking to the capital markets with its PRIME Capital deals were to achieve total coverage of $400 million or more, to broaden the investor base and to develop new parametric triggers as benchmarks.

"Due to the significant exposure we have in all these categories, it is important for Munich Re to get a sizable amount of cover," Mr. Seitz said. "Another very important element to us, aside from size, was to create the best possible environment from an investor perspective."

Ultimately, Munich Re placed its $300 million in securities with 31 investors. Seven of those investors are participating in the risk-linked securities market for the first time, which Mr. Seitz called "a very positive sign."

In the process of structuring the deals, the reinsurer learned that capital markets capacity for "BB" rated securities like the PRIME Capital instruments remains limited, though the market into which Munich Re issued—year's end with little market liquidity for BB rated issues—was particularly challenging.

"Would Munich Re be coming to the market again for other transactions? Yes, absolutely," Mr. Seitz said, though he added that the reinsurer has no deals planned at present.

Discussing the investor attractions of risk-linked securities, Mr. Goldberg noted that such securities can offer the dual benefits of increased yield with reduced portfolio variability. "From the standpoint that we look at it, it's a win-win," he said.

The investors in cat bond issues have included life insurers, pension funds, reinsurers, hedge funds, banks and investment advisers.

As an investor in risk-linked securities through its London fund, Munich Re has achieved average returns in excess of 12%, Mr. Seitz said.

"We are very successful overall in investing terms," he said. "As with everybody who has invested so far in insurance-backed securities, we haven't seen any losses."

Of the investors in catastrophe bonds, 90%-95% of the money they bring to the risk transfer market is money that is new to the property/casualty industry, Mr. Goldberg said. Without the bond market, that money never would have been applied to catastrophe protection through either investment in primary insurers or reinsurers, he said.

"From our perspective, this provides contingent capital that we wouldn't have had any other way," Mr. Goldberg said.

Mr. Seitz attributed the relatively high cost of risk-linked securitizations to the lack of a mature market and to investors not giving enough credit for the securities' value as portfolio diversification tools in the prices they are willing to accept.

"We still have a problem with overall economics. The risk transfer cost has to be set in such a way that it is a fair deal to both partners," Mr. Seitz said. BI

Cat bond buyers see risks as part of landscape

By RODD ZOLKOS

AVENTURA, Fla.—A group of catastrophe bond investors who recently offered their views on risk-linked securities seem firmly committed to that asset class, seeing the securities offer relatively high yields while providing the advantage of portfolio diversification.

The panel of investors offered opinions on the developing market for transferring insurance risk into the capital markets last month at the first Risk-Linked Securities Conference of the New York-based Bond Market Assn. in Aventura, Fla.

"These bonds seem to be a huge complement to a bond portfolio," said John B. Brynjolfsson, executive vp at Pacific Investment Management Co. in Newport Beach, Calif.

Noting that his firm seeks to avoid long-term positions in equity investments, Andrew Sterge, president of Cooper Neff Advisors Inc. in King of Prussia, Pa., said, "If you hate equity risk like I do, you look for places to get equity-like returns with low risk."

"I believe that this asset class in particular offers very attractive risk/reward characteristics," Mr. Sterge said.

Asked how investors will react when a loss hits a cat bond deal, Mr. Sterge said, "In buying these things you have to understand that there is a risk, so there's not much you do."

"Obviously there is a negative side, and that's what I would call 'headline risk.' These are called catastrophe bonds," PIMCO's Mr. Brynjolfsson said.

"There's business risk associated with buying these bonds."

"Our clients are fairly sensitive to the idea of holding cat bonds, and we have to be sensitive to our clients' needs," Mr. Brynjolfsson said. His company does not include cat bonds in all its investment funds, he said.

"The best way to avoid any trouble in this area is full disclosure," he said.

In the funds in which PIMCO does use cat bonds, "We really pepper them in the portfolio in very small quantities," Mr. Brynjolfsson said. For example, a $100 million portfolio might include $1 million in Florida hurricane bonds and $1 million in California earthquake bonds.

As with corporate high-yield bonds, in investing in risk-linked securities "You're hoping to get into that nice, fat coupon," the PIMCO executive vp said. "Obviously, the reason they're giving you that coupon is partially the actuarial risk, but also you're dealing with a lot of volatility."

"Cat bonds are also quite different from high-yield bonds," Mr. Brynjolfsson said. "The differences... kind of favor the cat bonds."

He noted that cat bond risks revolve around scientific modeling rather than financial reporting as in corporate bonds, and "geographical/ meteorological events vs. economic/managerial 'accidents.'"

And, perhaps most importantly, cat bonds bring diversity to a portfolio as an uncorrelated asset. In cat bonds, "the risk that's embedded in them is really a diversifying risk," Mr. Brynjolfsson said.

Michael Millette, a vp at Goldman Sachs & Co. in New York, noted that investments in cat bonds are spread among a variety of institutions, including mutual funds and investment advisers, proprietary or hedge funds, reinsurers and intermediaries, insurers and banks.

"This is really striking for a young market," Mr. Millette said, noting that often with a new asset class all the investors will come from a single area.

"This is a market where many investors have started out taking very modest positions and growing their positions over time," he said.

Keith Ashton, an associate at Teachers Insurance & Annuity Assn. in New York, said that TIAA manages a $120 billion fixed-income portfolio, "and at any given time we've got about 1% of that invested in catastrophe bonds," Mr. Ashton said.

TIAA made its first cat bond investment in 1996, and since that time has participated in 14 transactions. "We think the risk profile for cat bonds is complementary to our overall investment strategy," Mr. Ashton said.

Speaking on a separate panel, several reinsurers also spoke of cat bonds' appeal as an investment.

"In general, we're a buyer," said George F. Rivaz, chief operating officer at Tempest Reinsurance Co. Ltd. in Hamilton, Bermuda. "These prices are much better than where cat risk trades in the reinsurance market."

"Our view has been all along we are a buyer of cat bonds," said John D. Nichols Jr., senior vp-structured products at RenaissanceRe Holdings Ltd. in Hamilton, Bermuda. "When we price a cat bond, we do the exact same thing we do when we price a reinsurance transaction, except we have to reverse-engineer a synthetic portfolio of exposures."

As an investor in risk-linked securities, Mr. Nichols said he would like to see more than one modeling firm's opinions on the exposure underlying the transaction presented in the issues' offering documents, a view shared by some of the other investors.

George Hagood, managing principal at Willis Asset Management in Hamilton, Bermuda, said he thinks there might be merit to having two or even three firms model each deal. Doing so might be cumbersome and add to the deals' cost, but the higher comfort level provided to investors might allow larger deals, he suggested.

That would be a factor that would potentially encourage his fund to increase the size of its investments, TIAA's Mr. Ashton said.

"Internally we are comfortable with this risk, and I think our capacity to take a bigger bite would increase if the structures were more to our liking," he said. BI

Clark

Continued from page 3
Ms. Clark possesses this quality in spades.

"Among the officers of her company, over half of them are women, which we were very impressed with. And, also, just in the last couple of years, she's hired three very senior women from the reinsurance industry to join her organization," the APIW president said.

Ms. Kalaydjian said the nominating committee was pleased to see that Ms. Clark was reaching out to women to fill these roles.

Louise A. Ryan, a past APIW president and a vp at AIR, is one of the women whom Ms. Clark asked to join her at her company. Ms. Ryan is also responsible for nominating Ms. Clark for the award.

"I think (AIR) is an organization that generates such excitement and has such additional potential, really due to Karen's vision about the needs of reinsurers and insurance companies. She has great vision and intuition on how to meet the needs of clients," Ms. Ryan said.

Women are a major force at AIR, Ms. Ryan said, but she noted that Ms. Clark has shown, through her example, that "gender is no issue whatsoever."

Ms. Ryan said Ms. Clark provides inspiration to those with whom she works.

"I think that there's just such an energy and a dynamic to Karen in creating and leading the company that, just by what she does, she's such a fabulous role model for women who might be thinking that they could never attempt such a thing," Ms. Ryan said.

Ms. Clark explained that AIR nurtures its staff and encourages people to grow in terms of their own skills and talents.

"Most of the internal training programs educate employees about insurance, while most of the external courses teach on the technical level or in management and leadership," Ms. Clark said.

Furthermore, Ms. Clark said, she feels much like a coach, especially when it comes to public speaking.

"A lot of what we do is very technical, and it's difficult for the scientists and engineers to communicate with underwriters and others about how they take the science and build it into the applications that our insurance clients use on a day-to-day basis," she said.

> *'I've probably made many more than my fair share of mistakes...but that's part of growing and learning.'*
>
> *— Karen Clark*
> *Applied Insurance Research*

Although AIR's products are today used by virtually every global reinsurer in the world, there was a time when others did not share Ms. Clark's vision.

Ms. Clark explained that underwriters used to simply construct a worst-case scenario, without working through the theoretical effect of applicable variables. When AIR came along, she said, "our models provided them with a full range of probabilities that they could use for estimating expected losses for pricing or for underwriting or for insurance decision making."

It took a real event, Ms. Clark said, "to convince people that this very unusual computer simulation model could really be giving them information that was much more realistic than what they were using."

In 1992, within four hours of Hurricane Andrew making landfall, Ms. Clark said, AIR issued an estimate that losses could reach as high as $13 billion.

"Nobody believed that for months after the event until, finally, the actual losses ended up being $15 billion in Florida, and then everybody started believing our models," she said.

But despite the fact that her products are considered the industry standard, Ms. Clark continues seeking to improve her business practices.

"I've probably made many more than my fair share of mistakes going from A to wherever I am now but don't let them get you down because that's part of growing and learning," she said. "If you're not making mistakes, you're probably not learning or growing."

Ms. Clark said being named APIW's Woman of the Year is an unexpected honor, especially because she was selected from a pool of such deserving women in the industry.

Some tenets that Ms. Clark said she tries to live by include "always conducting yourself with the utmost integrity and professionalism, always trying to do your best, not giving up and don't be a quitter."

Ms. Clark said, "It's hard work and hard work is important. It's never easy; especially for women there's a lot of juggling, and you've got to keep a very positive and 'can do' attitude."

Ms. Clark lives in Weston, Mass., with her husband, Panka Tandon, an economics professor at Boston University, and her three daughters, Olivia, 13; Alexandra, 11; and Liliana, 9. BI

COMMENTARY

What were these people thinking?

In its ongoing quest to find unusual information about the lifestyles of its policyholders, Progressive Insurance has conducted a new survey.

You may recall some of the insurer's past scientific studies, including the favorite movies of motorcycle owners and the underwear shopping habits of policyholders.

The survey tracks another lifestyle quirk, but one that is a very real safety hazard for anyone traveling by car—talking on the cell phone while driving.

The findings are fairly alarming. In fact, I'm not sure some of those policyholders will be happy they were so candid with the insurer when their policies come up for renewal. I sure hope my car insurer does not start considering cell phone ownership as part of underwriting my policy.

More than 90% of the respondents to Progressive's survey reported using the cell phone while driving alone in their vehicles.

The survey does not appear to have asked about usage when driving with others. I assume that the percentage shoots up to 100% when driving with others, since a passenger can steer the car while the driver is chatting. Or maybe it's the opposite, and people get lonely when in their cars alone and have to reach out and touch someone.


Paul D. Winston

The problem, though, is that the risk of truly "touching" someone in another car jumps when on the phone. Progressive cited a New England Journal of Medicine study that found the use of cell phones while driving quadruples the risk of a vehicle collision.

Indeed, of those who talk on the phone while driving:

- 45% have swerved into another lane.
- 41% have sped up.
- 23% have tailgated.
- 21% have cut someone off.
- 18% have nearly hit another car.
- 10% have run a red light.

I think all these percentages should be much, much higher. That's because most cell phone talkers are oblivious to who or what is around them on the road, being cut off, run off the road or hit. They aren't keeping count of how many people they cut off or nearly clipped.

The thing that amazes me about this survey is not the unsafe behavior—heck, I own a cell phone and a driver's license. Rather, it's how candid these people were with a car insurance company.

It would be like volunteering on a life or car insurance application that one never wears a seatbelt, or never drives at or below the speed limit or never comes to a complete stop at intersections. What were these people thinking?

The survey contained some insights for employers. Of those who talk while driving, 50% do so while going to and from work. However, the majority—78%—of drivers are talking to friends or family, and not to their co-workers. I am surprised by the latter statistic, because I always figured that most people on the cell phones were captains of industry, brokering important deals, issuing buy/sell orders, etc.

The bad news for employers who share my misconception is that very little work is getting done on those phones. The good news is that half of the phone-induced accidents probably won't wind up as a workers comp claim.

So keep your phones turned off and your eyes open when on the road. Be safe like me and 43% of respondents to Progressive's survey who speed up to get past people who are chatting on their phones and driving erratically.

If you happen to run them off the road in the process, you might be doing yourself, other drivers and insurers a favor.

Editor Paul D. Winston's Commentary appears fortnightly. He can be reached at pwinston@crain.com.

For a copy of the Progressive survey, visit: www.progressive.com/media_relations/cell_phones.htm.

COBRA

Continued from page 1

and retirees' premium costs would be partially offset by a 50% federal tax credit also proposed in the legislation. In contrast to the new proposal, an employer currently must extend COBRA coverage only for 18 months to a former employee and can charge a premium equal to 102% of the group rate. No tax credits currently are provided for COBRA premiums.

In addition to expanding COBRA, the Democratic tax package would allow an employee age 55 and older who was laid off to purchase Medicare coverage for a monthly premium of about $460. In addition, an employees who retires at age 62 could purchase Medicare coverage for a monthly premium of about $325, plus an additional small monthly surcharge when he or she turns 65, the current normal eligibility age for Medicare. Beneficiaries would be eligible to receive a 50% tax credit for the pre-65 Medicare premium payments.

That latter provision could actually give employers an incentive to terminate health care coverage for pre-Medicare eligible retirees. An employer, especially one with a rich plan, would likely find it much less costly to subsidize an early retiree's pre-Medicare premium than to continue providing benefits under a private retiree health care program. Some experts doubt, though, that Congress intended such an outcome and would allow such a scenario to develop.

"I would be very surprised if that were to be permitted," said Mary Case, a principal in New York with Unifi Network, a unit of PricewaterhouseCoopers L.L.P.

It is the proposed expansion of COBRA, though, that is causing the most concern for employers. Their chief worry is that the 125% premium paid by beneficiaries wouldn't come close to covering their actual costs, especially for a long period of coverage. That is because individuals who opt for COBRA coverage typically are those most likely to use health care services.

> *'Should Medicare be expanded to cover younger retirees when it is already under financial stress providing coverage for those over 65?'*
>
> — Paul Dennett
> American Benefits Council

Indeed, for every $1 of premium paid by COBRA beneficiaries, their health plans pay out roughly $1.50 to $1.60 in claims, said Frank McArdle, a consultant in the Washington office of Hewitt Associates L.L.C. And for older beneficiaries, the ratio of claims paid to premiums collected could be even greater.

"The premium would not reflect the cost of the group of beneficiaries as a whole," said Paul Dennett, vp-health policy with the American Benefits Council, a Washington-based lobbying group.

In addition, keeping track of COBRA beneficiaries for what could be as long as 10 years would create a significant administrative burden for employers, Mr. Dennett said.

Given the new COBRA liability and administrative hassles, the Democratic proposal would be a powerful disincentive for employers to even consider offering retiree health care coverage, said Mark Ugoretz, president of the Washington-based ERISA Industry Committee, a benefits lobbying group representing large employers.

In addition, employer benefit lobbyists question whether broadening Medicare would be good health care policy.

"Should Medicare be expanded to cover younger retirees when it is already under financial stress providing coverage for those over 65? Shouldn't the priority be to meet the needs of those who are already eligible for coverage?" Mr. Dennett asked.

How seriously Congress will consider the proposal remains to be seen. Indeed, with the economy cooling, predictions of huge federal budget surpluses may prove inaccurate. And with the prospects of surpluses fading, congressional interest in expanding federal health care programs may be dissipating, Mr. Dennett said.

In fact, one of last year's hottest issues—the addition of a prescription drug benefit to the Medicare program—has received little attention during the current legislative session, lobbyists say.

With a significantly weaker economy, Mr. Dennett said, it is a "sobering reality" that health care proposals no longer are high-profile items. BI

Health

Continued from page 3

In late February, Blue Cross and Sutter reached an agreement and issued a joint statement expressing regret for the disruption. But by then, their mudslinging had spilled into the media, creating fears and confusion among some plan participants.

"Sutter and Blue Cross, unfortunately, went to the newspapers, which caused a lot of undue angst and a lot of telephone calls (from plan members), asking 'What does this mean to me, Mr. Employer?'" according to CalPERS' Mr. Freezor. "Sutter was the straw that broke the camel's back, in terms of our tolerance for that."

Employers have become concerned, because allowing medical group and health plan negotiations to go to the brink of collapse is a growing trend, said Peter V. Lee, president and chief executive officer of the Pacific Business Group on Health, a San Francisco-based employer purchasing coalition.

Hospitals and insurers, in general, are using the discomfort of plan members as a bargaining chip in attempting to gain negotiating leverage, Mr. Lee said.

Medical groups do so, he said, by threatening that a plan's members will lose access if they break off negotiations with health plans. Meanwhile, the health plans publicly blame hospitals and provider groups for holding them hostage and driving up costs.

Similarly contentious negotiations are on the rise nationwide for several reasons, including hospital attempts to make up for government revenue losses and the waning use of some managed care practices (*BI*, April 2).

So far, though, California leads the country in attempts to mandate related continuity-of-care provisions. Several national organizations that track health care legislation said they know of no other states with legislation similar to that recently introduced in California.

State legislators who intervened to help Blue Cross and Sutter reach an agreement recently introduced the legislation aimed at protecting plan members from service disruptions.

Assembly Bill 1522—introduced by Assemblywoman Helen Thomson, D-Davis, in February—would allow plan enrollees to receive continuity of care from a provider for 180 days or until an employer's next open enrollment, even if the provider and health plan part. It also would require that contracts specify terms for provider reimbursement for patient care after a contract expires.

Existing law merely requires health plans to notify enrollees in writing 30 days before a contract with a medical group expires. The proposed legislation also would require that letters sent to plan members, either by health plans or providers, be signed by both parties.

CalPERS, in its 2002 contracts, wants continuity-of-care provisions similar to those proposed in the legislation. Having both sides sign letters mailed to plan members reduces the possibility that either party can use such letters to place blame on the other, Mr. Freezor said. "It cuts out the 'He hit me first,' 'No, he hit me first' game."

In general, CalPERS supports Assemblywoman Thomson's bill, but it advocates some revisions. The 180-day continuity-of-care provision may not be sufficient, Mr. Freezor said.

CalPERS had about 40,000 members who nearly were forced to change providers when the Blue Cross/Sutter dispute arose. Some had already done so, and concessions from Blue Cross and Sutter helped others remain with their doctors, Mr. Freezor said.

Meanwhile, Senate Bill 103—also introduced earlier this year—would mandate that, if a health plan and provider fail to agree on a contract renewal, then their existing contract would be extended until an employer's next open enrollment. S.B. 103 is sponsored by Sen. Jackie Spier, D-San Francisco.

Both bills remain in their respective chambers.

Blue Cross of California and other health insurers endorse the legislation. "Anything that gets the patient out of the way of the commercial dispute," said Bob Scarlet, vp of state affairs in Sacramento for Blue Cross. BI

E-mail

Continued from page 1

wide's director of electronic communications searched Nationwide's electronic file server for e-mail indicating whether the letter had been sent. One such e-mail, from another agent's file of already-received and discarded messages, was retrieved. Nationwide subsequently terminated Mr. Fraser's agent's agreement.

Mr. Fraser sued, alleging violation of the Wiretap Act and the Stored Communications Act, which were both enacted as part of the Electronic Communications Privacy Act of 1986.

Judge Brody ruled Nationwide did not violate either the Wiretap Act or the Stored Communications Act. The Wiretap Act protects against unauthorized interception of electronic communications, she said. The Stored Communications Act prohibits unauthorized access to an electronic communication while it is in electronic storage, which she defined as occurring after it is sent but before transmission is complete or it is retrieved. Both provide protection only during the course of transmission, she ruled. Mr. Fraser's e-mail was retrieved, however, after it had been received by the recipient.

"Neither the Wiretap Act nor the Stored Communications Act cover Nationwide's alleged conduct," said Judge Brody. "Nationwide's retrieval of Fraser's e-mail from the Nationwide file server may in fact be ethically 'questionable'...but it is not legally actionable under the ECPA. Future legislation may delineate the extent of an employer's authorization to access e-mail stored for a period of time after transmission is complete."

Judge Brody also dismissed several other charges in Mr. Fraser's suit, including violation of the rights of free speech and assembly; wrongful discharge; breach of the implied covenant of good will and fair dealing; and breach of contract.

Mr. Fraser's attorney, James G. Wiles, of Blank Rome Comisky & McCauley in Philadelphia, said he plans to ask the court to amend the complaint to include the charge of invasion of privacy, and to permit the case to proceed to trial on those grounds. If that request is refused, he said Mr. Fraser may appeal.

Some attorneys say Judge Brody may have proposed too narrow an interpretation of the Stored Communications Act in suggesting it is applicable only during the period between when an e-mail is sent and it is read, but not subsequently.

"The judge seems to say that if an e-mail is in longer-term storage in the system that unauthorized access to that e-mail does not violate the act," said Charles Kennedy, an attorney with Morrison & Foerster in Washington who represents Internet service providers. "It seems to me that creates an enormous exception to the Act. I think most of us believe that if an e-mail is in the server of our e-mail provider, in longer-term storage, and someone gets unauthorized access to it, that we should have a remedy for that.

"This judge seems to say once the e-mail has been retrieved by the addressee that the stored version of the e-mail is no longer protected, and that is troubling, because if this is accepted by other courts, it would substantially reduce the protection that people have under the privacy act." he said. "I suspect that if it is appealed, it may very well be overturned."

Michael Overly, an attorney with Foley & Lardner in Los Angeles who represents employers, agreed that "if this went up on appeal, it would probably not be upheld," at least on this issue. While the court correctly believes Nationwide should not held liable, the problem is that conclusion was not reached "in a well-reasoned way."

Mr. Overly said, "This opinion will probably have greater weight as showing the inclination of the court as to what types of decision they want to reach in this area as opposed to having a significant legal precedent, if you will."

"I think she may indeed have read the statute a little narrowly" by stating the Stored Communications Act does not cover the post-transmission period, said Gregory Porter, an attorney with O'Melveny & Myers in Washington. He added however, it is an important decision because it is one of the few on this issue. "It will be one of the two or three decisions that courts looking at closely when ruling on this issue," so in that sense it will be influential, though whether or not they will follow it is another question, he said.

> *'Defendants are going to start arguing this case and holdings now in all sorts of contexts for the proposition that employers have broad discretion and broad power when dealing with the context of their computers.'*
>
> *— Gerald L. Maatman Jr.*
> *Baker & McKenzie*

"This decision goes further than any other decision that I'm aware of" in stating e-mail that has been opened is unprotected under the Stored Communications Act, said Robert Corn-Revere, an attorney with Hogan & Hartson in Washington, who often represents Internet service providers.

He said it is hard to say how influential the decision will be. "Because there aren't a great deal of decisions out there on these specific issues, any one decision may be very influential, but it is hard to tell to what extent other courts might be persuaded by the reasoning."

Some applaud Judge Brody's interpretation.

"I think this is a credible decision," said Jonathan A. Segal, an attorney with Wolf Block Schorr & Solis-Cohen in Philadelphia. "I think it is likely to have significant persuasive value, and I do believe it's consistent with the statute."

"I do not believe when Congress passed the law their intent was to preclude employers from monitoring e-mail messages," Mr. Segal said. "I think it's good news for employers, because if they own the technology they should be able to search it."

He added however, that because this is a district court decision, it is applicable only within its jurisdiction, "so other courts could come out the other way."

"Two different courts may come to different conclusions," agreed Mr. Maatman, who believes the decision will be influential. "Defendants are going to start arguing this case and holdings now in all sorts of contexts for the proposition that employers have broad discretion and broad power when dealing with the context of their computers," he said.

Some observers believe the court contradicts the 9th Circuit's ruling in *Robert C. Konop vs. Hawaiian Airlines Inc.*, which held that an employer violated the federal wiretap law by allegedly gaining unauthorized access to an employee's personal Web site (*BI*, Jan. 22).

The case is discussed in the decision by Judge Brody, who concludes the facts of the *Konop* case are different from those in the *Fraser* case.

"I think if the 9th Circuit were to look at the same facts, they would find a violation," said Brian T. Ashe, an attorney with Seyfarth Shaw in San Francisco. "As far as potency of the legal opinions, there's no doubt the 9th Circuit reigns supreme over the opinion of a single judge in the eastern district of Pennsylvania," he said.

But Mr. Maatman said, "I'm not sure it is contrary" to *Konop* because of the different facts surrounding the decision. "Both cases can stand on their own and internally aren't inconsistent at all," he said.

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Richard Fraser et al. vs. Nationwide Mutual Insurance Co. et al., U.S. District Court for the Eastern District of Pennsylvania; No. 98-CV-6726.

Bill would ease restrictions on MSAs

By JERRY GEISEL

WASHINGTON—All employers would be allowed to offer tax-favored medical savings accounts under bipartisan legislation introduced last week in the House of Representatives.

The legislation, sponsored by Ways and Means Committee Chairman William Thomas, R-Calif., and Rep. William Lipinski, D-Ill., would remove provisions in a 1996 law that limit MSAs to employers with 50 or fewer employees and put a 750,000 limit on the number of MSAs that can be established.

The measure also would make MSAs a permanent health care delivery option. Under current law, no new MSAs can be established after Dec. 31, 2002, though existing ones could continue.

In addition, the measure would allow employers and employees to contribute to an MSA. Current law mandates that an employer or employee, but not both, can fund an MSA.

Also, the measure would lower the minimum deductible for individual coverage in an indemnity plan, through which MSAs are linked, to $1,000 from $1,550, while the minimum deductible for family coverage would be lowered to $2,000 from $3,100.

Under an MSA, funds can be withdrawn tax-free to pay for uncovered health care expenses. Amounts withdrawn for other purposes are taxed as ordinary income but with an additional 15% surcharge. The 15% surcharge, though, is not assessed on funds withdrawn by individuals after they turn 65.

> *'MSAs are not the magic bullet that will solve all of our nation's health care problems.'*
>
> *— Nona Wegner*
> *Council for Affordable Health Insurance*

Only about 60,000 MSAs have been established so far—a much smaller number than backers predicted when the law authorizing them was enacted. That low acceptance, backers say, is due at least in part to restrictions Congress imposed.

Backers say that interest in the arrangements likely will rise in the wake of double-digit health care cost increases. They say if employees are responsible through MSAs, for paying a greater share of the cost of health care services, rather than small copayments, they are likely to be more careful consumers.

"MSAs are not the magic bullet that will solve all of our nation's health care problems, but they will have a significant impact on reducing health care costs," said Nona Wegner, president of the Council for Affordable Health Insurance, an Alexandria, Va.-based group representing small insurers and agents.

Benefit consultants, though, are skeptical about MSAs' cost-saving potential. They doubt, for example, that individuals would have the same purchasing clout commercial insurers and HMOs use to win big price discounts from providers on costly procedures.

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RRGs

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ed in 1986, the Risk Retention Act allows employers, professionals and others to form special, multiple-owner captives called risk retention groups. After meeting the licensing requirements of one state, an RRG can issue policies for members in any state. RRGs can write policies to cover all of their members' commercial liability risks except workers compensation. About 65 RRGs, roughly half chartered in Vermont, are now in operation. Of these, ALAS is the largest, with gross written premiums of more than $300 million in 1999.

RRG backers maintain that the federal law limits the rules and requirements of nondomiciliary states. Among other permitted requirements, nondomiciliary states can impose premium taxes on the groups—provided the taxes are imposed on a nondiscriminatory basis—and they can require RRGs to file certain financial reports.

But, according to the act, nonchartering states cannot regulate the groups. And that includes the imposition of regulatory fees such as Michigan's, said Phil Olsson, Washington general counsel for the National Risk Retention Assn.

"Fees, clearly, are verboten," said Jon Harkavy, a NRRA member and vp and general counsel in the Arlington, Va., office of Risk Services L.L.C., a manager of RRGs and captives.

RRGs that have taken that position have butted heads on numerous occasions with state insurance regulators, who have argued, at least initially, that nothing in the federal law pre-empts their imposition of fees.

For example, in 1997, the Maryland Insurance Administration demanded that RRGs operating in the state pay a $1,000 anti-fraud fee. The NRRA protested the fee, saying that the Risk Retention Act pre-empts states from imposing any financial assessment other than premium and other taxes. Maryland regulators backed off, though they did not directly concede the pre-emption issue; instead, they noted that the state statute establishing the anti-fraud fee did not cite RRGs as being subject to the fee.

> *'Fees, clearly, are verboten' under the federal Risk Retention Act.*
>
> *— Jon Harkavy*
>
> *Risk Services L.L.C.*

In 1999, RRGs protested a $406 fee the Hawaii Insurance Division imposed on each group. The assessment was to have been used to help defray the division's administrative costs. Later, though, the division dropped the fee. At the time, Insurance Commissioner Wayne Metcalf said the division did not intend to act out of variance with federal law.

While they have scored some victories, RRGs acknowledge they lack the resources to fight fees in every state. Indeed, many states impose registration fees that RRG advocates say are pre-empted by the federal law.

"It, generally, may be easier to pay than to fight. The legal fees to fight can be huge, while the fees often are small," said Mr. Harkavy, who strongly lobbied for enactment of the Risk Retention Act when he served as general counsel of the Risk & Insurance Management Society Inc.

ALAS' Mr. Breakstone said the group is challenging the Michigan fee on principle. "We think the pre-emption provision of the Risk Retention Act is important and that this is a very clear situation where a fee is not permitted," he said.

"We would hope that this issue can finally be resolved," Mr. Harkavy said.

While he said he did not have an exact figure, Mr. Breakstone estimated that, so far, the Michigan fee may have added $100,000 to the cost of coverage for ALAS' Michigan policyholders over several years. BI

Arbitration

Continued from page 4

Rice.

"The principle would apply with equal force to Title VII of the Civil Rights Act of 1964 and, arguably, to the Age Discrimination in Employment Act," Mr. Edwards said.

"The principle is quite important, because employers enter into arbitration agreements with an eye toward eliminating or, at least, substantially reducing their costs of litigation," Mr. Edwards said. "But if they have to both arbitrate with the employee and litigate with the EEOC, they have not only not reduced their costs—they've multiplied them. Then what happens if the arbitrator comes out one way for the charging party and the court comes out the other way in the EEOC suit? Which result trumps the other?" Mr. Edwards asked.

"A lot of complaints relating to employment discrimination have that dual-remedy possibility," said Quentin Riegel, deputy general counsel of the National Assn. of Manufacturers in Washington. "Any company that has an arbitration provision will want some assurance that the arbitration provision is effective and is exclusive. If the EEOC can go on a separate track, that reduces the benefit of the arbitration agreement. So it makes extra work to resolve disputes, it's not efficient and it provides remedies that the employer and employee may not have agreed upon," he said.

The government has quite a lot riding on the outcome of the case, said Gerald L. Maatman Jr., senior partner and chairman-global employment law practice at the Chicago law firm of Baker & McKenzie.

"I think a lot is at stake when the decision will be made, and it's coupled with the recent holding in *Circuit City*. It could twin cases that make or break the EEOC's enforcement plan, because a decision adverse to the commission could significantly impact its ability to obtain wide-ranging monetary settlements and verdicts in class-action situations," Mr. Maatman said.

An additional factor in the case is the nature of the EEOC itself, Mr. Edwards said.

"Another reason this is significant is (that) unlike the National Labor Relations Board, the EEOC is totally resistant to ADR procedures that would keep them from going to court," he said. "EEOC, as a government agency with, at least theoretically, unlimited resources, can, in effect, force a settlement by virtue of their power, which means that an employer may very well cave in rather than asserting its rights in multiple forums." BI

Louisiana fraud probe nabs 22

BATON ROUGE, La.—A claims examiner and other employees of the Louisiana Office of Risk Management have been arrested and charged with cheating the state's self-insurance fund out of more than $1 million.

In arrests last week, 22 individuals were charged with participating in a scheme to defraud the state by filing false claims for automobile damage they said was caused by hazards on state roads. The risk management office operates a self-insurance fund to pay such claims filed against the state.

Carry A. Emerson, a claims examiner with the risk management office, was charged with orchestrating the scheme. Also arrested were sheriff's deputies in two Louisiana parishes and other alleged participants, some of whom were state workers. A spokeswoman for the Baton Rouge Police Department said the continuing investigation could lead to as many as 400 arrests.

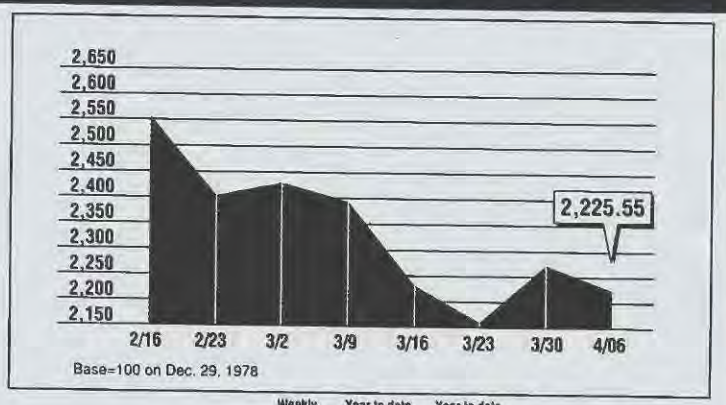
The four-month investigation by police, the district attorney's office of the East Baton Rouge Parish and the office of the state's legislative auditor uncovered the operation that investigators say began in November 1997 and resulted in 349 fraudulent insurance claims that total just over $1 million.

A report by Dan Kyle, the state's legislative auditor, was critical of the management of the Office of Risk Management. In the report, Mr. Kyle said that although a system of internal controls to detect fraud is in place, "management was negligent in its duties in ensuring that the controls were actually followed, rendering the system ineffective."

The report included a response by Seth Keener, the director of the state's risk management office, in which Mr. Keener agreed that some of the controls were bypassed and explained that procedures have been revised. Mr. Keener wrote that his department is hampered in its operations by budget cuts.

—By MICHAEL BRADFORD

BI Stock index - 4/6/2001



		Weekly Price	Year to date % change	Year to date % change	High	Low	Vol.(000)
BROKERS							
Aon Corp.	NYS	33.48	-5.69	-2.25	42.31	24.44	4745
Brown & Brown	NYS	37.00	8.66	5.71	39.92	19.00	222
Clark Bardes Holdings	NDQ	9.00	5.88	-11.11	17.88	7.25	33
E.W. Blanch Holdings Inc.	NYS	7.26	-8.68	-58.37	29.50	7.20	534
Gallagher Arthur J. & Co.	NYS	25.00	-9.75	-21.41	34.25	14.94	2146
Hilb, Rogal & Hamilton	NYS	34.40	-1.71	-13.73	42.13	26.94	191
Kaye Group Inc.	NDQ	13.06	-0.48	68.55	13.25	5.00	31
Marsh & McLennan	NYS	85.90	-9.61	-26.58	135.69	85.27	8307
BROKERS	AVERAGE		-6.04	-10.31			
INSURERS/REINSURERS							
ACE Ltd.	NYS	31.97	-13.87	-24.67	43.94	20.00	6864
Accel International Corp.	NDQ	0.17	3.13	-44.43	0.88	0.10	1
Acceptance Insurance Cos.	NYS	4.00	-1.96	-23.81	6.94	3.75	126
AEGON N.V.	NYS	29.75	1.74	-28.21	43.00	25.92	819
AFLAC Inc.	NYS	27.21	-1.20	-24.61	37.47	21.88	9790
Allmerica Financial Corp.	NYS	50.00	-3.64	-31.03	74.25	45.63	1376
Allstate Corp.	NYS	41.15	-1.88	-5.54	44.75	20.06	15864
Ambac Financial Group	NYS	59.97	-5.45	2.84	64.00	29.75	6253
American Financial Group	NYS	23.95	-0.62	-9.84	29.00	18.69	408
American General	NYS	42.29	10.56	3.78	42.70	25.84	37697
American Intl Group	NYS	76.55	-4.91	-22.33	103.75	66.70	44550
American Safety Insurance	NYS	8.90	0.91	45.31	9.10	3.25	9
Argonaut Group	NDQ	14.63	-7.87	-30.36	21.25	13.50	77
AXA-UAP Group	NYS	53.94	-1.48	-24.89	81.50	49.16	866
Baldwin & Lyons Inc.	NDQ	22.00	2.03	-5.38	28.75	15.25	17
Berkley W.R. Corp.	NDQ	43.06	-4.44	-8.74	48.75	18.13	1076
Berkshire Hathaway Inc.	NYS	67200.00	2.67	-5.35	74600.00	51600.00	1
Capitol Transamerica Corp.	NAS	13.06	-3.24	5.03	14.44	10.00	20
Chubb Corp.	NYS	69.09	-4.62	-20.13	90.25	58.56	4832
CIGNA Corp.	NYS	104.32	-2.83	-21.15	136.75	73.38	4196
Cincinnati Financial Corp.	NYS	36.44	-3.95	-7.90	43.31	31.00	1767
Citigroup	NYS	42.75	-4.96	-16.28	59.13	39.00	84511
CNA Financial Corp.	NYS	34.11	-2.57	-11.97	41.94	27.13	545
CNA Surety	NYS	13.61	2.48	-4.49	14.94	10.38	229
EMC Insurance Group Inc.	NDQ	12.19	3.72	3.72	13.13	6.81	110
ESG Re Limited	NDQ	2.38	-9.52	28.81	4.75	1.72	36
Enhance Financial Services	NYS	13.45	0.00	-12.87	17.00	8.63	0
Everest Reinsurance	NYS	64.60	-2.90	-9.81	74.75	27.31	2605
Fremont General Corp.	NYS	3.54	-8.76	25.87	6.88	1.50	766
Gainsco Inc.	NYS	1.50	-16.67	-42.86	6.13	1.40	544
Harleysville Group	NDQ	21.75	-1.97	-25.64	30.63	14.00	464
HSB Group Inc.	NYS	38.75	0.00	0.00	40.63	21.50	0
HCC Insurance Holdings	NYS	26.87	1.59	-0.25	27.50	10.94	2545
ING Groep N.V.	NYS	67.46	3.66	-15.81	83.94	52.44	1190
IPC Holdings Ltd.	NDQ	19.88	-11.17	-5.36	24.50	11.25	82
Hartford Financial Services	NYS	58.29	-1.20	-17.47	80.00	44.00	7723
John Hancock Financial Services	NYS	36.87	-4.11	-2.01	40.00	16.38	5085
LaSalle Re Holdings Ltd.	NYS	18.88	0.00	0.00	19.38	10.88	0
Lincoln National	NYS	42.70	0.54	-9.75	56.38	29.00	4431
MAIC Holdings Inc.	NYS	12.77	3.82	-23.48	21.00	10.00	164
Markel Corp.	NYS	185.13	-1.00	2.28	190.50	133.50	178
MBIA Insurance Group	NYS	75.10	-6.92	1.32	83.80	48.00	5793
Meadowbrook Insur. Group	NYS	3.07	-9.71	-62.22	8.38	2.90	43
MetLife	NYS	29.67	-1.26	-15.23	36.63	14.25	9563
Mutual Risk Mgmt. Ltd.	NYS	6.25	-13.79	-58.85	23.75	6.02	2239
Navigators Group	NDQ	13.44	0.00	0.94	14.50	8.63	49
NYMagic Inc.	NYS	18.15	0.55	-3.84	19.25	13.00	7
Ohio Casualty Corp.	NDQ	8.56	-8.97	-14.38	17.63	6.13	949
Old Republic Int'l	NYS	28.60	0.70	-10.63	32.06	12.25	1996
Partner Re Ltd.	NYS	47.91	-2.76	-21.46	62.50	33.63	680
Penn-America Group Inc.	NYS	10.10	-3.35	32.46	10.50	6.88	22
PMA Capital Corp.	NDQ	16.69	-3.96	-3.26	19.03	15.19	36
Philadelphia Cons. Holding	NDQ	26.63	-3.62	-13.77	31.92	14.25	354
PXRE Corp.	NYS	17.00	3.66	0.74	20.10	12.50	45
ReliaStar Financial Corp.	NYS	53.94	0.00	0.00	53.94	23.75	0
RenaissanceRe Holdings Ltd.	NYS	73.05	4.34	-6.72	84.19	36.13	676
RLI Corp.	NYS	39.50	-3.28	-11.61	46.16	31.25	30
St. Paul Cos.	NYS	41.90	-4.88	-22.85	57.00	29.31	5011
SCOR	NYS	43.64	2.92	-13.15	53.75	38.38	23
SAFECO Corp.	NDQ	27.13	-3.77	-17.49	35.88	19.56	3557
SCPIE Holdings Inc.	NYS	20.35	0.25	-13.86	31.40	18.31	NA
Seibels Bruce Group	NDQ	1.84	3.54	227.82	2.25	0.53	33
Selective Ins. Group	NDQ	23.13	-0.40	-4.64	26.94	15.25	135
Tokio Marine & Fire	NDQ	50.31	0.12	-11.73	61.00	45.25	151
Torchmark Corp.	NYS	37.95	-2.27	-1.27	41.19	21.63	2879
Transatlantic Holdings	NYS	103.86	1.32	-1.90	107.06	80.38	58
Trenwick Group Inc.	NYS	18.71	-5.17	-24.59	27.13	12.75	205
Unico American Corp.	NDQ	5.63	0.00	-4.26	7.75	4.50	5
United Fire & Casualty	NDQ	20.44	0.31	3.48	25.00	15.50	17
Unitrin	NDQ	34.63	-4.81	-14.77	41.94	27.19	426
UNUM Corp.	NYS	28.00	-4.18	4.19	30.44	14.81	4762
Vesta Insurance Co.	NYS	6.60	-0.75	30.37	8.39	4.13	205
XL Capital Ltd.	NYS	72.70	-4.43	-16.80	89.25	43.75	3990
Zenith National Ins.	NYS	24.20	2.54	-17.62	30.70	20.00	64
INSURERS/REINSURERS	AVERAGE		-2.05	-7.19			
HEALTH MAINTENANCE ORGANIZATIONS							
Aetna Inc.	NYS	36.09	0.47	-12.11	42.69	32.94	3104
Health Net Inc.	NYS	20.15	-2.23	-23.05	26.94	7.69	2068
Humana Inc.	NYS	8.99	-14.22	-41.05	15.81	4.75	5714
Oxford Health Plans	NDQ	25.63	-4.21	-35.13	42.75	13.50	5269
Pacificare Health Sys.	NDQ	25.88	4.02	72.50	72.31	9.81	6186
Sierra Health Services	NYS	4.60	0.88	21.05	6.70	2.44	462
United HealthGroup	NYS	58.94	-0.54	-3.97	64.36	28.88	12092
Wellpoint Health Networks	NYS	92.76	-2.68	-19.51	121.50	66.75	3708
HMOs	AVERAGE		-2.71	-4.17			
ALL COMPANIES			-3.60	-7.22			

Top advancing issues: American General, Brown & Brown, Clarke Bardes Holdings. Leading decliners: Gainsco Inc., Humana Inc., ACE Ltd. Most active issue: Citigroup. The *BI* Index decreased 2.1%; the Dow Jones 30 Industrials dropped 0.9%; the S&P 500 went down 2.8%, and the NYSE Composite decreased 2.1%. Average P/E: Brokers, 19.7; Insurers/reinsurers, 30.4; and HMOs, 15.6.

Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.

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