

Business Insurance

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Medical malpractice losses land PHICO in rehabilitation

HARRISBURG, Pa.—A Pennsylvania state judge has ordered PHICO Insurance Co. into rehabilitation after the medical malpractice insurer reported that massive first-half losses have nearly depleted its policyholders surplus.

The Pennsylvania Insurance Department sought the rehabilitation order shortly after Mechanicsburg, Pa.-based PHICO filed a

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Buyers grapple with brokers' staff battles

By SALLY ROBERTS

When an insurance broker enters into litigation with a rival broker over the departure of a key producer, it is the risk manager who often gets caught in the middle.

Nonsolicitation clauses—the subject of the legal battles—can disrupt the relationships that risk managers have established, because, in general, they prohibit producers who leave their original brokers from taking their business with them to the new, rival brokers.

Many risk managers resent such interruptions; they argue that they—and not the brokers—should decide whom they may conduct business with.

But that resentment may be tempered, depending on whether the individual risk

manager regards his or her brokerage relationship as existing principally with the account executive or with the brokerage firm as a whole

Lawsuits over such restrictive covenants—while often contentious and expensive—are common in the brokerage industry. In one recent case, London-based Willis Group Holdings Ltd. and Kansas City, Mo.-based Lockton Cos. Inc. clashed over the departure from Willis of three key construction executives who took with them several accounts and other employees when they joined Lockton (*BI*, Aug. 13).

Today, most brokers require their producers to adhere to nonsolicitation clauses as part of their employment agreements. Typically, the clause restricts the producer, for a speci-

fied period of time, from directly or indirectly soliciting—and, in some cases, servicing—any of that broker's previous accounts should he or she leave the broker for a rival.

Historically, brokers such as Marsh & McLennan Cos. Inc. and Aon Corp. did not require their producers to sign nonsolicitation clauses as a condition of employment. Both, however, either assumed or instituted restricted covenants as part of their acquisitions in recent years.

Several sources say that the two brokers now require their producers to enter into such agreements. Neither Marsh nor Aon would comment for this story.

As brokers increasingly require their top producers to ad-

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Sue/labor sees new test

Defect case may influence Y2K litigation

By JOANNE WOJCIK

ATLANTA—A Florida bad-faith lawsuit addressing the dual hot topics of construction defects and the sue-and-labor clause in property insurance policies has caught the attention of the insurance industry.

The American Insurance Assn. has filed an amicus brief in the case, which is on appeal to the 11th U.S. Circuit Court of Appeals in Atlanta. That's because the case has broad public policy implications, said Eric Goldberg, assistant general counsel for the AIA in Washington.

"It has implications for construction defect and other pending litigation, such as Y2K," Mr. Goldberg said. "All the big-money litigation pending now over Y2K is over the sue-and-labor clause."

Indeed, attorneys involved in Y2K coverage cases have been

following *Swire Pacific Holdings Inc. vs. Zurich Insurance Co.* because it is one of the few nonmarine cases involving the sue-and-labor clause that has reached the appellate level.

While researching the history of sue-and-labor cases on behalf of his policyholder clients, Larry Eisenstein, an attorney with Swidler Berlin Shereff Friedman L.L.P. in Washington, found that perhaps only 100 such cases have been litigated in the United States, and most of those were maritime cases.

"I do think the presence in the Y2K context has raised some awareness of it," Mr. Eisenstein said.

"The insurance industry is scared. They're concerned about what it would do to Y2K claims and other construction defect cases," said Scott Greenspan, an attorney with Greenberg Traurig L.L.P. in New York who rep-

resented Swire at the district court level. "They are running away from the policy language they drafted."

"It's significant because most of the law relating to sue and labor is old," concurred L.D. Simmons, an attorney with Smith Helms Mulliss & Moore in Charlotte, N.C., who defended Royal & SunAlliance in a Y2K sue-and-labor suit filed by Unisys Corp. that was dismissed last month (*BI*, July 23).

The half-dozen or so remaining Y2K coverage suits all cite the sue-and-labor clause that is typically contained in commercial property insurance policies. The clause, originating in maritime insurance contracts dating back to the 1600s, is a condition of coverage intended to reduce the insurer's exposure. The clause requires a policyholder to take all reasonable steps to pre-

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PHOTO: ROLL CALL PHOTOS

Sen. Edward Kennedy, D-Mass., will introduce a bill to give spouses more say over defined contribution plan distributions.

Impact on DC plans

Kennedy crafting spousal consent pension measure

By JERRY GEISEL

WASHINGTON—Legislation to give spouses greater say in how defined contribution plan distributions are taken would complicate plan administration and take from married employees their current right to automatically receive lump sums.

The bipartisan legislation, to be introduced next month by Senate Health, Education, Labor and Pensions Committee Chairman Edward Kennedy, D-Mass., and co-sponsored by Sen. Olympia Snowe, R-Maine, would require the written approval of a spouse before an employee could take a lump-sum distribution from a defined contribution plan.

Without such approval, an account balance would have to be distributed in the form of a stream of periodic payments payable over the expected lives of the participant and spouse. Or, a defined contribution plan could purchase an annuity to provide lifetime monthly benefits to the participant and spouse.

The new spousal approval requirement, which already exists for defined benefit plans under a 1984 federal law, would mark a radical change for defined contribution plans, such as 401(k) plans. Currently, employees in such plans can take a lump sum—without spousal approval—when they leave a

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- **A Colorado appeals court has ruled that liability insurers needn't cover the sometimes huge pollution investigation costs that policyholders incur before environmental authorities determine that third-party damage is insufficient to trigger cleanup orders. PAGE 6**
- **Congress must carefully assess the tradeoffs associated with legislation that would require a participant in a defined contribution plan to obtain the written permission of his or her spouse before taking a lump-sum distribution from the plan, this week's editorial says. PAGE 8**



- **Marine insurers are expressing opposition to recommendations by the Australian government to remove the insurable interest requirement from its Marine Insurance Act, the first change to the act in more than 90 years. PAGE 17**
- **The head of the Australian Prudential Regulation Authority has vehemently rejected criticism that Australia's insurance regulatory body failed to act to prevent the collapse of HIH Insurance Ltd. in March. PAGE 17**
- **The Regence Group and Health Care Service Corp. have canceled plans to merge the management services of Blues plans in several states. PAGE 23**

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UPDATES

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 quarterly financial statement showing a \$124.4 million net loss for the first half and a precipitous drop in surplus to \$6.8 million as of June 30 from \$127.2 million at year-end 2000. The June 30 surplus figure put PHICO within the "mandatory control level" in the state's risk-based capital requirements. Regulators will seek to determine, among other things, what led to the sudden increase in losses and decline in surplus, an Insurance Department spokeswoman said. PHICO has consented to the rehabilitation order. Insurer officials, including interim President and Chief Executive Officer Constance B. Foster, could not be reached. Ms. Foster, a former Pennsylvania insurance commissioner, assumed her posts with PHICO in April. PHICO, which writes malpractice coverage for hospitals, physician groups and individual physicians in all 50 states, last year developed a restructuring plan to boost its business. The insurer posted net losses in each of the last two years, while its surplus eroded by more than a third between year-end 1999 and year-end 2000. In the first half of this year, PHICO reported direct written premiums of \$122.6 million and a net underwriting loss of \$144.5 million, a huge deterioration from the \$23.7 million underwriting loss it reported for the same period last year. In 2000, when PHICO wrote more than \$242 million in direct premiums, the states with the largest number of PHICO policyholders included Florida, Indiana, New Jersey, Pennsylvania and Texas, according to the Pennsylvania department.

▶ **COURT DOWNPLAYS RSI** A career newspaper reporter whose repetitive stress injuries have significantly restricted her ability to type on a computer keyboard and to write by hand is not considered substantially limited under the federal Americans with Disabilities Act, the 9th U.S. Circuit Court of Appeals ruled 2-1 last week in *Thornton vs. McClatchy Newspapers*. Jacalyn Thornton, a 24-year employee of the Fresno Bee in Fresno, Calif., did not show she was limited in her ability to work at other jobs, such as teaching or performing manual labor, according to the court. "Thornton was able to perform a wide range of manual tasks, including grocery shopping, driving, making beds, doing laundry and dressing herself," wrote Judge Michael Daly Hawkins. Dissenting Judge Marsha Berzon said that the majority's decision ignores the significance of computers in everyday life. She noted that nearly half of all Americans use computers at work. The appeals court remanded the case for further proceedings. Ms. Thornton's dispute with her employer began in 1994, when she filed workers compensation claims alleging repetitive stress injuries. In following years, the company doctor imposed several work restrictions and the company made numerous accommodations, including adjusting workstations, modifying work schedules and her with a gym membership. Court papers indicate that, after her condition worsened, Ms. Thornton was granted an extended leave and subsequently terminated, though the Fresno Bee denies that she was terminated.

▶ **RECALL DELAYS BAYER LISTING** Product liability concerns stemming from the withdrawal of a cholesterol-lowering drug have led Bayer A.G. to postpone its listing on the New York Stock Exchange until February. Bayer's announcement came Thursday, one day after the filing in the U.S. District

Court for the Northern District of Illinois in Chicago, of the first of what could be many lawsuits seeking class certification. Kenneth B. Moll, the president of the



Chicago law firm of Kenneth B. Moll & Associates Ltd., said he filed the action on behalf of individuals who were prescribed and who took the drug, which is marketed in the United States as Baycol and elsewhere as Lipobay. Mr. Moll estimates the number of such consumers to be about 6 million worldwide. The action seeks compensation for those injured or killed by the drug, the creation a Bayer-funded medical monitoring fund for the testing and treatment of consumers and the reimbursement of consumers for the cost of the drug. Leverkusen, Germany-based Bayer had planned to join the Big Board Sept. 26, but the company voluntarily withdrew Baycol from all markets except Japan on Aug. 8 because of what Bayer called increasing reports of side-effects involving muscular weakness. On the same day, the federal Food and Drug Administration stated that it "has received reports of 31 U.S. deaths" associated with the use of Baycol. In an English-language transcript of an Aug. 13 press statement, Bayer Management Board Chairman Manfred Schneider said the company expected to prevail and saw "no reason" to make provisions in Bayer's balance sheet to deal with the claims.

▶ **WATSON WYATT SELLS UNIT** Benefit consultant Watson Wyatt & Co. is selling its U.S.-based public sector retirement practice to Gabriel, Roeder, Smith & Co., a privately held Southfield, Mich.-based firm that specializes in public sector retirement consulting. As part of the acquisition, GRS, which has about 500 clients, will take over from Watson Wyatt about 120 public sector retirement clients within the next few months. Those clients generate about \$6 million in revenues, less than 1% of Watson Wyatt's total business. Watson Wyatt, though, will continue to provide retirement consulting services to a small number of public sector clients, including federal government entities; businesses, such as hospitals and airports, that are managed by public entities; and some Native American tribes and nations. The sale of the public sector retirement practice is in line with the Washington-based consultant's strategy of concentrating on business lines in which it is a leading player, such as pension plan and human resource technology consulting, while shedding smaller and, in some cases, unprofitable lines. Watson Wyatt and GRS also have agreed to refer business to one another and will explore joint consulting assignments. Terms were not disclosed. Separately, Watson Wyatt reported net income of \$46.7 million for the year ending June 30, up 28% from last year. Revenues climbed 12.1%, to \$700.2 million.



▶ **COMP DELIVERY EXPENSES** Benefit delivery expenses account for nearly one in eight dollars spent on workers compensation claims in California, where litigation and adjusting costs are considerably higher than those in seven other large states, according to the Workers Compensation Re-

search Institute. In contrast, benefit delivery expenses in Texas and Wisconsin make up 6% of claims costs, or roughly half the rate in California, the WCRI states in a recent report, "Where the Workers' Compensation Dollar Goes." The Cambridge, Mass.-based WCRI also examined claims costs in Connecticut, Florida, Georgia, Massachusetts and Pennsylvania. Litigation and claims adjusting together account for 7% of claims costs in California, compared with 3% to 4% in the other states, according to the WCRI. Benefit delivery expenses also include cost-containment services, case management and bill review. "If the California system could improve its efficiency and reduce the share of costs absorbed by benefit delivery expenses, several billion dollars could be saved," WCRI Executive Director Richard A. Victor said in a statement. The WCRI's report will soon be available on the organization's Web site, www.wcrintel.org.



▶ **WORKPLACE DEATHS DECREASE** Workplace fatalities in the United States decreased 2.3% in 2000 compared with 1999, according to a report issued by the federal Bureau of Labor Statistics last Tuesday. According to the BLS, 5,915 fatal work injuries were recorded last year, compared with 6,053 in 1999. Fatal work-related highway accidents remained the leading cause of death, accounting for 1,363 deaths in 2000, down 8.9% from 1999. Other categories of workplace deaths that saw decreases in 2000 include fatalities caused by electrocution and those caused by fires and explosions. The number of workplace homicides increased 4.0%, though, to 677 in 2000, and the number of deaths from on-the-job falls increased 1.8%, to 734.

▶ **BRIEFLY NOTED** Bermuda reinsurer Max Re Capital Ltd. launched its initial public offering Tuesday, issuing 12 million shares at \$16 per share. Max Re will receive about \$176.5 million from the offering after expenses. The shares closed down 50 cents from the offering price....Average property/casualty insurance rates rose 14% at July renewals compared with last year, according to MarketScout.com, a Web-based insurance portal that connects agents with about 50 insurers....Herbert W. Kaufman, who in 1969 founded managing general agency Burns & Wilcox Ltd in Farmington Hills, Mich., died Monday after a brief illness. He was 76....Helen Darling, a senior health care consultant in the Stamford, Conn., office of Watson Wyatt Worldwide, will take over next month as president of the Washington Business Group on Health. Ms. Darling, a former congressional committee staffer, succeeds Mary Jane England, who left the 165-employer member health policy organization to become president of Regis College in Weston, Mass....Keith Fenwick has been named chief executive officer and regional manager of the U.K. operations of Guy Carpenter & Co. He replaces Mark Harding, who has left the reinsurance brokerage. Previously, Mr. Fenwick was chief operations officer of the unit....Aon Corp.'s risk services group has named Angie Tegan managing director of corporate communications. She previously worked in communication posts at other Aon divisions. **[B]**

▶ **To get breaking news as it occurs, visit Business Insurance's free online Updates, at www.businessinsurance.com. All of the material in the Updates 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.**

Cost runups cut into rate increase gains

By JUDY GREENWALD

The problem of rising medical costs is one that refuses to go away for the managed care industry.

Managed care companies are pushing through rate increases, but medical costs continue to climb, which contributed to lower first-half profitability for many companies.

And, of course, there are other concerns that could hamper profitability, including pro-

posed patient protection legislation in Congress and, to a lesser extent, layoffs at corporate clients, which may hold down managed care revenue growth.

In addition, employers continue to seek benefit buydowns—ways to offer less-generous benefits—in an effort to reduce the size of cost increases.

Currently, rate increases are outpacing health care costs, but

those costs are continuing to rise. Rate increases are exceeding health care inflation, "so there should be continued, very strong trends in the (health maintenance organization) business for the foreseeable future," said Michael LeConey, an analyst with Dirks & Co. in New York.

"We expect to grow," said John S. Penshorn, director of capital markets, communica-

tions and strategy for Minneapolis-based UnitedHealth Group Inc.

Despite higher rates, medical costs continue to be a challenge for managed care companies.

"Pricing looks to be very, very strong, but we do have a health care cost climate that is inflationary, more inflationary than it's been in recent years, and that's going to be a challenge for all of us to manage effectively," said David Olson, vp-investor relations for Woodland Hills,

Calif.-based Health Net Inc.

"I think we'll see continued premium rate increases due to medical cost trends," said Greg Crawford, an analyst with Fox-Pitt, Kelton Inc. in San Francisco.

Although there may be some margin improvements on the administrative cost side, "medical costs are still a big challenge here," he said.

Mr. Crawford said many managed care companies are merely

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Rulings that expanded exposures prompt legislation

Ohio narrows auto liability

By MEG FLETCHER

COLUMBUS, Ohio—Most Ohio businesses are hopeful that recently passed legislation will help the state's deteriorating market for automobile insurance regain its historic stability.

But real progress probably won't be seen until the law goes into effect Oct. 31, according to several employer and insurer representatives.

Re-establishment of Ohio's competitive market for auto insurance—including commercial trucks and car fleets—would be the best possible outcome of two years of turmoil that culminated in an overwhelming number of businesses and insurers supporting legislative relief from several problematic rulings by the Ohio Supreme Court, they say.

The court's most controversial 4-3 rulings on this topic substantially broadened employers' liability for employees and others hurt in collisions with uninsured motorists or underinsured



motorists.

UM insurance coverage is designed to protect a business or its employees from being injured by a motorist who is uninsured or insolvent. UIM coverage protects policyholders from drivers who carry auto liability insurance but lack adequate limits to fully compensate an injured policyholder. Ohio law historically required that such coverage be offered along with commercial and personal lines insurance, though buyers are not required to purchase it.

The latest upheaval began with the state high court's *Scott-Pontzer* decision in July 1999. It "expanded UM coverage to apply to relatives of employees who can collect under

the employer's commercial auto policy when they are driving a personally owned vehicle, even if they are not on company-related business at the time of the crash," according to the Ohio Insurance Institute, a trade and public information association.

The coverage was originally intended to protect employees driving company-insured vehicles while on business.

In such situations, employees in Ohio typically are eligible for workers compensation benefits to cover their medical care and wage loss, said Paul C. Blume Jr., vp for the American Insurance Assn.'s Midwest region. An employee may also seek compensation for non-economic losses, such as pain and suffering, from his or her employer's UM/UIM insurer as well as from a personal UM/UIM insurer, he added.

"UM/UIM coverage was further expanded by the court's December 2000 *Linko* decision,"

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Benefit funding through captives

Vermont captive director encourages application for exemptions

By RODD ZOLKOS

BURLINGTON, Vt.—While placing employee benefit programs in a captive can offer an employer considerable advantages, doing so isn't necessarily dramatically different from the ways benefit programs are currently funded, a benefit funding expert said.

"We're not doing something revolutionary. Benefits have been financed," said Markus Mende, senior consultant at Aon International Risk Management Group U.K. in Weybridge, England.

Speaking as part of a panel on employee benefits in captives at the annual conference of the Vermont Captive Insurance Assn. earlier this month in Burlington, Mr. Mende noted that benefit plans in both the United States and overseas traditionally have been financed through various methods.

Both domestically and abroad, companies have used techniques including full insurance, insur-



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ance with a profit-sharing component, self-insurance with a third-party administrator or international pooling.

In the United States, employers also have used such vehicles as voluntary employee beneficiary associations, trust-owned life insurance, trust-owned health insurance and company-owned life insurance.

"What we can say is that many of these vehicles are a type of onshore employee benefit funding captive vehicle," Mr. Mende said.

The types of benefit plan exposures that might lend themselves to being financed through

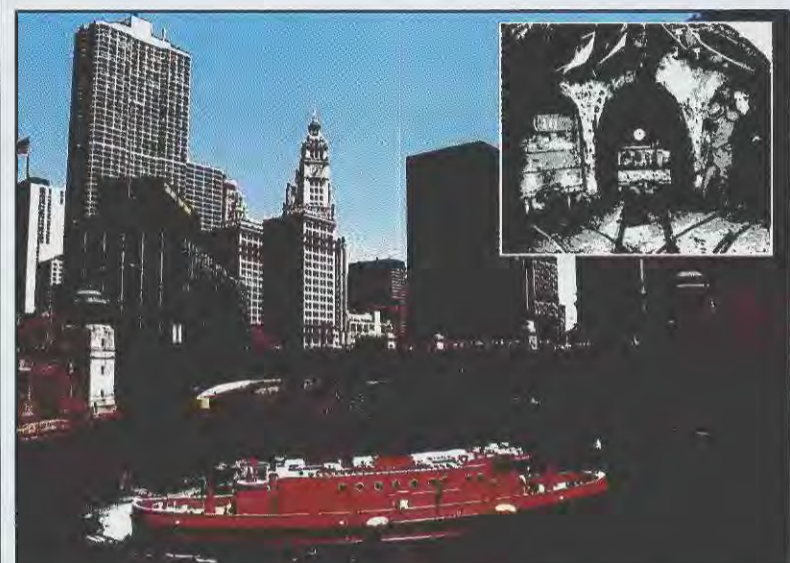
a captive include death or longevity risks, disability, personal accident, health and medical and post-retirement benefits.

In some European countries, a portion of pension benefits can be risk-financed in a captive, Mr. Mende said. And in Germany and Australia, exposures associated with lifetime work-hour accounts, which allow employees to save paid time off over the lifetime of their employment and consequently must be financed by the employer, might be an exposure that can be addressed in a captive.

"The types of benefits that are typically provided globally vary by country and they vary dramatically," Mr. Mende said. "The reason for that is that employee benefits supplement what is available under (local) social security legislation."

That wide variance is one of the factors that makes it difficult to risk-finance benefit ex-

See **Benefits** on page 20



PHOTOS: KRT, INSET: CHICAGO TUNNEL TERMINAL CORP.

Businesses and insurers are still litigating property damage claims from the 1992 flood that resulted from a leak in a Chicago River tunnel

Review sought on decision limiting Chicago flood cover

By DAVE LENCKUS

CHICAGO—Scores of Chicago businesses plan to ask a full federal appeals court to review an appellate panel ruling that dramatically restricts the amount of insurance that is available to cover the cost of property damage during the Great Chicago Flood.

The city of Chicago also is considering asking the full 7th U.S. Circuit Court of Appeals to review its three-judge panel's Aug. 10 decision. The ruling effectively bars the city from recovering \$29 million of insurance proceeds to help cover the city's settlements with flood claimants.

Overtaking a 1999 federal district court's decision, the 7th Circuit panel ruled that the limits available under an original and a replacement excess liability insurance policy written for the dredging contractor responsible for the April 1992 flood cannot be stacked to cover losses.

The appellate panel further limited insurance recoveries by ruling that flood claimants could not tap a \$60 million excess liability policy. The policy, which was in force for the con-

tractor when it performed bridge repairs that later triggered the flood, had been canceled before the city flooded.

Under the appellate panel's ruling, \$51 million of liability insurance limits would be available to cover losses—\$100 million less than would have been available under the district court's decision.

The city hired the dredging contractor, Great Lakes Dredge & Docking Co. of Oak Brook, Ill., in August 1991 to replace pilings protecting a bridge that spanned the Chicago River. The work damaged the roof of an old freight tunnel system that runs beneath the river and links with buildings in the city's downtown "Loop" financial district.

City inspectors spotted the damaged tunnel roof in February 1992. But although river water already was leaking into the tunnel, the city made no repairs.

The tunnel roof collapsed in April 1992 and flooded the basements of many buildings. Insured property damage totaled around \$300 million.

In August 1991, Great Lakes was covered by a \$1 million primary liability insurance policy

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Report sees more asbestos-related bankruptcies

By MICHAEL BRADFORD

A new wave of asbestos claims threatens to swamp some U.S. corporations, many of which already are mired in litigation over asbestos-related injuries, a recently released report warns.

The 500,000 individuals already have filed asbestos-related claims may represent less than half the ultimate number of claimants, the RAND Institute for Civil Justice states in the report, which was released last week. As a result, "all of the major asbestos defendants are likely to be in bankruptcy in 24 months," the report declares.

RAND compiled the information from published studies and from interviews with attorneys, insurers and other experts. The Santa Monica, Calif.-based think tank calls the 59-page report a "briefing" on the first part of its three-phase study on asbestos litigation. The document was prepared for meetings with members of congressional judiciary committees that were held Aug. 13-14.

Asbestos litigation already has driven 41 companies into bankruptcy, the report states. In addition, RAND notes that five corporations—which it did not name—each had more than

300,000 claims when they filed for bankruptcy, with one of them facing more than 500,000 claims. Furthermore, according to the report, three bankruptcy trusts have received a total of nearly 1.3 million claims.

The report notes that any analysis of the situation should consider the nature of asbestos-related claims. Because most plaintiffs file claims against multiple defendants, it says, "the magnitude of asbestos litigation is amplified beyond what it would be in more-traditional tort litigation, in which plaintiffs file lawsuits against one or a few defendants."

The report does not identify the "major asbestos defendants" that it says are likely to file for bankruptcy.

A policyholder attorney said the report may overstate the number of future bankruptcies.

"That's such an overgeneralization that I can't really agree with that," said John Sylvester, an attorney with Kirkpatrick & Lockhart in Pittsburgh who represents asbestos defendants. "I'm not sure who they consider major defendants."

Mr. Sylvester said insurance coverage will play a part in determining which companies survive. "Some of the defendants

have decent coverage, and some have thin coverage," he said.

Studies show that there is disagreement about how many claims are still to come, the RAND report notes. While one analyst has predicted that 500,000 more claims will be filed, another put the figure at closer to 2.5 million, the study says.

Insurers already have paid out about \$21.6 billion on asbestos claims, according to a figure by A.M. Best Co. that the report cites. Using court filings, RAND calculated that bankrupt corporations have reported expenditures related to asbestos litigation that range from \$450 million to \$5 billion each. Those figures include some costs that were recovered from insurers.

The report also refers to a Tillinghast-Towers Perrin analysis, released in June, that pegged the ultimate cost to insurers and corporations of asbestos litigation at \$200 billion.

The RAND report notes that claims have spread to businesses that don't have direct ties to asbestos, such as retailers, textile mills and refineries.

The types of companies affected by asbestos litigation continue to change, the report says.

The report notes that asbestos claims have spread from "traditional" defendants—such as asbestos manufacturers, distributors and installers—to other businesses that do not have direct ties to the product, such as retailers, textile mills and refineries.

"As the litigation has continued, the number of companies sued has grown dramatically," the report states. A list compiled by RAND shows more than 1,000 defendants, and that number is expected grow significantly, the report says.

The report also notes that asbestos litigation costs began to fall in the 1990s as, among other developments, insurance coverage issues were decided, plaintiff attorneys negotiated settlements and defendants pursued "cooperative strategies."

The report warns, though, that those costs may be on the rise again. "New insurance coverage battles are looming," it states. In addition, the report notes, defendants' agreements have dissolved, plaintiffs attorneys are "pursuing more-aggressive litigation strategies" and "non-bankrupt defendants" are representing their interests more vigorously.

Copies of the report, "Asbestos Litigation in the U.S.: A New Look at an Old Issue," may be either downloaded or ordered through the RAND Web site at www.rand.org.

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Pollution probe cover rejected

Unpublished Colorado ruling lets CGL insurers off hook

By DAVE LENCKUS

DENVER—Liability insurers do not have to cover the huge pollution investigation costs that a policyholder incurred before environmental authorities determined that third-party property damage was insufficient to trigger a cleanup order, the Colorado Appeals Court has ruled.

Unanimously upholding a lower court's summary judgment, the state appellate court on July 19 rejected the argument by policyholder Union Pacific Railroad Co. that its investigative costs should be covered because the railroad reasonably anticipated it would be held liable for third-party property remediation and performed some cleanup work.

The appeals court did not certify its opinion for publication, which means insurers may not

cite it as precedent in future coverage disputes in Colorado. Attorneys outside of the state may cite the case, but its influence on other courts would be difficult to predict, attorneys said.

The insurer defense attorney in the case, however, is contemplating asking the appeals court to publish the ruling.

Coverage disputes over investigative costs are beginning to mount, but currently there are only a handful of appellate-level court decisions nationwide on the issue, according to insurer attorney Laura A. Foggan, who represents the Insurance Environmental Litigation Assn. And most, if not all, of the earlier decisions—many of which insurers have won—did not turn on the issue of third-party liability, said Ms. Foggan, a partner with Wiley, Rein & Fielding L.L.P. of Washington.

The issue has not been litigated much because past pollution coverage disputes largely focused on much-broader coverage issues, such as the comprehensiveness of pollution exclusions.

The Colorado case involves dozens of Lloyd's and London market underwriters and Farmington Hills, Mich.-based Amerisure Mutual Insurance Co., which changed its name last year from Michigan Mutual Insurance Co.

All of the insurers wrote liability insurance for the former Denver & Rio Grande Western Railroad Co. during the 1960s. The insurers wrote coverage above self-insured retentions that began at \$50,000 and later exceeded \$100,000.

Omaha, Neb.-based Union Pacific acquired the Denver & Rio Grande in 1998.

Years earlier, the U.S. Environmental Protection Agency had sued the Denver & Rio Grande over its potential liability for elevated levels of lead at sites near the railroad's Leadville, Colo., property. The EPA was concerned that lead was leaching from the railroad's mountainous piles of slag onto other property. The railroad intended to use the slag—a rock-hard byproduct of smelting operations in the area at the turn of the 20th century—as ballast for new track.

The Denver & Rio Grande settled with the EPA in 1993 without admitting liability.

The two railroads spent nearly \$6 million to reimburse the EPA, investigate the claim themselves and perform some remediation work into the late 1990s, according to court papers.

The EPA never ordered either railroad to clean up any third-party property, though, because the agency determined that the lead contamination levels were not high enough to warrant a cleanup order, according to Union Pacific.

But Union Pacific argued that a settlement of potential liability is covered even if the policyholder eventually is not held li-

able for third-party property damage. It contended that the Denver & Rio Grande's policies covered "liability through compromise" and urged the lower district court and the appellate court to apply a "reasonable anticipation of liability" standard to its EPA settlement.

The lower court rejected that argument in 1999, and the appellate court last month affirmed that decision 3-0.

The appellate court ruled, "While the policies here provided coverage for expenses for which Rio Grand became liable through either adjudication or compromise, such expenses were required to be 'on account of...property damages.' Thus the policies' plain language requires a showing of property damage" before the policies must respond, the court explained.

Terry R. Howell, the insurer defense attorney in the case, characterized the decision as "very important."

'The (CGL) policy is not a slush fund for expenses incurred by the policyholder in response to government inquiries.'

— Laura Foggan
Insurance Environmental
Litigation Assn.

"It confirms that excess insurers do not have to pay losses where there is merely an allegation of property damage but the facts show that no property damage in fact occurred," said Mr. Howell, a partner with Lord, Bissell & Brook in Atlanta.

Ms. Foggan applauded the ruling. The decision underscores that "all environmental response costs are not covered," she said. "The policy is not a slush fund for expenses incurred by the policyholder in response to government inquiries about potential environmental hazards."

Union Pacific attorney Brent D. Stratton, a partner with Jenner & Block L.L.C. in Chicago said he would not comment on the case until the deadline for filing an appeal passes in early September. Union Pacific has not determined whether it will appeal the case, he said.

But policyholder attorney Robert M. Horkovich, a partner with Anderson Kill & Olick P.C. in New York, said the ruling has "zero value." The court's decision not to publish its opinion "shows its lack of confidence" in the ruling, he said.

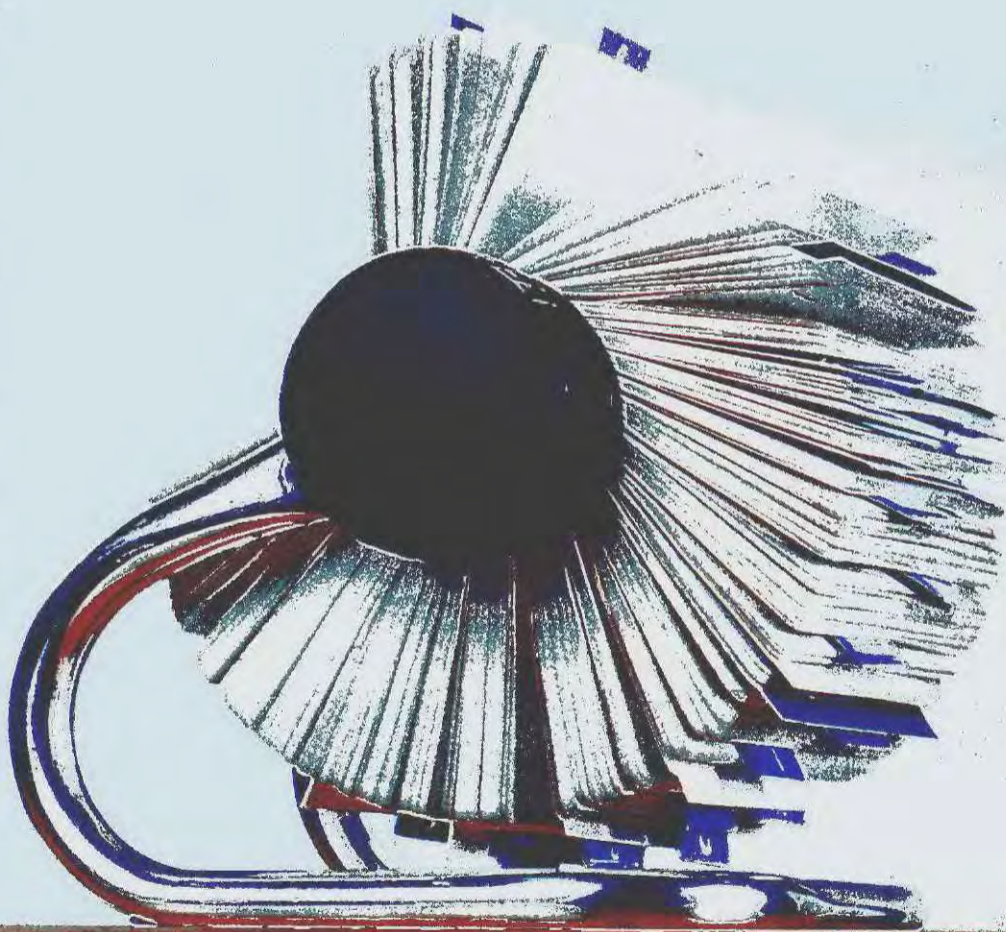
Union Pacific Railroad Co. vs. Certain Underwriters at Lloyd's et al., Colorado Court of Appeals, No. 00CA095; July 19, 2001.

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OPINIONS

Weigh pension proposal

SHOULD A DEFINED CONTRIBUTION plan participant be required to obtain the written permission of his or her spouse before taking a lump-sum distribution from the plan?

That question likely will receive increased attention in the coming months, because Senate Health, Education, Labor and Pensions Committee Chairman Edward Kennedy, D-Mass., plans to introduce legislation that would impose just such a requirement.

The issue is not a new one. Back in 1984, Congress, after listening to compelling evidence presented at numerous hearings, addressed a real problem in the defined benefit pension area: individuals who were left without pension benefits after the death of their spouses.

As many witnesses told congressional panels during the 1980s, employees—perhaps to save a little money—sometimes failed to opt for a joint and survivor benefit, which would have provided a surviving spouse with about half of the worker's promised benefit. As a result, the surviving spouse would get nothing.

The results of such situations could be devastating, especially in cases in which a surviving spouse never worked and had no pension benefit of his or her own.

Congress remedied that problem when it passed the Retirement Equity Act of 1984. That law requires a defined benefit plan participant to select a joint and survivor benefit unless his or her spouse waives the right to receive it. The REA, as we have said before, provided a good solution to a real problem.

Now, the issue is whether REA protections should be extended, as Sen. Kennedy will propose, to defined contribution plans. Under his legislation, unless a spouse waived his or her right, account balances from an employee's defined contribution plan would have to be paid either as a steady stream of periodic payments—based on life expectancies of the employee and spouse—from the plan or as a joint and survivor annuity purchased from insurers.

To be sure, Sen. Kennedy's proposal differs greatly from the one advanced in 1997 by then-Sen. Carol Moseley-Braun, D-Ill. That proposal would have required spousal consent for any distribution, such as loans and hardship withdrawals.

While the Moseley-Braun proposal was painted by its backers as supporting women's interests, that was hardly the case. It would be quite easy to think of situations, if spousal consent were required, in which a working woman who needed money from a 401(k) plan might have been blocked by an estranged husband who was unwilling to give the necessary approval. Mindful of that, Congress wisely killed the Moseley-Braun proposal.

Sen. Kennedy's proposal, to his credit, does not go as far as the earlier measure did. Under the new proposal, loans and hardship withdrawals are excluded from the spousal consent requirements.

Furthermore, Sen. Kennedy's staff has gone out of its way to share drafts of the proposal with employer groups to solicit their comments and suggestions. That open-door approach—which is the only way to produce well-drafted, carefully thought-out legislation—contrasts sharply with the approach Sen. Moseley-Braun took. She got her proposal attached—without any hearings or discussion—to a Senate tax bill. No substantive evidence was produced to establish that the legislation was needed, and congressional conferees, responding to the wave of criticism directed at the proposal, killed it.

While Sen. Kennedy is to be commended for his openness in developing his proposal, that isn't to say that Congress should rush to approve it. Unquestionably, adoption of the proposal would make it a little more expensive and complex to administer a defined contribution plan.

More substantively, it could discourage some employees, such as those in troubled marriages, from contributing to their defined contribution plans. Such employees may be less likely to contribute out of a concern that they could not take the funds as full lump-sum distributions upon retirement.

Still, the proposal would increase the likelihood



that more spouses would receive shares of defined contribution plan benefits.

Given such possibilities, it is Congress' duty to assess the tradeoffs associated with this legislation carefully and deliberately.

In doing so, we would expect legislators to conduct hearings on the proposal to obtain as much information as possible from participants, spouses, employers and plan administrators.

If, at the end of the day, Congress decides that the benefits of spousal consent significantly exceed the costs, we would hope that legislators set the effective date far enough in the future—one year after enactment seems about right—to give employers time to communicate the change and to make the necessary modifications to their benefit plan administrative systems.

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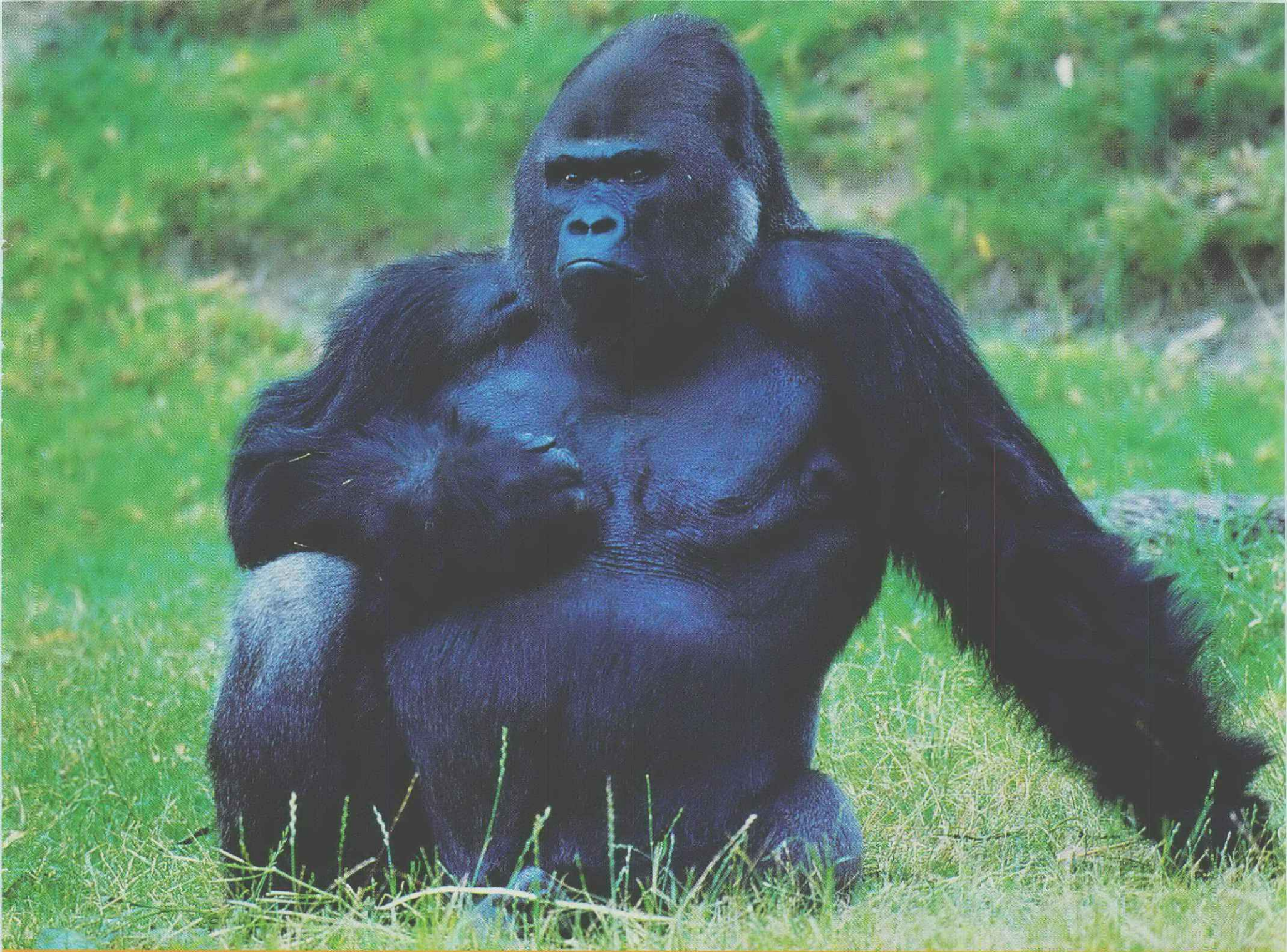
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WARD'S RESULTS

Ward identifies insurance industry best practices

By DOUGLAS McLEOD

No company operates with perfect efficiency, especially in the insurance industry, but insurers that come closest have done so by building centralized operating structures, avoiding multiple layers of management, relying on field underwriting and weighing carefully investments in new technology.

Those practices are among the hallmarks of the best-performing property/casualty and life/health insurers in an annual study of insurance industry best practices by Ward Financial Group, a Cincinnati-based insurance management consulting and investment banking firm.

One indicator of an insurer's efficiency, for example, is its hit ratio, the ratio of insurance quotes accepted to the total number issued. Top performers consistently produce higher hit ratios in given lines of coverage than do average performers, and in one line—commercial package business—the top performers win more than twice as much business as do their competitors, the study found.

"It highlights how much wasted effort is going on in the processing units of these companies," said John L. Ward, president and chairman of Ward Financial. "If you are a company and half of

your effort is in things that don't result in any business, that tends to elevate your expense ratio."

The Ward study begins with an analysis of publicly available statutory financial data of 2,700 property/casualty insurers and 1,300 life/health insurers obtained from the National Assn. of Insurance Commissioners.

While the analysis identifies the top performers, it does not reveal much about what those insurers are doing to achieve their superior results. For this, Ward employs a proprietary benchmarking program using databases built over several years to identify the best practices of top-performing companies. More than 250 insurers in the United States and Canada participate in the benchmarking program, according to Ward.

Each year, the study focuses on different areas of insurer operations, from distribution systems to claims management. This year, Ward's analysis concentrates on operating structure and technology, identifying several best practices within those broad categories among the property/casualty insurers in its benchmarking group. The study also includes a breakdown of the functions insurers are outsourcing to third-party vendors.

Operating structure

Ward's analysis shows that even

among the best-performing companies, those employing what Ward considers the best practices are in the minority.

For example, while the management consultant views a centralized operating structure as the most cost efficient, only 33% of the insurers in the benchmarking universe employ such a model.

"The trend is to more centralization, because there is a lot of consolidation going on," Mr. Ward said, citing not only increased merger and acquisition activity but also consolidation of regional offices and office closings aimed at improving expense ratios.

"Most companies that are decentralized don't do a very good job of making certain that they get a good return on their investment," he observed. "By definition, a decentralized structure tends to require more layers of management," which increases insurers' costs.

Still, 19% of the insurers in Ward's group have decentralized structures. These insurers, Ward found, continually weigh the benefits of being "close to the customer"—which should include better underwriting results—against the higher costs of decentralization.

A successful company with a decentralized structure typically has gained enough premium volume from a particular region—generally more than \$100 million—to justify maintaining branch

offices. These insurers expect superior underwriting performance from their branches, hold the executive in charge of a branch responsible for its results and give that executive a high degree of control over the branch's operations, Ward found.

Meanwhile, 21% of the benchmarking participants have implemented flat organizational structures, cutting unnecessary layers of management and maximizing the number of workers per supervisor, the study concludes.

Overall, Ward found that the optimal "span of control" for top-performing companies was in the range of six to eight nonsupervisory employees for each supervisor. Insurers with fewer than six employees per supervisor may be saddled with a heavy cost structure, while those with more than eight employees per supervisor may suffer from understaffing, the study notes.

Avoiding unnecessary payroll expenses is a key benefit of maintaining a proper span of control, Ward notes. Among the benchmarking participants, the difference in average compensation between a supervisor and a nonsupervisor ranged from \$45,000 to \$55,000, creating the potential for heavy payroll costs for those companies with too many supervisors.

"The ripple effect through your salary cost

See Ward on page 13

How Ward conducts its analysis

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Best practices in underwriting

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Ward's 50 property/casualty

Acuity
Alfa Insurance Group
Allstate Insurance Co.
American International Group
American Modern
Insurance Group
Amica Mutual Insurance Co.
Auto Club Insurance Assn.
Auto-Owners Insurance Group
California Insurance Group
Canal Insurance Group
Central Mutual of Ohio Group
Chubb Insurance Group
Church Mutual Insurance Co.
Cincinnati Insurance Group
The Commerce Group Inc.
Concord General Group
Country Cos.
The Doctors Co.
Employers Reinsurance Corp.
Farm Bureau Group
Federated Mutual Group
GEICO
GMAC Insurance
Greater New York Group
Harleysville Mutual
Insurance Co. Group
Hastings Mutual Insurance Co.
Horace Mann Insurance Group
Insurance Co. of the West
Interinsurance Exchange,
Automobile Club
of Southern California
Kentucky Farm Bureau Mutual
Insurance Co.
Markel Corp. Group
New Jersey Manufacturers Group
New York Central Mutual Fire
Insurance Co.
Philadelphia Insurance Cos.
Protective Insurance Group
Quincy Mutual Fire Insurance Co.
RLI Insurance Group
The SCPIE Cos.
Shelter Insurance Group
Southern Farm Bureau Casualty
Insurance Co.
St. Paul Cos.
State Auto Group
Tennessee Farmers Mutual
Insurance Co.
Travelers Insurance Group
United Fire & Casualty Group
USAA Group
Virginia Surety Co.
West Bend Mutual
Western World Group
Winterthur U.S. Holding Group

Source: Ward's Results, 2001 Property/Casualty edition

Ward's 50 life/health

Alfa Life Insurance Corp.
American Life Insurance Co.
American National Insurance Co.
American Republic Insurance Co.
American United Life Insurance Co.
Ameritas Life Insurance Corp.
Beneficial Life Insurance Co.
Central States Health & Life Co.
CGU Life Insurance Co. of America
Cincinnati Life Insurance Co.
Combined Insurance Co.
of America
Country Life Insurance Co.
Farm Bureau Life Insurance Co.
Farm Bureau Life Insurance
Co. of Michigan
Federated Life Insurance Co.
Golden Rule Insurance Co.
Great American Life Insurance Co.
Guardian Life Insurance Co.
of America
Hartford Life Insurance Co.
Horace Mann Life Insurance Co.
IDS Life Insurance Co.
Jackson National Life Insurance Co.
Jefferson-Pilot Life Insurance Co.
Lafayette Life Insurance Co.
Liberty National Life Insurance Co.
Massachusetts Mutual Life
Insurance Co.
Merrill Lynch Life Insurance Co.
Minnesota Life Insurance Co.
Mutual of America Life
Insurance Co.
Mutual of Omaha Insurance Co.
National Life Insurance Co.
National Western Life Insurance Co.
Nationwide Life Insurance Co.
Northwestern Mutual Life
Insurance Co.
Ohio National Life Insurance Co.
Pacific Life Insurance Co.
Penn Mutual Life Insurance Co.
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Insurance Co.
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Security Benefit Life Insurance Co.
Shenandoah Life Insurance Co.
Southern Farm Bureau Life
Insurance Co.
State Farm Life Insurance Co.
Teachers Insurance & Annuity
Assn. of America
Travelers Life & Annuity
USAA Life Insurance Co.
Western & Southern Life
Insurance Co.

Source: Ward's Results, 2001 Life/Health edition

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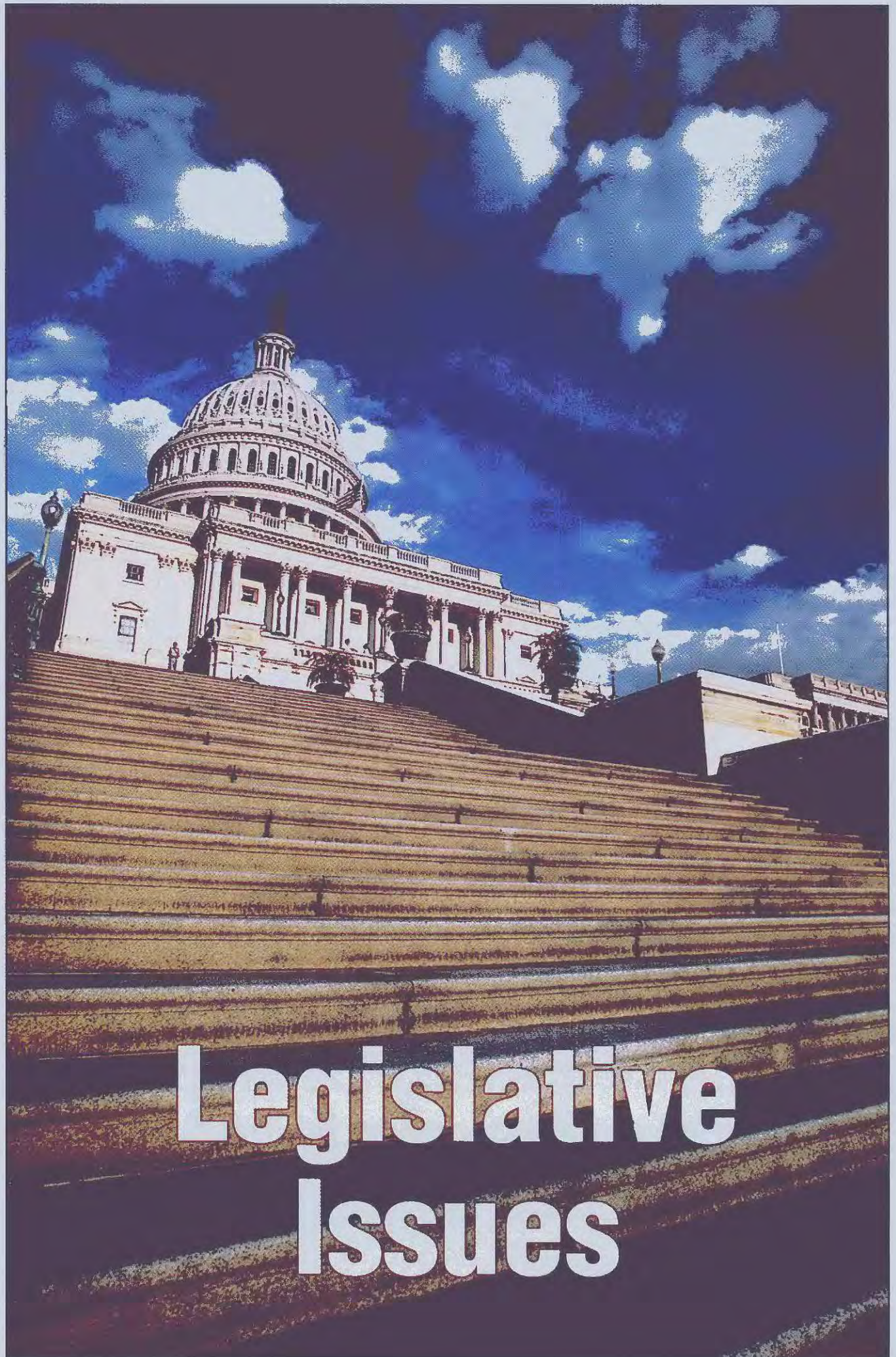
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Legislative Issues

Debate over federal chartering continues

By MARK A. HOFMANN

When it comes to insurance regulatory reform, it's all a matter of timing. For supporters of the American Insurance Assn.'s recent proposal for optional federal chartering of property/casualty insurers, "too little, too late" describes the efforts of state insurance regulators to modernize the system of state oversight. Advocates of an expanded federal insurance regulatory role maintain that the states have had more than enough time to standardize the patchwork of state regulations; now, they say, it's up to Congress to act.

But supporters of continued state-only regulation of insurance say that the AIA proposal calls for "too much, too soon." While they acknowledge that state regulation has its shortcomings, they say that regulators have made great strides in improving the process and Congress must give them time to finish the job.

Supporters of an enhanced federal role freely admit that change won't come overnight. AIA President Robert E. Vagley said at a press briefing late last month that he expected the process to take at least three to five years.

But the House Financial Services Committee has already commenced hearings on various aspects of insurance regulation. In fact, the chairman of the committee's subcommittee on capital markets, insurance and government-sponsored enterprises said months ago that he would like to start discussing optional federal insurer chartering as early as this fall. The chairman, Rep. Richard Baker, R-La., also made clear that he has drafted no legislation and wants only to talk about the issue, at least for the time being.

But the AIA proposal is the third such proposal to emerge in recent months. Both the American Bankers Insurance Assn. and the American Council of Life Insurers have released proposals that apply to their segments of the insurance industry. The AIA proposal is the first aimed specifically at the regulation of

property/casualty underwriters.

The AIA proposal would create a system of optional federal chartering for property/casualty insurers, overseen by a federal insurance chartering director based in the Treasury Department. That director would serve a six-year term and would have the power to establish chartering standards, including capital and surplus requirements based on a risk-based capital formula. He or she would have financial examination authority and could establish investment limitations and holding company requirements. The director also could promulgate rules on unfair claims and marketing practices consistent with Internet developments, conduct market examinations and levy fines.

An insurer that operates under a federal charter could write all lines of property/casualty business in any state without state rate and form regulation, and it would not have to file rates and forms with the federal regulator to get prior approval. Such insurers would not enjoy antitrust protection for rates, though, except for those set for participation in residual markets. Antitrust protection would remain in place for the development, dissemination and use of standard policy forms. In addition, not all insurers within a single holding company would have to choose the same type of chartering.

States would not be allowed to discriminate against federally chartered insurers. The proposal would pre-empt state laws that pertain to rate and form regulation, insurer licensing, solvency and market conduct. State law would also be pre-empted to the extent that it permitted a private right of action based on marketing activities regulated by the federal government.

State laws regarding residual market participation, mandatory reparation requirements, fees, taxes and guaranty funds would otherwise remain intact. State law would also remain unchanged with respect to agent licensing and the National Assn. of Registered Agents and Brokers provision of the 1999 Gramm-Leach-Bliley Financial Services Modernization Act. Finally, state law would remain unchanged with

respect to an insurer's state of incorporation, which would be considered the state of domicile for premium tax and retaliatory tax purposes.

Insurers that chose to remain state-chartered would retain all current protections under the McCarran-Ferguson Act of 1945.

The Kansas City, Mo.-based National Assn. of Insurance Commissioners responded calmly but firmly to the AIA proposal. "NAIC members recognize that change is needed and have embarked on a national drive to bring greater uniformity, uniform application, efficiency and effectiveness to state insurance regulation. This is the process we began in March 2000, following unanimous NAIC adoption of the Statement of Intent" on complying with the financial modernization law, the NAIC said in a statement last month.

"Despite the AIA's actions, our focus will not change, nor will we yield our mission of safeguarding consumers across the country, knowing that they are and will continue to be well served by the states. Our goal is creating a 21st-century regulatory system that not only makes it easier for companies to get products to market and gives consumers more choices but also enhances the protection of the very policyholders we are charged with looking out for," said the NAIC.

Nor does the Alexandria, Va.-based Independent Insurance Agents of America Inc. support the AIA's federal charter proposal.

"While we recognize that there are legitimate (insurance) company concerns that need to be addressed, we strongly believe that those concerns can be fixed through the state-based regulatory system," said Maria Berthoud, senior vp-federal affairs for the IIAA in Washington. The IIAA wants to "find a middle ground to help fix the state-based system, not dismantle it," she said.

Jack Ramirez, the president of the Des Plaines, Ill.-based National Assn. of Independent Insurers, said his group remains committed to state regulation—which he said he believes is best for consumers and for a competitive marketplace—and opposes "federal encroachment."

The NAII also believes that state regulation needs to be modernized, he said. The fact that state regulators have admitted that regulation needs to be improved is significant, he said.

"We think Congress needs to give ample time for the states to do that. What is ample time? That's debatable. It's a matter of years, not months," Mr. Ramirez said. "We think the emphasis should be to give them adequate time."

Mr. Ramirez noted that the Gramm-Leach-Bliley Act gave the states three years to adopt producer licensing reciprocity laws to avoid the imposition of a federally mandated National Assn. of Registered Agents and Brokers.

As far as Ken Crerar, the president of the Council of Insurance Agents & Brokers, is concerned, states have had ample time. "Let's look at our best example of regulatory reform, which we know well, which is licensing. The NAIC set out in their first year that uniformity and reciprocity are important issues. How long has that organization been around? About 130 years," he said.

"They don't have the power or control to change it. The control and power rests with the legislatures, and there's no reason for state legislatures to respond. Why did they respond on NARAB? Because there was a threat—the federal government had a huge club over their head," Mr. Crerar said.

The executive director of the Albany, N.Y.-based National Conference of Insurance Legislators disagrees. In fact, Bob Mackin pointed to the states' quick response in passing reciprocity legislation as proof that the states can do the job.

"I think the states did one hell of a job to get that done; that speaks for itself. We won that one—NARAB was an outstanding success for the states. It will continue to be," Mr. Mackin said.

He noted that the group passed a resolution at its July 13 Chicago meeting that read, in part, "NCOIL will oppose any proposal to establish either a federal or bifurcated system of insurance regulation, cede any authority to federal agencies to regulate financial institutions in-



volved in the business of insurance, or congressional ratification of trade agreements that pre-empt state insurance regulation."

"NCOIL adopted a commercial line deregulation bill three years ago; it has been passed by 21 states. The idea that states don't do the job is simply not accurate," Mr. Mackin said.

An AIA spokeswoman said that no one expects the issue to be resolved overnight. "We have said all along that optional federal chartering is a multiyear effort. And in that time period, we will continue to work actively at the state level. The states control their own destiny with respect to what their system will look like in the future. They have all the time in the world. Having said that, we would like to see meaningful progress at the state level soon," she said.

Meanwhile, a senior CIAB official said that NARAB can serve as a model for reform.

"Broader insurance regulatory reform is No. 1 in the context of NARAB" on the CIAB's list of legislative issues, said Joel Wood, senior vp-government affairs for the CIAB. "We believe that NARAB provides a good model for an achievable political solution to improved insurance regulation without necessarily having to go the full distance of the federal charter. I say that as a supporter of a federal charter."

NARAB is "neither fully federal nor fully state but is having a galvanizing impact on moving toward a more uniform regulatory environment," Mr. Wood said.

Sally Roberts contributed to this report.

Producer group looks to add benefits shops to ranks

By MARK A. HOFMANN

The Council of Insurance Agents & Brokers hopes to involve insurers in the Council's new effort to draw employee benefits producers into its ranks.

Last month, the CIAB chartered a new group, the Council of Employee Benefits Executives, that seeks to provide employee benefits producers with many of the same services that the CIAB furnishes to agencies and brokerages engaged in proper-

ty/casualty insurance business. This includes advocacy on Capitol Hill, continuing education, networking opportunities and a national industry forum.

In fact, the CEBE plans to hold its first Employee Benefits Leadership Forum at the Greenbrier resort in White Sulphur Springs, W.Va., on May 29-31, 2002. The CIAB has held its annual Insurance Leadership Forum—which brings together property/casualty producers and underwriters—at the Greenbrier every fall for nearly 90 years.

Robert Munao, who is the CEBE's chairman, said that the CEBE's Greenbrier meeting likely would follow the same format as that of the CIAB gathering.

"We will invite the major national carriers, as well as the major regional carriers, to a national meeting to accomplish the same thing as Greenbrier," he said. It will provide a chance for top people to discuss issues and products, he said.

"There's a reluctance among carriers," Mr. Munao said, "to talk to each other about how to make the

health care delivery business, for example, more efficient" with regard to such issues as handling claims and delivering data to employers in a common format. He described the current system as "totally archaic."

Mr. Munao said the creation of the group acknowledges the importance that employee benefits-related revenues have assumed for insurance agencies and brokerages that traditionally have focused on the property/casualty side of the business.

"Benefit operations as part of P/C

shops have always been the stepchildren of that agency," said Mr. Munao, who is president of Kaye Benefits Consulting, a HUB International Ltd. company in Woodbury, N.Y. But in recent years, he said, as property/casualty earnings have flattened, there's been a "spike-up" in the importance of benefits business. And in the last three or four years, "P/C shops have realized if they don't have a strong benefits shop, there's money being left on the table, because it's a

See Benefits on page 12D

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INSURER TOPICS

Benefits

Continued from page 12B

very critical part to round out a client's relationship," he said.

In some cases, Mr. Munao said, clients have moved property/casualty accounts but kept their benefits programs with incumbent producers; that's because "we're dealing with something much more personal than a P/C policy," he said.

CIAB Chairman Tom Rodell, managing director of Aon Risk Consultants in Chicago, said that after it merged with the National Assn. of Insurance Brokers in 1998, the CIAB began assessing how it could "move forward into the new decade with a recommitted focus." Mr. Rodell said the CIAB found that, "while there were numerous organizations representing consumers and underwriters," none represented employee benefits producers. The CIAB then held meetings across the country to determine how to reach this constituency, and, in March, its board decided to form the CEBE.

Mr. Rodell noted that benefits business already generates a significant portion of the revenues of

many CIAB members, reaching, in some cases, as high as 50%.

'There's a reluctance among carriers to talk to each other about how to make the health care delivery business...more efficient.'

— Robert Munao
Council of Employee
Benefits Executives

Mr. Rodell said there would be no change in the criteria for membership: CEBE members, like CIAB members, must have at least \$2.5 million in annual revenues, which could come from combined benefits and property/casualty business. The short-term focus will be to identify all current CIAB members that could participate and then reach out to non-CIAB members, he said.

CIAB members produce more

than 80% of all commercial domestic property/casualty premiums, said CIAB President Ken Crerar. As the CIAB builds the CEBE, "we also will reach out to those firms that are not council members but are dominant firms," Mr. Crerar said. Continuing the premium requirement provides "a delineator of who the players are," he said.

The concerns of larger intermediaries differ from those of smaller producers, Mr. Crerar noted. Furthermore, he explained, the lines dividing commercial property/casualty and benefits and life business are blurring, as producers seek to meet all of the needs of their commercial customers.

"I would like to encourage benefit-only organizations to join the council, since they are an important group of companies that we need input from," Mr. Munao said.

"The main goal is to create the professional networking for employee benefits executives, like there is on the commercial side," said Kathi Tripoli, director-employee benefits for Pasadena, Calif.-based Bolton & Co. Insurance Brokers and the vice chair of the CEBE.

"Another main focus is to offer top-quality education and a training program for employee benefits agents—producers and account managers. There really is nothing out in the industry that formalizes your continuing-education credits," Ms. Tripoli said. The CEBE will be putting together a program—"like a benefits university"—to provide the continuing-education opportunities, she said.

Both Ms. Tripoli and Mr. Munao stressed the importance of the CEBE's role in voicing the concerns of benefits producers.

"We want to have an advocate on Capitol Hill that will streamline the information," Ms. Tripoli said.

"We don't have a real lobbying source in Washington to hear our concerns," Mr. Munao said. He cited privacy legislation as one of the most pressing of those concerns, particularly the privacy provisions of the 1999 Gramm-Leach-Bliley Financial Services Modernization Act.

Mr. Crerar said the CEBE will choose carefully the issues it targets, seeking to concentrate "where we can truly have an impact, instead of being a 'me-too player.'"

The CEBE has not yet deter-

mined whether to form a parallel organization to the Council of Insurance Company Executives, an underwriter organization that meets with the CIAB at the Greenbrier gathering, Mr. Rodell said. "We would clearly give that some serious consideration," he said.

"Whether we need to do this, I'm not sure," Mr. Crerar said. "We want to maintain and develop strong relations with the markets that provide benefits products."

Mr. Crerar noted, though, that regional players tend to have a larger role in the benefits marketplace than they do in the property/casualty arena. Furthermore, he said, the benefits market has three distinct segments: pensions, health care and group life/disability.

"Each one of those markets is different," Mr. Crerar said. Consequently, he said, the CEBE would continue to have regional meetings, as well as a national meeting, he said.

The CIAB held a series of regional meetings over the past year to ascertain the needs and concerns of benefits executives. Two more meetings are scheduled to take place in Miami and Los Angeles in November. **BI**

Politics, insurance not strange bedfellows for lawmaker

By CURTIS M. WONG

When he began work at age 22 as an adjuster for Providence, R.I.-based Liberty Mutual Insurance in the winter of 1963, David Bates had no idea how committed he would eventually become both to the insurance industry and to his home state.

He has been president of the A.N. Nunes Agency of Barrington, R.I., which specializes in property/casualty insurance, since 1982 and has been a Republican member of the Rhode Island Senate since 1993. And Sen. Bates' hard work and dedication on the political scene have recently garnered him national recognition.

"Being an insurance agent, you get into a specific rhythm that can translate well into the political arena," said Sen. Bates. "You're definitely going to be criticized a lot. It's certainly a lot of work, and it's not something you can do without a thick skin. But it has very many rewards that make it all worth it."

At the 2000 convention of the Independent Insurance Agents of America, Sen. Bates was honored with the Sidney O. Smith Award for advancing the 1997 passage in Rhode Island of a groundbreaking law. Although state-regulated banks and insurers were traditionally barred from forming business alliances in Rhode Island, the law permitted state-regulated banks to sell insurance in towns with fewer than 5,000 residents. Furthermore, Sen. Bates said, the law established

the authority of the state's Insurance Department to oversee the business activities of all providers of insurance, including banks.

Since its passage, 28 other states have used the Rhode Island law as a prototype in crafting similar laws, Sen. Bates said.

"It was really a blending of two distinct businesses," he said. "At the time, it was very important for the state to set up a system with banks' agencies and how they were involved with insurance. It's a really comprehensive bill."

Although politics and insurance may seem to be two distinct fields, Sen. Bates said his insurance background has served him well in the Senate. As a small-business owner, he understands the everyday needs of citizens and he makes himself accessible, he said.

"You already get so involved in local and national issues by just being an insurance agent anyway," Sen. Bates said. "I think it provides a perspective that's useful in debates that many other senators can lack. People feel comfortable approaching someone that they already know with their issues."

Wesley Bissett, vp of state relations and state government affairs at the IIAA in Alexandria, Va., noted that the combination of insurance and politics is hardly a new one.

"We actually have a long history of insurance agents running for—and winning—elected positions," Mr. Bissett said. "The fact that they are natural leaders and trusted advisors makes them a shoo-in when it comes to running for an elected office."

Like many of his colleagues, Sen. Bates entered politics gradually and experienced some setbacks along the way. He began his career with the A.N. Nunes Agency in 1966. By 1972, he had joined Barrington's planning and zoning committee. Twelve years later, a town council seat opened up, and he decided to run for the office.

'We actually have a long history of insurance agents running for—and winning—elected positions.'

— Wesley Bissett
Independent Insurance
Agents of America

"Up until that point, I'd sworn I'd never run for an elected office," he said. "It was really a last-minute type of thing."

Despite what he describes as an "interesting" door-to-door campaign, Sen. Bates lost the 1980 election. In 1982—the same year he purchased the A.N. Nunes Agency from founder Al Nunes—Sen. Bates ran again and won. Just one year later, Sen. Bates was elected vp of the Barrington town council; four years after that, he was elected president of the council, a position he held until 1988.

But Sen. Bates didn't consider expanding his political role until Ann Hanson, a decade-long veteran of

the state Senate, decided not to run again. When Ms. Hanson suggested that he take her place on the ticket in the 1992 race, Sen. Bates jumped at the chance, he said. "I guess it seemed like the next logical step in my career."

Mr. Bissett said Sen. Bates' decision is not unusual.

"Once people get involved with the political process, they realize that they can take that next step and be elected themselves," Mr. Bissett said. "It's a lot of work to convince 25 colleagues that a specific issue is prevalent. But most state legislators don't have experience when it comes to selling things—things that an insurance agent does all of the time. The world of politics really takes advantage of their assets as agents."

When Sen. Bates first came to office, he said that he and many of his colleagues found the state's prohibition of cooperation between banks and insurers to be outdated. The legal bar to coordination between the two financial services, he said, failed to take into consideration the problems inherent in providing quality insurance coverage to the residents of towns with populations of fewer than 5,000 people, he said.

After the U.S. Supreme Court's 1996 ruling in *Barnett Bank of Marion County, N.A. vs. Nelson, Florida Insurance Commissioner*, which allowed federally regulated banks to sell insurance policies in towns with 5,000 or fewer residents, Sen. Bates began a focused campaign to grant state-regulated banks in Rhode Island the same privilege, he said. Although the

measure had its critics, Sen. Bates said that the entire business world "saw the bill coming."

"The fact that so many states used Rhode Island as a model for their own laws pretty much speaks for itself," Sen. Bates said.

Sen. Bates offers advice for other insurance professionals seeking to get involved in politics. Being a state senator, he said, has both allowed him to contribute to his community and helped his business.

As for his future political goals, Sen. Bates said that he'd like to work to preserve state regulation of the insurance industry.

Sen. Bates said he has been surprised by the way that his political status has advanced his career as an independent insurance agent. "Not only does it help the Legislature, but it also helps the agency," he said. "If an agent has the extra time, energy and ability to devote themselves to politics, I would definitely encourage it."

Sen. Bates said he advises insurance professionals looking for a political break to start small and gradually take on larger issues. An individual can't get to the state level, he said, without first getting his or her feet wet in local politics. Furthermore, he said, political activity isn't for everyone; an agent must be sure he or she has sufficient time to devote to campaigning and to the responsibilities political work entails, he said.

"Obviously, the business has to come first. You really have to weigh your time commitments carefully and weigh the situation in the job you already have," Sen. Bates said. **BI**

IT BRIEFS

NAIC license fees

In an effort to speed insurance products to market, the affiliate of the National Assn. of Insurance Commissioners that oversees its System for Electronic Rate and Form Filing announced it has ceased charging insurers license fees to use the system.

The 225 insurers and insurer groups that currently file rate and form information electronically to the 28 state insurance departments that accept such filings must pay filing fees in those states that require them, an NAIC spokeswoman said. Some states require fees when, for example, insurers introduce new products.

The number of state insurance departments that participate in SERFF is expected to increase by the end of this year, to 41 from the current 28, the NAIC spokeswoman said. SERFF reduces the time and cost of regulatory filings, helping to speed products to the marketplace.

Fire reimbursement

SANTA FE, N.M.—The federal government is moving to reimburse insurers for all claims stemming from the Cerro Grande fires in New Mexico, officials of the Federal Emergency Management Agency recently told insurer representatives.

So far, the federal government has closed about 12,000 claims stemming from the May 2000 fires, thus obligating about \$200 million of the \$455 million Congress had appropriated for individual fire victims and their insurers, FEMA representatives told insurers at a meeting in Santa Fe, N.M., late last month.

The blazes began when fires deliberately set by the National Park Service burned out of control and spread across 50,000 acres. At one point, the fires threatened to destroy the Los Alamos National Laboratory—the birthplace of the atomic bomb. While the nuclear facility sustained damage short of destruction, more than 220 structures were consumed, leaving hundreds of people homeless.

Congress reacted by approving special legislation to compensate the victims of the fires and their insurers. The payments to insurers are expected to begin in January.

"We are very pleased that FEMA is progressing in a systematic manner to compensate the fire victims and their insurers," said Carl Parks, senior vpgovernment relations in the National Assn. of Independent Insurers' Washington office, in a statement released earlier this month. "Prompt enactment of this special legislation and quick implementation by FEMA are prime examples of government working for the benefit of its people."

Auto insurance examined

WASHINGTON—The House Financial Services Committee's continuing examination of the impact of state insurance regulation has turned to automobile insurance.

The committee's Subcommittee on Oversight and Investigations tackled state regulation of automobile insur-

ance at an Aug. 1 hearing. In a statement prepared for that hearing, Financial Services Committee Chairman Michael Oxley, R-Ohio, pointed to the recent decisions by State Farm Mutual Insurance Cos. and American International Group Inc. to withdraw from the New Jersey market due to regulation and politicization as symptomatic of what he called "overregulation." The withdrawal of the two insurers from the state will affect more than 1 million New Jersey policyholders, Rep. Oxley said.

"Regulation becomes a real problem when it goes from protecting consumers to harming consumers," Rep. Oxley said in his statement. "How can you rationalize to the 1 million New Jersey consumers losing their automobile insurance that price controls are intended to help them? Pushing insurance companies out of the state undermines competitive pricing and eliminates the right of consumers to take advantage of the benefits of a strong and...competitive industry."

NAII appointments

AUSTIN, Texas—Don Hanson has been named manager of the National Assn. of Independent Insurers' new Southwest regional office in Austin, Texas. The Southwest regional office will serve the states of New Mexico, Oklahoma and Texas.

Prior to joining NAII, Mr. Hanson served as staff attorney for the Texas Department of Insurance and has several years of insurance industry experience in the private sector. At the Texas Department of Insurance, Mr. Hanson dealt with high-priority concerns in the department, including financial services modernization, agent licensing reform and electronic commerce.

The new office is at 816 Congress Ave., Suite 1100, Austin, Texas 78701. Mr. Hanson can be reached at 512-473-3686.

Also, Anne Sittmann, whose government public affairs and media relations expertise includes positions with the administration of George H.W. Bush and the private sector, has joined the NAII as the director of public affairs in the organization's Washington office.

Most recently, Ms. Sittmann served as an account supervisor for technology marketing with Edelman Public Relations Worldwide, where she was responsible for the creation of public relations strategies for high-tech companies.

Before joining Edelman, she was director of Strategic Alliance Management Inc., a communications consulting firm in Washington, where she developed and ran national public affairs campaigns for clients.

While with the Bush administration, Ms. Sittmann was the director of public affairs for the Bureau of Export Administration at the U.S. Department of Commerce.

Mold seminars

Several seminars on mold are scheduled in coming months, including one Oct. 29-30 that is sponsored by the Property Loss Research Bureau and the Liability Insurance Research Bureau and another scheduled for Nov. 8-9 that is sponsored by the American

Insurance Assn.

The PLRB/LIRB National Mold Symposium, titled "The Truth About Mold," will be held in Charlotte, N.C. Participants are to include some of the nation's foremost mold experts, who will examine concerns in the industry-wide mold crisis.

Among the topics for discussion are the science of mold, including a description of what it is, its health effects, its life cycles and remediation; practical experiences; air quality and the remediation processes; rapid-drying technologies; and the latest trends in case law.

Registration for the Mold Symposium is \$325, with the fee waived for

PLRB/LIRB members. To register or find out more about the symposium, visit www.plrb.org or call Valerie Berka at 630-724-2227.

The PLRB and LIRB are affiliates of the Downers Grove, Ill.-based Alliance of American Insurers, answering coverage-related questions for more than 600 member companies.

November's AIA seminar will be held at the Omni Shoreham Hotel in Washington and will feature experts covering topics that range from the health effects of mold to insurance concerns to the politics of mold.

The seminar will provide an opportunity to learn about the challenges that mold presents for the property/ca-

sualty industry.

For members of the AIA, the Council of Insurance Agents & Brokers and the Reinsurance Assn. of America, the conference fee is \$495. For nonmembers, the cost is \$795.

There is a 10% discount for additional registrants after the registration of the first full-price attendee from the same company. The conference hotel is the Omni Shoreham, with a preferred rate for conference attendees of \$179 per room per night, single or double.

Anyone interested in attending or sponsoring the conference should contact Stephanie Hennesy of the AIA, at 202-828-7139, for information. **BI**



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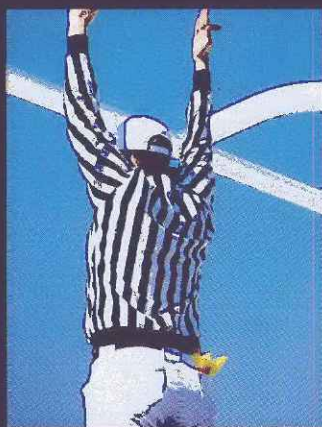
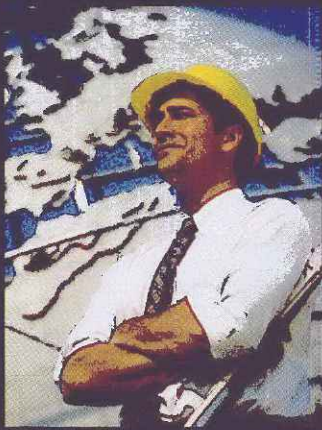
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Business process outsourcing can save time, money

By Dennis P. Mulligan

As companies deal with such monumental issues as mergers, reorganizations, technological advancements and globalization, their need to maintain focus on their core businesses has never been greater.

While management seeks to concentrate on strategy and profitability, it cannot overlook the day-to-day operations of its organization. This challenge leaves the resources of many businesses stretched to the limit.

In the insurance realm, companies often elect to outsource the noncore processes of their operations as one solution to this problem. Having discovered the savings of time and costs that can be achieved by hiring outside providers for noncore functions—and becoming increasingly comfortable with that concept—insurers are seeking even greater value in their outsourcing partnerships.

That search is leading many companies to tap into the benefits of business process outsourcing.

The origin of BPO

BPO is a relatively recent concept that has evolved out of a time-honored practice.

For years, companies in many industries have contracted with outside service providers to perform certain functions. Manufacturers contract with small firms to produce vital components for their products. Agribusinesses rely on independent growers for elements of their crop programs. Retailers use independent agents to serve as or to augment their sales forces. And insurers outsource functions that include underwriting, billing and claims processing.

Advancements in information technology also prompted companies to outsource certain technical functions. One of the earliest examples of this was the outsourcing of payroll processing, which relieved companies from handling a time-consuming, but essential, function. As technology has continued to evolve, more sophisticated functions are now being outsourced, such as data management, document storage and technology platform maintenance.

Today, because technology intertwines numerous processes within a business, the outsourcing of an entire chain of noncore operations—a process—is not only feasible, but is also of great value to a growing number of companies.

BPO is the next step in the outsourcing evolution. Whereas IT outsourcing typically involves managing a specific application or function for relatively short periods, the outsource vendor in a BPO

arrangement functions as a long-term ally for the organization, assuming responsibility for an entire process. BPO also introduces the fundamental component of service, which further expands the provider's role as the manager of a complete business unit rather than of a solitary function.

Multiple advantages

Companies that implement BPO do so to maintain a focus on their core business. By outsourcing noncore processes, the companies can expand their opportunities as well as their choices in the business environment, improve their efficiency and, ultimately, increase shareholder value.

BPO enables a company to improve service levels to customers, employees and vendors, as well as helping it reduce general and administrative costs. It also allows a company to enhance technical capabilities without expanding capital investments, to preserve its focus on core competencies, and to improve competitive positioning.

BPO also can help a company gain knowledge and expertise in specific areas. In addition, it can redirect management personnel from maintenance to strategic issues, build shareholder value as operational costs are lowered, avoid internal bureaucracies to improve organizational efficiencies, and enhance the flexibility of the organization's resources.

Multiple processes

BPO is typically used for the noncore processes of a business, such as administrative or human resource activities. And because BPO is used for activities that are common to every business, the concept is not industry-specific, although many BPO providers in the United States have become specialists in certain industries, such as health care or insurance.

Some of the processes commonly outsourced in BPO include:

- Finance and accounting, including billing, collection, reports, payment processing and commissions tracking.

- Customer service, such as call centers, enrollment, communications and self-serve technology.
- Sales and marketing, including sales staff management, telemarketing, direct marketing and communications.

BPO can help insurers and health plans reduce operating costs while making service more efficient.

A host of services are available in outsourced insurance program management. These services may include: consulting, including needs assessment and process analysis; underwriting; eligibility management; database marketing; client communications;

development and production of enrollment materials; quality control for compliance, program utilization and reporting; customer service; claims processing; and billing and collection.

A relative newcomer to the list of services, database marketing is becoming an increasingly sought-after and vital tool for insurance companies.

With advances in database technologies, highly effective, personalized marketing strategies can be developed. Such strategies deliver the right marketing message to the right customer at the right time—on a one-to-one basis—using the customer's preferred medium.

Integrated communications are delivered through a variety of media, including direct mail, advertising, Internet/e-mail, telephone, radio and television.

By cross-referencing extensive data sets, insurers can identify specific products to address the individual needs of the customer.

Customers are differentiated through a variety of demographic characteristics, financial activity and purchase behavior. Through mass customization and personalized, direct-response communications, outsourced database marketing can establish new customer relationships and strengthen existing ones.

Desired partner traits

When companies decide to enter into a BPO relationship, they are essentially bringing another company on board to work within the organization's operations. While individual companies may have different motives for adopting BPO, they often hold their BPO providers to similar standards.

Desirable attributes of BPO partners include:

- Expertise in the process being outsourced.
- Extensive project management skills.
- An understanding of the client's business.
- The ability to integrate best-in-class service providers into the

process.

- The willingness to establish performance measures.
- Similarities in corporate culture and philosophy.
- The experience and capabilities to integrate all aspects of a process.
- Knowledge or expertise that the company lacks internally.

Candidates for BPO

While considerable emphasis is placed on BPO partner and its involvement in the relationship, the organization itself also has certain responsibilities. Companies that are good candidates for BPO share several characteristics. These companies:

- Have established clear goals for what they want from the BPO relationship.
- Are already familiar with outsourcing certain functions and are comfortable with their outsourcing relationships.
- Understand that BPO is a long-term strategic relationship and not a short-term, quick change effort.
- Have established operational benchmarks for processes within their business so that BPO results can be verified and measured.
- Have delineated logical parameters for the process that will be outsourced.
- Possess the basic drivers for establishing a BPO relationship, such as the need to refocus on core businesses, reduce overhead, improve customer service and increase competitiveness.

Partnerships with potential

The practice of business process outsourcing has the potential to alter conventional ways of doing business. As more insurance companies embrace the concept of contracting sections of their business to outside providers, the traditional lines of business operations will become blurred. Companies and their BPO partners will be viewed as cohesive units in the marketplace, based on their shared philosophies, their joint efforts to build and maintain businesses and their mutual goals.

The BPO providers themselves are evolving. Large BPO providers are already offering end-to-end services for their clients' businesses, assuming responsibility for every step of a particular business process.

New trends show that the most technologically sophisticated BPO providers are moving beyond marketing their expertise in one specific process to bundling their offerings—packaging high levels of service with expertise in several key business processes to produce even greater efficiencies. In this way, one BPO firm can service a host of needs for a single client.

BPO produces dynamic, strategic partnerships that are reshaping the marketplace. It creates efficiencies that are surpassing traditional business models and presents appealing opportunities for companies striving to succeed in the new century. BI

Dennis P. Mulligan is senior vp-business development at Seabury & Smith Inc., a division of Marsh Inc. in Fort Washington, Pa.

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Ward

Continued from page 10
structure is phenomenal," Mr. Ward observed.

Along with cost control, the benefits of having fewer supervisors include allowing insurers to spend more time providing service to agents and policyholders and promoting better communication throughout the organization, Ward notes.

While the optimal overall span of control may be six to eight workers per supervisor, Ward found wide differences in the span of control in the various areas of insurers' operations.

The commercial policy processing units of top performers, for example, averaged 21 workers per supervisor while the other companies in the study averaged only 11.2 workers per supervisor.

Premium audits offer 'a significant revenue enhancement opportunity,' but their costs must be taken into consideration.

— John L. Ward
Ward Financial Group

By contrast, the commercial underwriting units of top performers had fewer workers per supervisor, averaging 4.9, compared with the 5.8 workers per supervisor for the remaining companies in the study. Likewise, the top insurers had only 5.5 information systems workers per supervisor, while the remaining companies had 6.2 workers per supervisor.

This suggests that the best-run companies impose more supervision on high-value tasks, such as underwriting, and less supervision on lower-value clerical tasks.

"It's good to be wide and flat but more in the less important functions," Mr. Ward said.

About 30% of the commercial insurers in the benchmarking group also relied heavily on the best practice of field underwriting, with commercial underwriters working with agents and potential policyholders in the field to inspect and underwrite specific risks. While the practice gives rise to added costs, it more than makes up for these with improved underwriting results, Ward results show.

Insurers whose underwriters work in the field with agents generally benefit from increased production from those agents, the study adds.

Having a centralized quote facility to speed responses to policy applications is another Ward best practice. While only 19% of commercial benchmarking participants have such facilities, those that do find the cost more than justified by increased business, the study shows.

Owing partly to these rapid-response units, top-performing insurers averaged a four-day turnaround time for commercial quotes, a huge advantage over the other compa-

nies, which took, on average, 25 days. Top performers also averaged a 15-day turnaround time for processing commercial policies, compared with a 40-day turnaround time for the remaining companies, the study found.

The vastly improved efficiency is reflected in the hit ratios reported by participating insurers. Ward reports that top performers, for example, recorded a 42.5% hit ratio on commercial package policies, while the other companies recorded a hit ratio of just 17.5%. On workers compensation business, the top performers' hit ratio was 52.5%, compared with 37.5% for the other companies; on business owners policies, 85.0% vs.

72.5% for the remaining companies; and on commercial umbrella risks, 12.5% vs. 7.5% for the remaining companies.

"People are paying a lot of attention to" hit ratios, Mr. Ward said. "As companies are focusing on top-line growth, this is a key part of that story."

The long turnaround times reported by many insurers "give you some insight into why the hit ratios are so low for some of these companies," he added.

Cost-effective premium auditing is another Ward best practice, followed by 30% of the commercial benchmarking participants.

Top-performing insurers typical-

ly vary the form of premium audits based on the size of the policyholder. Most conduct mail audits for small accounts—those with less than \$2,500 in annual premiums—and use telephone audits for medium-sized accounts, or those with up to \$15,000 in premiums. For large or high-risk accounts generating more than \$15,000 in premiums, insurers often visit policyholders to conduct audits, the study says.

Premium audits offer "a significant revenue enhancement opportunity," though insurers must balance the benefit of auditing against its costs, Ward notes.

As might be expected, the top-performing insurers in Ward's

benchmarking group showed higher employee productivity and lower underwriting and policy processing expenses than did their competitors.

The top companies among the benchmarking participants averaged \$537,000 in written premium per full-time equivalent employee, compared with \$487,000 for the other companies. Top performers also averaged 550 policies in force per employee vs. 423 policies for the remaining companies in the study.

Underwriting expenses, meanwhile, amounted to 2.1% of commercial premiums for the top-performing group, compared with 2.6% for the rest of the group studied,

See **Ward** on next page

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WARD'S RESULTS

Ward

Continued from previous page

while premiums written per full-time underwriting employee averaged \$3.4 million for top performers vs. \$3.0 million for the other companies.

Policy processing expenses averaged 1.7% of commercial premiums for top performers vs. 2.1% for the remaining companies, Ward found.

Information technology

Analyzing the best practices in information technology, Ward concludes that the best-run companies are not typically those that spend the most on new information systems, a result Mr. Ward called "counterintuitive."

Top performers "are smarter about where they will invest" in technology, he said. "The advantage of being smart about technology investment is huge."

Information systems expenses as a percentage of gross written premium averaged 2.6% among the high performers in Ward's benchmarking group, compared with 3.6% for the rest of the group studied. Those expenses also equated to \$25 per policy in force for top performers, compared with \$55 per policy for the other companies.

Likewise, information systems expense per full-time equivalent companywide employee averaged \$13,800 for the best-run insurers vs. \$18,300 per employee for the rest of the group studied.

One key best practice in the technology field, followed by 20% of the benchmarking group, requires insurers to link their information systems strategy to a carefully considered business strategy, Ward says. A successful company first outlines a business plan and then uses it to tailor the development of its information systems. It also masters the difficult job of forging "working partnerships" between the systems' users and data processing personnel,

Ward found.

Insurers that ease into information systems development with pilot programs

in noncritical areas of their companies before making big investments in technology.

Comparing the best with the rest

Selected benchmarks	High performers	Average performers
Employee productivity		
Premiums written per full-time employee	\$537,000	\$487,000
Policies in force per full-time employee	550	423
Span of control		
Average number of front-line workers per supervisor		
— companywide	6.7	5.9
— claims	7.2	5.1
— policy processing	21.0	11.2
— information systems	5.5	6.2
— underwriting	4.9	5.8
Policy processing and underwriting		
Policy processing expense as a % of commercial premiums		
	1.7%	2.1%
Policy processing expense per policy in force		
	\$37	\$59
Underwriting expense as a % of commercial premiums		
	2.1%	2.6%
Underwriting expense per policy in force		
	\$46	\$73
Service standards		
Turnaround time for quotes	4 calendar days	25 calendar days
Turnaround time to process new business	15 calendar days	40 calendar days

Source: Ward Financial Group annual benchmarking programs and Electronic Best Practices software databases

also tend to achieve better returns on their technology investments, Ward found. These companies, which make up only 17% of the benchmarking group, test sys-

"The cost of making a mistake in this regard can be significant in terms of financial resources, employee effort and general corporate morale," Ward concludes.

Ward's analysis shows that the companies with the lowest information systems expense also tend to be the most effective in linking their business and technology strategies, while those that spend the most on technology are not necessarily the most automated.

Insurers in the benchmarking universe cover a wide range of information systems expenditures, ranging from a low of 0.6% of premiums to a high of more than 8% of premiums, Mr. Ward explained.

"For those that are spending, say, 6% of gross written premiums, it's usually a sign of a failed system," Mr. Ward said, noting that costs that high may indicate problems with implementing a system.

"It's very unusual for a company spending that much on technology to be getting a good return on their investment," he said.

Outsourcing

The outsourcing of various functions by insurers continues to grow, the Ward study finds.

"The breadth of things within a company that can be outsourced continues to increase," Mr. Ward observed, noting that the percentage of benchmarking participants that use outsourcing is rising, as is the number of functions being outsourced.

Within the benchmarking group, corporate administrative functions are commonly outsourced, with employee benefit administration outsourced by 91% of the companies and payroll processing by 57%. Many also outsource elements of property/casualty operations, including after-hours loss reporting work, by 71% of the participants; regular-hours loss reporting, by 7%; claims adjusting, by 29%; claims litigation defense and glass claims handling, by 87%; and claims fraud investigation, by 16%.

Outsourcing "is a tool that many companies are using to make sure that their internal operations are working efficiently," Mr. Ward said.

How Ward selects its lists, analyzes top performers

The Ward's 50 Benchmark Group lists comprise the property/casualty and life/health insurers that have provided superior financial safety, consistency and performance over the past five years, as determined by a Ward Financial Group analysis.

In the course of its evaluation, Ward reviews publicly available statutory financial data obtained from the National Assn. of Insurance Commissioners on about 2,700 property/casualty and 1,300 life/health insurers in

the United States and Canada. Analyzing this financial data, Cincinnati-based Ward arrives at its lists of the 50 top-performing companies in each industry segment.

In the next stage of its review, Ward tries to identify what the best-run insurers are doing to achieve their superior results and to describe the best practices followed by the top performers. In this stage, Ward uses information from 250 participating insurers in the United States and Canada, including about 175 property/casualty and 75

life/health insurers.

The best practices analysis also employs proprietary databases that Ward has built over several years covering all areas of insurer operations, according to the insurance management consultant and investment banking firm.

All 250 participants in the best-practices analysis are Ward clients, said John L. Ward, the firm's chairman and president. Within the top 50 lists, 15 property/casualty insurers are Ward clients, while 14 life/health insurers are clients, Mr. Ward said.

This year's top 50 lists include eight property/casualty and two life/health insurers that have appeared in all 11 years that Ward has conducted its evaluation.

Those property/casualty companies are Alfa Insurance Group, Auto-Owners Insurance Group, Canal Insurance Group, Cincinnati Insurance Group, GEICO, RLI Insurance Group, Tennessee Farmers Mutual Insurance Co. and USAA Group. The life/health insurers are Jefferson-Pilot Life Insurance Co. and Physicians Mutual Insur-

ance Co.

Ward publishes the results of its analysis annually in two volumes. Copies of the current property/casualty and life/health volumes of Ward's Results are available from Ward Financial Group for \$545 each. They can be obtained by contacting Ward Financial Group, 8040 Hosbrook Road, Suite 100, Cincinnati, Ohio 45236-2908. Orders may also be placed by telephone, at 513-791-0303; by fax, at 513-985-3442; or online, at www.wardinc.com.

—By Douglas McLeod

Use of underwriting teams seen as best approach

Maintaining top-flight underwriting operations is one way the best-run property/casualty insurers attract and retain larger shares of business and achieve superior financial results, an annual study by Ward Financial Group suggests.

Analyzing a group of top-performing insurers, Cincinnati-based Ward found that the most-effective underwriting organization structure is one that uses underwriting teams that focus on geographical areas or particular groups of agents.

Companies that use underwrit-

ing teams retain business at a rate that is 10% to 15% higher than those that do not, Ward found. Premium production per full-time employee is also 20% to 25% higher at insurers that use such teams, according to Ward, an insurer management consulting and investment banking firm.

Overall, 45% of the commercial property/casualty insurers participating in Ward's benchmarking analysis use underwriting teams.

For commercial lines, an insurer's method of producing quotes on new business can have a big impact on its hit ratio, the proportion of quotes accepted to those issued.

Some insurers require agents or field representatives to mail submissions to a central office for quotes, a process that can take 30 to 45 days before a quote is produced, according to Ward. Other companies, though, set up central quote units that can respond to faxed or express mail submissions within 24 hours.

Insurers that have rapid-response, centralized quote units typically win more new business than do those that don't have such units, Ward's results show. On commercial package business, for example, top-performing companies bind, on average, 42.5% of the risks for which they

provide quotes, while the hit ratio for the rest of the companies in the study for commercial package business averages just 17.5%.

On commercial auto risks, top performers have a hit ratio of 32.5%, compared with 27.5% for the other companies studied. On business owners policies, the top performers bind 85% of the risks they quote, compared with 72.5% for the rest of the group.

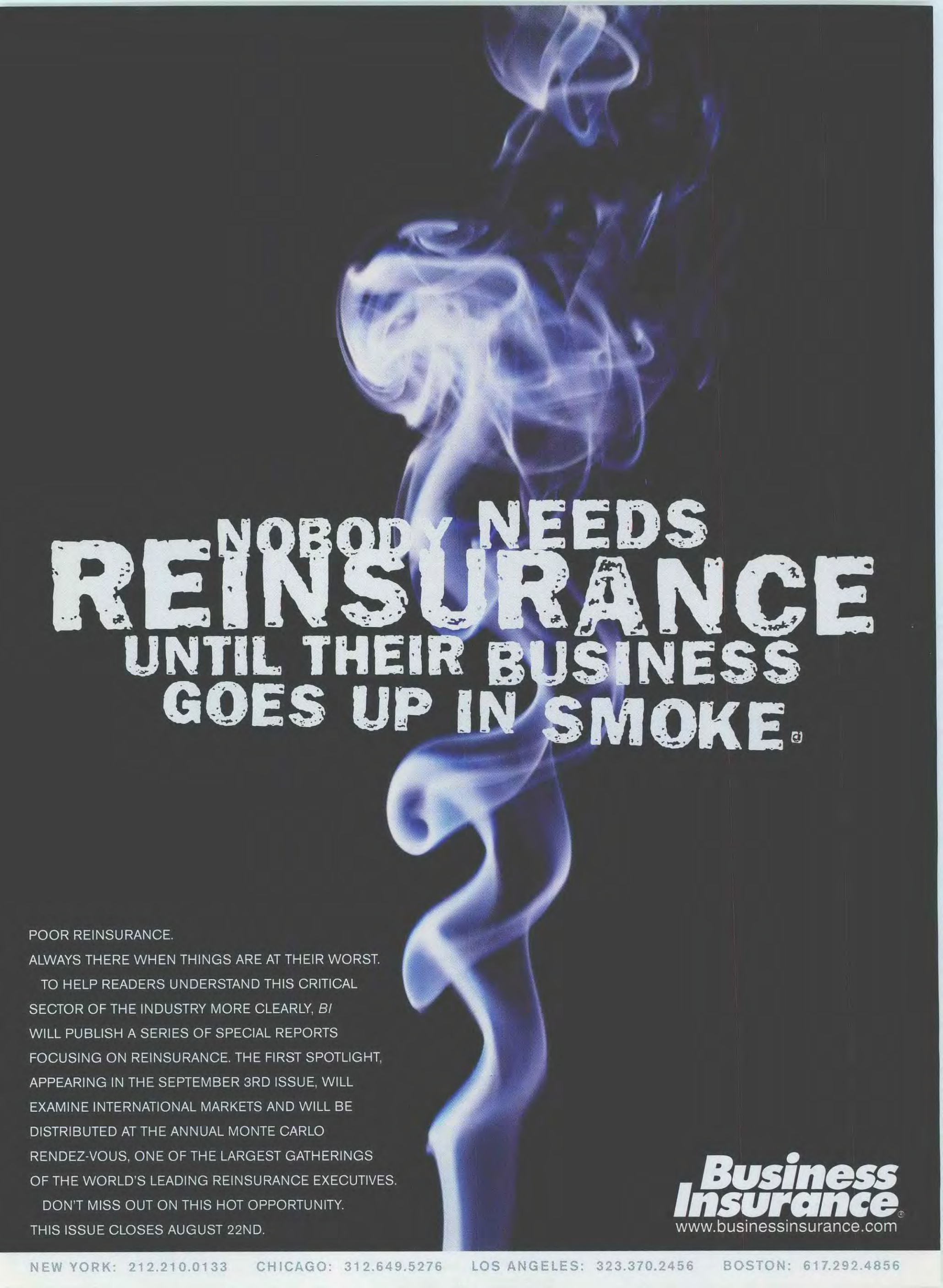
Overall, only 19% of the commercial benchmarking participants have centralized quote units.

Methods that insurers use to speed up the quotation process include expediting service for key

agents and—in the case of those with independent agents—moving automated quote systems into top agents' offices to allow them to generate quotes. A growing number of insurers are also using Internet-based quote engines that allow the insurers' home-office underwriters to review and approve accepted quotes before binding, said John L. Ward, the president and chairman of Ward Financial.

"This ensures that the company is only spending its time on the business that's being accepted," thus improving the insurer's efficiency, Mr. Ward said.

—By Douglas McLeod



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HMOs

Continued from page 3
keeping up with rising costs with their rate hikes, "which suggests more premium rate increases are on the horizon."

Results of some major companies for the first half of 2001, compared to the same period last year, are:

- St. Louis-based Right-CHOICE Managed Care Inc. reported \$28.2 million in net income, up 72.8%.

- Trumbull, Conn.-based Oxford Health Plans Inc. reported a 65.3% increase in net income, to \$142.4 million.

- Louisville, Ky.-based Humana Inc. reported \$52 million in net income, up 30%.

- UnitedHealth Group posted \$435 million in net income, a 26.5% increase.

- CIGNA Corp. of Philadelphia reported \$528 million in net income, up 22.2%.

- Thousand Oaks, Calif.-based WellPoint Health Networks Inc. recorded net income of \$132.1 million, a 20.3% increase.

- Kaiser Permanente of Oakland, Calif., had \$296 million in first-half net income, a 1% decline. For the second quarter, Kaiser posted a 10.8% decrease, to \$140 million.

- Health Net posted \$28.2 million in first-half net income, down 61.2%. For the second quarter, Health Net reported a \$14.2 million loss vs. \$38.7 million in net income for the year-earlier peri-

od. The company cited the effects of charges and operating losses posted in the quarter in connection with the sale of its Florida health plan.

- Santa Ana, Calif.-based PacificCare Health Systems Inc. reported \$28.4 million in net income, down 80.3%. The company attributed the decline to rising costs.

- Hartford, Conn.-based Aetna Inc. reported a \$37.6 million net loss for the first half, compared with \$356.6 million in net income for the comparable period a year earlier.

"Finally, we've seen a period where pricing is exceeding costs and margins are beginning to rise, and earnings pretty much across the board have been quite good," said Mr. LeConey of Dirks & Co., pointing to Humana and Oxford in particular.

"I would say, overall, the second-quarter results were in line with expectations," said Douglas L. Meyer, senior director at Fitch IBCA in Chicago. The general theme has been rising medical costs, "and this has impacted everyone in the sector," he said, citing Aetna as an example. Aetna blamed its loss on higher medical costs, resulting primarily from higher utilization.

Mr. Meyer said the strong performers, including UnitedHealth and WellPoint, continue to do quite well, while Humana "continues to be on track in terms of their turnaround," and Health Net, as expected, reported a one-time charge in connection with its

Florida health plan.

"The results were, by and large, OK," said Mr. Crawford of Fox-Pitt, Kelton. "Different companies are struggling to different degrees with the continuing escalation of medical costs. Some companies recognized the cost trends a bit earlier than others and have priced for it effectively," he said, noting that that was the case with UnitedHealth and WellPoint in particular.

'Most employers can't afford the kind of increases the industry's been putting forward.'

— Todd Richter
Bank of America
Securities L.L.C.

"Other companies are still paying catch-up," said Mr. Crawford, citing PacificCare, Aetna and, to a much lesser degree, CIGNA.

Even though second-quarter results were, on balance, mixed, looking at the results "relative to what people expected them to do six months ago, when the talk was all about the price increases, the results were pretty disappointing," said Todd Richter, managing director at Banc of America Securities L.L.C. in New York.

For the fifth or sixth year in a row, "once again, health care cost trends have accelerated way beyond what people have thought," said Mr. Richter.

As premium rates continue to rise, employers are looking for ways to minimize hikes. "Most employers can't afford the kind of increases the industry's been putting forward," Mr. Richter said.

With the labor market less tight, there is much greater interest in benefit buydowns, because employees "don't have quite the leverage" they had before, Mr. Crawford said. Those measures include increased cost sharing and attention to cost-sensitive benefit designs, he noted.

Meanwhile, the efforts to enact a patients' bill of rights remain a concern.

The issue of patient protection is a "huge wild card," said Rob Mains, an analyst with Advest Inc. in Albany, N.Y. The House-passed bill is "pretty benign," but the Senate version "could be a disaster," he said. A House-Senate conference committee still must work out differences between the two chambers' bills.

UnitedHealth's Mr. Peshorn said that though his company prefers the House bill because it puts some caps on punitive damages and reduces its own liability insurance costs, the Senate version is "fine, too. It'll just cost a little bit more."

There is a "high likelihood that there will be a bill this year and that it is going to add cost," said

Health Net's Mr. Olson, who added he will withhold further judgment "until we see a bill that gets sent to the president."

"The issue of the patients' bill of rights has been like a cloud hanging over the industry for the last four years or more," said Fitch's Mr. Meyer. "It looks like it's getting close to being resolved, and it looks like the results could be something that the industry could work with."

A less-urgent issue is the effect of layoffs at managed care companies' clients.

The thousands of layoffs already instituted by employers have not had a significant impact to date, observers say.

"I haven't heard a lot of complaints about layoffs yet," said Mr. Mains. "It doesn't appear that there have been massive losses of membership yet due to layoffs among the publicly traded companies."

The impact has been negligible, said Mr. Meyer. "It doesn't impact loss experience to a great degree," he said, although "it may have some impact on individual companies in terms of their ability to grow the book of business."

Most of these companies were not seeking "tremendous" enrollment gains anyway, said Mr. Crawford. "They were still trying to improve their own books of business, so enrollment expectations may have been brought down by a percentage point here or there, depending on the company," he said.

Although unemployment has risen slightly, it has not jumped, "so it hasn't been a large, meaningful kind of trend," said Mr. Crawford. Nor is it likely to become one, he said. "Unless you see a real strong economic slowdown, I don't think, on the pure enrollment side, you'll see an issue," he said.

Mr. Olson of Health Net said, "Historically, for our company, the unemployment rate has to exceed 7% for us to see it at the margins, and what it has historically done is reduce our growth rate."

But Mr. Richter said the layoffs might potentially have a significant negative impact. The concern, he said, relates not to a decline in enrollment but to the risk of pool deterioration, if the people who stay behind turn out to be poorer risks.

HMO stocks have not done as well this year as they did in 2000. Through Aug. 10, the nine managed care organizations included in the BI Stock Index declined 1.9% this year. The sector "has been beaten down so far this year compared to last year, when they had a very large run up," said Mr. Meyer. "Part of the correction this year was associated with the concern over the medical cost trends," he said.

Companies that have done well this year will continue to do well in the stock market, said Mr. Meyer. However, "I think year-over-year comparisons are going to be somewhat challenging for the sector as a whole," said Mr. Meyer.

The group "has some real solid companies and some companies that are on shaky ground," said Mr. Crawford. Overall, though, "I think the group is pretty well positioned," he said.

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A.M. Best Co. has affirmed its A rating of **Lloyd's of London** and has removed its negative outlook on the Lloyd's market. The Oldwick, N.J.-based rating agency said that the negative outlook, assigned June 28, reflected Best's concerns about the accelerating rate of asbestos-related claims. Best in June said such claims could lead to a significant shortfall in the reserves of Equitas Ltd., the runoff reinsurer for Lloyd's pre-1993 long-tail liabilities. Last week, though, Best removed its negative outlook, stating that its assessment of Equitas' results led it to believe that "Lloyd's is unlikely to be adversely affected by Equitas in the foreseeable future."...Standard & Poor's Corp. said it has a negative outlook for the **European reinsurance market** and announced that ratings are more likely to be downgraded than to remain the same. S&P said that, despite an estimated 9% premium growth in 2000, rate increases at the January 2000 renewal period were patchy. S&P added that there was almost no improvement in the operating performance of the European reinsurance market in 2000 compared with 1999....Insurers' ability to retain **AAA financial strength** ratings could diminish over the long term, according to S&P. With the growing pressure on insurers to improve their use of capital and to deliver shareholder value, it is becoming increasingly difficult for companies to justify the large reserves needed to maintain an AAA rating, the rating agency said. S&P cited as an example its downgrade of Allianz A.G. Holding to AA+ from AAA after the insurer's acquisition of Dresdner Bank last month (*BI*, July 30)...The Assn. of British Insurers has announced details of a compensation package for creditors of the collapsed insurer **Chester Street Holdings Ltd.**, which went bankrupt earlier this year because of asbestos claims. The London-based ABI and the U.K. government agreed to the £5 million (\$7.1 million) package, which covers claimants whose claims date from before employers liability insurance became compulsory in Great Britain in 1972 and in Northern Ireland in 1975....Net income at German insurance giant **Allianz A.G. Holding** dropped 7.8%, to 1.4 billion euros (\$1.25 billion), for the first half of 2001, the group announced this week. Allianz said the drop in profits stemmed from reduced investment gains. The group's premium volume from property/casualty insurance rose 9.7%, to 22.3 billion euros (\$19.93 billion), for the first half of 2001. Property/casualty insurance represents 59% of the insurer's premium volume...London-based loss adjuster **Cunningham Lindsey International Ltd.** has opened an office in Vietnam. CLI said it had been performing claims work and risk surveys in Vietnam for the last six years....Keith Fenwick has been named chief executive officer and regional manager of the U.K. operations of reinsurer broker **Guy Carpenter & Co. Inc.** Mr. Fenwick was previously chief operating officer of Guy Carpenter's U.K. arm....The London-based Assn. of Local Authority Risk Managers has teamed up with Marsh Public Risk Services, a U.K. arm of New York-based Marsh & McLennan Cos. Inc., to issue guidelines to help public entities manage **workplace stress**. Stress in the workplace was the No. 1 risk concern within the public sector, according to an ALARM survey released last year. The guidelines will be distributed free to ALARM members and can be purchased from the ALARM administration office. For more information, call 44-13-922-3399 or e-mail admin@alarm-uk.com.

Australia considers marine law changes

Insurers oppose removal of insurable interest rule

By DAMIEN TOMLINSON

CANBERRA, Australia—Marine insurers are opposing federal government recommendations to remove the insurable interest requirement from Australia's Marine Insurance Act 1909.

The act has remained virtually unchanged for more than 90 years but has become the subject of a major review by the Canberra-based Australian Law Reform Commission at the request of Australia's attorney general.

In a 422-page review of the Marine Insurance Act sent to Attorney General Daryl Williams earlier this year, the ALRC proposed 44 changes to give Australia's marine insurance market "a competitive edge" and provide more fairness to marine insurance buyers, said ALRC President David Weisbrot.

"Australian insurers cover ships and cargo from all over the world. They are competing with international marine insurance companies, but they are operating under legislation that hasn't been updated in almost a century," he said.

Australia's marine insurance market is the world's 10th largest, with annual total premium volume of \$400 million Australian (\$205.8 million), according to



the ALRC.

Ian Davis, ALRC commissioner in charge of the review, and a marine insurance law expert, said the recommendations would "soften the sometimes harsh and disproportionate impact" on policyholders making claims.

Ric Clarke, executive director of Perth-based marine insurance broker Gault Armstrong & Kemble Pty. Ltd., said insurance buyers would welcome the changes.

"It is evident that the commission has undertaken considerable research and identified the key issues that are in need of legislative reform and have likewise advanced practical and workable solutions," he said.

"In our capacity as brokers representing the interests of policyholders, we are of the

opinion that the recommendations made by the ALRC are equitable, represent modern commercial practices, and should be adopted."

Mr. Williams, who directed the ALRC to review the Marine Insurance Act in January 2000, has invited comments on the review before the end of this month. A spokesman for Mr. Williams said the attorney general's office so far has received "a handful" of comments.

Robert Drummond, executive manager
See **Marine** on page 19

U.K. plans broadening eligibility, study says

By SARAH VEYSEY

Among the findings of a wide-ranging study of U.K. employer-sponsored health plans are that employers have expanded eligibility to their plans and that health plans tend to favor married couples over unmarried partners.

The survey, conducted by London-based consultant William M. Mercer Ltd., drew responses from 527 U.K. employers. Respondent companies ranged in size from 10 to 150,000 employees, with an average size of 3,453 employees.

According to the survey, 70% of the respondents said they had operated a medical plan for more than five years, and 52% said they had operated such a plan for more than 10 years.

Because the survey was the first of its kind that Mercer has conducted, data from prior years is not available.

Whereas most U.K. companies traditionally have provided health coverage only to their senior employees, 40% of respondents stated that they now provide coverage to all of their workers. Mercer found that, over the past three years, 12% of respondents had broadened health plan eligibility.

"The trend, in recent years, has been to extend private health care down the organization," said Steve Clements, European partner at Mercer, in a statement. "In extending coverage to all employees, organizations appreciate the productivity benefits of accelerating medical treatment and of returning employees to work much more promptly."

Mr. Clements noted that the figures may also reflect an acknowledgement by employers of ongoing problems within the National Health Service, Britain's
See **Plans** on page 19

Defends response in HIH collapse

Aussie insurance regulator slams critics

By DAMIEN TOMLINSON

BRISBANE, Australia—The head of the Australian Prudential Regulation Authority has strongly rejected criticism that Australia's insurance regulatory body failed to act to prevent the collapse of HIH Insurance Ltd. in March.

APRA Chief Executive Officer Graeme Thompson told attendees at the recent annual conference of the Investment & Financial Services Assn. in Brisbane that "the speed with which some people became experts in prudential supervision and related matters after HIH's failure has been breathtaking."

"It has been truly humbling to observe some commentators becoming experts in two or three months, without one day's hands-on experience," Mr. Thompson said. "Apart from the fact that this lack of understanding from gifted amateurs is seriously annoying, there is a more substantive concern for us all if it leads to knee-jerk regulatory overreactions."

Mr. Thompson said there was little appreciation of the judgments APRA supervisors make "about when to use a sledge-

hammer" and when more subtle regulatory approaches would produce better results for a company's creditors. "There has also been little understanding of the complexity of valuing insurance liabilities," he said.

Mr. Thompson predicted that the findings of a royal commission, whose establishment was announced in May to look into the collapse of HIH (*BI*, May 28), will show that "not only did APRA inherit a flawed regulatory system, we inherited a deeply flawed company in HIH."

"There will, no doubt, be some valuable lessons for us from the HIH episode, and we will, as a result, be a stronger, wiser regulator," he said.

Mr. Thompson said he is confident that the commission, headed by Neville Owen, a state Supreme Court judge in Western Australia, will confirm that APRA could not have done anything to prevent HIH's collapse. "In fact, there were things that we could have done that might have produced a worse outcome," Mr. Thompson said.

"We look forward to participating in

the royal commission, as it will produce a full account of events in a way that trial by media cannot," he said.

APRA has been criticized by industry bodies and media commentators over the demise of HIH (*BI*, March 26).

Shortly after HIH's March 15 collapse, Bruce Ferguson, the president of the Sydney-based Assn. of Risk & Insurance Managers of Australasia, said APRA should have stepped in last year, "when the alarm bells were ringing."

Mr. Ferguson said that, despite APRA's assertions that there were insufficient triggers to take action, the sharp decline in HIH's share price and market speculation that HIH's loss for the half-year ending June 30, 2000, would be more than \$500 million Australian (\$249.5 million) constituted sufficient warning signs.

Angus Maciver, the executive director of Sydney-based broker Willis Australia Ltd., said in March that "it is worrying that the regulator did not do anything, especially in light of speculation surrounding HIH since it posted a disastrous result last year." **BI**

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LEGAL NOTICES

FREMONT INSURANCE COMPANY (UK) LIMITED

(SCHEME OF ARRANGEMENT)
 Notice of Declaration of a Third Interim Dividend

NOTICE IS HEREBY GIVEN that a third interim dividend of 5% of Scheme Creditors' Ascertainable Scheme Claims has been declared in the above matter bringing total dividends declared to date to 35%.

Dividend cheques in respect of those claims that have been agreed will be despatched to Scheme Creditors shortly.

P J SINGER and D N RACKHAM
 Joint Scheme Administrators
 Fremont Insurance Company (UK) Limited
 Plumtree Court, London, EC4A 4HT, United Kingdom
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California Teachers Association, a not-for-profit organization representing public school teachers, has two immediate openings (one permanent and one temporary) in our Burlingame office for experienced Benefits Analysts. The successful candidates will have outstanding organizational and research skills pertaining to a broad spectrum of insurance programs, including business insurance and AD&D, and a ES or BA in a related discipline or 6+ years' comparable work experience (ARM & HIAA Certification will be given high consideration). Candidates will conduct workshops throughout the state and, therefore, must be able to travel and work some weekends. Strong communication skills and proficiency with word processing software are essential. CTA offers an excellent compensation package that includes 48K annual salary and a 100% employer paid benefits package (after 60 working days for temp position): medical, dental, vision, EAP, life & salary protection insurances, generous vacation & holiday leaves. Submit cover letter and resume to: **CTA, HR Manager, Attn: ad# C-536, P.O. Box 921, Burlingame, CA 94011-0921; fax (650) 552-5006; e-mail to: jchao@cta.org. AAEOE**

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Risk/Employee Benefits:
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Sub-total ... 33,088

Associations ... 254
 Government, Unions and Educational Institutions ... 913

Commercial Consumers
 Sub-total ... 34,255

Insurance Agents and Brokers ... 7,538
 Insurance Companies ... 5,634
 Accountants, Actuaries, Attorneys & Consultants ... 2,010
 Adjusters, Appraisers, TPA's Captive Managers & Health Care Providers ... 1,092
 Others Allied to the Field ... 1,444

Total Qualified ... 51,973

Non-qualified/Paid Subscriptions ... 30

TOTAL CIRCULATION ... 52,003

• Source Business/Occupational breakdown of qualified circulation, November 27, 2000 Issue, as submitted to EPA for December 2000 BPA Publisher's Statement

LEGAL NOTICES

LEGAL NOTICES

UNITED STATES BANKRUPTCY COURT DISTRICT OF MASSACHUSETTS

In re: _____
 Petition of Clayton Price as the Foreign Representative of TRANSCON INSURANCE LIMITED,
 Subject of a Foreign Proceeding.

In a Proceeding Under Section 304 of the Bankruptcy Code
 Case No. 01-16228-CJK

SUMMONS TO ALL THIRD-PARTY INSURANCE, REINSURANCE AND RETROCESSION CREDITORS OF THE COMPANY: A petition dated August 6, 2001 (the "Petition") in a case ancillary to a foreign proceeding was filed in the United States Bankruptcy Court for the District of Massachusetts, 1101 Thomas P. O'Neill, Jr. Building, 10 Causeway Street, Boston, Massachusetts 02222-1074 (the "Bankruptcy Court"), requesting an order pursuant to 11 U.S.C. § 304 (the "Proposed Order") giving full force and effect in the United States to the scheme of arrangement (the "Scheme of Arrangement") dated July 12, 2001 between TRANSCON INSURANCE LIMITED (the "Company") and its creditors in respect of its third-party insurance, reinsurance and retrocession liabilities (the "Scheme Creditors") and making the Scheme of Arrangement binding on and enforceable against all Scheme Creditors in the United States.

YOU ARE SUMMONED and requested to submit to the Clerk of the Bankruptcy Court a motion or answer to the Petition by no later than 4:00 p.m. on September 5, 2001 at the United States Bankruptcy Court, 1101 Thomas P. O'Neill Building, 10 Causeway Street, Boston, MA 02222-1074. At the same time you must also serve a copy of your motion or answer on the petitioner's counsel at the address listed below. If you fail to respond to this Summons, the Proposed Order will be entered.

PLEASE TAKE NOTICE that a hearing to consider the request for entry of the Proposed Order will be held at 10:00 a.m. on October 1, 2001 before the Honorable Carol J. Kenner, United States Bankruptcy Judge, at the United States Bankruptcy Court, Courtroom Number 4, 1101 Thomas P. O'Neill Building, 10 Causeway Street, Boston, MA.

The foregoing Summons is served upon you by publication pursuant to an order of the Honorable Carol J. Kenner, United States Bankruptcy Judge, dated August 7, 2001 and filed with the Petition and other papers in the office of the Clerk of the Bankruptcy Court.

PLEASE TAKE NOTICE that copies of the Scheme of Arrangement, together with a related explanatory statement, the Summons, the Petition, and the Proposed Order are available upon written request to the petitioner's counsel:

GOODWIN PROCTER LLP
 Exchange Place, Boston, MA 02109-2834
 Tel: (617) 570-1000
 Fax: (617) 523-1231
 Attention: Daniel M. Glosband, P.C.

REQUEST FOR PROPOSALS

REQUEST FOR PROPOSALS

NOTICE TO PROSPECTIVE PROPOSERS

REQUEST FOR PROPOSALS NO. 01-31 OPERATIONS INSURANCE BROKER SERVICES

The Santa Clara Valley Transportation Authority (VTA) seeks proposals from qualified firms to provide all professional insurance broker services necessary to design and implement a cost-effective insurance plan for the operations of VTA. Parties interested in obtaining a copy of the Request for Proposals may do so by faxing their request to (408) 955-9729, or by e-mailing it to don.kimerer@vta.org. Please include the following information:

- Name and Address of Firm
- Contact Person
- Telephone AND Fax Number
- Ref: Request For Proposal (RFP) 01-31

A pre-proposal conference is scheduled for Wednesday, August 29, 2001 at 1:30 PM in Building No. C, Room C.19, 3331 N. First Street, San Jose, CA. Proposals are due by close of business on September 19, 2001.

Contractors are encouraged to visit VTA's website at www.vta.org for information regarding other contracting opportunities.

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Health

Continued from page 17
state-run medical program.

The survey also examined the extent to which employers pay for health coverage.

Half the survey respondents reported that they fully subsidize their employees' health insurance but do not fund coverage for dependents. Another 46% pay for full family coverage, 3% pay only for employees and their spouses, and the rest share the cost of family coverage with employees.

Many plans favor married couples over unmarried partners, Mercer found. Only 48% of plans cover common-law spouses, and just 44% cover same-sex partners.

"Surprisingly, a significant number of plans appear to be out of tune with current social trends," Mr. Clements said. "As things stand, many employers could be accused of acting unjustly, as a large proportion of partners are not allowed membership. However, with the increasing emphasis on equal treatment and inclusiveness, there are signs that more com-

panies are looking to address this issue."

In terms of plan enrollment, the survey found that while 75% of full-time employees participate in their companies' plans,

timers may face additional costs, because employers' contributions often are prorated based on the number of hours the part-time employee has worked. "This means they must

pose limits on that coverage. Seventy-six percent of such plans limit coverage to a specified number of inpatient days per year—the average being 50 days—and 10% impose annual

sored plans offer coverage for pre-existing medical conditions, subject to the terms of the plan.

• Thirty-eight percent of employers offer dental coverage. Of these, half provide access to discounted insurance plans that employees can pay to join, while 41% pay for the coverage. The remainder offer dental coverage through extensions to their existing health plans.

• Just over two-thirds—67%—offer some form of group disability or income replacement insurance.

• While 65% of respondents offer health screening to employees, 55% of these provide the benefit only to senior staff. Just 18% offer such screening to all members of the workforce.

• Thirty-two percent of respondents have introduced prevention programs for back injuries, and 22% have established stress-management programs.

Copies of the report are available, at £225 (\$321) each, by contacting Monica Charles-Batson by telephone at 44-137-238-5368, or by e-mail at monica.charles-batson@u.k.wm.mercer.com.

Health care subsidies

A survey of U.K. employers identifies benefit trends

50% fully subsidize employees' health insurance but do not fund coverage for dependents

46% pay for full family coverage

3% pay only for employees and their spouses

1% share the cost of family coverage with employees

Source: William M. Mercer Ltd.

'We were surprised that employers are still restricting coverage, given the growing incidence of stress-related illness.'

— Steve Clements
Mercer

just 57% of part-time employees elect to enroll.

Mr. Clements said some employees may opt not to join because participation in such plans is taxed as compensation, or because employees have health care coverage through plans in which spouses are enrolled.

Mr. Clements noted that part-

make up the balance, typically from an already below-average salary," he said.

The survey also found that, despite the rising rate of stress-related illness and absence, 13% of plans exclude coverage for the treatment of mental disorders and substance abuse.

In addition, 88% of plans that do cover mental disorders im-

tal disorders impose no limits on such coverage.

"We were surprised that employers are still restricting coverage, given the growing incidence of stress-related illness and the increase in employer liabilities in this area," Mr. Clements said.

Other survey findings include:
• More than two-thirds—68%—of the employer-spon-

Marine

Continued from page 17
of the Sydney-based Insurance Council of Australia and a member of the ICA's marine standing committee, said the industry was generally pleased with the ALRC's review, except for the proposal to remove the insurable interest requirement. "The only weakness is that the ALRC has oversimplified the insurable interest provisions of the legislation, and the ICA will suggest that more careful consideration be afforded to that recommendation."

The ALRC recommends abolishing the requirement that marine policyholders have an insurable interest in the insured property at the time of a loss. This requirement creates two problems, the ALRC said.

When goods are purchased on a "free on board" or "cost and freight" basis, where risk is consigned to the cargo owner once it is loaded aboard a ship,

the policyholder has no insurable interest before goods are loaded, unless the policy includes warehouse-to-warehouse coverage.

'The only weakness is that the ALRC has oversimplified the insurable interest provisions of the legislation.'

— Robert Drummond
Insurance Council
of Australia

"Secondly, the assignment of a policy of marine insurance can be ineffective if it is assigned when the insured has already parted with or lost its insurable interest," the review said.

Insurers consider the require-

ment integral to marine insurance law, but the ALRC said it was "not convinced the requirement for an insurable interest is necessary to preserve marine insurers' legitimate rights."

Long-held principles of indemnity in insurance contract law make the marine law's insurable interest rule unnecessary, the ALRC said.

The ALRC review focused on four areas of the Marine Insurance Act: coverage of the act; warranties and similar provisions; non-disclosure, misrepresentation and obligations of utmost good faith; and insurable interest.

During its review process, the commission considered repealing the act and incorporating it into the existing Insurance Contracts Act 1984 but decided against that because of the "familiarity of practitioners both within Australia and overseas with the MIA," the review said.

Ron Salter, a marine insurance law specialist at Sydney-based law firm Phillips Fox,

said the Australian marine insurance legislation was introduced just three years after the United Kingdom's Marine Insurance Act 1906, and was "largely a copy" of that law.

Mr. Salter said the ALRC's review and recommendations tried to "bring marine into line" with other non-life classes and likely "will be passed largely intact."

The ALRC's Mr. Davis said the commission hoped to remove confusion over the difference between contracts covered by the Marine Insurance Act and those covered by the Insurance Contracts Act 1984.

The review recommends abolishing implied and other warranties in marine policies. Mr. Salter said warranties apply from the date of a breach and, regardless of whether the breach and the loss are related, allow insurers to avoid claims.

For example, an insurer with a warranty in the policy requiring a vessel never to go more than 20 miles beyond the coast

could avoid an unrelated claim on the basis that it became aware that the vessel had, at some stage, traveled beyond the 20-mile limit, Mr. Salter said. However, he said many insurers did not use the warranties because of the potential unfairness for claimants.

The ALRC also recommends insurers be relieved of liability if an insured voyage is for illegal purposes. In such cases, premium would not be returnable, "as the breach can be regarded as seriously as fraud," the review said.

The ALRC advised repealing the concept of "utmost good faith" in marine contracts. The concept means if one party does not observe utmost good faith to the other, the injured party may void the contract. "This remedy is of almost no value to insureds who, in most cases, want the contract to remain on foot if there has been a breach by the insurer, so that the insured gets the benefit of indemnity if there is any loss," the review said. **BI**

Some RRGs prospered during soft market

By RODD ZOLKOS

BURLINGTON, Vt.—While many risk retention groups were formed because of hard market conditions, those that survived and even thrived during soft market times have done so by making good business decisions, serving members well and stressing the differences between themselves and traditional market competitors.

"We prospered despite the soft market," said Michael Bemi, president and chief executive officer of National Catholic Risk Retention Group Inc. in Lisle, Ill.

The Vermont-domiciled RRG owes its success to strict adher-



ence to a set of business strategies and practices, said Mr. Bemi, a participant in a panel discussing RRG soft market survival stories during the Vermont Captive Insurance Assn.'s annual conference earlier this month in Burlington, Vt.

Among them are adhering to core competencies, good claims and litigation management, effective risk control standards

and measures, a well planned investment program and an effective board governance protocol, the group's president and CEO said. The risk retention group writes various liability coverages for Roman Catholic dioceses around the country.

"Next, we always make sure we demonstrate our differentiation," Mr. Bemi said. "We take nothing for granted."

It's critical to discern the needs of your clients, attend to those needs and make sure those clients are aware of how well you've attended to their needs, Mr. Bemi added.

Bringing added value to the membership on a regular basis also is important. National

Catholic RRG has always looked to increase its array of member services and the quality of those services.

Communication with membership also is important. "Communicate regularly, communicate in a variety of formats," Mr. Bemi said.

W. Hamilton Smythe III, president of Paratransit Insurance Co., a Mutual Risk Retention Group, and chairman of Southern Transportation Co. in Memphis, said it's important to pick the right partners and the right risks for the group to cover. The Tennessee-domiciled RRG writes livery business risks.

"Pick the right partners," Mr. Smythe said. "If your members

aren't qualified self-insurers, work with them so they become that."

Good underwriting also is important, he said. "It's really important to ask all the questions. Leave nothing unanswered," Mr. Smythe said.

Another panelist, Donald Breakstone, senior vp and general counsel in Chicago at Attorneys' Liability Assurance Society, A Risk Retention Group said the three key factors to success in a soft market are differentiation, mutuality or a "feeling of clubbiness" and consistency.

Mr. Breakstone noted that when ALAS started in 1978 as a

See RRG on next page

Benefits

Continued from page 3
exposures, the consultant said.

Looking at such benefits as life, disability, medical and pensions or endowments, Mr. Mende said, "There is substantial underwriting profit in a lot of these schemes. And if it's not risk-financed (through a captive), it falls to the insurer."

Different approaches to funding benefits can provide various advantages to the employer, Mr. Mende noted, including providing a risk management platform, resulting in premium deductibility from taxes, tax sheltering of income, tax-efficient reserving and global capacity.

"To make choices, you have to understand what your requirements are for funding benefits," he said.

As no single risk financing mechanism scores highest across all the possible advantages to the employer, a captive can be an attractive approach because it "gives you an

extra bit of flexibility and it provides the insurance wrapper," Mr. Mende said.

Outside the United States, there are no significant regulatory obstacles to using a captive to fund employee benefit programs, noted Mr. Mende, who suggested that there are numerous benefits to placing international benefits in captives. "A key advantage is the extra flexibility in underwriting and possibility of product design," he said.

In the United States, however, the federal Employee Retirement Income Security Act prohibits transactions between benefit plans and their sponsors' captives without an exemption.

Jim Ostertag, who recently retired as a risk management specialist for Columbia Energy Group and now serves as a consultant to NiSource Inc., the Merrillville, Ind.-based company that acquired Columbia Energy last year, discussed his company's experience winning such an exemption from the U.S. Department of Labor.

The exemption, granted last year,

allows the company to reinsure its employee long-term disability program through a Vermont branch of its Bermuda-domiciled captive.

Discussing the Labor Department's requirements in considering an exemption application, Mr. Ostertag said that a requirement that the program pay no more than adequate consideration for insurance contracts in the captive is an effort "to protect the individual premium payers from getting gouged."

He also suggested that a Labor Department requirement that the program written through the captive provide an immediate and objectively determined benefit to the plan's participants was easily met in his company's case. Columbia Energy sought approval to use its captive for long-term disability benefits, "and it turns out the LTD program we were considering was going to be a quantum leap for beneficiaries," he said.

The Department of Labor has the authority to grant such exemptions, Mr. Ostertag said, if it finds the exemption is administratively feasi-

ble, in the interest of the plan and of its participants and beneficiaries, protective of the rights of the participants and beneficial to the plan.

He noted the approval process took about a year. "I have no reason to tell you as to why it took about a year except that the wheels of federal government move fairly slowly," he said.

And he advised employers seeking such an exemption to "have a business plan that will convince people. They really looked long and hard at our business plan."

For Columbia Energy, putting employee benefits in its Columbia Energy Insurance Corp. Ltd. captive helped diversify the captive's book of business, provides the captive substantial third-party premium and allows Columbia to enjoy earnings on premiums paid for long-tail business.

"I would encourage you, if you're thinking about this at all, to really go back and review it, because we're talking about a large amount of premium dollars," he said.

Leonard D. Crouse, director of captive insurance in the Vermont Department of Banking, Insurance, Securities and Health Care Administration, said that while widespread acceptance of placing U.S. employee benefits in captives hasn't developed as quickly as hoped, "I truly believe employee benefits will be a driving force in the area of captives in the next two-and-a-half or three years."

"It's true that there's not yet been another applicant for the exemption, and it's annoying to me that that's the case," Mr. Ostertag said. "It's crucial that a second player gets in and gets the exemption." If a second exemption is granted, the Department of Labor is required to handle subsequent applications on an expedited basis, Mr. Ostertag said. "That's when the floodgate opens," he said.

Asked whether Vermont would be ready if those floodgates open, Mr. Crouse, who moderated the session, said, "We think we are. If we have to get geared up, we'll get geared up in a hurry." **BI**

Captives use goes beyond traditional insurance

By **RODD ZOLKOS**

BURLINGTON, Vt.—In addition to addressing traditional insurance exposures, captive insurance companies could benefit their parent companies through various creative uses, according to one group of industry experts.

During a panel discussion at the annual conference of the Vermont Captive Insurance Assn. earlier this month in Burlington, Vt., speakers outlined various innovative captive uses that address problems ranging from insuring "uninsurable" exposures to achieving favorable accounting treatment for hedging activities.

Outlining one possible alternative use, Robert Curtis, senior vp at AIG Risk Finance in New York, described an enterprise risk management approach that involves using the captive to insure "uninsurable" exposures. "We're starting to see a lot more activity in that area," he said.

Mr. Curtis cited the example of a transportation company that sought to use its captive to prefund property catastrophe risk to its infrastructure, as well as to address global risks to cash flow the company faced from strikes and truck blockades.

The captive issued a policy that blended property catastrophe coverage with the social disruption coverage. The captive then reinsured the social disruption exposure into a blended finite insurance policy, in which the company's retention was adjusted based on its loss experience.

Because the captive stood to benefit from positive loss experience, the program's structure offered the possibility of expanding the coverage in later years.

Another situation Mr. Curtis discussed involved a company that sought to buy out liabilities to improve its standing in the capital markets. He described a situation in which a company's credit rating was threatened by asbestos liabilities it had inherited through an acquisition made decades earlier.

The company's goal was to "ringfence" the asbestos exposure in order to regain the confidence of rating agencies and improve the market's view of the company's financial strength, Mr. Curtis said.

The company used its captive to cover underinsured periods or gaps in historical policy periods, and it then reinsured that exposure.

Ultimately, the solution involved obtaining a retrospective

reinsurance policy for asbestos liabilities with annual caps on amounts paid. The program returns funds to the captive if asbestos claims do not develop as expected.



William S. Troy, director-alternative risk services at Safety National Casualty Corp. in St. Louis, offered several other possible uses for captives, including converting a qualified self-insured program to a captive or fronted loss portfolio transfers.

One possible captive use he suggested involved the captive parent fully funding the aggregate policy limits. "This is a case where you really just need the paper," Mr. Troy said. "You're basically fully funding your aggregate limit on the front end, but the benefit is, you have that paper."

In addition to providing the proof of insurance that might be required in certain situations, fully funding an exposure in the captive

can offer benefits by providing access to reinsurance markets, Mr. Troy said.

A captive also could be used to avoid undesirable aspects of Federal Accounting Standards Board rules for derivative instruments, said Carl Groth, managing director-enterprise risk strategies at Willis Risk Solutions in New York.

Noting that FAS 133 defines derivatives broadly, and suggesting that the rule's requirements for accounting a derivative contract's value can negate the quarterly earnings protection the derivative-user is seeking, Mr. Groth said FAS 133 presents "a huge stumbling block" to hedging exposures efficiently.

The trick, he said, is to structure hedging vehicles that do not have the characteristics of derivatives as defined in the accounting rule. In such a case, a captive could be used to assume risk that would otherwise be hedged in a derivative contract, such as commodity price risk, foreign exchange risk or interest rate risk.

"We believe that this situation could be solved using a captive and essentially having the captive write what's equivalent to a derivative contract," said Mr. Groth, who moderated the session.

While noting that such a captive application is "untested," Mr. Groth said that the approach would involve using the captive to create a contract under which the captive records a premium for assuming the risk and accounts for losses as insurance losses. The captive's exposure then would be reinsured using a "loss ratio" cover.

In such a structure, the coverage trigger would be expressed as a loss ratio rather than an underlying index, strike price and notional amount as it would in a derivative contract. Under a strict interpretation of FAS 133, the loss ratio coverage would not fall under the definition of a derivative contract, Mr. Groth said.

"So that's maybe something we'll see over the next couple of years," he said. **BI**

RRG

Continued from previous page
Bermuda mutual company, it was a response to hard market conditions.

"We thought we were starting up in a hard market," he said. "But we found out that, the day after we started, suddenly rates were half what they were the day before."

As it turned out, large law firms soon found available limits drying up over a short period of time, and the only place they could buy those large limits was ALAS.

For ALAS, initial success was a matter of being in the right place at the right time with the right structure in place, Mr. Breakstone said. **BI**

During that time, the group started a major loss prevention program and started to develop its own claims management capabilities.

Faced with competition in a soft market, his group's thinking was "a little behind the curve" in terms of market development, Mr. Breakstone said, but ALAS was able to hold membership on the basis of loyalty.

Mr. Breakstone said it's important that a group differentiate itself from traditional market competitors, saying that no captive can go head to head with a traditional insurer on price, Mr. Breakstone said.

And, he suggested, "The time to plan for the next soft market is in a time when you're in a better position to control your current business." **BI**

More than 800 attend captive conference

BURLINGTON, Vt.—The 16th Annual Vermont Captive Insurance Assn. conference drew 841 attendees and 841 exhibitors to Burlington Aug. 7-10. Among those at the conference were approximately 150 first-time attendees.

During the conference, the VCIA presented its annual Captive Crusader Award for exceptional service to the association to Tina Truax McCuin, vp/captive insurance

consultant at The Stratevest Group N.A. in Burlington. The association's other annual award, the Industry Service Award, was given to John L. Primmer of the Primmer & Piper P.C. law firm in St. Johnsbury, Vt.

Next year's VCIA conference is scheduled for Aug. 13-16, 2002, at the Sheraton Hotel & Conference Center in Burlington. For more information, call the VCIA at 802-658-8242.



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Speaking anonymously

The issue of when and why we protect the identity of our sources at *Business Insurance* arose last week in the most innocent of questions.

I got a call last week from a lawyer asking me if there was any way to determine the name of a person identified in a *Business Insurance* article simply as a company spokesman.

Of course, I said. When we identify someone as a company spokesman it is a person designated by the company to speak to the press but is not an officer of the company. The person usually has the title of public relations manager or representative.

We aren't trying to hide anyone's identity when we attribute information or a quote to a company spokesman, I explained. Just call the company and ask for the public relations department and you will find the person who gave us the information, I said.

After I hung up the phone, I was troubled that a reader would think that we were hiding the identity of a company spokesman by not providing his or her name. We don't quote people anonymously lightly; it is a very serious issue at *Business Insurance*.

Then it hit me. The term "company spokesman" is journalism jargon and I shouldn't expect our readers to know that it is shorthand for a public relations staffer.

Why don't we quote public relations person by name? Few public relations people expect to be quoted by name because they know the glory of a quote should go to their bosses. A few would love to see their names in print, but we don't oblige them because we don't want to encourage public relations people to give interviews.

Don't get me wrong. Good public relations staffers are very valuable to us for providing background information and setting up interviews with company executives. But when it comes to the interview, we prefer to interview officers of the company—the people who are setting the policy and making the decisions.

As I thought about the term "company spokesman," however, I could imagine why many readers might think we are indeed protecting a source. After all, we regularly hear information on television news reports and in the national newspapers attributed, for example, to "a White House spokesman." And very often that is information that no one would want attributed to him or her by name.

While the term "company spokesman" is not intended within these pages to signal protecting the identity of a source, there are times that we do use information in articles in *Business Insurance* that our sources ask us not to attribute to them. We try to keep these instances to a minimum because we believe that our readers should know where we are getting our information so that they can judge the credibility of our sources.

There are instances, however, when we trust the credibility of our sources and understand why they don't want to be quoted by name on information we think our readers should know.

One simple example is when underwriters, brokers or reinsurers tell us which insurers and brokers were involved in the insurance covering a major loss. Nearly everyone in the insurance marketplace knows and is talking about who is on the loss, but no one wants to be the one tagged in *Business Insurance* with spilling the beans. To give this information to our readers who are not so plugged in to the market requires that we do indeed protect our sources.

There are, of course, even more serious circumstances under which we protect sources. Often, for example, officials investigating allegations of fraud and those cooperating with them will talk to us before official action can be taken against any suspects. If we need to protect sources' identity to alert our readers to potentially fraudulent companies, we'll do it to protect them from losing their money to crooks.

We do not, however, protect the identity of those who want to trash their competitors but retain anonymity. If we were to protect the identity of the source of any derogatory quote that comes our way in the course of reporting almost any story, the quantity of juicy quotes in *Business Insurance* would go way up. But our credibility, I believe, would plummet in direct proportion.

Publishing Director Kathryn J. McIntyre's commentary appears fortnightly and on www.businessinsurance.com. She can be reached at kmcintyre@rcrain.com.



Kathryn J. McIntyre

Clause

Continued from page 1

vent or mitigate losses that the insurer would be liable to pay if they occurred. The clause is being used in the Y2K cases in an attempt to recover expenses incurred for upgrading computer systems to avoid their potential failure on Jan. 1, 2000.

In the Florida case, Swire is using the sue-and-labor clause in its builders risk policy to force its insurer to pay for correcting design defects discovered in the plans for a Miami condominium project under construction in 1998.

At the time, Swire's insurance broker, Sedgwick of Florida Inc., wrote to Zurich to inquire "what, if any, coverage will be available to them under the builders risk to assist in paying for the cost of the damage repairs." Swire incurred approximately \$4.5 million in costs in the course of correcting the structural deficiencies, according to court papers.

Zurich said, though, that there was no coverage for two reasons: because there was an ex-

clusion for design defects in the builders risk policy, and because the sue-and-labor "clause applies only to expenses incurred by an insured to mitigate an actual loss, rather than to prevent a threatened loss."

The district court agreed with the insurer, denying Swire's plea for coverage in its April 16 ruling.

"Swire's actions...were made directly and primarily to correct design defects in the building, expenses which are excluded under the terms of the policy," the district court ruled.

Swire appealed the case in June. The deadline for briefs was last week, and a mandatory mediation conference has been scheduled for Sept. 20, according to Thomas Brunner, an attorney with Wiley, Rein & Fielding in Washington who is representing Zurich.

"We were gratified by the trial court ruling, and we are confident it will be affirmed," Mr. Brunner said.

Insurer attorneys maintain that Zurich will prevail. They say that in order for the sue-and-labor clause to be invoked, the expenses must have been in-

curred to prevent what would have been a covered loss, and the discovered design defect was not covered, they say, because of the exclusion.

"The sue-and-labor clause is to provide reimbursement for the insured to prevent a covered loss," Mr. Simmons pointed out.

Mr. Eisenstein said, though, that the design defect exclusion would not necessarily apply to all Y2K coverage cases that cite the sue-and-labor clause. "There are a number of Y2K cases with no design defect exclusion," he said.

Furthermore, Mr. Eisenstein said, "this case already defines design defect," while in the Y2K cases, he noted, the courts have not yet decided whether the inability of old computer software to acknowledge the change from 1900 to 2000 is a design defect.

The AIA's Mr. Goldberg disagreed.

"This is an analogous situation," he said. "There was a conscious decision made to design the chip a certain way. It was a design flaw, the same as the design flaw in the condominium project."

See Sue on next page

Flood

Continued from page 3

and two excess policies that its corporate parent, Itel Corp., purchased from about 50 Lloyd's and London market underwriters. Itel named Great Lakes as an additional insured under the excess policies, which provided \$40 million of coverage excess of \$1 million and \$60 million of coverage excess of \$41 million.

But on Oct. 15, 1991, Itel sold Great Lakes to Blackstone Dredging Partnership L.P. The underwriters canceled all of the excess coverage and rewrote only the \$40 million excess layer for Blackstone, naming Great Lakes as an additional insured. The insurers charged the same amount of premium they had refunded to Itel for the original first-layer excess policy they had canceled mid-term.

Great Lakes did not replace the \$60 million excess layer. Instead, it purchased a \$10 million layer excess of \$41 million from Continental Insurance Co., now a subsidiary of CNA Financial Corp. of Chicago.

The city and more than 100 damaged businesses, which eventually were assigned Great Lakes' insurance rights, argued that all of the policies should respond, including both \$40 million first-layer excess policies.

The district court agreed.

The district court's ruling also triggered an insurance-recovery provision in the 1997 \$3 million cash settlement the city reached with Great Lakes, said a spokeswoman in the city's law department.

Under that provision, if the plaintiffs succeeded in stacking policy limits, the city would recover \$29 million of the insurance proceeds to help cover its own settlements with flood claimants. In 1995 and 2000 deals, the city settled its flood claims for \$54 million, though

that amount would increase by about \$11 million if limits stacking is eventually allowed, the spokeswoman explained.

But the 7th Circuit panel ruled 3-0 that the district court erred in allowing stacking. The panel's unanimity, though, largely ended there.

'In Illinois, as elsewhere, an occurrence policy is not triggered unless loss to the claimant happened while that policy was in force.'

— 7th U.S. Circuit Court of Appeals

The panel ruled 2-1 that the Illinois Supreme Court still was wrestling with the stacking issue but that the panel predicted the state's high court eventually would bar stacking. The panel's majority ruled that the language in Great Lakes' policies and the premium that the contractor paid for its coverage demonstrate that both \$40 million first excess layers should not respond to the loss.

"There ain't no such thing as a free lunch, even in the insurance business," the majority wrote.

The court then determined that only the \$1 million primary policy, the second \$40 million excess policy and Continental's \$10 million excess policy should respond, because they were in force when the city flooded.

The majority ruled that "in Illinois, as elsewhere, an occurrence policy is not triggered unless loss to the claimant happened while that policy was in force."

That ruling "is not inconsistent" with rulings by courts—including the Illinois Supreme Court—that have adopted the triple-trigger theory of coverage in asbestosis bodily injury cases, said insurer attorney Richard M. Kuntz of Bollinger Ruberry & Garvey in Chicago. Bollinger represented the insurers on appeal.

Under the triple-trigger theory, all coverage on a risk from the time a claimant was exposed to asbestos until the claimant's illness manifested can be stacked to respond to the claim.

Both the triple-trigger theory and the 7th Circuit panel consider the occurrence of a loss as the point when someone was injured—even unknowingly—or property actually was damaged, Mr. Kuntz said.

Chicago-based plaintiffs attorney William J. Harte, co-counsel for the businesses, said he plans to ask the full 7th Circuit to adopt the opinion by the appeals panel's dissenting justice on what constitutes an occurrence. If the full appeals court agrees that an occurrence is the action that ultimately causes a loss, then the \$60 million excess layer as well as the original \$40 million excess layer and the \$1 million primary policy should respond, he said.

Mr. Harte said he would not ask the court to stack the limits of the two \$40 million excess policies but was not sure how he would ask the court to treat Continental's \$10 million excess policy.

Whether the city can recover any insurance proceeds if the business group succeeds in tapping the \$60 million excess policy but not all \$151 million of limits is unclear, the spokeswoman said.

Great Lakes Dredge & Dock Co. vs. City of Chicago et al., 7th U.S. Circuit Court of Appeals, Nos. 99-3844, 99-3877 and 00-4295; Aug. 10, 2001.

Clause

Continued from previous page

And even if there isn't an exclusion for design defects in the property insurance policies being litigated in the Y2K cases, "every policy that I have reviewed—whether or not there's EDP coverage—contained some exclusions that would apply," Mr. Simmons said.

He noted, for example, that computer errors are generally excluded.

"And it has to be a fortuitous loss," Mr. Simmons added. "It must be unexpected."

"In every sue-and-labor case, there is a lawsuit within a lawsuit," he explained. "First, the policyholder has to prove there was a loss, and, second, that the loss would have been covered."

The 11th Circuit also will determine whether the sue-and-labor clause constitutes a separate coverage designed to protect the insurer, an argument put forth in most of these cases.

"There is a line of case law that sue and labor is an independent grant of coverage," Mr. Eisenstein explained. "This means it has to be looked at separately, like 'Coverage A' and 'Coverage B.'"

"We have seen arguments from policyholders that the clause is a separate insuring agreement," Mr. Simmons said, "but this court ruled it is not."

Swire Pacific Holdings Inc. vs. Zurich Insurance Co., on appeal to the 11th U.S. Circuit Court of Appeals from the U.S. District Court for the Southern District of Florida, April 16, 2001; Case No. 01-12597-F.

Ohio

Continued from page 3

which basically voided all UM/UIM rejection forms used by Ohio insurers, thus providing coverage to Ohio policyholders regardless of whether or not they paid for it," according to the Columbus-based institute.

As a result, the institute estimates that the combined rulings "exposed insurers to \$1.5 billion in claims going back 15 years—claims for which premiums were never collected," said Sean McManamy, director of public affairs for the AIA's Midwest region. "Trial attorneys rifled through old files, sending out fax alerts and even running television commercials in an effort to 'mine' claims from cases that had been closed for years," he said.

The combination of unanticipated claims and legal uncertainties led to "a very significant disruption of the commercial lines market," said Holly Saelens, assistant director for policy and legislation for the Ohio Department of Insurance, which ultimately supported the new law.

Several insurers notified the department that they would no longer write new auto-related coverages or planned to cut back on their writings and not renew existing policyholders. For example, Travelers Insurance ceased writing new commercial

Compete

Continued from page 1

here to restrictive covenants and as they wrangle over the enforceability of such agreements when they are broken, insurance buyers have had to figure out how to deal with such situations.

"In a lot of cases, when the brokers do go to litigation, the innocent party, the insured, does get caught in the middle," said Bobby Reagan, the president and chief executive officer of Reagan Consulting Inc. in Atlanta.

"The insured is not a party of the contract and the insured is not restricted, yet they end up being precluded from doing what they want to do," Mr. Reagan said. "If they want to continue to conduct business with the producer, that's the challenge—and it is a problem for them."

Restrictive covenants raise an interesting philosophical question, said Timothy J. Cunningham, a principal with INSIGHT Management Group Inc. in Chicago. "What is more important—the buyer's right to choose its broker, or the sanctity and integrity of a broker's book of business?" Mr. Cunningham asked. "I don't know what the answer is."

"Brokers are very protective of their turf," said Richard Meyers, the president and CEO of Richard Meyers & Associates Inc., a Florham Park, N.J.-based executive recruiting firm that specializes in the insurance industry.

"The risk manager's take is that these guys need to continue to deal within an environment of free enterprise and an environment of democracy," Mr. Meyers said. "This is not a dictatorship."

Whether or not risk managers

object to restrictive covenants seems to depend on the nature of their relationships with brokers.

"There is a place for (restrictive covenants), because brokers are in the intellectual capital business and they need to protect their resources as much as they reasonably can," said David L. Mair, associate director of risk management for the U.S. Olympic Committee in Colorado Springs, Colo. "I don't think they affect risk managers in a tremendously adverse fashion."

'What is more important—the buyer's right to choose its broker, or the sanctity...of a broker's book of business? I don't know what the answer is.'

— Timothy J. Cunningham
INSIGHT Management Group Inc.

"I think a lot of this has to do with how risk managers view their relationship with their broker," Mr. Mair said. Risk managers are more troubled by restrictive covenants, he said, if they value the relationship with a specific account team or producer more than they do the resources the broker offers as a whole.

"The sooner the brokerage business looks at this issue from the customer's point of view, the sooner these restrictive covenants will be reduced or will disappear," said Joe Hardy, the director of risk management and insurance for

Hudson's Bay Co. in Toronto.

Mr. Hardy said that risk managers will switch brokers if they want to. With restrictive covenants, he said, "the process of switching is only delayed, and by doing so, (brokerages) have not made any friends with the buying community."

"If the brokerage industry has to rely on the restrictive covenants to maintain their business, then I believe we are dealing with the wrong broker," Mr. Hardy said.

Randy Thurman, the director of risk management for Gaylord Entertainment Co. in Nashville, Tenn., said he believes that restrictive covenants can "threaten the relationship" between the broker and the client.

"In my view, even though a broker that has lost one of its salespeople can try to enforce the contractual agreement the two parties entered into, it shouldn't be imposed...on the client," Mr. Thurman said. "The client isn't a party to that agreement, and the insurance buyer should be free to purchase insurance or consultative services from any broker they choose to do business with."

"I have openly told certain brokers that my relationship is with a certain account executive, and so long as that certain account executive continues to have a relationship with that broker, we're fine. But I've very openly said that if the account executive leaves, we will leave with him," Mr. Thurman said.

Wayne Salen, the director of risk management for First Niagara Financial Group Inc. in Amherst, N.Y., said that while restricted covenants can "pose a problem," he tries hard to avoid facing a dilemma should a producer change firms. "I don't focus on the individual (producer); I fo-

cus on the team and the broker as a whole, and I focus on a succession plan," he said.

"I need to be prepared for even the most unusual circumstance down the road...so there is the ability to carry on" with a particular brokerage firm, Mr. Salen said. "People tend to come and go in a heartbeat these days," he said.

One attorney who is familiar with litigation over nonsolicitation agreements said that clients remain a key focus for the brokers as they dispute these contracts.

"Without exception, in the litigation that I've dealt with and seen, every effort is made to minimize the inconvenience and burden of the people who are receiving the services," said Michael P. Zweig, a partner in the law firm of Loeb & Loeb L.L.P. in New York who represented Willis in its suit against Lockton. "I have not seen clients' services materially disrupted. Either employer No. 1 or employer No. 2 is servicing these people, knowing that if they don't, they will be out the door."

Still, it appears likely that risk managers will continue to have to cope with restrictive covenants and contention among brokers.

"I've seen an increase in litigation regarding these restrictive covenant issues; there is generally more fighting about it these days," said Marc Jacobs, a partner with the law firm of D'Ancona & Pflaum L.L.C. in Chicago. More companies, he said, have lately been implementing the restrictive covenant agreements.

Furthermore, Mr. Jacobs said, the current business climate encourages companies both to hire away individuals from rivals and to fight the hiring away of one's own staff. "When there is a downturn," he said, "there's more of a risk-taking mentality." **BI**

auto and umbrella policies in Ohio in January of this year, said Raul Allegue, the Hartford, Conn.-based insurer's second vp for government affairs.

Insurers also raised rates on commercial auto-related coverages.

'I think that the wide and deep support for the bill from so many groups, coupled with the trial bar's opposition, crystallized the issue for lawmakers.'

— Paul C. Blume
AIA

Rates for UM/UIM coverages increased 110% from Jan. 1, 2000, to May 15, 2001, Ms. Saelens said.

As of mid-May, many companies already received renewal notices with 50% to 100% increases in the cost of UM/UIM coverage, said Tony Fiore, director of labor and human resources policy for the Ohio Chamber of Commerce.

"This reached beyond merely

being an insurance problem and became a serious business issue," said Rita Nowak, assistant vp of property/casualty for the Alliance of American Insurers in Downers Grove, Ill.

Businesses felt the squeeze in a variety of ways, according to testimony presented at a hearing on reform legislation introduced as S.B. 97 by state Sen. Scott Nien, R-Middletown.

For example, Spartan Stores Inc., a Midwestern grocery retailer and wholesaler with 60 supermarkets and four warehouses in Ohio, estimates that the court cases in Ohio added \$175,000 to its premium for insuring its 725-vehicle fleet this year, according to testimony from Mary Dechow, director of government and regulatory affairs for the Grand Rapids, Mich.-based company.

That was notable because only 25% of that fleet operated in Ohio, she said in an interview. In addition, Spartan Stores is facing at least six potential legal cases because of the *Scott-Pontzer* decision, she said. "Some of these cases involve family members of employees who worked in stores. These employees never drove or sat in a vehicle owned by or insured for our company," Ms. Dechow said.

The solution proposed by Sen. Nien's legislation was to eliminate the mandatory offering of UM/UIM coverage because that mandatory offering "is the hook

that the Ohio Supreme Court uses every time it imposes new requirements and further expands the scope of this coverage," he said.

The final version of the bill also: allows for exclusions in UM/UIM policies; reduces to three years from 15 years the period in which an insured may make a claim; and requires that insurance regulators periodically report on the status of the market.

"I think that the wide and deep support for the bill from so many groups, coupled with the trial bar's opposition, crystallized the issue for lawmakers," said the AIA's Mr. Blume. "This wasn't about the insurance industry; it was about the economic well-being of the state."

The final version of the bill passed both houses of the Legislature with overwhelming support and Gov. Bob Taft signed it July 31.

With the law going into effect Oct. 31, "the Ohio Chamber is cautiously optimistic that the premium rates that have been charged to businesses are going to return to a more competitive level, rather than continue at the current high level or rise even higher," Mr. Fiore said.

"We feel very strongly that the legislation should correct a better part of the problem," Ms. Dechow said. Spartan Stores anticipates that the market will change after the law goes into

effect and then plans to rebid its auto coverage contract, in hopes of obtaining more favorable rates, she said.

Travelers also plans to resume writing new commercial auto and umbrella policies after the law goes into effect, Mr. Allegue said.

Meanwhile, The St. Paul Cos. Inc. is re-evaluating its plans about writing automobile-related coverages in the state, a spokeswoman said. The St. Paul previously announced plans to cease writing new commercial auto coverage and not renew existing policies beginning with those expiring June 1, but the insurer never implemented those plans, she said.

Several observers expect that UM/UIM coverage will continue to be available in the state for both commercial and personal policies.

In fact, re-establishment of a competitive market will "reinvigorate this line of coverage," said Mr. Blume.

The continued availability of such coverages contradicts a prediction by trial attorneys during negotiations over S.B. 97, during which they unsuccessfully lobbied to retain the mandatory offer for personal lines. As the chief opponents of the bill, they argued that insurers would likely not offer the coverage unless mandated to do so, said Steven Collier, president of the Ohio Academy of Trial Lawyers. **BI**

Pension

Continued from page 1
company or retire.

The new spousal consent requirement would complicate administration, but it also would increase the likelihood that spouses, such as those in troubled marriages, would receive a share of a defined contribution plan account balance.

The legislation, known as the "Women's Pension Protection Act of 2001," also would require joint and survivor benefit options offered by defined benefit and defined contribution plans to provide a survivor benefit equal to at least 75% of the participant's benefit. Under current law, which applies only to defined benefit plans, plans must offer a joint and survivor benefit option that pays a surviving spouse 50% of the participant's benefit.

Other changes in the legislation would affect divorcing spouses. According to HELP committee staff, women going through a divorce often are unaware that they can ask a state divorce court to award them a share of a spouse's pension as well as pension survivor benefits. By the time the mistake is discovered and a woman obtains a new court order, she may be unable to recover benefits, as pension plans often won't honor modified court orders.

Under the legislation, however, a pension plan would have to honor a state divorce court order, even if it were issued long after the divorce.

While the Kennedy legislation would give spouses new rights in deciding how participants' defined contribution plan account balances are distributed, it would not go nearly as far as a proposal made four years ago by then-Sen. Carol Moseley-Braun, D-Ill. That proposal would have required written approval by a spouse before an employee could take a hardship withdrawal, a loan or a lump-sum distribution from the plan.

The Moseley-Braun measure, included as part of a Senate-passed tax bill, ignited a massive lobbying campaign by employers, who warned that requiring written spousal consent before loans and hardship distributions could effectively end the electronic processing of many 401(k) transactions.

Benefit lobbyists also said the Moseley-Braun proposal might have done more harm than good under certain circumstances. For example, under one scenario advanced by the bill's opponents, a working woman who needed immediate ac-

cess to funds in her 401(k) account might have that access blocked if her husband had abandoned her.

In addition, lobbyists predicted that the spousal approval requirement would have prompted some participants, especially those who were lower paid, to reduce their contributions to 401(k) plans.

Such arguments apparently swayed legislators, who knocked the proposal out as they hammered out a final agreement on a 1997 tax law.

terms.

For example, under current law, an employee can electronically request a lump-sum distribution from his or her defined contribution plan. That would not be possible under the Kennedy bill, as the employee would have to obtain the written consent of his or her spouse before taking a lump sum.

"You go from one step to several steps. You complicate the procedure tremendously," said Kyle Brown, a pension attorney with Watson Wy-

Pension act provisions

What the Women's Pension Protection Act of 2001 would do:

1. Spousal consent required for defined contribution plan participants to take lump-sum distributions.
2. Pension plans have to offer 75% joint and survivor benefit option.
3. Expand opportunities for divorced women and men to receive a share of their former spouses pension benefit after a divorce.

The Kennedy proposal, however, is not nearly as restrictive. Written spousal consent would not be required for loans, hardship withdrawals or for the transfer of a defined contribution plan account balance to another qualified employer-sponsored plan, such as when an employee changes jobs.

Indeed, a committee staffer said that the bill's authors had sought to minimize requirements—and administrative burdens—while still providing new benefit rights and protections for spouses.

Benefit lobbyists note that staffers have made a point to get their input.

"They have made an effort to work with us, and we very much appreciate that," said Mark Ugoretz, president of the ERISA Industry Committee, a Washington-based benefits lobbying group representing large employers.

Benefit experts, while not outright opposed to the Kennedy bill, suggest that legislators should carefully consider the measure.

Given that defined contribution plans have become the primary retirement plans for many, "this is an area that warrants serious consideration, but I have concerns about jumping into this too quickly," said Larry Sher, a principal in Teaneck, N.J., with Unifi Network, a unit of PricewaterhouseCoopers L.L.P.

The spousal consent requirement will complicate plan administration, experts note, particularly in the area of automated benefit sys-

att Worldwide in Washington.

Still, Mr. Brown added: "I'm not saying don't pass it. Just first figure out how to do electronic consent."

Others note that legislators need to weigh the tradeoffs inherent in the proposal. Requiring employees to obtain spousal consent to take a lump-sum distribution from a defined contribution plan could deter some employees, such as those in shaky marriages, from contributing as much as they might, notes Ethan Kra, chief actuary with William M. Mercer Inc. in New York.

On the other hand, additional protections will be provided to spouses, Mr. Kra noted.

Similarly, there are tradeoffs involved in requiring plans to offer a 75% joint and survivor benefit option.

Take the example, provided by Mercer's Mr. Kra, of an employee in a defined benefit plan entitled to a \$1,000 monthly benefit for life at 65. If the individual takes a joint and survivor benefit, the monthly benefit would be reduced to about \$920, while a surviving spouse would get half of that amount, or \$460.

Under a 75% joint and survivor benefit, the employee would receive about \$865 per month, while a surviving spouse would receive about \$649.

"It is another tradeoff. There is a smaller benefit paid while the participant is living and a greater benefit to the survivor when the participant dies," Mr. Kra said. **B**

Regence, HCSC call off merger

CHICAGO—The Regence Group and Health Care Service Corp. have canceled plans to merge the management services of Blues plans in several states.

Despite talks since March about a system merger, the two companies notified regulators Wednesday that they were calling off the deal.

A spokesman for Seattle-based Regence BlueShield, one affiliate within The Regence Group, said incompatibilities between the two companies had emerged that would have hurt customer service if the deal had gone ahead. Among other things, the spokesman said, the Regence Group was in the process of implementing a claims and customer service system that was not compatible with that of HCSC.

HCSC and The Regence Group had anticipated that merging management functions would have improved their efficiency, resulting in cost savings and increased competitiveness.

"We would have had a single management system moving in one direction," the Regence BlueShield spokesman said. Some functions, though, such as marketing, local customer service and doctor network management, were to remain separate, he said.

The spokesman said The Regence Group also had anticipated that its alliance with HCSC would have improved its ability to provide national employers with similar health plan products and services over a wide geographic region. The Regence

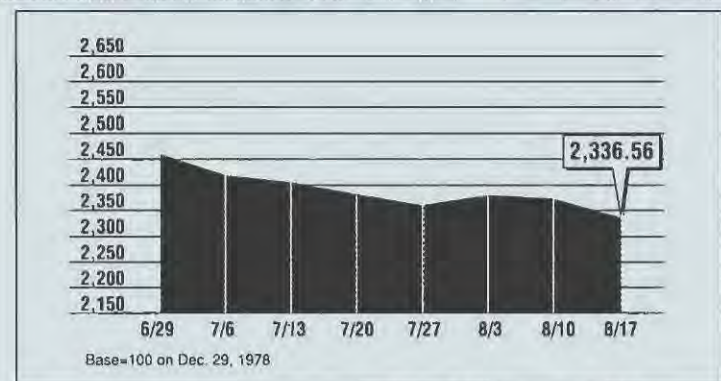
Group, based in Portland, Ore., has about 3 million members, and is viewed as regional insurer, he said.

Chicago-based HCSC has about 7 million members and is well regarded for managing many large nationwide accounts, according to employer representatives. Blues plans in other states often cede the management of national accounts to HCSC because of its reputation as a "control plan," with an efficient system for handing claims and customer service nationwide.

HCSC is the parent of Blues plans in Illinois, New Mexico, and Texas. The Regence Group is affiliated with Blues plans in Idaho, Oregon and Utah and with Regence BlueShield.

—By Roberto Cenicerros

B/Stock Index - 8/17/2001



BROKERS

Company	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol. (000)
Aon Corp.	38.17	-1.62	11.45	42.31	28.13	3816
Arthur J. Gallagher & Co.	27.02	-3.57	-15.06	34.25	21.88	1139
Brown & Brown	47.17	-1.42	34.77	50.69	26.16	316
Clark Bards Holdings	26.97	9.86	166.37	33.90	7.25	254
E.W. Blanch Holdings Inc.	13.50	0.00	-22.58	29.50	6.70	0
Hilo, Rogal & Hamilton	46.39	-2.58	16.34	48.16	33.75	101
Marsh & McLennan	95.21	-6.18	-18.62	135.69	80.30	3562
Willis Group Holdings Ltd.	18.60	5.08	12.05	18.60	15.50	653
BROKERS AVERAGE	-0.05	23.09				

INSURERS/REINSURERS

Company	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol. (000)
ACE Ltd.	35.89	1.07	-15.43	43.94	31.59	4717
Accel International Corp.	0.07	0.00	-76.42	0.64	0.06	0
Acceptance Insurance Cos.	5.40	3.65	2.86	6.94	3.70	75
AEGON N.V.	30.25	-0.75	-27.00	43.00	25.92	816
AFLAC Inc.	27.77	1.35	-23.06	37.47	23.38	10430
Almerica Financial Corp.	51.10	2.53	-29.52	74.25	46.30	866
Allstate Corp.	33.81	1.23	-22.39	45.90	28.38	14116
Ambac Financial Group	59.35	2.40	1.78	64.00	41.38	1973
American Financial Group	23.61	-1.50	-11.12	30.75	18.69	280
American General	45.01	-0.66	10.45	47.44	33.66	11080
American Int'l Group	79.21	-3.02	-19.63	103.75	72.64	26940
American Safety Insurance	10.15	-1.93	65.71	10.36	3.25	6
Argonaut Group	18.06	0.50	-14.00	21.25	13.50	183
AXA-UAP Group	29.65	0.41	-17.42	39.88	24.58	1385
Baldwin & Lyons Inc.	24.03	0.50	3.35	28.75	17.63	29
Berkley W.R. Corp.	38.80	-0.64	-17.77	48.75	22.88	358
Berkshire Hathaway Inc.	69200.00	0.58	-2.54	74600.00	53500.00	1
Capitol Transamerica Corp.	16.30	0.31	31.06	16.50	10.31	54
Chubb Corp.	68.94	-0.71	-20.30	90.25	63.30	2640
Cincinnati Financial Corp.	41.24	3.38	4.24	42.92	32.56	1253
Citigroup	46.60	-6.12	-8.74	59.13	39.00	51639
CNA Financial Corp.	31.42	-3.20	-18.92	41.00	31.42	964
CNA Surety	14.29	-0.76	0.28	14.70	10.63	59
EMC Insurance Group Inc.	13.40	0.37	14.04	15.86	9.00	2
ESG Re Limited	3.30	-4.90	78.98	4.00	1.72	15
Everest Reinsurance	67.71	-0.07	-5.47	75.50	39.25	1107
Fremont General Corp.	8.20	8.96	120.44	6.97	1.50	722
Gainco Inc.	1.31	8.26	-50.10	4.56	1.10	49
Harleysville Group	25.30	8.12	-13.50	30.63	18.52	884
HCC Insurance Holdings	25.00	0.00	-7.19	29.66	17.63	850
ING Groep N.V.	32.14	-1.38	-19.78	41.97	27.92	835
IPC Holdings Ltd.	22.75	-1.47	8.33	25.05	15.25	116
Hartford Financial Services	64.50	0.09	-8.67	80.00	53.50	2894
John Hancock Fin. Services	40.00	3.09	6.31	42.00	22.31	5653
Lincoln National	50.20	0.76	6.10	56.38	38.00	2557
Market Corp.	192.20	-3.71	6.19	207.47	133.50	147
MBA Insurance Group	57.11	1.04	15.57	57.36	40.05	2273
Meadowbrook Insur. Group	2.65	-14.52	-67.38	8.38	2.45	39
MetLife	29.11	1.78	-16.83	36.63	23.13	8622
Mutual Risk Mgmt. Ltd.	10.55	-3.21	-30.53	23.75	3.40	1294
Navigators Group	19.20	0.52	44.23	20.86	10.63	5
NYMagic Inc.	20.30	-0.83	7.55	22.70	13.94	4
Ohio Casualty Corp.	13.53	-0.51	35.30	14.34	6.13	1735
Old Republic Int'l	27.67	1.10	-13.53	32.06	21.25	1551
Partner Re Ltd.	49.53	-3.77	-18.80	62.50	39.31	419
Penn-America Group Inc.	10.20	0.99	33.77	10.60	6.69	25
PMA Capital Corporation	18.09	3.79	4.87	18.94	15.19	178
Philadelphia Cons. Holding	35.14	1.53	13.81	37.50	16.38	384
ProAssurance	17.75	10.94	6.37	18.50	11.63	149
PXRE Corp.	17.00	7.94	0.74	20.10	12.56	70
RenaissanceRe Holdings Ltd.	71.27	1.81	-8.99	84.19	46.56	189
RU Corp.	42.55	0.83	-4.78	46.16	36.94	58
St. Paul Cos.	44.11	2.56	-18.78	57.00	39.58	6299
SCOR	46.20	4.41	-8.06	53.75	40.50	19
SAFECO Corp.	30.10	-1.70	-8.44	35.88	21.50	3939
SCPIE Holdings Inc.	21.04	0.38	-10.94	31.40	17.78	NA
Seibels Bruce Group	2.64	10.00	369.33	3.25	0.55	10
Selective Ins. Group	26.30	3.54	8.45	28.22	15.25	109
Tokio Marine & Fire	48.80	5.08	-14.39	58.25	45.10	96
Torchmark Corp.	42.50	1.87	10.57	42.83	26.31	944
Transatlantic Holdings	75.22	-1.01	6.57	84.16	56.33	82
Trenwick Group Ltd.	15.20	-7.26	-38.74	27.13	14.75	841
Unico American Corp.	6.30	0.00	7.23	7.75	5.27	2
United Fire & Casualty	29.00	-0.85	-46.84	34.52	16.19	10
Unitrin	37.57	0.45	-7.52	41.94	28.56	166
UNUM Corp.	27.77	0.98	3.33	33.75	19.25	2563
Vesta Insurance Co.	9.40	-21.34	85.68	11.95	4.25	1068
XL Capital Ltd.	79.32	-0.60	-9.22	89.25	64.31	2657
Zenith National Ins.	29.10	0.34	-0.94	30.70	20.00	42
INSURERS/REINSURERS AVERAGE	0.33	5.12				

MANAGED CARE ORGANIZATIONS

Company	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol. (000)
Aetna Inc.	27.00	1.81	-34.25	42.69	23.02	4521
CIGNA Corp.	90.17	0.36	-31.84	136.75	86.48	2664
Health Net Inc.	18.27	4.64	-30.23	26.94	15.56	3082
Humana Inc.	10.85	2.36	-28.85	15.81	7.94	2719
Oxford Health Plans	27.67	1.10	-29.95	32.06	21.25	1551
Pacificare Health Sys.	16.43	7.67	9.53	57.19	9.81	5244
Sierra Health Services	9.84	2.93	158.95	10.27	2.44	1126
United HealthGroup	65.62	1.93	6.92	68.00	44.53	4038
Wellpoint Health Networks	103.12	2.62	-10.52	121.50	79.50	1489
MANAGED CARE AVERAGE	2.82	1.08				

ALL COMPANIES

1.03 9.76

Top advancing issues: ProAssurance, Seibels Bruce Group, Clark Bards Holdings, Fremont General Corp., Gainco Inc. Leading decliners: Vesta Insurance Co., Meadowbrook Insurance Group, Trenwick Group Ltd., Marsh & McLennan, Citigroup. Most active issues: Citigroup, American International Group, American General, Allstate Corp., AFLAC Inc. The B/Stock Index fell 1.53%; the Dow Jones 30 Industrials dropped 1.68%; the S&P 500 fell 2.37%; and the NYSE Composite dropped 1.51%. Average P/E: Brokers, 25.12%; Insurers/reinsurers, 21.34%; and managed care companies, 16.10%.

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

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