Court gives AXA bad review of suit over film losses / 3

NAIC aims to clarify how terror risk is handled / 4

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$4

# St. Paul slashes key operations

## Medical malpractice, reinsurance cut back to boost profits

By RODD ZOLKOS

**ST. PAUL, Minn.**—Among several lines of business that The St. Paul Cos. Inc. plans to exit to improve profitability, the most prominent will be in medical malpractice liability insurance.

The company is the largest medical malpractice underwriter in the United States and, ultimately, may serve as a case study in what can go wrong in the malpractice insurance market.

In an effort to increase profitability, the St. Paul, Minn.-based insurer announced last Wednesday that it would exit the medical malpractice market, as well as certain reinsurance lines and countries where it is not likely to be competitive. The company also said it would reduce annual expenses by $50 million through staff reductions and expense controls.

St. Paul Re will no longer underwrite aviation reinsurance, bond and credit reinsurance or offer financial risk and capital markets insurance products, and it will "substantially reduce" the amount of North American business it writes in London, the company said.

The company's main London operation, St. Paul at Lloyd's, will exit most of its casualty insurance and reinsurance business, U.S. surplus lines and certain nonmarine reinsurance lines.

The move to exit the medical malpractice market "is obviously a big strategic decision for us, given that we've been a major player in that market for a number of years," said Tom Bradley,

See ST. PAUL/page 20

## RIMS survey finds 2000 cost down 7.1%

# Cost of risk is expected to reverse course, rise

By MICHAEL BRADFORD

Risk managers are not likely to again see declining cost-of-risk figures for the profession any time soon.

The 2001 RIMS Benchmark Survey, which was released earlier this month, shows that the overall cost of risk for U.S. companies fell 7.1% in 2000 to its lowest point in more than a decade: $4.83 per $1,000 of revenue. It marks the second consecutive year of decline; the 1999 figure of $5.20 was down 8.9% from the previous year.

That downward trend will not continue, though, as hardening in the market and the impact of the Sept. 11 terrorist attacks drive costs higher in 2001. In fact, the report warns that, because the most recent results reflect respondents' experience prior to the market disruption caused by the attacks, users of the survey should be cautious when using the information for benchmarking purposes.

The survey's authors further warn that the number of large company respondents to the latest survey skews the 2000 data compared with that used for the report issued last year.

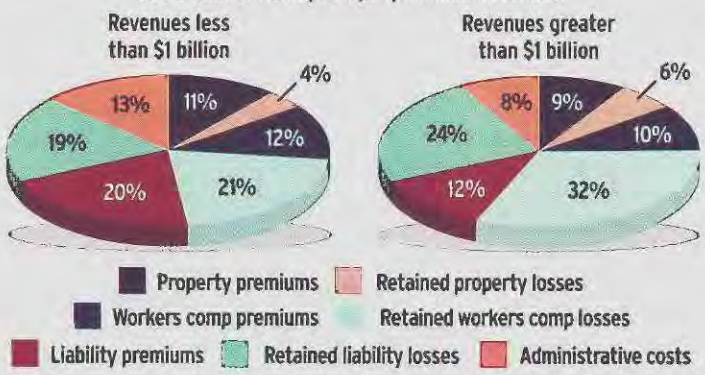
"Something that the reader should keep in mind is that there is quite a difference in cost of risk depending on the size of the company," said Tom Welgoss, the director of risk management for the Massachusetts Turnpike Authority in Boston and a member of the research committee of the Risk & Insurance Management Society Inc. "You have to use the data very carefully."

The most recent survey included a larger group of respondents with more than $10 billion in revenue

See COST/page 21

### HOW THE RISK DOLLAR IS SPENT

2000 cost of risk by company's annual revenues.




SOURCE: RIMS

GRAPHIC BY JOHN HALL

# Congress taking stock

## Enron saga puts focus on plan rules

By JOANNE WOJCIK

**WASHINGTON**—Members of Congress are considering revamping pension law to limit the amount of stock in its own company that a defined contribution plan can hold.

Congressional hearings were held last week on the need for the proposals, spurred by the collapse of Enron Corp. Not only were Enron employees hurt by the collapse but thousands of retirement plans were exposed to the meltdown of the Houston-based energy firm.

Pension experts are urging lawmakers to wait until all investigations into Enron's financial failure are complete, though, before considering drastic changes to retirement policy or regulation.

Two House Democrats—Peter Deutsch of Florida and Gene Green of Texas—are preparing legislation that would impose a 10% cap on the amount of employer stock that

See PENSIONS/page 23

## Late News

### Aetna to cut 6,000 jobs in bid to lower costs

Aetna Inc. announced last week that it will cut about 6,000 employees over the next year. The cuts represent 16% of Aetna's current workforce. As Aetna faces lower 2002 health plan membership, following higher rates and previously announced product withdrawals, "we must be sized to match the needs of our business," Dr. John Rowe, Aetna's chairman and chief executive officer, said in a statement. Hartford, Conn.-based Aetna will take a fourth-quarter charge of $125 million to cover severance and other costs. Aetna reported $92 million in losses in the first nine months of 2001, a 117.2% decline from 2000. Most other large commercial health insurers saw strong net income growth during that period.

### Lloyd's sets record-high capacity for 2002

Lloyd's of London will have the capacity to accept premiums of £12.3 billion ($17.63 billion) in 2002, the market's highest-ever capacity figure. For 2001, Lloyd's capacity was £11.0 billion ($16.42 billion). The previous highest capacity figure was £11.3 billion ($21.81 billion, at the applicable rate) in 1991. Lloyd's said in a statement that the £1.3 billion ($1.86 billion) in extra capacity pledged for 2002 was the result of additional capital being committed to the market in the wake of strong rate hikes. It added that several Lloyd's syndicates "are currently expected to announce further increases in their capacity in the first half of 2002."

### Harassment suit filed against Aon subsidiary

An Aon Corp. underwriting subsidiary engaged in a widespread pattern of sexual harassment and sex discrimination, according to 10 current and former female employees who filed suit against Chicago-based Combined Insurance Co. of America. The suit, filed in the U.S. District Court for the Northern District of Illinois, alleges that Combined "engaged in a shocking campaign of cruel, severe and pervasive sexual harassment and economic discrimination against its female

Continued on page 2





## International

## FRENCH TO FORM TERRORISM POOL

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# Inside



## Departments




**REPORTING WEEKLY ON CORPORATE RISK, EMPLOYEE BENEFIT AND MANAGED HEALTH CARE NEWS**

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**CONTINUED FROM PAGE ONE**

workforce." Male managers and sales agents inflicted sex-related abuse on female employees that ranged from verbal taunting to a "gang-bang style" rape, according to the complaint, which was filed Dec. 13. Furthermore, the lawsuit alleges that Combined refused to offer female employees the same opportunities it offered to males in the company. Richard Ravin, Combined's chairman and chief executive officer, said in a statement: "We have longstanding policies against sexual harassment and discrimination, and as a matter of practice do not tolerate such behaviors in our company."

### Latex allergy not covered by ADA, jury finds

A registered nurse with a latex allergy is not protected by the Americans with Disabilities Act because her symptoms can be alleviated by prescription drugs and by avoiding latex, a federal court jury in Philadelphia has ruled.

Jennifer Scanlon, a former nurse at Temple University Hospital in Philadelphia, sued Temple University last January in the U.S. District Court for the Eastern District of Pennsylvania. Her suit alleged she was terminated due to a latex allergy disability and that Temple failed to reasonably accommodate this disability by providing a latex-free work environment. Temple argued that her allergy did not substantially or materially limit her major life activities, as required under the ADA. Specifically, defense counsel argued that, regardless of her work environment, Ms. Scanlon suffered no limitations caused by her allergy when she is in a latex-free environment and that the impairment was controlled with medication.

# Late News

### Willis to buy San Francisco brokerage

Willis Group Holdings Ltd. plans to buy Goldman Insurance Services, a San Francisco-based brokerage, for an undisclosed amount in a stock-and-cash deal. Privately held Goldman, which places property/casualty and employee benefits coverage, mainly for middle-market policyholders, handles total annual premiums of about $160 million and revenues in excess of $10 million. Goldman's operations will be combined with those of Willis' existing San Francisco office. The deal is expected to close Dec. 31.

### Workers comp insurer CEO resigns

Carl B. Lehmann resigned as president and chief executive officer of RTW Inc. as part of a realignment of the workers compensation insurer's management. He will be replaced by J. Alexander Fjelstad III, a former director and chief operating officer of sales and marketing for RTW. Mr. Fjelstad was president of RTW's insurance subsidiary, American Compensation Insurance Co., from 1989 to 1998. In addition, Alfred L. LaTendresse, the company's former chief financial officer from 1990 to 1998, has returned as executive vp and president of American Compensation Insurance. The move, requested by company founder David C. Prosser, follows announcements last week that the company would close its Missouri and Massachusetts offices effective Jan. 31, 2002, after a merger deal with American Physicians Capital Inc. fell through.

### N.C. Blues planning for-profit conversion

Blue Cross & Blue Shield of North Carolina intends to file a plan with the state for conversion to for-profit status next month. The Blues plan's trustees voted to proceed with the conversion at a special meeting last week. In accordance with a 1998 law governing the conversion, the plan calls for the creation of an independent charitable foundation that would initially hold all of the Blues' stock. Both the state insurance commissioner and the state attorney general must approve the plan before it can take effect. BC/BS of North Carolina intends to file the conversion plan in early January.

### Senate urged to follow House lead on terror relief

The chief sponsors of a terrorism insurance relief measure passed by the House last month are calling on the Senate to follow their lead by requiring insurers to pay back any government financial assistance. Financial Services Committee Chairman Mike Oxley, R-Ohio, and Rep. Richard Baker, R-La.–the driving forces behind the Terrorism Risk Protection Act–last Wednesday said they favor using government loans to assist insurers coping with large future terrorism-related losses. Although the Senate has yet to vote on its own terrorism insurance legislation, draft legislation would have insurers and the federal government share the costs of paying losses from catastrophic terrorist events without any requirement that insurers repay the government for its share (*BI*, Dec. 10). In a statement prepared for a Capitol Hill news conference, Rep. Oxley said, "We have a simple message to the other side of the dome–no payback, no bill." He said that the House would not pass "another typical bailout" benefiting the insurance industry.

### Check out Businessinsurance.com

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All the material in the Late News 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.

### Briefly noted

An American Airlines flight attendant on Thursday filed a lawsuit in federal court in Los Angeles accusing her employer of sexual discrimination for offering **a health plan that covers Viagra** for men but does not cover infertility treatments, birth control pills and other services used by women....**Ken Haddon** will retire as executive chairman of the London Underwriting Centre at year end. His successor is expected to be named shortly. Mr. Haddon has spent his entire 37-year career working in the London insurance market and was a founding member of the LUC in 1993. In 1999, he retired from AXA Re, now AXA Corporate Solutions.... Greenwich, Conn.-based **W.R. Berkley Corp.** announced Friday that it would set up a $12 million reserve, after taxes and net of reinsurance, for losses related to the recent bankruptcy filing of Enron Corp. Berkley, which may face surety reinsurance losses stemming from Enron's collapse, also said it will cease writing large, national surety risks starting Jan. 1, 2002. Berkley will focus instead on regional surety reinsurance business.

# Court vacates a ban on class-action suits over Union Carbide pollution in India

By DAVE LENCKUS

**NEW YORK**—Union Carbide Corp. has killed a legal challenge to its settlement of claims arising from the world's deadliest industrial accident, but it faces additional litigation over the historical operation of the plant at the center of the catastrophe.

A 2nd U.S. Circuit Court of Appeals panel upheld a federal district court judge's decision to dismiss claims that Union Carbide and a former top official have violated their settlement over the 1984 toxic gas leak in Bhopal, India. In class-action litigation, Indian plaintiffs sought additional compensation for the hundreds of thousands of victims and their families.

The appellate court panel, however, has vacated the portion of the district court judge's ruling that, without explanation, also barred the plaintiffs from seeking compensation for environmental contamination that Union Carbide's former Bhopal plant allegedly caused before and since the 1984 accident.

The appeals court has remanded that issue to U.S. District Court Judge John F. Keenan in New York, but it did not prohibit the judge from again dismissing those claims with an explanation.

The plaintiffs have not specified how much more compensation they want, but it will be "considerable," said plaintiffs' attorney Kenneth F. McCallion of McCallion & Associates L.L.P. of New York.

Danbury, Conn.-based Union Carbide was acquired by Dow Chemical Co. in February 2001.

The 2nd Circuit panel returned its unanimous rulings on Nov. 15, a couple weeks shy of the 17th anniversary of the Bhopal disaster. More than 2,000 residents of the city in north central India were killed and more than 200,000 were injured when an industrial pesticide manufacturing plant run by Union Carbide subsidiary Union Carbide of India Ltd. leaked a large quantity of the highly toxic gas methyl isocyanate.

Shortly after the disaster, Indian lawmakers passed the Bhopal Act, which gave the Indian government exclusive authority to represent the disaster victims in courts worldwide. The govern-

**See UNION CARBIDE /page 20**

PHOTO: AP/ WIDE WORLD

**A woman gathers water near the Union Carbide plant in Bhopal, India, two months after a 1984 toxic gas leak that killed thousands.**

PHOTOS: AP/ WIDE WORLD

AXA lost a round in its battle over coverage of film financing deals, including policies written for "The Crew" and "The People vs. Larry Flynt."

# Film litigation not following AXA's script

## Jury hands AXA unit defeat on cover issues

By DOUGLAS McLEOD

**NEW YORK**—Litigation over massive losses from insurance-backed movie finance deals may be far from over, but AXA Reassurance S.A., one of the biggest participants in the deals, can't be encouraged by its results so far.

A New York state jury last week ruled against AXA on two coverage matters, clearing obstacles for a possible multimillion-dollar recovery by Chase Manhattan Bank on loan losses involving the 2000 Burt Reynolds film "The Crew."

The case is one of 11 similar lawsuits pending in the United States and many more in United Kingdom over policies written by AXA and other insurers promising to repay the bank loans of movie industry borrowers if films were to fail to recoup their costs. Insurance industry experts have estimated insurers' total exposure to film finance losses at $1.5 billion to $2 billion.

In a declaratory judgment action pitting AXA against Chase, broker Stirling Cooke Brown Holdings Ltd. of Bermuda and others, a New York State Supreme Court jury concluded that Chase has a valid cut-through endorsement allowing it to collect directly from AXA, which reinsured the Woodland Hills, Calif.-based fronting company Underwriters Reinsurance Corp. on a policy covering "The Crew."

The jury also rejected AXA's claim that a Stirling Cooke employee knowingly made false representations to AXA officials on the policy for "The Crew" and a second policy guaranteeing repayment of a $7.5 million loan Chase made to the film's producer, Beverly Hills, Calif.-based George Litto Productions. New Hampshire Insurance Co., a unit of New York-based American International Group Inc., acted as the fronting insurer on the second policy.

Earlier, New York Supreme Court Justice Ira Gammerman threw out several AXA defenses, including that the insurance placements were fraudulent; that their structure virtually guaranteed losses, meaning that losses were not "fortuitous" and, therefore, not insurable; and that AXA's own Paris-based underwriter—subsequently fired—had no authority to bind the business.

Judge Gammerman must still rule on two AXA defenses and will then issue a final opinion and enter a judgment, lawyers involved in the case say. AXA will appeal any judgment against it, said Stephen Cozen, a Philadelphia-based partner with Cozen & O'Connor, representing the insurer.

A final accounting of the film's performance will not be made until April 2002, but its distribution pre-sales totaled only $14 million, of which $11 million has been collected to date, and a claim on the film is expected.

Chase, a unit of J.P. Morgan Chase & Co., and Stirling Cooke both praised the jury

See CHASE /page 20

# Ex-employees' bias suits under ADA, FMLA upheld

By JUDY GREENWALD

**ATLANTA**—Two federal appellate court decisions show that employers must take care to comply with employment laws even when it comes to former employees.

In *Johnson vs. Kmart*, a three-judge panel of the 11th U.S. Circuit Court of Appeals in Atlanta ruled a former employee can sue his employer under provisions of the Americans with Disabilities Act. Similarly, in *Smith vs. BellSouth*, another 11th Circuit panel decided an ex-employee could sue his former employer under the Family and Medical Leave Act. Both decisions reverse lower courts' dismissals of the suits.

"Both cases illustrate the principle that employers may be stuck with employment-related claims long after a person leaves their employment," said Richard D. Tuschman, an attorney with Baker & McKenzie in Miami. There are "two different factual scenarios and two different statutes, but both involve former employees and, in both cases, the 11th Circuit held that the former employees were entitled to protection under the law," said Mr. Tuschman, who noted that neither decision involves the typical wrongful discharge claim.

"*Smith* and *Johnson* illustrate that just because the employment relationship ends doesn't necessarily mean that the nondiscriminatory treatment obligation ends as well," said Jeremy J. Glenn, an attorney with D'Ancona & Pflaum in Chicago. "I think you're seeing a developing consistency in broad interpretations of how long the employment relationship truly lasts for purposes of these statutes," said Mr. Glenn.

"The real message to employers is: Don't play lawyer. Don't think that just because the employment relationship has ended that your obligation to comply with federal anti-discrimination statutes has ended," said Mr. Glenn.

Attorneys say the *Johnson* case is particularly significant because the court broke from other appellate courts in concluding that disparate long-term disability benefits for mental and physical disabilities may be discriminatory. Mental health benefits parity is an issue

See COURT/page 22

## Cost emerges a major issue for corporate health plans

# Health care cost increases among employers' top worries

By JERRY GEISEL

Rising health care costs, a modest corporate concern during the boom years of the late 1990s, has become a top corporate worry as cost increases have accelerated and the economy has cooled.

More than 60% of about 700 large employers responding to a new Hewitt Associates L.L.C. survey say cost increases are of "critical concern" in managing their health care programs.

By contrast, only 7% of respondents said health care quality was of critical concern, though 61% said quality was of "significant concern."

"A couple of years ago, health care costs was not the major issue that it is today for organizations. And for some, it wasn't even on the radar screen because of how stable health care costs were in the early to mid-1990s," said Jack Bruner, a Hewitt national

See HEWITT/page 22

**HEALTH CARE PROGRAM CONCERNS**

Employers' biggest concerns about their health care programs

| | Significant concern | Critical concern |
|---|---|---|
| Health care cost increases | 38% | 61% |
| Liability and regulatory exposure | 48 | 13 |
| Employee dissatisfaction | 63 | 12 |
| Benefit delivery and administration problems | 52 | 8 |
| Health care quality | 61 | 7 |

Source: Hewitt Associates L.L.C.

# Employers seeing 401(k) matches as potential area to trim expenses

By MICHAEL PRINCE

As the recession erodes corporate profits, some employers are cutting their matching contributions to employees' 401(k) plans as a way to save money.

The move will create short-term savings, but it risks alienating employees, benefit experts say. Therefore, observers believe the isolated cases of cutting the match will not become a trend.

While employers may struggle, they are largely "resistant to reducing some of these benefits at this point unless things get much worse," said Robert Liberto, vp at Segal Advisors Inc. in New York.

"It's a big step," said David Wray, president of the Profit Sharing/401(k) Council in Chicago.

Despite the drawbacks, a number of prominent employers have taken the step. For example, Ford Motor Co. announced that it would suspend its matching contribution to its salaried workers' 401(k) program starting Jan. 1, 2002. Along with other cost-cutting measures, the move is designed to save the Dearborn, Mich.-based automaker $300 million next year.

Visteon Corp. an auto parts maker based in Dearborn, has also suspended its 401(k) match, starting next year. This year, the program provided a 60% match for the first 6% of an employee's contribution, a company spokesman said. The cutback will affect all of Visteon's 9,900 salaried U.S. workers. The company hopes to save $25 million with the move.

Also, DaimlerChrysler Corp. will suspend its match as of Jan. 1. The Auburn Hills, Mich.-based automaker had been contributing 60% of an employee's first 8% of salary contributed to the plan, a spokeswoman said. The suspension of the match for 15,000 salaried workers is part of a restructuring to return the company to profitability.

These moves come amid the well-publicized bankruptcy filing by Enron Corp. and the huge financial losses to Enron employees whose 401(k) matching contributions were invested in company stock (see story, page 1). Enron suspended its matching contribution program as of Nov. 30.

And last Friday, General Motors Inc. announced it is cutting its match-

See MATCHING/page 22

# NAIC discusses need for terrorism insurance relief

## Insurance regulators facing pressure to find solutions to coverage problems

By MEG FLETCHER

**CHICAGO**—While lawmakers and lobbyists wrestle over the language and timing of proposed federal relief for insurers' terrorism risks, state insurance regulators also are feeling pressure to resolve issues stemming from the Sept. 11 attacks, especially for policyholders whose coverage expires at year end.

Federal and state response to the terrorist attacks and insurance fallout was a central theme of the National Assn. of Insurance Commissioners' winter meeting, held last week in Chicago.

"We are pretty close to the time when departments must take some action" if they are going to be able to keep their respective insurance markets functioning effectively for consumers and insurers alike, said Terri M. Vaughan. Ms. Vaughan, Iowa's insurance commissioner and former NAIC vp, was elected to succeed Kathleen Sebelius of Kansas as president of the NAIC last week.

Many large corporate policyholders last month received cancellation and nonrenewal notices from their primary insurers, many of which are uncomfortable writing coverage for terrorism exposures without firm reinsurance support. Meanwhile, many insurers are asking individual state commissioners to approve new policy endorsements that would exclude losses from terrorist activities.

Responding to widespread uncertainty in the market, the Kansas City, Mo.-based NAIC canceled its fall quarterly meeting in late September and instead held a special meeting in Washington to discuss how best to cope with the industry's situation. The NAIC in October issued a statement of principles for federal terrorism insurance relief and continues to encourage federal lawmakers to include those points in proposed legislation, though the NAIC has not endorsed any proposal now before Congress.

The NAIC took additional steps last week to help resolve insurance issues arising from the Sept. 11 attacks, including disseminating for public comment a definition of terrorism developed by association subgroups. The definition is designed to provide guidance for the federal coverage programs as well as exclusions in policies not covered under such federal programs.

Under the proposed definition, approved by NAIC subgroups, an act of terrorism would be "an act intentionally dangerous or destructive to human life, health, tangible or intangible property or infrastructure, carried out by a person or group that is not an agent of a sovereign state, but is acting on behalf of an organization based in a country other than the United States, and motivated by political, religious or social beliefs."

The NAIC added in a drafting note that "the above definition is tailored narrowly to respond to the particular risk that, prior to Sept. 11, 2001, was considered remote." The definition, which would not apply to domestic terrorism, is intended to distinguish international terrorism from both acts of war and vandalism.

The sense of urgency among state insurance regulators was underscored when Ms. Vaughan verbally authorized immediate distribution of the proposed wording by the organization's new Legal Issues Ad Hoc Group. While the commissioners received little or no comment on the newly disseminated document at the meeting, John Morrison of Montana, who chairs the group, invited attendees to send comments by e-mail last week. Regulators plan to continue discussing the matter by conference call in the near future.

In a statement last Wednesday, the National Assn. of Mutual Insurance Cos.' legislative and regulatory counsel, Peter Bisbecos, said that the NAIC's proposed definition should not require association with a terrorist organization. He said the identity of a terrorist, whether domestic or foreign, is irrelevant and that the impact of a terrorist act on an insurer's solvency is the same regardless of affiliation.

> **'Insurance is truly the glue that holds our economy together, and without that glue, the prospect for...growth is not very encouraging.'**
>
> *Rep. Mike Oxley R-Ohio*

One of the most pressing issues that state insurance regulators face is deciding whether to approve—even conditionally, pending federal action—various terrorism exclusions, which have been filed in every jurisdiction on behalf of a variety of insurers.

Last month, the New York-based Insurance Services Office Inc. filed in every U.S. jurisdiction, and subsequently amended, the most uniform, optional endorsement related to terrorism that has been proposed to date. The two-part filing would apply to boiler and machinery, business owners, commercial crime, commercial inland marine, commercial property and farm risk insurance policies as well as the liability risks related to those lines.

The exclusion for property damage would apply only when total damage from a terrorism incident exceeds $25 million or, regardless of the amount of damage, the terrorism incident involves nuclear materials or pathogenic or poisonous biological or chemical materials. The exclusion for liability would apply if damage exceeds $25 million or 50 or more people sustain "serious physical injury" or death.

Thus far, "the ISO endorsements are approved or available for use in Colorado, Idaho, Massachusetts and South Dakota," said Stephen Noceti, vp-government relations for ISO. "We know if Congress does not act that more states are likely to approve the filings, especially to preserve the solvency of insurance companies," he said.

Representatives of some insurer groups who spoke at the NAIC meeting urged the commissioners to be wary of certain elements of federal relief proposals.

For example, Scott A. Gilliam, secretary and director-government affairs for the Cincinnati Insurance Cos. in Cincinnati, said that if H.R. 3210 had been in effect on Sept. 11, his company would have had to pay back the government $172 million on actual losses of $8.7 million, assuming the World Trade Center loss was at least $40 billion and triggered a maximum assessment on all insurers of $20 billion.

Robert Zeman, vp and assistant general counsel of the National Assn. of Independent Insurers in Des Plaines, Ill., also urged regulators to beware proposals that would cause small commercial risks to subsidize large commercial risks.

Several regulators and a few consumer representatives also voiced concerns about whether insurers are taking advantage of the current uncertainty by price gouging. As a result, the NAIC established a Rate and Market Trends Oversight Working Group to review the situation.

"We are all committed to oversight," said Illinois Insurance Director Nathaniel S. Shapo, who was elected NAIC secretary/treasurer at the meeting.

Ideas for a federal relief plan also were briefly discussed during meetings of several other NAIC groups, including the Property & Casualty Insurance Committee. At that meeting, Sam Meyer, assistant director of the South Dakota Insurance Department, suggested that federal lawmakers consider modeling the current relief proposal on two existing programs—crop and flood insurance—that already have full federal reinsurance protection.

"Both plans are agencies of the federal government, and the insurance is sold and serviced by commercial insurers," he said. "The crop insurance program is particularly relevant because of the potential devastation that a biological contaminant could cause in food-growing states," he said. The programs have existed for many years and have worked, so "people forget that they are there," Mr. Meyer said.

U.S. Rep. Mike Oxley, R-Ohio, who gave the keynote address at the NAIC meeting, emphasized the need for regulators and federal lawmakers to resolve these complex issues. "Insurance is truly the glue that holds our economy together, and without that glue, the prospect for our economic growth is not very encouraging," he said.

# Commissioner's fund-raising letter raises hackles

By MEG FLETCHER

**CHICAGO**—A brouhaha over a fundraising letter sent by Montana Insurance Commissioner John Morrison to former plaintiffs' attorney peers caused several insurer trade groups to question whether he is seeking to protect consumers' interests by encouraging class-action litigation in lieu of state regulation.

Several leaders of the Kansas City, Mo.-based National Assn. of Insurance Commissioners generally rejected that negative interpretation of his letter and emphasized their support of him and his work within the organization. For example, they refused a request by the National Assn. of Mutual Insurance Cos. to delay implementing a computerized database of consumer complaints against insurers.

The recent controversy involving Mr. Morrison began with an Oct. 2 fund-raising letter that he said he sent to about 800 plaintiffs' attorneys outside of Montana, who are members of the Assn. of Trial Lawyers of America's Insurance Section. Mr. Morrison, previously had a successful career as a plaintiffs' attorney and served as president of the Montana Trial Lawyer's Assn.

Mr. Morrison, who contributed $103,992 of the total $247,068 he spent to win the November 2001 race, was seeking $35,000 from the solicitation, he said.

In the letter, Mr. Morrison—who technically was elected to the post of Montana's state auditor, which oversees both insurance and securities operations—emphasized actions he was taking to help consumers. For example:

- Serving as chair of the Consumer Protection Working Group and launching a new consumer complaint database. "In Phase II—next year—we will try to make the individual complaints themselves available," he wrote.

Mr. Morrison

Insurer critics—which include the Alliance of American Insurers, the American Insurance Assn., the National Assn. of Independent Insurers and NAMIC—however, said in a letter that they had several questions about the database, including the extent to which individual data would be added.

- Asking the NAIC to produce a survey of states to determine the adequacy of private civil remedies for insurance bad faith and volunteering to send a copy—which he thought was public—upon request.

*Business Insurance*, however, was told more than two months later that the survey "is not yet public information," though the results were made public at the working group meeting last week.

- Requesting that the NAIC develop a model bulletin to prohibit insured ERISA plans from conferring discretion on the plan administrator, which "makes it easier for a consumer who is right to prevail," he said.

Kansas Insurance Commissioner Kathleen Sebelius, who co-chairs the consumer working group with him, strongly criticized several aspects of the insurer groups' complaints, including what she called an attempt to "mischaracterize" the committee's work.

New NAIC President Terri M. Vaughan of Iowa said she personally thought "people overreacted to" Mr. Morrison's letter. She emphasized that "a single commissioner does not set policy" but is one of 51 votes.

While Arkansas Insurance Commissioner Mike Pickens, the new NAIC vp, acknowledged "the activist" tenor of some of Mr. Morrison's comments, he organized a private meeting between Mr. Morrison and trade group representatives to discuss the controversy.

Attendees from both sides described the meeting as "productive" and reported that they expected to be able to work together in the future.

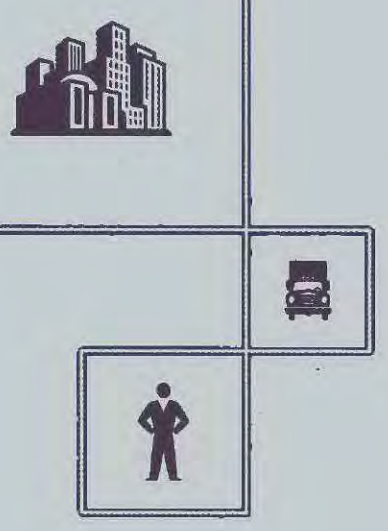
# Benchmarking.

# Best practices.

# Performance metrics.

# BUZZWORDS

# from 2001 or 1912?



Let's face it, the language of risk management has changed, but the principles that make it effective have not: Knowing a client's business. Pinpointing areas for improvement together. Setting goals. Applying innovative thinking. And measuring the results. Frankly, this is exactly what we do – and have done – since Liberty was founded in 1912. Since then, we've helped thousands of clients become safer and more efficient. Last year alone, this comprehensive approach saved them $129 million and 750,000 disability days, while reducing claims by 20%. And because Liberty is consistently rated A+ (superior) by A.M. Best, clients know we'll always be there for them. But ultimately, it's about more than just protecting your business. We want to strengthen it, no matter what the terminology.

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# Commentary

## 'Tis the season for renewal anxiety

There's something about the traditional song "The 12 Days of Christmas" that always sets my teeth on edge.

Maybe it's the song's frantic escalation of gift giving or its rushed repetition of verses. Or perhaps it's the imagery of all the squawking fowl, the outrageously expensive jewelry, the nervous noblemen and the discomposed dairymaids. Whatever it is, for me, the song captures the frenetic pace and anxious activity of the holiday season.

This year, I imagine, there also is much frenzy and anxiety in the efforts of brokers and their clients to put together reasonable insurance programs before their existing policies expire. I imagine, too, that there are some goose eggs being laid, some gold exchanging hands and plenty of leaping and milking going on.

With that in mind, maybe singing this song will put your mind at ease (or set your teeth on edge) and become an annual favorite. Happy holidays.

**Paul D. Winston**

***On the first day of Renewals,***
My broker gave to me:
A Promise of a Policy

***On the second day of Renewals,***
My broker gave to me:
2 Outrageous Quotes
And a Promise of a Policy

***On the third day of Renewals,***
My broker gave to me:
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

***On the fourth day of Renewals,***
My broker gave to me:
4 B-rated Choices,
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

***On the fifth day of Renewals,***
My broker gave to me:
5 Unreturned Voice Mails,
4 B-rated Choices,
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

***On the sixth day of Renewals,***
My broker gave to me:
6 Evasive Answers,
5 Unreturned Voice Mails,
4 B-rated Choices,
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

***On the seventh day of Renewals,***
My broker gave to me:
7 Higher Retentions,
6 Evasive Answers,
5 Unreturned Voice Mails,
4 B-rated Choices,
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

***On the eighth day of Renewals,***
My broker gave to me:
8 Pleading E-mails,
7 Higher Retentions,
6 Evasive Answers,
5 Unreturned Voice Mails,
4 B-rated Choices,
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

***On the ninth day of Renewals,***
My broker gave to me:
9 Names of Politicians,
8 Pleading E-mails,
7 Higher Retentions,
6 Evasive Answers,
5 Unreturned Voice Mails,
4 B-rated Choices,
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

***On the 10th day of Renewals,***
My broker gave to me:
10 Brochures on Captives,
9 Names of Politicians,
8 Pleading E-mails,
7 Higher Retentions,
6 Evasive Answers,
5 Unreturned Voice Mails,
4 B-rated Choices,
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

***On the 11th day of Renewals,***
My broker gave to me:
11 Let's Start Overs,
10 Brochures on Captives,
9 Names of Politicians,
8 Pleading E-mails,
7 Higher Retentions,
6 Evasive Answers,
5 Unreturned Voice Mails,
4 B-rated Choices,
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

***On the 12th day of Renewals,***
My broker gave to me:
12 Bills for Service,
11 Let's Start Overs,
10 Brochures on Captives,
9 Names of Politicians,
8 Pleading E-mails,
7 Higher Retentions,
6 Evasive Answers,
5 Unreturned Voice Mails,
4 B-rated Choices,
3 I'll Try Agains,
2 Outrageous Quotes
And a Promise of a Policy

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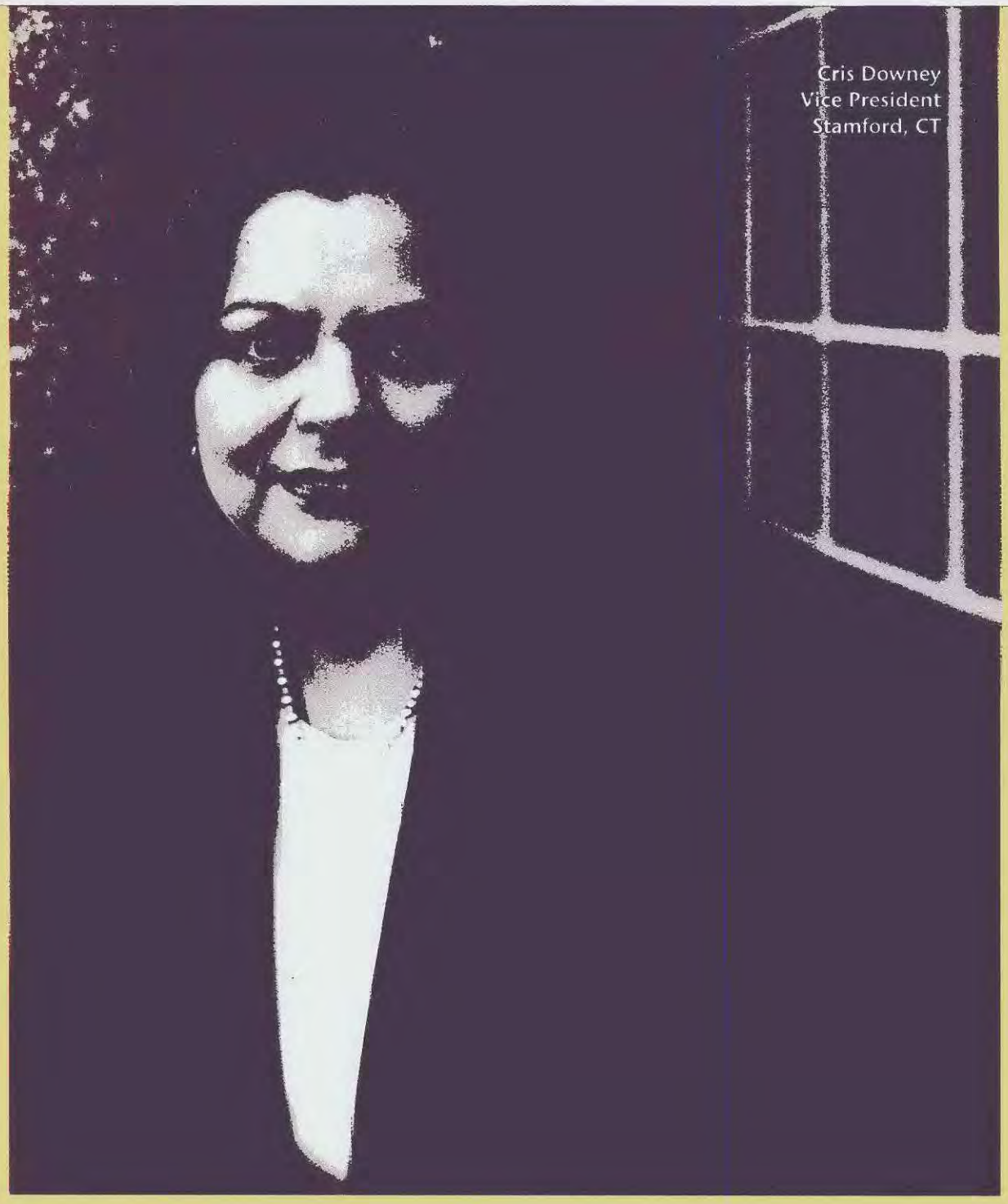
*Editor Paul D. Winston's commentary appears fortnightly and on www.businessinsurance.com. Mr. Winston can be reached by e-mail at pwinston@crain.com.*

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## Editorial

# Congress should get behind terrorism cost-sharing bill

WE ARE discouraged that federal lawmakers have been so slow to reach agreement and approve a plan to provide insurers and insurance buyers with much needed financial relief from possible future terrorism losses.

The need for this relief is great, and both it and the preferred course of action can be summed up in one paraphrased sentence: "It's the economy, so keep it simple, stupid."

The fact that no terrorism insurance legislation has reached the president's desk more than three months after the Sept. 11 attacks means that a risky game of political chicken has gone on far too long on Capitol Hill.

Action was needed weeks ago because many U.S. businesses are running out of time before they have to arrange their 2002 insurance protection. They already know that their coverage costs will be sharply higher, as insurers make up for the terrorist losses and reappraise their exposures. But without some sort of federal guarantee to pick up some of the insurance industry's future terrorism losses, insurers either will raise rates even higher or simply refuse to underwrite certain risks. That's exactly what an already fragile economy doesn't need.

The delay and failure to reach legislative agreement can't be blamed on discord in the insurance industry, and the confusion that arises from lobbyists backing different approaches.

This time, the insurance industry came together and produced a consensus proposal that every major insurance trade group could support. Insurers claimed that it was the best proposal out there—and they were probably right—but even then they remained flexible and willing to work with lawmakers.

Unfortunately, lawmakers have been unable to reach agreement among themselves.

The measure passed by the House late last month casts the federal government in the role of a lender of first resort, issuing loans to insurers that would that have to be repaid. The Senate, in contrast, favors a risk-sharing approach, which is also favored by the Bush administration.

Proponents of the House bill claim that without a payback provision, a federal guarantee is nothing but an unwarranted bailout. We beg to differ. Unlike the airline industry, for example, insurers did not rush to Capitol Hill seeking compensation for Sept. 11 losses. They're paying them without federal aid.

What insurers are asking for is federal backup should a future catastrophic terrorist attack further drain their already-diminished surplus.

We think the Senate proposal—which we hope has been introduced and approved by the time you read this—is far preferable. Under the Senate approach, insurers would continue to pay claims up to a multibillion-dollar trigger, and then share additional loss costs with the government. At no point do insurers avoid any portion of the risk.

It makes sense that the government should share the risk, as a chief function of government is to protect against internal and external attack. The events of Sept. 11 mean that function was not fulfilled.

Lawmakers need to get over what we can only assume is their distaste for the insurance industry and do what's right for the economy.

Without some form of federal backup, which we hope would never be triggered, insurers will balk at writing coverage. Without insurance coverage, economic activity sputters.

Unfortunately, this simple fact has been obscured in the congressional debate by a variety of factors.

One of the more notable distractions is the inclusion of tort reform provisions. Attempts to use the terrorism insurance legislation as a vehicle for broad tort reforms could jeopardize the underlying bill.

While we have long argued for tort reform, and we certainly agree that some limits on punitive damages are needed to cap federal and insurer terrorism coverage payouts, we would regretfully jettison those reforms rather than lose the financial relief this bill would afford insurers and their policyholders. Tort reform can be addressed in other legislation, but the time for relief of insurers' terrorism exposures is now, as policy renewals loom.

The debate over this issue has dragged on far longer than it should have. For the sake of the country's economic well being, Congress should close ranks behind a cost-sharing terrorism insurance bill and get it to the president.

The simpler—and the sooner—the better.

## Schillerstrom


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# Products & Services

## ACE USA covering power outages

**PHILADELPHIA**—ACE USA Power Products is offering a new coverage for utilities that protects against losses from long-term power outages.

With limits up to $100 million, PowerBacker LTO protects investor-owned utilities and municipalities against losses that result when one or more generating units are out of operation for long periods. Unlike traditional business interruption coverage that is offered as a subpart of a property program, the new coverage specifically addresses the risks associated with the outages.

"In today's generating world, long-term outage protection can no longer be considered a sidebar to other property coverages," Kurt Husar, vp of Philadelphia-based ACE USA Power Products, said in a statement. "CFOs recognize the impact that these outages have on their business and are looking for a product that can protect their market capitalization. The costs of lost generating capacity associated with a long-term outage can be far more severe than the physical damage loss."

More information is available from insurance brokers or by calling ACE Power Products at 800-356-2827.

## Near North offers Web-based training

**CHICAGO**—Near North Insurance Brokerage Inc. is offering an interactive Web-based employee safety and health training program.

OccuTrainer uses video, audio and animation in courses of 30 to 50 minutes each that teach and test workers on topics ranging from defensive driving and ergonomics to laboratory safety and the transportation of hazardous materials. The program provides employers with documentation required by the U.S. Occupational Safety & Health Administration, as well as certification of employees' completion of the courses.

The program covers 20 safety courses; customized modules can be developed as well.

Chicago-based Near North said in a statement that the program's benefits include promoting employee safety, reducing the costs associated with unsafe work practices, preventing OSHA citations and fines, and providing documentation of training efforts.

Additional information is available at *www.occutrainer.com* and at 800-829-6922.

## ISO launches rehabilitation module

**LONDON**—Insurance Services Office has launched a rehabilitation module for its Claims Outcome Advisor personal injury claims management system in the United Kingdom.

The new module assesses the impact an injury may have on the injured worker's household and workplace activities by considering the injury, treatments, complications and pre-existing conditions. The result is to help claims handlers rehabilitate injured workers and to provide both sides with information that can produce an early settlement of claims, thereby reducing costs.

The module bases its conclusions on an understanding of 20,000 medical conditions and 14,000 occupations.

More information on the module is available from ISO by e-mail at *global@iso.com* or on the Web at *www.iso.com*.

## Software analyzes discrimination risks

**PHILADELPHIA**—New software is being developed that will allow employers and corporate attorneys to analyze the likelihood and risks of employment discrimination litigation.

The self-audit software assesses the magnitude of disparities among protected groups in the workforce, based on hiring, promotion and layoff policies. It considers age, race, gender and other protected category factors.

The software program was developed by David W. Griffin, vp of the Philadelphia-based Center for Forensic Economic Studies. Mr. Griffin has completed a prototype of the software program and is seeking feedback on it from employers, employment law specialists as well as human resources directors.

The Windows-based program can be used as an ongoing monitoring tool and also is useful for testing the effects of contemplated reductions in force, Mr. Griffin said.

For a demonstration and more information on the software, contact Mr. Griffin at 800-966-6099 or at *bdl@cfes.com*.

# Integrated benefits model offers many advantages for employers

By Frank Conklin

Employers recognize that separate claims processes for group health, workers compensation and disability insurance run counter to the economic interests of all who provide and participate in health care services. These impediments have prohibited sustainable value in employee benefits.

Now that workforce productivity has become a critical component of value in the health benefits equation, the traditional commodity orientation of employee benefits will be replaced by a new value-based management approach. The real problem must be addressed: How can employers create sustainable, measurable value from their benefits programs, given the artificial operational barriers in the health care and insurance systems?

Instead of simply shifting liability for medical plan selection away from employers and onto employees, many companies see benefits coordination as an opportunity to improve outcomes, reduce costs and improve productivity. But is there a business model that will begin restraining the underlying growth in unabated health cost inflation and contribute to making an organization more competitive?

One strategy is an integrated employee benefits model that will eliminate inefficiencies and reduce errors. A true seamless benefits model will foster the development of more sophisticated outcome measures and preventive and disease management programs.

Under an integrated benefits model, the incentives are to more successfully manage the programs that treat costly medical events regardless of where such events originated, and whether their costs are for medical care or lost work time. This approach would promote better allocation of medical resources and foster transparency in medical prices, because a single insurer or administrator would handle all claims processes. Integrated benefits would add value to the quality/cost equation and encourage the use of evidence-based medicine, as well as promote new medical technologies that simplify complex problems.

Though managed care has developed a large body of knowledge about medical management, existing benefits financing mechanisms continue to influence treatment protocols, create redundancies and encourage cost shifting.

The current health insurance marketplace provides no economic incentive to stabilize the worsening underwriting cycle. Each course ultimately leads to further price spikes that leave medical cost inflation at a higher base rate due to cherry picking and new cost drivers. Optimal resource coordination among prevention, patient advocacy, medical appropriateness and economic productivity techniques is unachievable by existing managed care and provider organizations.

Integrated benefit initiatives by large employers have been successful. Employers that understand the potential of benefits integration created their own models for streamlining benefits and because the employers do not have a vested interest in maintaining separate occupational and nonoccupational insurance silos, these initiatives achieve significant savings.

By integrating benefits and using absence management, insurers can change the entire model of measuring employee benefits value. The integrated insurer can demonstrate abilities to increase the number of productive days per employee and reduce premium costs.

In addition, the risk finance structure of integrated benefits is superior to the individual components of managed care, workers comp and disability. Integrated benefits will promote the development of a platform for securitizing employee benefits. This could take the form of bond issues for tax-exempt insurance programs. These multiyear benefit programs could provide the capital and liquidity necessary to align the motivations of consumers, employers, insurers and providers to deliver optimal medical and return-to-work outcomes.

In years past, several insurers developed integrated benefit programs, but very few were successful. Conflicting management systems among group health, workers compensation and group disability departments within the insurance industry and other sectors of the health services industry, prevented this integration. Though an increasing number of new integrated benefits products exist, these programs, like earlier ones, have been largely geared to administrators' operational constraints instead of market needs.

Employers will be absorbing double-digit benefits plan increases for several years. There is a dire need for a real integrated product for the fully insured market, which represents well over 80% of covered employees. Large employers have successfully experimented with their own models, yet no insurer or benefits administrator offers a fully integrated benefits model.

U.S. employers require an effective integrated benefits product if they are to remain competitive in the global marketplace. Maximum socioeconomic value will be derived from a seamless benefits plan option. Successful integrated benefits will make employers and insurers become patient advocates. Providers will have greater incentive to make decisions about which costs to incur, so that their skill levels and organizational structures are more closely matched to the difficulty of the medical problems.

Integrated benefits will provide financial incentives, emphasize care management, promote community health care and prevention, reduce employment risk, increase workforce productivity and increase efficiency in the benefits cost structure. This business model will produce both top- and bottom-line growth for all economic interests, so that reinvestment can be made for improving employers' economic performance, achieving consumer satisfaction and reforming the health care delivery system.

*Frank Conklin is founder and managing partner of Fianna Partners L.P. in Westport, Conn.*

# HIPAA deadline puts focus on compliance

## *Employers, health plans, providers struggling with law's complexities*

By Stephen Harri

For several years, health care providers, insurers and employers have been watching the compliance date of the Health Insurance Portability & Accountability Act draw near. The Bush administration's decision to let the 1996 law's regulations proceed clearly indicates that the time come into compliance is now. While much of the initial focus involved HIPAA's impact on health care providers, the ramifications for employers are now receiving considerable attention.

The basic goals of HIPAA, which include promoting e-commerce in health care to improve efficiencies, lower costs and safeguard patient confidentiality, are noble and generally supported. There is little agreement, though, on how to reach those goals.

As the compliance deadline for HIPAA nears, physicians, health plans and employers are grappling with complex questions, including:

- How is the law's demand for patient confidentiality balanced with the need of health care organizations to communicate appropriate patient information that could not only improve lives but also better manage costs?
- What rights do employers have to access information that is necessary to manage the plans they fund and develop programs that mitigate costs?
- At what point does the quest to implement and enforce HIPAA, as well as the possible expense of HIPAA-related litigation, end up costing more than the actual savings that this law is supposed to create?

The intent of HIPAA is relatively straightforward, but no one knows how the regulations supporting the law will be enacted. Final rules for these regulations—such as standards for electronic transactions and privacy and patient confidentiality standards—are expected to be finalized starting this year. Those rules and regulations will have staggered compliance dates throughout 2003 and 2004.

Enforcement for noncompliance is still in the future, though insurers and providers are expected to react now.

**The intent of the Health Insurance Portability & Accountability Act is relatively straightforward, but no one knows how the regulations supporting the 1996 federal law will be enacted.**

While the guidelines for providers are becoming better understood, employers' concerns are more complicated. Employers will be held to the same privacy and confidentiality standards as other participants in the health care delivery system and will be monitored for "unintended use" of health information. Therefore, employers need to understand what areas of the law could expose them to fines, litigation or criminal charges.

Employers will want to look carefully for health plans that will be HIPAA-compliant, as they will not escape liability simply because of those agreements.

To address the demands of HIPAA, many large employers may develop their own vendor assessment compliance analyses or subcontract that work to consultants.

To ensure compliance, providers, insurers and employers should:

- Learn about requirements that will affect them by attending seminars, reading journals and seeking the advice of qualified consultants.
- Train employees in safeguarding confidentiality. Remind them that HIPAA provides for significant fines for release of individually identifiable medical information. Even innocuous slips, such as casual conversations about a fellow

See HIPAA/next page

# HIPAA: Approaching deadline puts focus on compliance

**Continued from previous page**
employee's upcoming surgery, can result in fines.

- Adopt appropriate security measures, such as pass codes-protected access to electronic data, and conduct readiness assessment reviews of current procedures.
- Understand how HIPAA will affect communication with other vendors or entities.
- Adopt consistent or generally accepted medical information forms and use standardized wording, particularly for consent forms.
- Ensure they have the right protection and insurance coverage. Existing property and liability coverage may well provide the protection needed, but it should be carefully analyzed. Many consultants will offer insurance-gap analysis, readiness assessments or other services to help employers ensure that they have the appropriate risk management plan in place to meet HIPAA's demands.
- Research insurance coverages. Existing policies may offer some indemnification against civil fines and penalties, but there may well be potential gaps in coverage. Over the last year, insurers have been considering modifying existing terms and offering stand-alone policies with broader terms to protect providers, insurers and employers.

But in the midst of the continuing debate about HIPAA, some key points should not be overlooked. First, e-commerce is a vital component, not only to employers' bottom line but also to our nation's health care system as a whole. Second, every consumer should feel secure in the knowledge that his or her personal health care data will not be improperly communicated.

The challenges are many, and there is still a long way to go before all the details, implications and hazards of HIPAA are fully understood. Employers and providers can't bury their heads in the sand and hope these sensitive issues will pass them by. They need to take steps to become compliant now.

---

*Stephen Harri is managing director of Aon Healthcare Alliance in New York.*

# Estate of claimant entitled to benefits

## Legal Briefs

The Court of Appeals of Michigan ruled that the estate of a deceased workers compensation claimant was entitled to medical and disability benefits ordered to be paid before the claimant's death.

James Grier was an attorney who worked for Yellow Freight System Inc. as a dock laborer. While at work in November 1989, Mr. Grier suffered a heart attack. He filed an application for workers comp benefits, listing no dependents. Following a trial, a magistrate concluded that Mr. Grier was not entitled to workers compensation because, with his qualifications and training, he was not "disabled" within the meaning of the statutory definition of "disability."

After several proceedings and appeals, Mr. Grier was awarded medical benefits related to the treatment of his heart attack and benefits for the period afterward when he was totally disabled, a period lasting up to three months. He filed an appeal, seeking more benefits, but died in January 1998.

The employer sought to have his application for benefits dismissed on the basis of his death. The compensation commission substituted the personal representative of Mr. Grier's estate as the party plaintiff and again awarded the estate medical benefits and three months' disability. The employer appealed.

The appellate court said that state workers comp law did not preclude benefits where the decedent died and left no dependents. The court said that an employer may remain liable to a decedent's estate for an amount due and owing an employee as a result of a final award entered by the compensation commission before the employee's death even where no death benefits are available.

Furthermore, the court said that the fact that the employee had no dependents was irrelevant. The medical and disability benefits awarded were affirmed.

*Grier vs. Yellow Freight,* Court of Appeals of Michigan, March 9, 2001, *Released for Publication* May 7, 2001. (*BI*/05/J-$10)

### Suit over termination motive pre-empted by ERISA

An employee's claims against his former employer alleging he was terminated so that the company could avoid heightened pension obligations fell squarely within the scope of the Employee Retirement Income Security Act provision prohibiting acts of economic retaliation and, thus, were pre-empted by ERISA, according to the 5th U.S. Circuit Court of Appeals.

Thomas Bullock started working for The Equitable Life Assurance Society of the United States in 1973, becoming an agency manager in 1994. The written agreement governing Mr. Bullock's employment had no fixed duration. In 1998, Equitable informed him that it was restructuring and several agency managers, including Mr. Bullock, were to lose their positions. All managers were offered other management or sales agent positions. Mr. Bullock resigned after declining an offer that included a benefits package and required a release of claims.

Mr. Bullock sued Equitable in Mississippi state court alleging, among other claims, breach of contract. He argued that Equitable terminated him to avoid heightened pension obligations that it would bear once he turned 65. Equitable had the suit removed to the federal courts and sought a declaration that ERISA pre-empted Mr. Bullock's state claims for breach of contract. The federal trial court requested the 5th Circuit rule on Equitable's pre-emption claim.

The appellate court noted that ERISA prohibits an employer from terminating an employment contract to deprive an employee of pension benefits. Since Mr. Bullock alleged that Equitable terminated his employment contract to prevent him from becoming eligible for pension benefits at age 65, the court concluded that those allegations fell squarely within the scope of the pre-emption provision. Therefore, the court said that Mr. Bullock's exclusive remedy was through an ERISA enforcement proceeding and not under state law.

*Bullock vs. Equitable Life Assurance Society of the United States,* 5th U.S. Circuit Court of Appeals, July 24, 2001. (*BI*/02/J.-$10)

### Worker's false statements about health bar comp benefits

The state workers compensation law prohibits compensation benefits in certain instances where the injured worker has made a written misrepresentation about her physical medical history when being hired, according to the Supreme Court of Kentucky.

Cheryl Gutermuth applied in writing for a job with Excel. The employer's hiring procedure required her to undergo a pre-employment physical exam as a part of which she completed a written questionnaire on her medical history. In response to a question concerning any prior operations, she listed only a hysterectomy and vein strip.

In fact, Ms. Gutermuth had a history of several surgeries, including bilateral carpal tunnel releases, bilateral pronator release and bilateral thumb joint replacements. Also, her medical history included spinal stenosis, a herniated cervical disc and osteoarthritis, none of which were listed in her application.

She was cleared to work without restrictions and was hired as a packer. Later, she injured her neck on the job while driving a cherry picker over a break in the concrete floor. She filed a claim for workers comp benefits after undergoing surgical fusion at the C5-6 vertebrae. An administrative law judge, the board of appeals and the Court of Appeals denied her claim.

The state Supreme Court said the false representations concealed her true physical condition from the examining physician, led the physician to conclude that she could work without restrictions and defeated the purpose of the exam. The court also said that the administrative law judge concluded that there was a causal connection between her false representation and the injury for which compensation was claimed. The court affirmed the decision to deny her benefits.

*Gutermuth vs. Excel,* Supreme Court of Kentucky, April 26, 2001. (*BI*/01/J.-$10)

### Court clarifies rules in partial plan termination

Only nonvested Employee Retirement Income Security Act plan participants were required to be counted in determining whether a partial termination of an ERISA plan occurred, according to the 7th U.S. Circuit Court of Appeals.

Robert J. Matz filed an ERISA action claiming entitlement to benefits as a result of a partial termination of a retirement benefit plan. The Internal Revenue Service in its rulings concluded that all terminated participants, both vested and nonvested, should be counted in determining whether a partial termination had occurred. The federal trial court deferred to the IRS' position and held that both vested and nonvested participants could be counted to determine whether partial termination occurred and that employee terminations that occurred in multiple plan years could be aggregated. The 7th Circuit affirmed; however, the U.S. Supreme Court vacated that decision and returned the case for further proceedings.

The 7th Circuit, on remand from the Supreme Court, held that the IRS' position was an informal policy pronouncement not entitled to deference. According to the court, the IRS' position was not born from a formal policymaking procedure. Furthermore, the court found that the meaning of "partial termination" was unclear because the statutory language was ambiguous.

The court looked to the statute's purposes, which are to protect employees' legitimate expectations of benefits and to prevent employers from abusing pension plans to reap tax benefits. The court said vested participants do not need further protection for their pension benefits and do not benefit from a finding of partial termination. The trial court decision was reversed.

*Matz vs. Household International Tax Reduction Inv. Plan,* 7th U.S. Circuit Court of Appeals, Sept. 7, 2001. (*BI*/04/J-$10)

### CGL exclusion barred coverage of truck accident

A collision between an overhanging skidder on a tractor-trailer and a truck arose out of the "use" of an "auto" and, thus, an "auto" exclusion clause of a commercial general liability policy barred coverage for the resulting damage, the Court of Appeals of Georgia ruled.

Greg Lee, doing business as Greg Lee Logging, was covered under a CGL insurance policy issued by American Interstate Insurance Co. The policy covered bodily injury or property damage but excluded liability arising out of the use of any auto. Under the policy, "auto" was defined as "a land motor vehicle, trailer or semitrailer designed for travel on public roads, including any attached machinery or equipment."

In 1998, a Lee Logging employee was driving a tractor-trailer loaded with a logging skidder. The skidder extended two feet off each side. Stephanie Jacobs was driving a truck in the opposite direction on a two-lane bridge, and the overhanging portion of the skidder struck her truck, fatally injuring Ms. Jacobs and injuring her two children.

Ms. Jacobs' husband sued Lee Logging for the wrongful death of his wife and the personal injuries to his children. The insurer sought a declaration from the court that the CGL policy did not provide coverage. The trial court ruled for the insurer.

On appeal, Mr. Jacobs conceded that the tractor-trailer was an "auto" as defined in the policy but argued that the collision did not involve "use" of the tractor-trailer because the point of contact in the collision was between the truck and the overhanging portion of the skidder. "The collision and resulting injuries," the court said, "clearly flowed from Lee Logging's 'use' of the tractor-trailer as contemplated by the 'auto' exclusion." The trial court decision was affirmed.

*Jacobs vs. American Interstate Insurance Co.,* Court of Appeals of Georgia, June 1, 2001. (*BI*/03/J-$10)

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*These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available, at $10 each, by sending a check payable to Mayo H. Stiegler, to* Business Insurance, *360 N. Michigan Ave., Chicago, Ill 60601-3906. Provide the listed number for each opinion ordered.*

INSURER TOPICS

A MONTHLY EDITORIAL SECTION SENT EXCLUSIVELY TO INSURERS AND REINSURERS

# Niche Underwriting

# Unmet urban needs offer opportunities

## *Workshop promotes understanding required to serve a growing marketplace*

By MEG FLETCHER

As the nation's urban population increases, insurers and agents have new opportunities to write coverages that meet the needs of this growing marketplace, experts say.

"Urban markets offer excellent business opportunities" for the insurance industry, said Madelynne Brown, assistant director of the Illinois Insurance Department.

To compete effectively, though, insurers and agents must understand the inner-urban marketplace, which is characterized by the need for affordable housing and services.

To further that goal, the Urban Insurance Partners Institute recently hosted a two-day national workshop in Chicago titled "Writing Business Successfully in Urban Areas." The Chicago-based organization is the only insurance industry organization devoted solely to educating the insurance industry and consumers about urban insurance issues and model programs, said Suzanne Reade, the president of UIPI.

The workshop, which featured more than two dozen speakers, was co-sponsored by the Local Initiatives Support Corp., a nonprofit organization dedicated to rebuilding communities. About 70 people attended.

Population shifts that have resulted in eight out of every 10 people living in metropolitan areas mean that urban markets are growing, said Michael A. Yeager, president and chief executive officer of Lehigh Mutual Insurance Co. in Allentown, Pa. When the former farm mutual insurer began losing clients, Mr. Yeager said, he realized that "this country boy had to become a city slicker."

His company's success in finding business in city settings means "I'm well aware there is good business to be found in urban markets," said Mr. Yeager, who serves as the institute's chairman.

An information gap exists, though, about urban consumers' spending potential, said Paul Sill, director of corporate consulting for Urban Logic, an affiliate of Shorebank Corp. Chicago-based Shorebank, the nation's first and largest community development bank, has invested $1 billion in so-called "underserved" communities since 1973.

"There is opportunity in the inner city despite lower incomes and common misperceptions," Mr. Sill said. For example, census data tend to understate the buying power of urban consumers because these consumers tend to be more concentrated than are those in many other neighborhoods and they tend to use cash rather than credit to make purchases, he said.

"Using unique data and metrics can help during the initial identification of gap areas," Mr. Sill said. Urban Logic uses supplemental information, including building permits, school enrollments and property-related data.

Such data can help insurers and agents by identifying geographic areas of highly concentrated buying power, as well as areas of high "float," in which consumers are buying outside their own area, Mr. Sill said. "Float and concentrated buying power can be customized for the insurance industry to highlight pockets of missed opportunity," he said.

"After pockets are identified, insurance companies must review their policy guidelines for inadvertent barriers " Mr. Sill said. For example, one insurer's underwriting guidelines prohibited insuring a roofing material that is common in urban neighborhoods even though further analysis showed the prohibition was unwarranted.

In addition, "insurers must research and evaluate the insurance needs of these consumers through focus groups and survey research," Mr. Sill said. "You must adapt your business to fit (consumers') needs, or someone else eventually will," he said.

"The urban market is the final frontier for large-scale, domestic market-share acquisition for all business, including insurance," Mr. Sill said.

Another model urban information program is available through the Cook County Assessor's Office, said Mario Duque, the office's Webmaster. By next summer, the office expects to be done posting photographs of all the buildings in Cook County on its Web site, *www.cookcountyassessor.com*.

Mr. Duque said the unique feature of the free program is the additional data provided about the buildings, including details about the type of construction, the number of floors, the square footage and the existence of attics or garages. Such information allows properties to be compared with others, regardless of the underwriter's location.

Insurers and agents wanting to explore urban markets should be encouraged by the experience of banks, speakers said. Banks often form partnerships with politically savvy organizations that encourage the development of low- and moderate-income housing and businesses.

The primary motivation for banks has been the federal Community Reinvestment Act, which requires that banks invest in urban communities.

At the present time, the CRA requirement does not apply to insurers, although federal and state lawmakers have periodically discussed their inclusion. Most recently, some members of Congress reportedly have discussed imposing such a requirement as part of the terrorism reinsurance legislation that the insurance industry is seeking, said a spokeswoman for the Washington-based American Insurance Assn.

Insurance commissioners also have considered the general topic. For example, California's top insurance regulator asked insurers this year to identify their urban-related investments. Meanwhile, though, Illinois Insurance Director Nat Shapo told the group that while insurers' investing in urban areas makes "good political sense," he does not favor such a mandate.

The primary problem with imposing a CRA-type requirement on insurers is the regulatory restrictions on the investments insurers can make, said Charles M. Chamness, vp-public affairs for the National Assn. of Mutual Insurance Cos. in Indianapolis.

Mr. Chamness said that insurers already support urban

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INSURER TOPICS

# Urban: Needs create a market

Continued from page 12A

communities through the payment of losses and participation in community organizations such as the institute, which NAMIC helped establish.

Urban investments offer advantages. "The recently enacted federal tax credit law offers insurance companies greater opportunities to use investments as an overall business strategy," Andrew Mooney, LISC senior program director, said in a statement.

Overall, "there are opportunities out there that meet traditional business standards that can have a huge impact," said Robert S. Grossinger, senior vp with La Salle Bank in Chicago.

Mr. Grossinger said he found that some of his colleagues made CRA-acceptable investments simply to generate profits and that they were "do-gooders...by accident."

Other speakers noted that several national and community groups are available to work with investors, including the Community Development Trust Inc., National Equity Fund Inc. and Neighborhood Housing Services of Chicago Inc.

In addition, other groups specialize in redeveloping brownfields and in helping to prevent environmental pollution.

Such groups may be able to help insurers or agents offering cost-effective programs to link up with commercial and personal lines customers, workshop speakers said.

For additional information about urban insurance issues, contact Urban Insurance Partners Institute at 773-880-8780, or visit the UIPI Web site, at *www.uipi.org*.



# Poe family takes to underwriting role

## *Agency experience serves new venture*

By MARK A. HOFMANN

It wasn't the kind of opportunity just anyone would grab.

After Hurricane Andrew wreaked havoc in 1992, the state of Florida wanted to shrink the joint underwriting association it had created following the disaster. The state was willing to pay new insurers up to $100 per policy—plus a few other incentives—to take the business off its hands.

The arrangement was called a "takeout" because the new companies could literally "take out" the business from the JUA. When the takeout began, the JUA had in force about 1.5 million policies, making it the second-largest homeowners' insurer in the state, noted Bill Poe Jr. Mr. Poe and his father, Bill Poe Sr., lead Tampa, Fla.-based Southern Family Insurance Co.

Still, taking out JUA policies was risky business in more ways than one. The younger Mr. Poe admitted that some individuals may have questioned the wisdom of the family in getting involved with the insurance company end of the business in the aftermath of Hurricane Andrew, "but they didn't say it to our face," he said.

Nonetheless, the takeout represented an opportunity the Poe family couldn't pass up. Bill Poe Sr. had started with what had been a one-man insurance agency in 1956 and built it into Tampa-based Poe & Associates—one of the largest brokerages in the country—before merging it with Brown & Brown Inc. of Daytona Beach, Fla., to create Poe & Brown Inc. in 1993. He left about a year later, soon followed by his son. The younger Mr. Poe pointed out that the family had liquidated its assets in Poe & Brown, and the JUA opportunity came up just as the family was seeking ways to invest its assets.

"When we got down to brass tacks, we decided to do the takeout," he said. That was the genesis of Southern Family Insurance, which started operating in 1996.

Bill Poe Jr., chief operating officer of Southern Family, said the Poes were not totally unprepared for the challenge. Both Poe & Associates and Poe & Brown did wholesale and retail brokerage business, and the elder Mr. Poe had built a national specialty dentists' property program from the ground up, acting as a managing general agent first for Chubb Corp. and then for CNA Financial Corp.

"We were a bit of hybrid," said the younger Mr. Poe. As an MGA, Poe & Associates had "acted like an insurance company," except it did not have its own actuaries, he said. In fact, it even paid some claims.

"But it really was a big change going from agency hybrid into straight underwriting," said the younger Mr. Poe. "I won't say we were running in the dark; it was very much a learning experience."

Southern Family agreed to take the JUA policies on "assumption" rather than upon renewal. That meant that the new company would be flooded with policies. On Dec. 1, 1996, "we kind of just flipped the switch and we were in business with 35,000 policies and another 35,000 soon," said the younger Mr. Poe.

William Poe Jr.

The company had a staff of about 12, mostly in customer service. Southern Family focused on customer service because its managers knew that area best from their previous experience on the agency/brokerage side of the business. "From the agency, we knew that you had to have excellent customer service. Those had to be top notch," said the younger Mr. Poe.

Initially, information technology and even claims handling had to be outsourced, the younger Mr. Poe said. Those functions were brought in-house "within a very short period of time," he said. "We knew it would be hard work and a lot to learn."

Southern Family is part of the Poe Financial Services Group, which is also in Tampa. The company writes both personal and commercial insurance through independent agents and has about 110 employees.

One of the more significant segments of its commercial insurance business is commercial habitation, which covers condominium associations.

Earlier this year, Poe Financial Services Group's insurance operations grew through its acquisition of Orlando, Fla.-based Atlantic Preferred Insurance Co. Atlantic Preferred's book of business is very similar to that of Southern Family, though much smaller, said Bill Poe Jr.

Atlantic Preferred, like Southern Family, is a takeout company. A spokeswoman for the group said that, as of mid-November, the insurance companies had in force

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INSURER TOPICS

# Groups most open to nontraditional products identified

By RODD ZOLKOS

Affluent single individuals, both young and old, and empty nesters in their 50s or 60s are the most promising markets for life insurance companies looking to sell nontraditional products, a new study shows.

The survey, conducted by KPMG L.L.P. and the American Council of Life Insurers, was intended to gauge consumers' willingness to buy nontraditional products from life insurance companies. It was released last month at the ACLI's Business Solutions 2001 conference in Boston.

The 21st Century Financial Services Consumer survey was sent in July to a national sample of middle- to higher-income individuals in more than 900 U.S. households. The subsequent study divided the survey respondents into six psychographic segments, based on characteristics that included risk tolerance, willingness to try new financial products and motivation to build wealth.

The group found to be the most receptive market for life companies' nontraditional sales efforts was dubbed "Successful Innovators." The wealthiest of the six segments, that group included affluent young singles, affluent older male singles, affluent empty nesters and couples with dual incomes and no children.

Successful Innovators tend to be the first ones to buy new financial products and services, according to the study. And with a lot at stake in the stock market, members of this group regularly review their financial situations.

Representing about 14% of the population, according the study, Successful Innovators are the most likely of the six groups to use the Internet for information.

The biggest reason behind that group's behavior is free time, according to Christopher J. Swift, partner and national industry director of KPMG's insurance practice in Chicago. "I think, generally, these people have more time and can do research and can do different things," Mr. Swift said.

Other groups identified by the survey included "Naïve Innovators." About 18% of the U.S. population, this group is most willing to try new products as soon as they come on the market. According to the study, Naïve Innovators are risk takers who believe it is important to take a leadership role and for whom making money is important; consequently, they tend to be wealthier than average. A large percentage of this group is men in their mid 30s or early 40s.

"Cautious Investors," about 17% of the population, have considerable stock market investments, keep up with financial news and review their financial situations regularly. The group tends to be affluent empty nester males in their 50s and 60s.

"Carefree Spirits" stress spiritual value over material goods, and making money is low on their agenda. Representing about 13% of the population, according to the study, they tend to be optimistic, believing they will fare well in any economy. The group's average age is 44 and has more low- to mid-income families, larger households and the highest percentage of women. The group tends to favor bargain hunting over brand loyalty, according to the study.

"Pessimist Conformists," about 22% of the population, are socially conscious and are willing to try new things, but they aren't necessarily risk takers. They are not the first to buy new financial products and typically have little at stake in the stock market, do not feel financially secure and are not confident of their economic future. The group tends to be in their late 20s or early 30s and includes a higher percentage of younger working parents.

**'You want to start with success and build a revenue stream that can be broadened into other groups.'**

*Christopher J. Swift*
*KPMG L.L.P.*

The final segment identified by the study is "The Laggards," individuals who don't keep up with changes in the financial markets or financial news. They have little investment in the stock market. Comprising about 16% of the population, this group does not like risks, preferring to stick to the familiar, and they tend to be loyal to brands. The group tends to consist primarily of lower- and mid-income families, households with four or five members and a higher percentage of women, according to the study.

In comparing the segments, the study showed Successful Innovators, Cautious Investors and Naïve Innovators as the primary financial decision-makers, with Successful Innovators having the highest level of investments, followed by Cautious Investors.

According to the study, roughly 20% to 30% of the population is aware that insurance companies offer nontraditional services such as annuities, 401(k)s, IRAs and mutual funds, with Successful Innovators the most aware.

The study showed that, overall, about 16% of the population is apt to look to nontraditional sources for services; Successful Innovators are most likely and Cautious Investors are second most likely to do so. According to the study, about 9% of the population is likely to use insurance companies as a source for nontraditional products, with Successful Innovators taking the lead.

Mr. Swift said the study gives a clear picture of where life insurers should be focusing their marketing efforts as they try to sell nontraditional products.

"Why would you want to waste your time on certain of those groups? They don't have the willingness or time," he said.

"I think segmentation, certain customer relationship management programs, are giving people better data, better insight into who's going to buy when and why," Mr. Swift said.

*The study The 21st Century Financial Services Consumer can be found on KPMG's Web site at* http://www.us.kpmg.com.

# Poe: Agency family takes to underwriting

Continued from page 12B

106,000 personal lines policies, which generate $52 million in premium, and 1,070 commercial lines policies, which generate $25 million in premium.

The elder Mr. Poe is chairman of the holding company, while the younger Mr. Poe is president of the holding company and COO of the insurer. Jim Wurdeman, a longtime business associate of the elder Mr. Poe, is executive vp of the group.

The younger Mr. Poe said that his father remains "very, very active" with the group. "Frankly, we couldn't do this without him," he said. "His advice, ideas and counsel are invaluable."

Florida has seen no big storms in the past five years, though smaller storms have produced lots of smaller claims. The lack of significant storm loss has allowed Southern Family to build up its capital base as it prepares for the future, the younger Mr. Poe said.

"Our intent is to build an insurance organization in this state—and maybe regionally—and build a name that people recognize as providing quality service, both in the customer service and claims area, both to our agents and our retail customers," he said. "We'd like to become regional, but we're taking baby steps. We want to do it the right way. We'd like to be around for the long haul."



# ITBriefs

## AAIS endorsements exclude terrorism

**WHEATON, Ill.**—In response to requests from member insurers, the American Assn. of Insurance Services is filing commercial lines endorsements across the country that would exclude losses resulting from acts of terrorism.

Wheaton, Ill.-based AAIS said the endorsements address the needs of insurers whose reinsurers have moved to exclude terrorism losses in contracts effective Jan. 1, 2002.

The exclusions base their definition of terrorism on the U.S. Criminal Code. By drawing on a statute, AAIS uses a definition of terrorism that is generally accepted and periodically updated, said Deborah Summerlin, the AAIS vp of insurance lines, in a statement. The exclusions also expand the scope of terrorism to exclude coverage for losses arising from damage to or denial of the use of Web sites, computer networks, telecommunications equipment and mechanical equipment.

The exclusions' language recently was distributed to all AAIS member companies. Those not affiliated with AAIS who would like to see the language can contact Robert Schnoll, marketing manager, by e-mail, at *bobs@AAISonline.com*, or by telephone, at 800-564-2247.

The AAIS is a national insurance advisory organization. More than 600 property/casualty insurers use the AAIS policy forms, manual rates and loss-cost rating information.

## Insurers reducing staffing levels: ISO

**JERSEY CITY, N.J.**—According to the Insurance Services Office Inc.'s Engineering and Safety Service unit, insurers remain committed to loss control services and enhanced levels of performance despite significant staff cutbacks in recent years.

The ISO unit surveyed insurers to develop benchmarks on loss control staffing levels and the standards of loss control performance.

Overall, professional loss control staffing dropped 11% over the past five years, with large insurers reducing staff by 14%, according to ISO. The staff reductions are largely the result of insurers outsourcing much of their underwriting inspection activity.

But ISO suggests that outsourcing has allowed insurers to provide clients with more service, because many companies have redeployed loss control professionals as consultants who can devote their expertise to helping clients identify exposures and develop cost-effective ways to manage them.

Insurer Topics

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# 401(k) plan sponsors making few changes so far

## Employers' communication efforts following Sept. 11 have resulted in few shifts

By RODD ZOLKOS

Despite 2001's economic downturn, a volatile stock market and the Sept. 11 terrorist attacks, 401(k) plan sponsors and participants generally have made few changes in their retirement plans.

In the wake of the Sept. 11 attacks and the subsequent stock market downturn, one of the most common responses by plan sponsors was increased communication as they looked to remind participants about the importance of investing for the long-term.

As a result, there were not widespread shifts among plan participants to shift how their retirement savings are allocated among investment options.

"There was sort of a barrage of what I'll call 'Don't Panic Memos,' " said Gregory D. Metzger, director of defined contribution consulting at Watson Wyatt Worldwide in Sherman Oaks, Calif.

Employers often rely on 401(k) plan investment managers for that added communication.

"Part of (the extra communication) is in conjunction or working with the Vanguards of the world," said Irene Frentel, director of compensation and benefits at Tribune Co. in Chicago, referring to the mutual fund/asset management company. "They do a lot of that."

"I think from the plan administrators' side, the vendors, I think they did a tremendous job of reminding people why they're in the plan in the first place," said Mike Falcone, vp in the retirement consulting practice at Aon Consulting in Philadelphia.

"They're doing a great job of educating people that these events have happened in the past. The market tends to repeat itself," he said. "I think you've seen a lot from the vendors in terms of pushing people to think more strategically, a lot more information, a lot more educational materials."

Many quarterly plan statements for the three months ending Sept. 30 included information for participants on the impact of Sept. 11, the Aon consultant said.

"There hasn't been a huge hue and cry that our participants haven't been getting the comfort information that they need," said Christine C. Kellogg, Midwest unit defined contribution practice leader at William M. Mercer Inc. in Minneapolis. "The vendors seem to be very focused on that."

One reason sponsors are relying on 401(k) vendors for education is that they remain concerned about the potential fiduciary pitfalls associated with investor education vs. providing investment advice.

"A lot of sponsors are still fearful of going that step to providing advice because there are fiduciary issues associated with that," Mr. Falcone said. "I think there are people who want to do it but are afraid to do it because of the fiduciary issues."

But, Mr. Metzger said, there is more indication of employers being involved in plan communications. They aren't necessarily producing the educational materials, "But we do see them involved in designing the message," and using the resources of plan providers to execute the strategy, he said.

**'We've had questions from (plan) sponsors about what other sponsors are doing—are they changing their match because of the economy?'**

*Mike Falcone*
*Aon Consulting*

Not every employer stepped up communications post-Sept. 11, however. A spokesman for Chicago-based Boeing Co. said his company has simply stuck to an ongoing commitment "to providing information on a consistent basis."

"What we will be working on is tax law changes," such as catch-up provisions for people over 50, he said. "So there are things that we will want to reach out to make sure people are aware of."

While some plan participants might have moved to shift allocations after the stock market's September fall, most sat tight.

"Everything that we saw showed that participants really didn't shift a lot of money," Ms. Kellogg said.

"It varies across the board, but what we're hearing is people for the most part are standing pat," agreed Aon's Mr. Falcone.

Of those who did make changes post-Sept. 11, "the non-investors—people who don't understand about investing—they're the type of people who probably are going to overreact," Mr. Falcone said. "From a risk tolerance standpoint, they probably shouldn't have been where they were in the first place."

Employees taking a longer-term investment approach might evaluate the performance of their investments and consider changing allocations, he said.

"I think you're probably going to see a lot of rebalancing and rethinking—'What happened with my account in 2000?' " Mr. Falcone said. "I think you're going to see a lot of people at the end of the year look at where they are and make changes."

"We haven't seen as much of a flight to safety as one would think," Watson Wyatt's Mr. Metzger said. And what movement there was among 401(k) investments tended to be focused on current contributions "being a little more balanced and less aggressive," he said.

Mr. Metzger noted that employees often make an allocation decision once and then don't adjust allocations as their portfolios change with market fluctuations. "Most employees don't rebalance," he said, so some employers are considering providing plans that offer automatic rebalancing.

Among other changes employers are discussing in the economic downturn is reducing plan matches. While there has been more talk than action on that front so far, the instances where it has been done have been prominent. Ford Motor Co., for example, recently said it would eliminate its matching contribution to its salaried workers' 401(k) plan (see story, page 3).

"Probably for the first time in a long time, we've had questions from sponsors about what other sponsors are doing—are they changing their match because of the economy?" Mr. Falcone said. "We've heard a lot of talk about that. We haven't seen a lot of action yet."

Mr. Metzger said he knows of a couple of "very large, visible companies that are cutting their match," though these are rare.

"Cutting the match is one of the last things a company will do when they're looking to save money," he said. "Employee satisfaction and employee morale are still very important. Employers who are looking at these short-term economic blips are loath to make changes to benefit plans. However, there are some companies out there that are distressed."





# Directories approaching

*Business Insurance* will publish its annual directories of case management services providers and prescription benefit managers on Feb. 11, 2002. That issue will include a Spotlight report on managed care trends and issues.

To be included in the case management directory, a company must directly sell case management services on an unbundled basis directly to corporate or institutional employers. *BI* defines case management as coordinating and monitoring treatment for catastrophic, complex or prolonged illnesses and injuries.

To be included in the PBM directory, a company must provide general prescription benefit management services to corporate and institutional employer clients on an unbundled basis. Companies that provide services only to third-party vendors, such as insurers or HMOs, will not be included.

If your company qualifies for either directory and has not received a questionnaire, please download one at *www.businessinsurance.com* or contact *bidirectory@crain.com*.

Questionnaires for these directories must be returned by the Jan. 11 deadline.

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# Property/casualty industry's behavior puzzling

By MYRON PICOULT
and JODI PICOULT

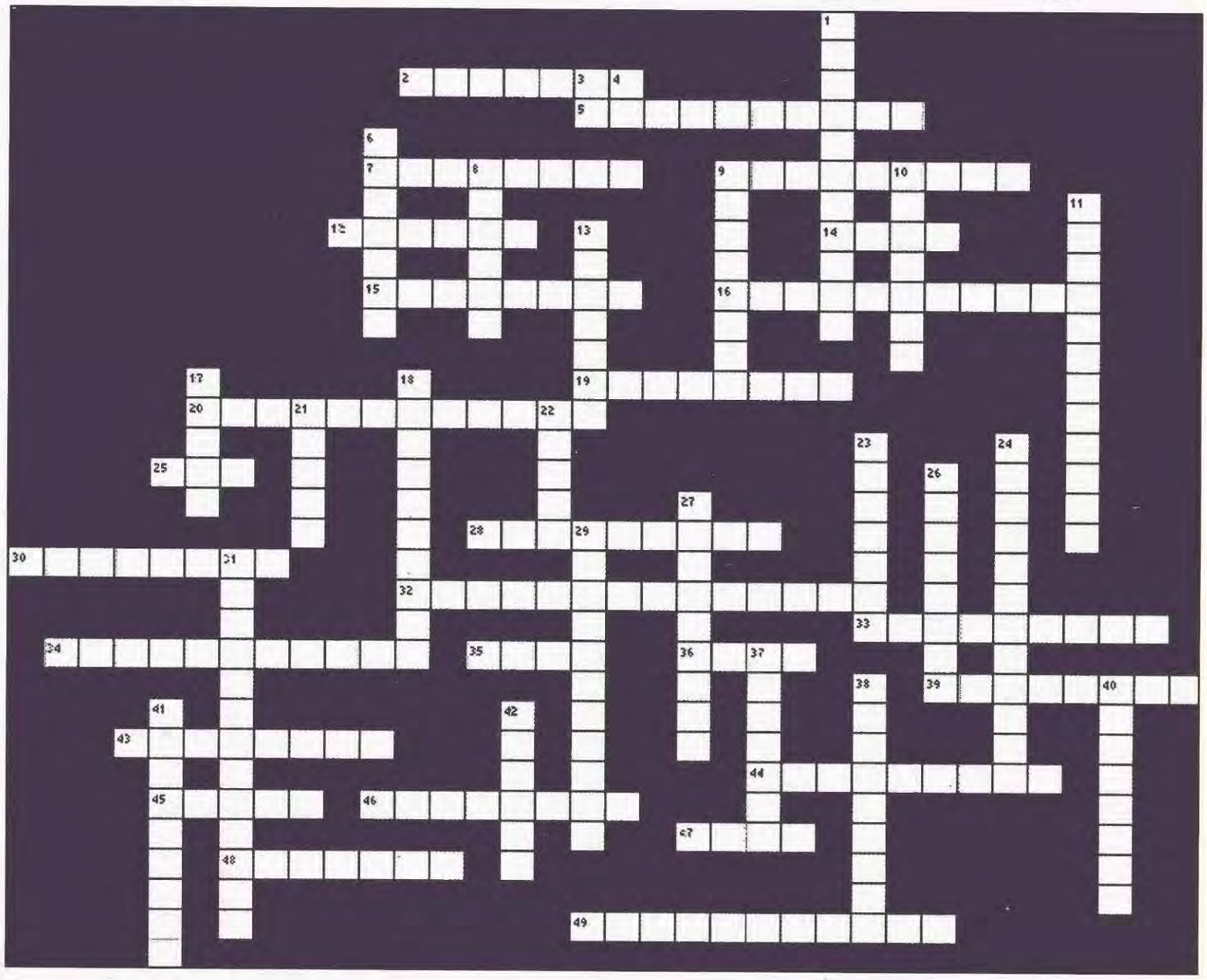
In past years, in tune with the season, we have conveyed our year-end thoughts on the state of the property/casualty industry through rhyme and verse. For many years, we were drawn to Clement Clarke Moore's classic poem, "A Visit from St. Nicholas." This year, we decided to make a bit of a change and came up with a crossword puzzle.

The deficient pricing and compromised underwriting standards used by most insurers in recent years finally started to take its toll. Managements began to take corrective actions that were beginning to show some promise, albeit the quagmire ran far and deep. Then came the horrific acts of Sept. 11 and the industry was faced with its biggest loss. Clearly, a hardening market has evolved into a much harder market.

Logic says that the improved pricing and underwriting trends should prevail for a while. Unfortunately, logic has not worked well in the property/casualty business. It is a business that traditionally has not been able to withstand prosperity. Perhaps it will be different this time. A rapid buildup in retained earnings, however, could be the industry's undoing. Only time will tell.

In any event, aided once again by my 35-year-old elf, Jodi Picoult (who is publishing her ninth book in the spring of 2002), the following puzzle arose.

*Answers to the crossword puzzle will be published in the Dec. 24 issue of* Business Insurance.



## ACROSS

2. The newest CEO in the industry.
5. Don't take it "personally"...the primary beneficiaries of the hard market are _____ lines.
7. Costs, which are still too high.
9. Former CEO whose "Lease" ran out.
12. Length of an insurance cycle, or coveted collegiate professor's prize.
14. Opposite of the last decade's soft market.
15. Source of recurrent claims, which, contrary to beliefs, did not dry up like dust.
16. Along with 20 Across, an two-word oxymoron for monies owed to insurers.
19. Extra armed forces, or money put up to pay future claims.
20. See 16 Across.
25. Firm headed up by Brian Duperreault; also, a WWI flying pro.
28. Related to, or having to do with money.
30. Co-dependent name for a venerable old insurer that hit the skids this year.
32. Difficult hurdle for new start-up companies.
33. Surname of fictional chairman highlighted in past Picoult Christmas pieces.
34. Reputation, a.k.a. what this industry lacks.
35. Name of one of the first new 2001 Bermuda start-ups.
36. Mascot of AFLAC's TV spots; Donald's cousin.
39. Opposite of specialty business: _____ lines.
43. The Chairman.
44. America's current war targets this, which reared its ugly head on 9/11.
45. _____ and conditions.
46. Industry gurus who have been far too optimistic.
47. Humble origin of penicillin as well as recent toxic claims.
48. Meteorological reason why Dorothy was not in Kansas anymore.
49. Adverse loss _____.

## DOWN

1. Shrinking; direction in which returns on equity had been going.
3. Air conditioner, for short.
4. Opposite of yes.
6. State regulation may have to be shared with this type of overseer.
8. After a premium is written, it is _____.
9. Workers comp company that was not as exemplary as some thought.
10. Site of the Angle.
11. Risk assessors.
13. Many of these folks had to be taught how to ask for a price increase.
17. The premium that's charged.
18. Good fortune, or something that this industry can't seem to stand.
21. The industry's "Dean;" or the airport at which you'd rather not make connections
22. Company that ran out of energy.
23. Paralyzed state of net investment income; or a car battery on a cold morning.
24. A piece of "the Rock."
26. International Business _____; or something most managements feel compelled to feed.
27. The ease with which one can buy and sell a stock.
29. Guaranty funds are a form of these.
31. Mixed; or the result of the loss and expense ratio added together.
37. "Upper-case" term for monies that are now being allocated by all insurers.
38. One step up from a tropical depression.
40. Misadventure; or the opposite of calendar-year results.
41. A form of charge-offs.
42. Insurers of Betty Grable's legs.

# French insurers form terrorism pool

## *Government reinsurance plan expected to aid risk managers*

By EDWIN UNSWORTH

**PARIS**—A government-backed reinsurance program for terrorism exposures will likely solve coverage problems for policyholders in France, but more details are needed before the pool-based system can be fully assessed, insurance executives and risk managers say.

Details on the structure of the pool are still being worked out and the expense of the coverage remains unknown, but, in general, the program should provide much-needed relief to insurers and their commercial policyholders, they say.

The Federation Francaise des Societes d'Assurances, the French insurers' association, announced last week an agreement under which state-owned reinsurer Caisse Centrale de Reassurance will cover insured losses from acts of terrorism above an annual accumulated level of 1.5 billion euros ($1.33 billion). Insurers and reinsurers will form a pool to pay for terrorism-related losses up to that amount.

Guillaume Rosenwald, FFSA member responsible for market damage assessment and liability insurance, said the association is working with insurers and reinsurers now to establish the pool. The aim, however, is to create a first layer of coinsurance of 250 million euros ($222.4 million) for which primary insurers would be responsible; a second 750 million euro ($667.1 million) layer of reinsurance; and then a 500 million euro ($444.7 million) layer for which the CCR would pay claims but be reimbursed by insurers over 10 years.

With details of the pool still being worked out and not widely made public, however, policyholders, which are anxious to complete their Jan. 1 renewals, believe they need more information about the program.

Franck Baron, associate corporate risk manager of Paris-based food manufacturer Groupe Danone, welcomed the agreement, saying he is "quite happy to see that a solution has been found." But key questions are still unanswered, he said. Namely, how much will terrorism coverage cost under the program and how will claims be paid? he asked.

For example, if there is a terrorism-related property claim, would the lead property insurer pay the entire claim and then settle with the pool members, or would each pool member pay its own share of the claim directly to the policyholder, he asked.

Marie-Claude Delaveaud, risk manager for Paris-based St. Louis Sucre S.A., said, "We don't know the details of the agreement.... Nothing is clear or obvious."

She said, for example, policyholders don't know if the 1.5 billion euros is the amount for the marketplace or if there is a deductible.

Ms. Delaveaud noted, too, that the agreement comes very late in the year. She said it is estimated that around 15% of French companies will not have full coverage on Jan. 1, and that about 50% may not have property coverage. With pre-

See FRANCE/next page

ARIMA CONFERENCE

# Need to return to profit fueling rate hikes, exec says

By KATE TILLEY

**CANBERRA, Australia**—Risk managers next year will face sharp rate increases and find some coverages scarce, says the head of Lloyd's of London.

As a result of the Sept. 11 terrorist attack in the United States, capacity for certain types of coverage will shrink, Lloyd's Chairman Sax Riley told attendees of the Association of Risk & Insurance Managers of Australasia's recent national conference in Canberra, Australia. Coverages most affected by the terrorist attacks, he said, include aviation, business interruption and liability.

Mr. Riley

"Clearly, risks that do not aggregate, correlate or introduce systemic risk are most attractive to the market," he said.

Mr. Riley said losses from the attack could not yet be quantified. "It may take years before we can really settle on an accurate figure," he said.

Loss estimates from various industry sources have run as high $80 billion. Lloyd's estimates that its net exposure to the attack is £1.90 billion ($2.68 billion) (*BI*, Dec. 3).

Mr. Riley said the attack would affect rates as well as the industry's solvency and capacity for years to come. The Sept. 11 losses likely will lead to some individual company failures, but the industry as a whole will withstand the loss, he said.

And, he said, the industry is not profiteering by imposing large rate increases, which are "needed to preserve a healthy, robust insurance and reinsurance industry."

Many property underwriters previously provided terrorism coverage without charging an additional premium, as the chance of terrorist attacks was considered slight.

"Now, as underwriters look at that business, they have to make judgments about what terrorists will do next, what countries will be affected and what the impact on reinsurance availability will be," Mr. Riley said. "Many underwriters now adopt the position that reinsurance will not be available. Although this is purely a theoretical position, it allows them to adjust their books accordingly.

"In short, underwriters have no choice but to return to the notion of needing to make a gross underwriting profit over the next few years," Mr. Riley said.

ARIMA CONFERENCE

# Inattention led to failures

By KATE TILLEY

**CANBERRA, Australia**—A lack of corporate governance and sound risk management were common factors in the collapse of several major Australian corporations this year, says Bruce Ferguson, the president of the Assn. of Risk & Insurance Managers of Australasia.

Speaking at ARIMA's 25th annual conference, Mr. Ferguson, who is also risk and insurance manager with Sydney-based Sydney Water Corp., cited the failures of HIH Insurance Ltd. of Sydney, Ansett Airlines Ltd. of Melbourne, telecommunications company One.Tel of Sydney and retailer Harris Scarfe Ltd. of Adelaide.

In a separate presentation, Rick Sarre, associate professor of law and criminology at the University of South Australia in Adelaide, told delegates that a massive change in corporate culture is needed to prevent businesses from going under. Mr. Sarre said that common themes in corporate failures are greed, a failure to remember that booms always end in busts and regulatory inadequacy.

See ARIMA/next page

# Asbestos liability rejected

**LONDON**—A decision by the U.K. Court of Appeal last Tuesday may make it harder for some asbestos claimants to win compensation from employers.

Individual mesothelioma victims who have been exposed to asbestos at more than one workplace must be able to prove where they were employed when they contracted the disease to claim compensation, the court ruled. Mesothelioma—a malignant tumor, usually of the lung—can be caused by exposure to a single fiber of asbestos and is usually fatal.

In *Fairchild vs. Dovener, Waddingtons and Leeds City Council*, the court considered appeals from six claimants who had developed mesothelioma. In three of the cases, the victims had been exposed to asbestos from more than one source, and the judges were asked to determine whether any or all of the employers involved should be held liable for the resulting disease.

The judges ruled it was impossible to determine which asbestos fibers had caused mesothelioma and that it was, therefore, impossible to determine which employer was liable.

Halliwell Landau, a Manchester, England-based law firm that represented one of the employers in the case, hailed the ruling as "one of the most significant decisions in the history of insurance law."

"The decision will be of deep interest to insurers, since it profoundly affects a growing problem—how to meet the challenge of the ever-growing number of mesothelioma claims," said Chris Phillips, head of insurance litigation at Halliwell Landau, in a statement.

U.K. mesothelioma claims are not expected to peak until 2020, and each successful claim is usually valued at £100,000 to £150,000 ($143,330 to $214,995), excluding costs, he said.

*— By Sarah Veysey*

# World Updates

## FSA to regulate nonlife brokers

The Financial Services Authority will take over the statutory regulation of U.K. nonlife insurance brokers. The London-based FSA, the U.K. financial services regulator, will assume the responsibility as regulator of the nonlife brokering industry from the voluntary self-regulating General Insurance Standards Council. The move comes in response to the European Insurance Intermediaries Directive, agreed to on Nov. 26, which requires E.U. members to introduce the statutory regulation of general insurance and reinsurance intermediaries.

## ATI reaches deal with Gerling

The African Trade Insurance Agency signed an agreement with two units of Cologne, Germany-based Gerling Group to allow individual companies trading with and within Africa to buy single policies to cover commercial and political trade risks. Under terms of the deal, Gerling Namur Insurances of Credit and Gerling Credit Emerging Markets will operate a joint underwriting management program with ATI. ATI will issue and manage the credit policies, which Gerling will underwrite. The pan-African ATI, which is sponsored by the World Bank, was created in August to encourage foreign investment in Africa.

## Zurich completes Converium IPO

Zurich Financial Services has completed its initial public offering of Converium Holdings A.G., the rebranded Zurich Re. ZFS sold 35 million shares, representing 87.5% of Converium's share capital. Shares will trade on the SWX Swiss Exchange and the New York Stock Exchange. The global offering was priced at 82 Swiss francs ($49.42) per registered share or $24.59 per American Depository Share. Each ADS represents one-half of one registered share. Zurich said the IPO raised $1.1 billion net of expenses and Zurich's capital contribution to Converium. Gross proceeds of about $2.0 billion were in line with expectations.

## Azema to head French mutual group

Federation Francaise des Societes d'Assurance Mutuelle has elected Jean Azema, chief executive officer of Groupama-GAN S.A., as president. He succeeds Christian Sastre. Mr. Azema has spent his career at Groupama, both in its regional offices and in its Paris headquarters, where he has been CEO since June 2000. The FFSAM comprises 122 mutual insurers.

# France: Pool to cover terrorism

**Continued from previous page**

miums already anticipated to rise by 35% to 80% for industrial risks, there is also worrying uncertainty of what buyers will end up paying, she added.

The FFSA has welcomed the agreement, which it helped negotiate. "The solution will make it possible to cover all insureds against the risk of acts of terrorism in France," an FFSA statement said.

Mr. Rosenwald was less positive, however. "It's a very bad solution, but it is the only one. It will be very bad because it will be a very expensive solution for the insurers and for the insureds," he said. FFSA members will decide on Monday whether to participate in the pool, he said.

AXA Corporate Solutions, a unit of France's largest insurers, AXA S.A., which was instrumental in pressing the government to provide help when it said last month it would not be renewing terrorism cover in the current renewals, said it would join the pool.

Patrick Cerceau, the insurer's marketing and communications director, said the market is "in a far better position" following the agreement. He believes that French insurers and reinsurers will widely support the pool. And, despite the agreement coming late in the year, Mr. Cerceau believes it will not cause undue problems for clients of companies like AXA Corporate Solutions, which has been negotiating renewals on the basis that an agreement would be reached.

Reinsurers are assessing whether they will join the pool.

Jamie Veghte, director general-designate of French reinsurer Le Mans Re, said the company is awaiting further details of how the pool will operate. "In principle, we think this is a good idea for an industry and governmental approach to a very difficult problem of enormous complexity," he said.

The availability of coverage for terrorism risks became particularly problematic in France after the Sept. 11 terrorist attacks in the United States. French commercial property insurers are required to offer terrorism coverage up to the overall limits of a property policy. The law, however, places no such requirement on reinsurers, and several reinsurers have indicated that they will exclude terrorism risks when they renew coverage.

Insurers have been turning down renewals of large property/casualty risks, fearing that they would be overexposed. Last month, AXA S.A. announced that it would cease offering automatic renewals on large commercial policies (*BI*, Dec. 3).

With major corporate policies due for Jan. 1 renewals, it had been widely expected by that that the French government would assist with a solution.

The CCR had already guaranteed coverage for terrorist risks for aviation risks, following Sept. 11.

Meanwhile, insurers in Germany are seeking to establish a similar arrangement.

The federation of German insurers, the Gesamtverband der Deutschen Versicherungswirtschaft e.V., is trying to put together a pooling arrangement involving its members, but has been unable to get an agreement on the level of capacity to be made available.

# ARIMA: Attention to risk urged

**Continued from previous page**

But strengthening regulations and laws does not necessarily prevent collapses, he added.

"Bolstering the laws is an inept response," Mr. Sarre said. Instead of preventing a failure, such an effort only "mops it up afterwards."

After corporate failures, he said, it is common for directors to claim ignorance, for auditors to claim they had been given incorrect information, and for regulators to claim they were underresourced.

"All that illustrates that liability avoidance—rather than risk management—is alive and well in the world of corporate governance," he said.

Mr. Sarre said that businesses must do more than merely meet minimum regulatory requirements; they must build organizational pride and develop corporate social responsibility.

Corporate social responsibility is about developing "a vigilant and constant awareness of the possibility of wrongdoing, a personal ethic of care and an assumption of individual responsibility for the consequences of one's actions," he said.

One notion that Mr. Sarre cited as a complement to corporate social responsibility is the "triple bottom-line concept." According to this concept, he said, the success of a business is measured by positive financial, social and environmental developments. "We have a duty to future generations to rethink the way we do business and to use new criteria to judge its success and prevent its demise," he said.

Other conference speakers echoed Mr. Sarre's call for organizations to focus more on corporate governance.

In a separate presentation, Clare Endicott, a director of Brisbane-based Queensland Rail Corp., said the rail network has adopted an enterprise-wide approach to risk management and established a board-level risk management committee. Queensland Rail, owned by the state of Queensland, maintains Australia's largest rail network, with more than 5,800 miles of track and annual revenue of more than $2.0 billion Australian ($1.04 billion).

Ms. Endicott said the risk management committee identified three key areas of risks—business, operational and financial—and implemented strategies to handle each.

The rail company also determined that it could reduce its insurance costs by establishing a captive insurer. That facility—On Track Insurance Pty. Ltd.—has been in operation for a year.

Lynn T. Drennan, head of the division of risk at Caledonian Business School in Glasgow, Scotland, said risk management is now recognized as much more than loss prevention, and is regarded as an essential element in an organization's strategic planning and in the achievement of corporate objectives.

"Corporate governance demands that risk management is monitored as to its appropriateness and effectiveness, and that it is embedded throughout the organization. This embedding may require some cultural change," Ms. Drennan said.

Employees must understand that risk management is part of everyone's job description. "If risk management becomes a box-ticking exercise, then the potential for real management of risk—for the benefit of the organization, its members and staff and the public—will decline," Ms. Drennan told delegates.

Joshua I. Owen, director of Sydney-based risk management consultant Joshua Owen & Associates, said that responsibility for risk management is too important to be delegated to just one employee, no matter how senior that person might be. "The buck should stop with the chairman of the board, who also chairs the risk management committee," Mr. Owen said.

"Far too many organizations are either collapsing or cutting ethical corners. As organizations face more global competition, it is incumbent on them to take measures to ensure that their leaders operate under sound principles of corporate governance and risk management," he said.

## *ARIMA hosts 25th conference*

**CANBERRA, Australia**—About 300 delegates attended the 25th annual conference of the Assn. of Risk & Insurance Managers of Australasia, held Nov. 18-21 at the National Convention Center in Canberra, Australia.

The theme of the conference was "Risk Management, the Foundation of Effective Corporate Governance."

The 2002 conference, whose theme will be "Limiting Liability: Legislation and Litigation," will be held Nov. 17-20 in Perth, Western Australia. For information, phone Intermedia Convention & Event Management, 61-7-3858-5525, or contact by e-mail at *arimaconf@im.com.au.*

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# Union Carbide : Appeals court issues mixed ruling

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ment then sued Union Carbide in U.S. federal court.

In May 1986, Judge Keenan dismissed the suit on the condition that Union Carbide submit to the authority of Indian courts, where the Indian government began proceedings a few months later.

In addition, Indian authorities filed criminal charges in connection with the toxic gas leak. Union Carbide; Warren Anderson, who was the company's chairman and chief executive officer in 1984; UCIL; and others were charged with culpable homicide, causing death by use of a dangerous instrumentality and causing grievous injury.

In two rulings in February 1989, the Supreme Court of India approved a civil settlement in which Union Carbide would pay $425 million and UCIL would pay $45 million to the Bhopal claimants.

The court quashed the criminal charges at that time but reinstated them in October 1991.

When Union Carbide and Mr. Anderson refused to appear to answer the charges, an Indian court ordered the attachment of Union Carbide's remaining Indian assets—its majority interest in UCIL.

Before the attachment order was issued, however, Union Carbide sold those holdings for about $90 million, according to court papers. The company contributed the proceeds to a trust set up to fund a new hospital in Bhopal.

In the latest litigation in U.S. courts, the Indian plaintiffs alleged that Union Carbide and Mr. Anderson violated the 1989 settlement. They sought additional compensation for the Bhopal victims under the U.S. Alien Tort Claims Act.

The 2nd Circuit panel's ruling upholds Judge Keenan's August 2000 dismissal of those claims.

The appeals panel rejected the plaintiffs' argument that Union Carbide and Mr. Warren breached the 1989 settlement by refusing to answer the criminal charges against them. Those charges never were part of Union Carbide's civil liability settlement, the panel ruled.

Additionally, the panel noted, "the Bhopal Act and the 1989 settlement orders make it clear that the settlement precludes the sort of claims brought by the plaintiffs under the ATCA."

The appeals panel also dismissed the plaintiffs' assertion that Union Carbide breached the settlement by using its UCIL sale proceeds to finance a new hospital in Bhopal.

The appeals panel was troubled, however, by Judge Keenan's unexplained decision to dismiss the plaintiffs' claims that the UCIL plant caused environmental contamination before and after the 1984 gas leak.

Those claims are based largely on a 1999 report by the environmental group Greenpeace. Quoting the report in their complaint, the plaintiffs contend there is "substantial and, in some locations, severe contamination of land and drinking water supplies with heavy metals and persistent organic contaminants both within and surrounding the former UCIL pesticide formulation plant."

Twenty-one percent of the facility's premises was designed for waste disposal, and a drain from the plant carried away hazardous materials into the ground under the plant, the plaintiffs assert.

The plaintiffs—contending that Union Carbide designed the Bhopal plant and its systems and operations and regularly inspected it—alleged that the company "knew or was reckless in not knowing about the historical improper handling of hazardous material" there.

But defense attorney William A. Krohley said Union Carbide was not involved in designing or operating the Bhopal plant and that the plant disposed of waste in accordance with Indian regulations.

Also, the company has had no role in overseeing the plant since it was shut down after the 1984 gas leak, said Mr. Krohley, a partner with Kelley Drye & Warren L.L.P. in New York. Indian authorities have controlled the facility since then, and the plant's new owner relinquished the facility to the state of Madhya Pradesh years ago, he said.

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*Sajida Bano et al. vs. Union Carbide and Warren Anderson, 2nd U.S. Circuit Court of Appeals, Nov. 15; Docket No. 00-9250.*

# St. Paul: Insurer exiting med mal to raise profits

Continued from page 1

chief financial officer and executive vp at The St. Paul. "That decision for us is based on our view of the economics of the business."

Going forward, "if we thought this was a business we could have stayed in and had adequate returns on, we would have stayed in," Mr. Bradley said.

Earlier this year, The St. Paul clashed with Georgia insurance regulators when it moved to withdraw from writing medical malpractice coverage there on an admitted basis (*BI*, July 23).

As for the other businesses from which The St. Paul is withdrawing, "that really is a very sharp narrowing of the focus, maybe not feeling a need to be in every business in every part of the world, " the company's CFO said.

John W. Wicher, principal at insurance investment bank John Wicher & Associates Inc. in San Francisco, suggested that with no "legacy" in any of The St. Paul's business segments, Jay S. Fishman, who joined the company in October as chairman and chief executive officer, can do what's needed to improve financial performance.

"It was not a surprise," Mr. Wicher said. "It just took someone like Jay Fishman to roll up his sleeves and clean up the dead rat off the kitchen floor."

The St. Paul will record an estimated fourth-quarter pretax charge of $900 million, including $600 million in increased medical malpractice reserves. For the year, the company expects its medical malpractice business to produce a $940 million underwriting loss.

"That's been a troubled business group for them," said Mr. Wicher. "Management has said for the last couple of years that they have deep concerns about the business."

"It's absolutely shocking" but could have been expected "in light of the trouble they have had in health care and the amount of reserves they have put up and their strategy going forward," said E. Dow Walker Jr., chairman of the national health care practice at Willis North America Inc. in Nashville.

"St. Paul was well respected," Mr. Walker said. "Outstanding underwriters, great company, dedicated to the business, and I guess the shocking thing is how did this company—great company, such bright people—get it so wrong?"

With The St. Paul's acquisition of medical malpractice insurer MMI Cos. Inc. last year (*BI*, Jan. 3, 2000)—a move analysts heralded at the time for its expansion of St. Paul's market reach—it may have became more difficult for The St. Paul to succeed in the malpractice market.

Earlier this year, another leading medical malpractice insurer—PHICO Insurance Co.—was ordered into rehabilitation after falling victim to its own rapid growth in a soft market and the marketwide trend toward increasingly severe malpractice claims (*BI*, Aug. 27).

The industry's combined ratio for medical malpractice has been climbing year by year, reaching 130% in 2000. Increased claims activity, higher awards and rising reinsurance prices all are making the medical malpractice business a more difficult one in which to succeed, Mr. Wicher said.

"All of these companies whose strategy was growth on the top line either are not around or have serious problems and are retrenching," Mr. Walker said. "It is a line of business that is not one that is played well by the entrepreneurs."

While The St. Paul's departure from medical malpractice will no doubt be felt, most think there will be adequate capacity in the market, with physician-owned mutual insurers—so-called "bedpan mutuals"—likely to play a bigger role.

Others will move in, "but it's a matter of supply and demand and there's a limited supply of capacity," said Mark L. Hubbard, senior vp for human resource management and risk management at the Loma Linda University Adventist Health Sciences Center in Loma Linda, Calif.

"Our biggest concern as a health system is going to be dealing with the issue of how many physicians will end up without any insurance or need to change their insurance," said Dale L. Schultz, vp of business health at Banner Health Systems in Phoenix.

"We're well into a contingency plan to make sure there are stable markets and all our physicians are insured," Mr. Schultz said.

"The first option is the bedpan mutuals....Then, the second choice is the commercial carriers," he said. Banner also has put together a risk purchasing group as an alternative if physicians can't find other markets.

"I believe there is capacity to absorb the St. Paul book," Mr. Walker said. "The question is, at what price and with what sort of terms."

# Chase: AXA unit loses lawsuit over film losses

Continued from page 3

verdict.

"We always felt strongly that AXA's charges were utterly without merit, and the fact that the jury took less than four hours to agree after sitting through six weeks of testimony suggests that they must have shared that view," said Stephen A. Crane, the chairman and chief executive officer of Stirling Cooke, in a statement.

The verdict follows a July decision by a U.K. appeals court that severely limits insurers' ability to rescind policies issued on Chase-financed films produced by Los Angeles-based Phoenix Pictures Inc. The July ruling, in a case Chase filed against HIH Casualty & General Insurance Ltd., AXA and others, held that insurers must prove fraud—rather than merely misrepresentation or failure to disclose facts—to void the policies.

Chase has filed claims totaling more than $38 million on two Phoenix films—the Barbara Streisand flop "The Mirror Has Two Faces" and "The People vs. Larry Flynt."

Insurers are appealing the July ruling to the House of Lords.

Numerous other film finance suits are pending in the United Kingdom, including actions filed by Chase on films produced by Paramount Pictures Corp. and actions filed by Royal Bank of Canada and Paris-based Groupe Societe Generale on several other films, court filings and lawyers involved in the cases say. A London High Court judge has scheduled a case management conference on all the U.K. litigation for Dec. 20.

More cases, meanwhile, are pending in the United States. In addition to the case regarding "The Crew," Chase has filed four suits in New York Supreme Court against AXA, New Hampshire and others over films produced by London-based J&M Entertainment Ltd., along with a fifth suit against New Hampshire related to another money-losing movie, "Looking for an Echo." In these suits and the complaint on "The Crew," Chase is seeking to recover a total of $60 million, including interest, according to John N. Thomas, a lawyer with Morgan Lewis & Bockius in New York, representing the bank. Still other suits have been filed in California courts. These include:

- Three complaints filed in federal court in Los Angeles by Santa Clara, Calif.-based Silicon Valley Bank for roughly $35 million in unpaid claims on loan losses stemming from five films, all from small independent producers and some never released. Insurers named variously in the suits are AXA, New Hampshire, AIG Europe (U.K.) Ltd., Great Lakes Reinsurance (U.K.) Ltd. and Royal & SunAlliance Insurance P.L.C.
- Two suits filed in California Superior Court in Los Angeles by Tokyo-based Fuji Bank for a total of $9.4 million in losses on two little-noticed films, "A Rumor of Angels" and "Green Sails." Both suits name Royal & SunAlliance, and one also names General Star International Indemnity Ltd., a London-based Berkshire Hathaway Inc. unit that reinsured Royal & SunAlliance subject to a cut-through endorsement, court papers show.

Yet another film lender, Los Angeles-based Imperial Bank, has settled all of its film finance disputes—numbering at least half a dozen—with AXA, AIG and General Star for substantially less than the amount of its original claims, according to sources familiar with the cases who could not comment on settlement amounts. Imperial Bank had a portfolio of more than $100 million in film production loans, court papers say. The bank was acquired by Detroit-based Comerica Inc. earlier this year.

An Imperial Bank official could not be reached for comment on the cases.

# Cost of risk: Survey registers longtime U.S. low

Continued from page 1

compared with those that responded to the report issued last year. These largest companies tend to have a lower cost of risk, the survey's authors said.

The number of large participants had such an impact on the results that it was the "most significant factor helping to drive down the overall U.S. cost of risk," in 2000, according to the survey.

Steve Lawrence, national practice leader for insurance risk management at Ernst & Young L.L.P. in New York, said that while overall risk costs are down, "there is a story behind the data." When the results are "normalized"—by taking out the additional large companies and comparing the data with that of the previous survey—the cost of risk actually increased by 3%, Mr. Lawrence explained.

RIMS and Ernst & Young co-produce the annual survey, which is published as a benchmarking tool for risk managers. The survey defines the cost of risk—a concept developed in 1962 by former RIMS President Douglas Barlow—as made up of expenses related to the following: insurance premiums; retained losses; internal administration; outside services, including consulting, captive management and other vendor services; financial guarantees; and fees, taxes and similar expenses.

The 2001 survey was compiled from responses to a questionnaire by 837 participants in the United States and Canada, including risk managers, deputy members of RIMS and certain Ernst & Young clients.

It shows that just as the cost of risk declined in the United States, Canadian employers saw their cost of risk fall, dropping 34.7% in 2000, to $1.88 Canadian per $1,000 Canadian of revenue. The 1999 figure of $2.88 Canadian represented a 65.5% increase over the 1998 cost of risk.

Canadians saw a lower cost of risk as a result of falling premiums and fewer losses among the respondents. The survey said the Canadian results also reflected the fact that, on average, the size of the Canadian company respondents in the latest survey was much larger than those for the previous survey.

The producers of the survey are quick to point out that, even though the greater representation of large companies affected the 2000 data, the report remains a useful benchmarking tool. They say that the survey, when used properly and in concert with other information, can provide risk managers with a helpful way to gauge and lower their costs.

"This is a source of information, a good source of information, but it should be used with other information," Mr. Welgoss said. He suggested risk managers exchange information with peer companies to "get at the root of the differences in the cost-of-risk figures for one firm vs. another. That's how we come up with ideas on how to reduce the costs."

Mr. Lawrence said risk managers would find useful the survey's data on individual industry sectors. Those sections provide the demographics of respondents for particular industries and information on the cost of risk and other risk management measures for each industry. Particularly helpful is information that allows insurance buyers to determine whether they are in line with their industry peers in purchasing liability limits or keeping deductibles and retentions, he said.

In 2000, U.S. risk managers saw their liability risk costs rise 19.1% from the previous year, to $2.24 per $1,000 of revenue. Liability premiums, meanwhile, decreased 7.2%, to 64 cents per $1,000 of revenue.

Higher retained liability losses contributed to the increasing cost of liability risks. Those retained losses rose 35%, to $1.62 per $1,000 of revenue.

U.S. insurance buyers saved money on property risk costs in 2000, with those costs falling 20%, to 68 cents per $1,000 of revenue. Property premiums fell 17.3%, to 43 cents per $1,000 of revenue.

Retained property losses per $1,000 of revenue dipped 24.2%, to 25 cents in 2000. As in 1999, fewer catastrophic losses among respondents contributed to the decline, according to the survey.

The survey shows that workers compensation costs for U.S. respondents decreased 8.4% in 2000, to $1.86 per $1,000 of revenue. Much of the decrease was in retained losses, which fell 10.3%, to $1.40 per $1,000 of revenue. Premiums dropped one penny in 2000, to 46 cents per $1,000 of revenue.

When the data excludes the eight largest respondents and is analyzed for comparative purposes, it shows that overall workers comp costs rose 28.5% overall, to $2.39 per $1,000 of revenue.

Administrative expenses were virtually flat in both the United States and Canada. Those costs rose one penny in the United States, to 42 cents per $1,000 per revenue, and fell one penny in Canada, to 19 cents Canadian per $1,000 Canadian of revenue.

Canada's declining cost of risk in 2000 follows a sharp increase in 1999 that was could be blamed, in part, on retained losses and changes among the mix of survey respondents. The $2.88 Canadian per $1,000 Canadian of revenue in 1999 was up 65.5% over the previous year.

The lower cost of risk in Canada last year was influenced, in part, by falling liability risk costs. In contrast to rising U.S. liability costs, those expenses in Canada fell 35.2%, to 70 cents Canadian per $1,000 Canadian of revenue.

Liability premiums fell 31.3% in 2000, to 33 cents Canadian per $1,000 Canadian of revenue. Self-assumed losses fell 30.2%, to 37 cents Canadian per $1,000 Canadian of revenue.

Property costs in Canada saw an even larger drop in 2000, falling 40.4% to 99 cents Canadian per $1,000 Canadian of revenue. The drop comes after property costs more than doubled in 1999 over 1998. A 57% decrease in the amount of retained losses helped drive down the cost in 2000.

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*Individual copies of the 2001 RIMS Benchmark Survey are available at a cost of $395 for RIMS members, $445 for associate members and $495 for nonmembers. Telephone orders can be placed at 317-843-2523; orders also may be sent by fax to 317-816-1001.*

# Hewitt: Survey finds cost is major worry for employers

Continued from page 3

practice leader in Lincolnshire, Ill.

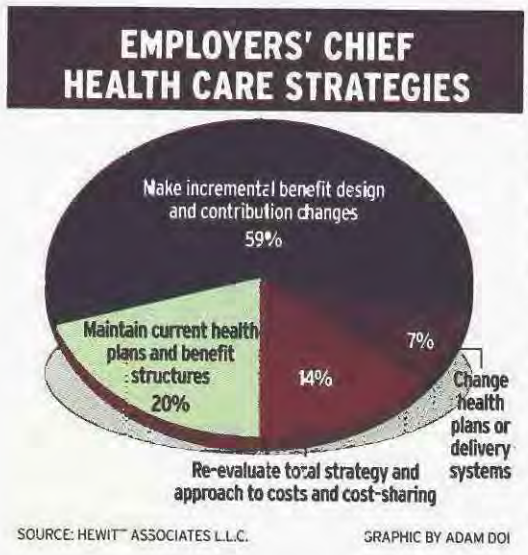
While many employers say they are prepared to absorb some hefty cost increases—30% say they can absorb, over the next five years, annual increases of up to 10%, and 18% say they can absorb annual increases of 8%—projected increases are likely to exceed that. Several recent surveys report that next year's health care increases are likely to average 12% to 15%, with no immediate prospect for a lessening of double-digit cost increases.

With those kind of increases looming, most employers will use a familiar strategy—cost shifting to employees—to deal with increases rather than adopt radical new plan designs.

"Employers have faith that cost shifting will help stem the tide, at least in the short run," said Jack Bruner, a Hewitt national practice leader in Lincolnshire, Ill.

"Succinctly put, if employers expect 12% to 15% cost increases, and the most they can afford is 8%, they will have to rely on cost-shifting," Mr. Bruner added.

Nearly 60% of respondents said in the coming year their chief health care strategy will be to make incremental benefit design and contribution changes, while 20% said they will keep their current health plans and benefit structures. Just 7% said they will change health plans or delivery systems, while 14% plan to re-evaluate their total strategy and approach to health care costs and spending.




In fact, a majority of respondents—87%—said they had either a moderate interest or primary focus in increasing employee premium contributions.

But cost shifting to employees generally will be modest. For example, 65% of employers say they will impose "moderate" increases in employee premium contributions, compared with 22% who say they will impose "aggressive" increases.

Employers, though, intend to take firmer action in the area of prescription drug copayments. This is because prescription drug cost increases over the last few years have outpaced cost increases for other health care-related services. According to the survey, 29% of respondents will seek aggressive increases in prescription drug copayments, while 45% will seek moderate increases.

While employee cost shifting—such as through greater employee premium contributions—is many employers' immediate strategy for dealing with soaring cost increases, they are open to new approaches, the survey shows.

For example, 78% of employers say they would be interested—so long as costs were cut—in a so-called multitier network, in which employees' inpatient deductibles would, for instance, vary depending on the cost of the service at hospitals where employees elect to have a service done.

In addition, 78% of employers said they would be interested in offering employees access to a broader choice of health plans arranged through a third party if the arrangement ensured a 10% cost reduction.

In another area, 5% of respondents say they would terminate health care coverage if legislation is enacted that would expose employers to greater liability for coverage decisions. However, 40% say they would designate a third party as a coverage decision maker, a strategy that would presumably provide greater insulation from liability.

*Free single copies of "Health Care Expectations: Future Strategy and Direction," are available from Publications Desk, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60069; 847-295-5000 or e-mail to* infodesk@hewitt.com.

# Court: Ex-employees' suits for discrimination upheld

Continued from page 3

Congress is now considering as well (*BI*, Nov. 5).

James Johnson had worked for Kmart Corp. since 1967 but left in 1996 when his physician advised him to stop because of mental illness. Under Kmart's LTD plan, employees who are disabled because of mental illness may receive salary-replacement benefits for just two years, while those disabled because of a physical illness may receive these benefits until age 65. Mr. Johnson sued Kmart under the ADA, charging discrimination.

In its Nov. 21 decision, the court concluded Mr. Johnson could sue under the ADA even though he was a former employee. The decision points to the U.S Supreme Court's 1997 decision in *Robinson vs. Shell Oil Co.*, which allows suits by former employees under the 1964 Civil Rights Act.

The court then turned to the issue of less generous benefits for mental than for physical disabilities. Kmart's policy "appears prima facie to distinguish among beneficiaries on a basis that constitutes a form of discrimination contravening" the ADA, says the decision.

The decision says, however, that the law's safe harbor provision may apply. This exempts an employer from liability for a bona fide benefit plan, provided it is not being used as a subterfuge to evade the ADA's purposes. Mr. Johnson must prove "that the employer specifically intended to discriminate based on disability," says the decision.

Henry Saveth, an attorney with William M. Mercer Inc. in New York, said previous appellate courts "just have held as matter of law that as long as all participants in the plan, whether disabled or not, were eligible for the same benefits, it's acceptable for the benefits to be different for certain conditions."

He said it is possible the full appellate court will either reverse the panel's decision or that the U.S. Supreme Court may eventually consider the issue.

**The end of employment 'doesn't necessarily mean that the nondiscriminatory treatment obligation ends as well.'**

*Jeremy J. Glenn*
*D'Ancona & Pflaum*

Kmart's attorney, Richard Antonelli, of Littler Mendelsohn in Pittsburgh, said the company has filed for a rehearing by the full court.

Lorraine Davis, assistant general counsel for the Equal Employment Opportunity Commission in Washington, which submitted an amicus brief on Mr. Johnson's behalf, said the decision supports the EEOC's position that it is discriminatory to treat one disability less favorably than another. She said although several federal appellate courts have ruled contrary to the 11th Circuit on this issue, the decision may be influential with other courts.

The *Smith vs. BellSouth* case involved Arthur Leroy Smith, who resigned as a BellSouth service representative in October 1998. He had taken leave under the FMLA while working at BellSouth. He unsuccessfully reapplied in January 1999. While talking with a former supervisor about Mr. Smith, a BellSouth staffing manager wrote notes that said "took a lot of FMLA, attendance bad, work ethic bad, abusive, temperamental." At the bottom of the note, she wrote and underlined, "Do not rehire."

After analyzing the statutory and regulatory language and other court decisions, the appellate court concluded Mr. Smith could sue under FMLA even though he is a former employee. "If former employees like Smith knew they would have no remedy if their former employers retaliated against them for their past use of FMLA leave, it would tend to chill employees' willingness to exercise their protected leave rights and would work against the purpose of the FMLA," said the decision. The case was remanded to the lower court for trial.

Mr. Smith's attorney, Heather Newsom of the Birmingham, Ala.-based Stewart Law Group, said this is only the second appellate court to rule this way—the 1st U.S. Circuit Court of Appeals in Boston was the first in a 1998 decision. This means "it is more than likely" that other courts considering the issue will rule the same way, she said.

*James Johnson vs. Kmart Corp., No. 99-14563, and Arthur Leroy Smith vs. BellSouth Telecommunications Inc., No. 00-15708, 11th U.S. Circuit Court of Appeals.*

## ADVERTISER INDEX

**Issue of December 17**



# Matching: Cost-cutting turns to benefits

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ing 401(k) contribution from to 20% from 60% of the first 6% of its salaried workers' contribution.

While few employers may eliminate their matching contribution, many are thinking about restructuring their program, said Lori Shapiro, principal with William M. Mercer Inc. in Philadelphia. One idea is to turn a fixed matching contribution into one that is partly fixed and partly based on the company's profits for the year.

In general, about half of plans have fixed contributions, while the other half varies, Mr. Wray said. While it's common for the profit-sharing to disappear in a down year, companies rarely eliminate the fixed contribution, he said.

Cutting the match does save money, but few take this step, out of concern of upsetting employees, said Greg Metzger, director of defined contribution consulting in the Sherman Oaks, Calif., office of Watson Wyatt Worldwide.

Despite the recession, employers are still struggling over talent, he said. Because a 401(k) plan is a visible benefit, cutting the match hurts recruitment and retention efforts. "Smart companies don't make it harder to attract talent," he said.

Cutting the match will also reduce the money that employees will save for retirement. As a result, employees will be forced to work longer. With fewer people retiring, the workforce in general will age, leading to higher medical, disability and compensation costs, he said.

When cutting a match, employers also should encourage participants to increase their own plan contributions, he advised.

Whatever employers do, they must do cautiously to minimize negative feelings, Ms. Shapiro said. This requires a long lead time to let employees adjust their contribution levels and let the employer communicate the changes clearly, she said.

To cushion the blow, some companies have been increasing other benefits. DaimlerChrysler is restarting its tuition reimbursement plan. Employees can get up to $6,000 per year for tuition leading to a college degree, a spokeswoman said. In addition, starting next year, Visteon has given its employees an immediate vesting of the company's previous 401(k) match in company stock. Currently, employees have to wait five years before they vest in that stock, a spokesman said.

# FTR

**[Week of 12/10-12/14]**

**This roundup of news from the previous week is generated by *BI*'s daily news reporting. To get breaking news as it occurs, log on to *www.businessinsurance.com*, or sign up online for free *BI* Daily News by e-mail.**

## Iordanou quits Zurich to join Arch

Constantine Iordanou, who had been senior executive vp of group operations at Zurich Financial Services Group, has joined Arch Capital Group Ltd. as president of Arch Worldwide Insurance & Reinsurance Group. He also will be a board member of the Bermuda-based holding company, Arch Capital Group. The move comes amid other top management changes at Zurich, including the appointment of James J. Schiro as chief operating officer-group finance. Mr. Schiro had been global chief executive officer of PricewaterhouseCoopers L.L.P. Zurich also appointed Peter Eckert COO-group operations and business development. Mr. Eckert had been CEO of Zurich's Continental Europe division.

Mr. Iordanou

## Insurers forge dispute resolution pact

Nine insurers and their affiliates will attempt to mediate disputes arising from Sept. 11 claims rather than immediately go to court, under a recent agreement. The New York-based CPR Institute for Dispute Resolution, which brokered the pact, said the commitment was developed to avoid the expense, delays and uncertainties of litigation at a time when the quick resolution of disputes among insurers is crucial. The group comprises Royal & SunAlliance Insurance Co., Allstate Insurance Co., Chubb Corp., CNA Financial Corp., Fireman's Fund Insurance Cos., Great American Insurance Co., Kemper Insurance Cos., Nationwide Insurance Co. and Risk Enterprise Management Ltd.

## Some unprepared for terrorist risks

Midsize companies are ill-equipped to deal with high-impact risks resulting from terrorist activity, a study by Marsh Ltd. in London says. A survey of 600 companies in six European countries found that just 50% of European companies have a plan in place to address risks of high financial impact. Thirty-one percent of the European companies surveyed said that management was likely to review risk more frequently than once every six months, while almost 20% admitted risk reviews took place only on an ad hoc basis.

## PXRE raising underwriting capital

PXRE Group Ltd. is raising $150 million in new capital. The Hamilton, Bermuda-based reinsurer said it will use the new capital to increase its underwriting capacity. The new capital will come from the sale of convertible preferred stock to an investment group including Capital Z Financial Services Fund II, funds managed by Reservoir Capital Group and investor Richard Rainwater. The transaction is expected to close in the first quarter of 2002. The additional capital will increase PXRE's total capital to more than $500 million.

## Highlands stops underwriting

Troubled Highlands Insurance Group Inc. said it will halt new and renewal underwriting as it considers strategic options. Highlands, which last month saw its A.M. Best Co. rating cut to C- from B and its top management resign, said it might sell books of business or transfer renewal rights to other insurers. Its investment advisers will continue to examine alternatives as Highlands cuts staff, the insurer said. At Sept. 30, Highlands' revenues rose 40.4%, to $452.7 million, from a year earlier, while deteriorating loss experience led to a $64.8 million net loss, compared with a slight profit the year before.

## Aon forms management consulting unit

Chicago-based Aon Corp. has reorganized some of its consulting services into a new unit called Aon Management Consulting. The unit, part of Aon Consulting Worldwide, aims to help employers improve productivity, efficiency, bottom-line growth and organizational leadership. The management consulting unit will offer the Rath & Strong Six Sigma suite of quality management services, which were formerly offered through Aon Consulting Rath & Strong.

## Briefly noted

Israel-based **Clal Insurance Enterprises** acquired Lloyd's of London syndicate 1301 from Paris-based Groupama Reassurances S.A. Syndicate 1301, which writes international property and accident and health insurance, will continue to be managed by Chaucer Syndicates Ltd. The syndicate's 2002 capacity is £35 million ($50.2 million)....The **National Assn. of Insurance Commissioners** elected Iowa Insurance Commissioner Terri M. Vaughan as president for 2001-2002. Arkansas Insurance Commissioner Mike Pickens was elected vp, while Nathaniel S. Shapo, Illinois' director of insurance, was elected secretary/treasurer....The **New York State Insurance Department** plans to form a task force to study the long- and short-term impact of the World Trade Center disaster. Among other things, it will study the availability and adequacy of commercial insurance....Employees will be able to make pretax contributions of up to $185 a month in 2002 to cover **parking expenses**, up from the $180 as a cost-of-living adjustment. The limit on tax-favored contributions for employees' mass transit expenses will rise to $100 from $65, as mandated under a federal law.

## *BI* Stock Index [12/10-12/14]

**Up-to-the-minute data for all 87 companies that comprise the *BI* Stock Index can be found at *www.businessinsurance.com***

**Percentage change of *BI* Stock Index vs. key indicators**


**Largest gains**

| | | | |
|---|---|---|---|
| ESG Re Ltd. | 25.63 | PacifiCare | -18.79 |
| SCPIE Holdings Inc. | 12.89 | Gainsco Inc. | -11.76 |
| Vesta Insurance Co. | 12.15 | Brown & Brown | -10.41 |
| EMC Insurance Group | 11.18 | NYMagic Inc. | -8.91 |
| Clark Bardes Holdings | 9.45 | ING Groep N.V. | -7.34 |

**Weekly change by market segment**

| | |
|---|---|
| Brokers | -2.51 |
| Insurers/Reinsurers | -0.30 |
| Managed Care Organizations | -4.34 |

Source: CNET Investor (investor.cnet.com)

# Pensions: Enron collapse draws scrutiny of laws

**Continued from page 1**

can be held in 401(k) accounts.

Enron's collapse was so widely felt because millions of retirement savings plan participants invest in stock funds with a utility component and in stock funds indexed to the S&P 500, which is one of the more common fund options available.

"Enron's collapse has drained the investment savings of investors across the country who put their retirement and other investments into mutual funds, pension funds and other vehicles that invested in Enron," House Financial Services Committee Chairman Michael G. Oxley, R-Ohio, said last Wednesday at the start of a hearing on the Enron collapse.

Hardest hit, though, were the approximately 11,000 participants of Enron's own 401(k) plan, which had more than 60% of its assets invested in company stock, Rep. Oxley said.

To prevent another Enron-like debacle from occurring, limits should be placed on the amount of company stock defined contribution plans can hold, asserted committee member Rep. Luis V. Gutierrez, D-Ill.

"We all know you are not supposed to put all your eggs in one basket," he said. "ERISA limits the amount of company stock that can be held by defined benefit plans, but traditional pension plans are disappearing."

Under the Employee Retirement Income Security Act of 1974, no more than 10% of defined benefit plan assets can be invested in a company's own stock. However, no such limits have been placed on defined contribution plans.

The pattern of pension plan investments in the two types of plans show the impact of these federal limits, said a spokesman for the Employee Benefit Research Institute in Washington, pointing to a survey by Greenwich Associates, a Greenwich, Conn.-based consulting and research firm that serves the institutional financial services industry.

The survey found that in 2000, just 1.2% of defined benefit pension fund assets were invested in a company's own stock, compared with 26.8% of the assets of defined contribution plan funds.

**'Don't make fundamental changes based on an anecdotal event that could reduce returns for participants.'**

*David Wray*
*Profit Sharing/401(k) Council of America*

Benefit experts say that regulators and lawmakers should move carefully on any reforms.

"They're assuming every other company is doing the same thing," said David Wray, president of the Profit Sharing/401(k) Council of America in Chicago, who added that lawmakers should think long and hard before making any changes to pension and securities laws.

"The Enron situation is unique; we don't want to make policy that penalizes the entire system. Don't make fundamental changes based on an anecdotal event that could reduce returns for participants," Mr. Wray said.

Limiting employers from making 401(k) matching contributions in the form of company stock may have a deterrent effect on company matching contributions overall, he added.

"The Enron situation has less to do with the concentration of 401(k) plan assets than with employees relying on public information" in making their investment decisions, Mr. Wray said.

Michael Pikelny, corporate actuary and employee benefits consultant for Chicago-based Hartmarx Corp., agreed that legislation limiting the amount of company stock employees can have in their 401(k) plans is not necessary.

Like Enron, Hartmarx matches employee 401(k) contributions with company stock. And, like Enron, its share price is currently at an all-time low.

"Employees have always had a choice," he said. "If the employee doesn't want to buy stock, they don't have to."

And even though the company match is in stock, rather than cash, "that's free money anyway. They haven't lost their own money," Mr. Pikelny said.

"We have always pointed out that our company stock fund is risky because it's not diversified," he said. "But as much as you try to educate employees, there's always somebody who comes up at the end and says, 'That was a nice presentation, now tell me where to put my money.' They're savers, not investors."

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