

Business Insurance

Reporting Weekly on Corporate Risk, Employee Benefit and Managed Health Care News / \$4

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Employers await Bush's patient rights proposals

By MARK A. HOFMANN

WASHINGTON—Employers are greeting President Bush's proposed approach to managed care reform with less than a warm embrace.

But that's still a much friendlier reception than employers gave the new Bipartisan Patient Protection Act of 2001, unveiled last week by a bipartisan group of senators and representatives led by Sens. John McCain, R-Ariz., and Edward M. Kennedy, D-Mass. Conspicuous by his absence from among those lining up behind the new

measure, though, was the father of so-called "patients' rights" legislation, Rep. Charles Norwood, R-Ga.

Rep. Norwood, along with Rep. John Dingell, D-Mich., drafted the Norwood-Dingell managed care bill in the last session of Congress. That bill would have allowed health plan participants to sue managed care plans—and, in some cases, the employers that sponsor plans—over coverage denials. Rep. Norwood has agreed to a request made by President Bush for Republican lawmakers to wait until the president's own proposal could be introduced be-

fore signing onto the McCain-Kennedy measure.

The president followed that request with his own Principles for a Bipartisan Patients Bill of Rights, which was attached to a letter sent to House and Senate Democratic leaders on Feb. 7, one day after the McCain-Kennedy bill became public. The president's principles are:

- Patient protections should apply to all Americans.
- Patient protections should be comprehensive.

See Rights on page 22

Asbestos facility to ease rules on claim settlements

PRINCETON, N.J.—The Center for Claims Resolution is changing its procedures to allow member companies more leeway in deciding whether to settle or litigate asbestos claims.

Responding to requests from its 14 corporate members, Princeton, N.J.-based CCR said it will abandon its practice of settling cases on a group basis for all members named as defendants, and will no longer require members to share. See Updates on next page



PHOTO: KRT PHOTOS

From left, Sens. John McCain, R-Ariz., Bob Graham, R-Fla., and Edward Kennedy, D-Mass., unveil their bipartisan patient rights bill.

Comp insurers can be sued for data errors

By JOANNE WOJCIK

SAN FRANCISCO—California employers may sue their workers compensation insurers in civil court for bad faith when insurers' misreporting of financial data to the state's ratemaking organization results in higher premiums, the state Supreme Court has ruled.

Before the Feb. 1 decision in *State Compensation Insurance Fund vs. Schaefer Ambulance Service Inc. et al.*, there had been confusion among employers and insurers over whether such disputes should be handled by an administrative law judge within the workers comp system or through civil litigation.

Insurers have opposed using the civil courts, and for the past several years have supported legislation that would have kept such disputes within the workers comp system. But employers have long sought a remedy outside that system for resolving disputes with their insurers.

"This is a great development for the employers and a wake-up call for the insurance industry," said Lori Kammerer, executive director of the California Coalition on Workers Compensation, which comprises more than 5,000 insured and self-insured employers in both the public and private sectors.

"We support preservation of the exclusive remedy doctrine of workers compensation, which protects the employers from civil liability in connection with workers compensation disputes. But it shouldn't be used as the exclusive remedy for employers to use in resolving disputes with their insurers.

"Other types of insurance disputes are handled by the See Court on page 21

Layoffs bring new risks

Base cuts on objective criteria to avoid bias suits

By JUDY GREENWALD

As layoffs become more frequent in corporate America, employers should prepare for the risks that accompany downsizing.

In recent weeks, several major corporations—including Lucent Technologies Inc., DaimlerChrysler, Amazon.com Inc., Hewlett-Packard Co., Xerox Corp., AOL Time Warner Inc. and Sears, Roebuck & Co., to name a few—have announced workforce reductions.

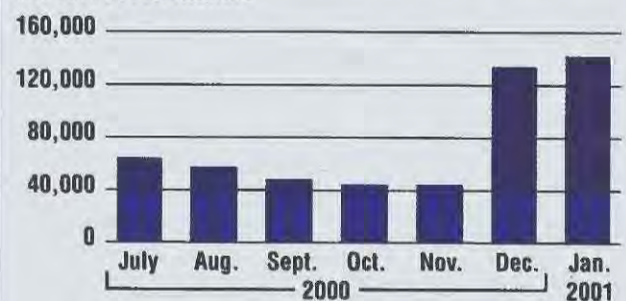
According to Challenger, Gray & Christmas, a Chicago-based executive recruiter, the total number of job cuts announced by U.S. businesses in December and January alone totals 275,921 (see chart).

In the midst of an economic slowdown—which some feel could be the start of a recession—more worker cutbacks are expected. Employers generally try to avoid layoffs, though, and instead achieve workforce reductions through a combination of attrition, early retirements and voluntary departures

See Layoffs on page 13

Job cuts rising

Total number of job cut announcements for each of the last seven months



Total includes workers who receive early retirement and enhanced severance offers. Source: Challenger, Gray & Christmas Inc.

GRAPHIC BY JOHN HALL

Using multiple brokers

When one isn't enough

By SALLY ROBERTS

To use one broker or to use multiple brokers: that is the question for some risk managers.

Although it is not an oft-debated topic at industry gatherings, risk managers continue to confront the issue of whether to turn over their entire insurance program to one broker or divide the work among several.

The answer, risk managers and consultants say, is that no single method works in all cases and that each risk manager's personal philosophy, management style and needs will dictate his or her approach. Some risk managers, for instance,

may wish to use only one insurance broker, who will act as an extension of the risk management department. Other risk managers may find product-line expertise within several brokerage firms and, consequently, will have several brokers handling different aspects of their risk management programs. Still others may find that having one broker handling the property exposure and one broker handling the casualty exposure produces competition between the two, resulting in better service overall.

"Two different risk managers with the exact same situation can have opposite views on this," said Richard S. Betterley, president of

Betterley Risk Consultants Inc. in Sterling, Mass. "Both (approaches) can work, and both can work well. There are advantages and disadvantages to each."

"There is not a right or wrong" to this, agreed Richard Hackenburg, president and chief executive officer of Willis of Missouri Inc. in St. Louis. "A lot depends on the culture of the company and how it buys outside services—professional, product or otherwise," he said.

Mr. Hackenburg said that Willis tends to be one of several brokers on its Fortune 500 to Fortune 1000 accounts, but is the sole broker for many of its small and middle-market. See Brokers on page 20

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Claims facility revising role

Continued from previous page

settlement costs. Instead, CCR will now settle claims separately for each member and will offer claims processing, litigation support and settlement negotiation services separately, rather than providing them as a single package.

The new procedures will allow members to choose whether to settle or litigate each claim. "They can pick and choose their corporate strategy," said CCR Chief Executive Officer Mike Sheppard.

The changes follow an unexpected rise in the frequency and severity of asbestos claims that has driven several asbestos defendants into bankruptcy in recent months, including longtime CCR member Armstrong World Industries Inc. (*BI*, Dec. 11, 2000). Some defendants have announced that they plan to defend asbestos claims more aggressively than they have in the past and have expressed concerns about having to shoulder larger liabilities because of the bankruptcy of other defendants.

"Against a changing landscape, including a number of bankruptcies of asbestos defendants, we are naturally evolving to meet the needs of our member companies," Mr. Sheppard said. "Basically, times have changed, and we have to change with them."

Employer found liable in DUI

BARRIE, Ontario—Employers in Canada may face greater liability exposures following a ruling that an employer was partially responsible for a worker's drunken-driving accident after an office party.

Ontario Superior Court Judge Clair Marchand ruled last week that the company should have prevented the employee from driving drunk. The judge suggested the employer could have confiscated the employee's keys, insisted she take a taxi home, called her husband or informed the police.

The employer and the owner of a bar the employee visited after the party were found jointly liable for 25% of the employee's damages, or \$281,229 Canadian (\$185,892). The employer's liability insurer, Zurich Canada, is considering an appeal.

If the judgment is not overturned, alcohol-free office parties may be the only way to avoid the increased liability, risk managers say.

The suit stemmed from a December 1994 auto accident involving Linda Hunt, a part-time receptionist at Sutton Group Incentive Realty in Barrie, Ontario. Ms. Hunt was seriously injured while attempting to drive home after she had been drinking at an office party and then visited a tavern with other employees afterward, court papers say.

Ms. Hunt, who sued her employer, was drunk when she left the party and turned down her employer's offer to call either a taxi or her common-law husband to take her home, court papers say.

Those offers were not enough for the employer to escape liability, Judge Marchand ruled. The employer had a duty to ensure that she did not become so intoxicated while on the premises so as to impair her ability to drive safely home, the judge ruled. Additionally, the employer must have known that Ms. Hunt planned to stop off for more drinks on the way home, the judge ruled.

State changes wage calculation

SEATTLE—A recent Washington state Supreme Court decision requiring that health benefits be included in wages when computing workers compensation benefits will not increase workers comp premiums in the state in 2001, according to the state Department of Labor and Industries.

A department spokeswoman said the decision in *Dianne L. Cockle vs. Department of Labor and Industries* had been expected, and its estimated \$20 million annual impact on workers comp insurers in Washington had already been incorporated into the current year's rates.

The decision marked the first time the court had considered whether employer-provided health care coverage should be included in calculating workers comp premiums.

The department had calculated Ms. Cockle's workers comp benefits on the basis of her paycheck at the time of her work-related injury in 1993. She appealed to the Board of Industrial Insurance Appeals, arguing that health care coverage was a substantial component of her negotiated "contract of hire" compensation and was part of her wages as defined by the state's workers comp law. The law mandates that wages include "the reasonable value of board, housing, fuel or other consideration of like nature received from the employer as part of the contract of hire."

After the board disagreed and affirmed the department's benefit calculations, Ms. Cockle appealed to the Pierce County Superior Court, which granted her partial summary judgment. The Court of Appeals affirmed, and the Supreme Court agreed to hear the department's petition for review.

In its 6-3 decision on Jan. 18, the high court affirmed both lower court rulings and found that Ms. Cockle's health care coverage was "consideration of like nature" under state statutes. The court ordered the department to recalculate her workers comp benefits.

401(k) balances up 18%: Study

WASHINGTON—The average account balance for active 401(k) participants grew by 18% to \$55,502 at year-end 1999, according to an analysis done by the Employee Benefits Research Institute and the Investment Company Institute.

See Updates on page 22

AIA backs limited role for federal regulation

By MARK A. HOFMANN

WASHINGTON—The American Insurance Assn. is willing to break with industry tradition and support optional federal chartering of insurance companies under certain circumstances, the AIA's president says in a Feb. 7 letter to the head of the National Assn. of Insurance Commissioners.

Although the AIA has not rejected the state regulatory system, "the demands of the 21st century—insurance industry mergers and acquisitions, convergence across financial sectors, technology and globalization—have led us to consideration of a larger federal

role," wrote AIA President Robert E. Vagley in his letter to NAIC President Kathleen Sebelius. "AIA will support this activity on Capitol Hill, including optional federal chartering, as long as it is consistent with our core principles."

The guiding principles for regulatory reform, adopted by the AIA's board last summer, are:

- Market forces, rather than regulatory approvals, should dictate the products sold by insurers and the prices they charge. Thus, rate and form deregulation is crucial, according to AIA.

"AIA is willing to consider scaling back the McCarran-Ferguson

antitrust exemption in exchange for a market-based system that eliminates the type of command and control regulation that has been repealed for so many other industries in the U.S.," say the AIA principles.

- National treatment, meaning that companies should have the option of obtaining a single charter that would allow them to do business in all states.

The AIA holds that "states must be prohibited from discriminating against such companies in favor of those that obtain licensing on a state-by-state basis."

- Uniform regulatory requirements

See AIA on page 22

U.K. expands pension access

LONDON—Confirmation of a European Court of Justice ruling by the United Kingdom's highest court could cost U.K. employers billions of pounds in retrospective pension benefits.

The House of Lords has confirmed in U.K. law an earlier ruling by the ECJ that significantly increased the number of years for which thousands of part-time workers could make claims for retrospective pension benefits.

In May, the ECJ ruled that part-time employees could make retrospective claims as far back as 1976, the year of a significant ruling on discrimination in pension eligibility (*BI*, May 22, 2000). Previously, under U.K. law, part-time employees could seek only two

years of retrospective benefits.

Under the terms of the ECJ ruling, to be eligible for retrospective membership in an employer's pension plan, a part-time worker must demonstrate that exclusion was based on indirect sex discrimination—that "significantly more members of one sex than another are affected by a particular eligibility rule," said London law firm CMS Cameron McKenna.

In addition, the House of Lords upheld the law that part-time workers must file for benefits within six months of leaving a job.

U.K. employers are expected to be hit by a spate of new claims. "It is impossible to say what the precise cost to employers will be, but previous estimates have ranged up

to £17 billion (\$24.56 billion)," said CMS Cameron McKenna.

The ECJ ruling stemmed from a test case brought by a labor union, and gave about 6,000 part-time workers—most of them women—retrospective access to pension rights.

Joy Drummond, employment partner at London-based law firm Lawfords Solicitors, who represented the union in the test case, said that the House of Lords' ruling would prompt more claims.

"We expect thousands of similar claims against banks and other employers, who had denied part-time workers access to non-contributory pension schemes, to now be settled."

—By Sarah Veysey

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INSIDE

- The 'new' patient protection bill now before the Senate would actually have the opposite effect, prompting some employers to cancel their health care coverage, this week's editorial says. **PAGE 8**

- In Perspectives, Craig L. Boilla writes that medical bill review services can lower a company's costs. **PAGE 11**

- Risk managers in China are facing more stringent regulations. **PAGE 15**

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Health plans have room for improvement: Survey

By JERRY GEISEL

Most employers say health plans have a long way to go to improve their analysis of health care data as well as delivering information through the Internet, according to a new survey.

Fifty-eight percent of 600 employers surveyed by Hewitt Associates L.L.C. said that health plans need to improve health plan data analysis and tracking, while 57% said plans must strengthen their Internet information access.

Plans "talk about world-class service, but employers feel they

have not delivered it," said Ken Sperling, a consultant in Hewitt's Norwalk, Conn., office.

A majority of employers say health plans do better in performing administrative functions, though a sizable percentage says improvements still are needed in those areas as well.

For example, 37% of respondents said plans need to improve financial reporting and accounting, while 34% say plans need to improve customer service, and 32% say improvement is needed in the enrollment process.

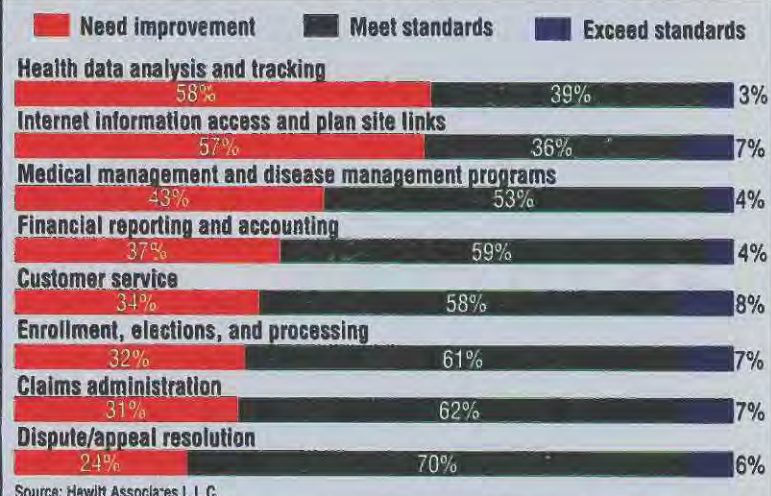
Switching to another plan isn't

likely to bring much of an improvement in technological or administrative areas, according to the survey. For example, only 18% of employers said there were "dramatic" differences in the Internet capabilities offered by health plans, and 40% saw no real differences among companies.

Similarly, just 15% of respondents said there were dramatic differences between plans in terms of claims administration service, while 41% said there was no real difference. In addition, just 10% of employers saw a dra-

See Plans on page 20

Employers grade health plans



GRAPHIC BY LANCE PRATHER

States face a deadline for creating privacy rules

By MEG FLETCHER

State legislatures are working against the clock to enact measures to protect the privacy of consumers' financial and health information in accordance with a 1999 federal financial modernization law.

By the state-imposed deadline of July 1, each state is allowed to adopt legislation or regulations that would bring its privacy laws into compliance with

Title V of the Gramm-Leach-Bliley Act. That provision governs the use by insurers of consumers' nonpublic financial information—which may include health information—especially for marketing purposes.

If states fail to meet the deadline, they lose the opportunity to adopt privacy regulations for banks' sale of insurance that are stricter than those found under the federal law. Under the federal act, state insurance regula-

tors are the enforcing agent if states have given them that authority.

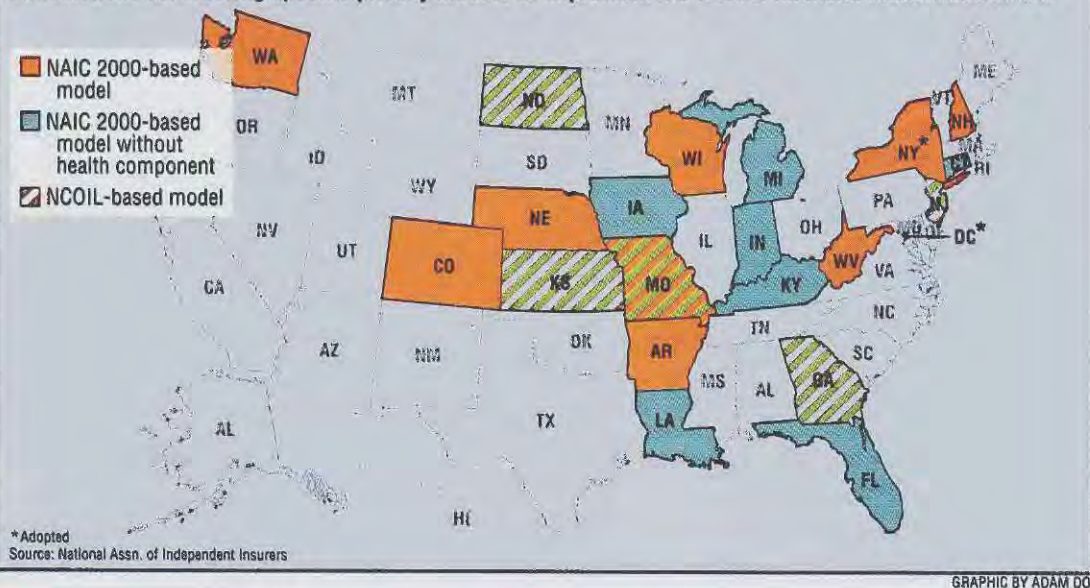
In passing Title V, federal lawmakers sought to protect consumers from the unauthorized use of personal information resulting from the breaking down of the barriers between financial institutions such as insurers and banks.

Businesses are monitoring the states' legislative efforts and

See Privacy on page 6

Privacy proposals

Jurisdictions considering specific privacy models to implement the federal financial modernization law



GRAPHIC BY ADAM DOI

Court puts limits on cleanup cover Indemnity under CGL policy at issue

By ROBERTO CENICEROS

SAN FRANCISCO—A California Supreme Court ruling could increase litigation as policyholders find court-ordered damages against them are now a prerequisite for obtaining pollution cleanup coverage under commercial general liability policies, policyholder attorneys say.

But attorneys who represented insurers in the widely watched case disagree with the contention that the court's Feb. 1 finding in *Certain Underwriters at Lloyd's of London et al. vs. Powerine Oil Co. et al.* will generate more lawsuits.

The court ruled in a 5-2 decision that insurers are not obligated under CGL policies to indemnify policyholders for pollution remediation orders issued by government agencies. Language in the CGL policies limits insurer responsibility for indemnity costs to "damages," which the court said result only from court orders to pay for losses specified in a policy's coverage.

"This is a big victory for insurers," said Laura A. Foggan, a partner at Wiley, Rein & Fielding in Washington. "Everybody has been watching and waiting for this decision." Ms. Foggan represents the Insurance Environmental Litigation Assn., which filed an amicus brief on behalf of insurers.

The impact, however, will not be felt by insureds that have legitimate claims, such as when a

truck accident causes a sudden pollution spill, said Patrick A. Cathcart, a partner in the Los Angeles office of Hancock Rothert & Bunshoft. Mr. Cathcart represented the Lloyd's underwriters in the case.

An impact will be felt where policyholders "historically have been making claims against insurers and (alleging) bad faith and suing and having expensive discovery in order to drive a settlement that is not covered," Mr. Cathcart said.

The decision mostly affects CGL policies issued before 1986, when insurers changed their language to exclude pollution coverage, attorneys said.

In its *Powerine* decision, the high court also stated that policy language dictates that insurers are obligated to indemnify insureds only under settlements reached with the insurer's approval, Ms. Foggan pointed out. That means cleanups that policyholders voluntarily agree to undertake, without an insurer's approval, are not covered, she said.

"That is an important recognition of the policy terms that are often overlooked by policyholders that are eager to rush out and enter a settlement and then charge it back against their insurer without having involved their insurer in the first place and in that way undercutting the insurer's right to control the defense and determine whether settlement is appropriate," she said.

See Powerine on page 10

Indictment charges duo and broker in fraud scheme

Premium finance loans used to aid company, prosecutors say

By DOUGLAS McLEOD

HAMMOND, Ind.—Former officials of an Indiana manufacturer and its insurance broker are facing charges that they arranged tens of millions of dollars of bogus premium financing and bank loans to shore up the ailing company's deteriorating finances.

Federal prosecutors last month unsealed a 10-count conspiracy and fraud indictment against two ex-officers of the now-bankrupt White Trailer Corp., a Monon, Ind.-based maker of tractor trailers. Named in the indictment are

Thomas J. Rosby, the company's former president and chief executive officer, and John M. Franklin, its former executive vp and chief financial officer. Also named is Michael A. Peterson, owner of Rhode Island-based Peterson & Associates, White Trailer's broker.

According to the indictment, Mr. Rosby and Mr. Franklin plotted with Mr. Peterson's help to obtain \$9.9 million in bogus premium finance loans, allegedly for premiums owed to Mutual Indemnity Ltd. units under a workers compensation rent-a-captive pro-

gram. Instead of using the funds to pay premiums, however, they used the loan proceeds to cover White Trailer's payroll and other costs, prosecutors charge.

Mr. Rosby and Mr. Thomas also submitted phony applications to obtain more than \$34 million in loans under a credit arrangement with Chicago-based Congress Financial Corp., the indictment alleges.

If convicted, the three men face maximum statutory penalties of five years in prison and \$250,000 in fines on each count against them. They are scheduled to be ar-

raigned in Hammond on Feb. 14.

James H. Voyles Jr., an Indianapolis-based lawyer for Mr. Rosby, declined to comment on the indictment. Mr. Franklin, Mr. Peterson and their lawyers could not be reached.

White Trailer was originally known as Monon Corp. and was controlled by a Delaware holding company—Rosby Corp.—that was 72% owned by Mr. Rosby and 14% owned by Mr. Franklin, according to court papers. In 1996, White Trailer and its operating subsidiary, White Trailer Inc., separately filed for Chapter 11 bankruptcy reorganization. While the operating company's case was initially a debtor-in-possession

proceeding, creditors in 1997 succeeded in converting it to a Chapter 7 liquidation, and the parent company's case was consolidated with the subsidiary's in 1998, court records show.

The bankruptcy estate has sold White Trailer's manufacturing operations, and HPA Monon Corp., a company formed by the new owners, continues the business as one of the largest U.S. manufacturers of truck trailers and cargo containers. HPA Monon is not part of the ongoing White Trailer bankruptcy and is not involved in the criminal case against the former White Trailer officers.

See Indictment on next page

Indictment

Continued from previous page

For several years leading up to the bankruptcy, White Trailer placed its workers comp coverage with Mutual Indemnity's rent-a-captive program through its broker, Mr. Peterson. Under the program, White Trailer self-funded workers comp claims up to \$250,000 through the Bermuda-based rent-a-captive, while Mutual Indemnity's U.S. unit, Legion Insurance Co., insured claims in excess of \$250,000, according to the indictment.

The arrangement continued from 1993 to 1997, with White Trailer's annual premiums ranging from \$4.9 million the first year to a low of \$2.1 million for the 1996-97 policy year, court papers say.

White Trailer also began financing its workers comp premiums in 1994 with loans from A.I. Credit Corp., a unit of American International Group Inc., and Dublin, Ohio-based Anthem Premium Finance.

As the manufacturer's financial condition deteriorated in early 1996, though, Mr. Rosby and Mr. Franklin devised a scheme to use premium finance loans to ease the company's severe cash flow problems, federal prosecutors allege.

Over a period of several months, the two men, aided by Mr. Peterson, submitted a series of phony premium finance applications to A.I. Credit and Anthem, with plans to use the proceeds to cover various White Trailer operating expenses.

In March 1996, for example, Anthem loaned the company \$2.4 million to pay 1996-97 workers

comp premiums, but Mr. Rosby and Mr. Franklin used \$1.9 million of the proceeds to make a loan payment to Congress Financial, according to the indictment.

The following month, the three

based Contract Freighters Inc. for used truck trailers that White Trailer had agreed to buy, prosecutors charge.

In May 1996, Messrs. Rosby, Franklin and Peterson went back

Prosecutors in the case allege that premium finance loans were used to ease severe cash flow problems at the trailer manufacturer.

men submitted another bogus loan application to A.I. Credit for premiums purportedly owed for the same policy year. A.I. Credit loaned White Trailer \$2.7 million, virtually all of which the company then used to pay Joplin, Mo.-

to A.I. Credit, claiming that White Trailer owed Legion and Mutual Indemnity additional premiums after an audit. A.I. Credit provided another \$954,098, which White Trailer used to pay Anthem under that company's earlier premium

finance deal.

Later that month, the three men returned to Anthem for another loan to cover Legion and Mutual Indemnity premiums.

Anthem loaned the company an additional \$3.8 million. White Trailer used \$1.5 million of the money to make its payroll, \$450,922 to pay A.I. Credit under an earlier premium finance loan and \$500,000 for various other corporate expenses, the indictment charges.

Meanwhile, from March to August 1996, Mr. Rosby and Mr. Franklin were pursuing a separate scheme to defraud Congress Financial, which provided White Trailer with a revolving credit facility secured by the manufacturer's accounts receivable, according to prosecutors.

Under the credit agreement, Congress Financial would lend White Trailer up to 85% of amounts due from customers that had ordered trailers and containers, the indictment says.

Over the six-month period, Mr. Rosby and Mr. Franklin regularly met to discuss plans to inflate the company's accounts receivable to increase the amounts it could borrow from Congress Financial, prosecutors charge.

Messrs. Rosby and Franklin also directed White Trailer employees to falsify production figures and accounts receivable records sent to Congress with loan requests, the indictment alleges.

Messrs. Rosby and Franklin made loan requests claiming more than \$40 million in phony accounts receivable during the six months, and Congress loaned White Trailer more than \$34 million based on the figures, the indictment says.

The indictment charges Mr. Rosby and Mr. Franklin each with 10 counts of conspiracy, mail fraud and wire fraud. Mr. Peterson is charged with six counts of mail and wire fraud.

The flurry of allegedly desperate borrowing throughout early 1996 didn't save White Trailer: By October of that year, both the company and its parent had sought bankruptcy protection. Congress Financial remains one of the proceeding's largest creditors. EJ

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Privacy

Continued from page 3
will oppose any proposed privacy measures that would restrict an employer's access to an injured worker's medical records, said Daniel Barry, director of government affairs for the New York-based Risk & Insurance Management Society Inc. That information is crucial for employers to process workers compensation claims and speed return to work, Mr. Barry said.

Faced with the July 1 deadline, state legislatures are wasting no time in tackling the issue, according to recent surveys of legislative activity.

Many jurisdictions already have begun to review their existing laws, as well as consider model privacy legislation from the Na-

tional Assn. of Insurance Commissioners and the National Conference of Insurance Legislators.

The two advisory groups' models generally outline the requirements for state-licensed entities, such as insurers, that have access to consumers' nonpublic personal financial and health information that could also be used for marketing purposes. The model legislation outlines the privacy notices that companies must issue in connection with consumer information, as well as when and what type of permission is required from consumers before information about them can be released. The models also include exclusions for some business activities, such as the payment of claims.

While the NAIC and NCOIL models are fairly similar, there are a few notable differences, industry analysts say.

For example, the NCOIL model explicitly excludes commercial lines coverages from its provisions, while the NAIC's 2000 model appears to include commercial lines

'We are seeing a lot of chaos and unanswered questions surrounding the privacy issue in the states,' says Robert L. Zeman.

in certain limited situations. A 1982 NAIC privacy model is limited only to personal lines, though.

In addition, the NCOIL model tries to take a less-restrictive approach to the privacy of an individual's health information but questions have arisen on whether

that was achieved.

Following a preliminary analysis, RIMS' Mr. Barry said: "We are pleased that the NAIC made allowances for the appropriate use of medical information by licensees and insurance buyers. However, NCOIL's explicit exclusion for commercial lines policies is probably the preferred option. Such an exclusion is clear to licensees and regulators alike and, in addition, is not as open to subjective interpretations or applications of facts."

According to a recent survey by the Des Plaines, Ill.-based National Assn. of Independent Insurers, nine jurisdictions are leaning toward adoption of the NAIC 2000 model, including New York, which has already adopted legislation based on this model (see chart, page 3). The other eight states are Arkansas, Colorado, Missouri, Nebraska, New Hampshire, Washing-

ton, West Virginia and Wisconsin.

In addition, eight other jurisdictions are considering the NAIC 2000 model but have removed provisions related to the protection of personal health information. Those are: Connecticut, Florida, Iowa, Indiana, Kentucky, Louisiana and Michigan. The District of Columbia also adopted this model without the health component.

Meanwhile, the NAIJ survey reports that Georgia, Kansas, New Jersey and North Dakota are considering the NCOIL model. Missouri, which is looking at the NAIC 2000 model also is looking at the NCOIL model, according to the NAIJ.

Other states are taking a different tack. For example, at least seven of the 16 jurisdictions that previously adopted the NAIC's 1982 model privacy measure plan to amend it, said a spokeswoman for the Washington-based American Insurance Assn.

With the range of options out there, states face "a challenge to achieve uniformity," which is an important priority for the AIA, said J. Stephen Zielezienski, an AIA assistant general counsel.

But while the consideration of multiple options is not conducive to homogeneity among the jurisdictions, legislators should not "buy into poor public policy for the sake of uniformity," said Robert L. Zeman, vp and general counsel for the NAIJ.

"We are seeing a lot of chaos and unanswered questions surrounding the privacy issue in the states," Mr. Zeman said. "There are encouraging signs that order is on the horizon, but many states have a long way to go," he said.

One encouraging development is that 46 states and the District of Columbia enacted measures to extend the state-imposed deadline for compliance with the federal act to July 1 from Nov. 13 of last year. The four states that have not extended the deadline are Hawaii, Montana, Nebraska, North Dakota, according to the NAIJ. While the potential impact of this is uncertain, it is not expected to pose a serious problem.

Several outstanding concerns remain, including resolving the ambiguity in the NCOIL model about whether it applies only to domestic insurers or to all licensed insurers, as the NAIC's model clearly does, said Robert Mackin, executive director of Albany, N.Y.-based NCOIL. NCOIL members are expected to resolve that matter during a March 1-4 meeting in Hilton Head, N.C.

Another issue is how states can best update the 1982 NAIC privacy law to reflect the requirements of the Gramm-Leach-Bliley Act. Several industry representatives are working together to develop a template of essential changes.

Such matters must be resolved because individuals are becoming increasingly aware of the potential for the misuse of personal financial and health information, said Jim Ellenberger, assistant director for the AFL-CIO's department of occupational safety and health in Washington.

For example, when it comes to workers comp claims, "there is a proper degree of inquiry that should take place, but it has to be limited" to the condition in question, Mr. Ellenberger said. Furthermore, there must be limits on what insurers can do with the information, he said.

"We find it highly objectionable for people to disseminate this information and that it be used to screen folks or deny appropriate health care benefits," Mr. Ellenberger said. **BI**

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OPINIONS

'New' patient bill is still flawed

Balancing the rights of health care plan enrollees to receive coverage they are entitled to without exposing employers and health plans to costly litigation should be a top priority for Congress.

Unfortunately, the latest so-called patient protection bill doesn't come any closer to meeting that objective than previous failed measures.

If enacted, the new bill would, ironically, have the opposite effect of its goal of protecting enrollees. Employers would terminate those plans rather than be exposed to costly liabilities that could, at least, in the case of smaller firms, wipe them out.

The measure, the Bipartisan Patient Protection Act of 2001, is being hyped by its main sponsors, Sens. John McCain, R-Ariz., and Edward Kennedy, D-Mass., as a new and improved version of legislation that ran into opposition in the Senate last year. They point to its bipartisan support as evidence of how much they have improved the bill.

While the measure would offer some important protections for patients that we support, it remains fatally flawed in one critical area: making it easier for health plans and employers to be sued for coverage denials.

That was the main complaint with a measure that the House approved during the last congressional session, but which died after a storm of employer protest. As with that earlier bill, employers will continue to oppose the legislation as long as it contains provisions that would expand their liability.

Under the legislation, employers would be protected from liability unless they are involved in denying a claim that results in a beneficiary's injury and death. While that may be a relatively infrequent occurrence, it is hardly uncommon and creates a real exposure for many employers. The effort to determine how to define an employer's involvement by itself would trigger a slew of litigation.

The proposal would allow disputes over "medically reviewable" decisions to be heard in state courts, where defendants could face punitive damages. Only disputes over administrative decisions would be heard in federal courts. While punitive damages would be banned in federal cases, the bill would allow special penalties of up to \$5 million in such cases for bad faith. That provision—which is merely punitive damages under another name—would undercut much of the liability relief that otherwise would be afforded by having some cases brought in the federal court system.

Furthermore, even if tighter restrictions in lawsuits ultimately are adopted, the proposal would allow state laws deemed "more protective" of patient rights to supersede the federal law. That alone would erode all the benefits that any federal curbs on lawsuits would bring.

In short, the measure still would expose health care plans and employers to significant liabilities. If employers' liability exposure increases because of this legislation, some companies—especially smaller employers—are bound to drop their health plans. The plans are, after all, offered voluntarily. Other companies would pass on



their higher costs to employees. Those consequences hardly can be in the best interests of enrollees.

We believe that it is possible to assure a fair review and adjudication of patient claims—and even allow access to the courts—without triggering the disastrous consequences of this bill.

The key to this would be mandating internal and then external review of disputed claims before a case could be brought in the courts. If the review process is exhausted, only then could suits be filed in court—preferably in federal court. Since federal law governs employee benefit plans, it makes sense for federal court to be the forum for most benefit disputes. And any cases heard in federal court should not be subject to punitive damages or special penalties.

While we remain opposed to the lawsuit provisions in the proposal, there are other elements of the bill that make sense and could still make a difference in protecting people from managed care plan abuses.

There is widespread agreement, as the bill would require, that health plan enrollees' emergency room visits should be fairly covered, and that women should be able to see obstetrician/gynecologists without first requiring a referral. There also is a consensus that there should be, as the bill would mandate, fewer restrictions on access to specialty services for people who have a continual need for such health care services.

We also support the requirement that external reviews of coverage decisions would be heard by independent medical experts.

President Bush is urging Republican lawmakers not to line up in support of this new measure and to instead wait for him to advance his own patient rights proposal. Given the sorry state of the McCain-Kennedy proposal, that is sound advice to follow.

LETTERS

LETTERS TO THE EDITOR

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New rules require thought

To the editor: I am writing in reference to the Jan. 22 article, "Privacy Tops HIAA State List," about medical records privacy legislation expected to be introduced in several states in 2001.

As a telephonic case manager, I wonder if any one has addressed how this would affect us. And, if they have, what are the results? If not, how would these new privacy rules affect insurance companies that do telephonic reviews of medical claims?

I understand the need to tighten security to assure a patient's privacy, but I feel

there also must be thought given to how these new policies and regulations will affect all health care providers. Yes, one should not give information out to any particular person calling to inquire about a particular patient, but I think careful thought and consideration should be taken into account when making new rules and regulations.

Nicole Blanchard
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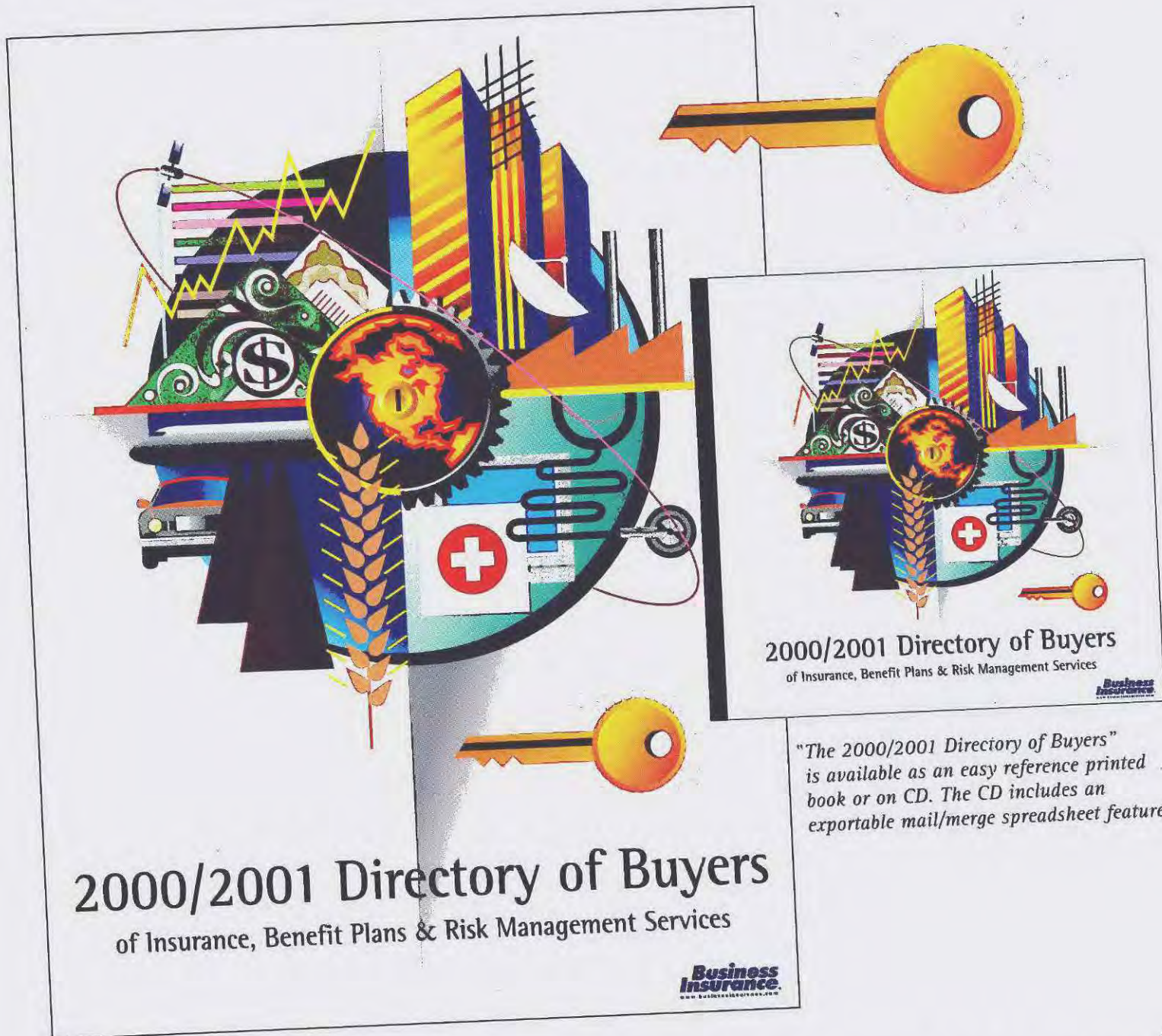
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Powerine

Continued from page 3
ate," added Ms. Foggan.

Attorneys in the *Powerine* case note that no other state supreme courts evaluating CGL policies have issued rulings similar to the California high court's decision.

High courts in Alabama, Maryland, Minnesota and Wyoming that have considered various pollution liability issues have all ruled that insurers' duty to indemnify policyholders is limited to a court's order to pay for damages. Justice Stanley Mosk wrote for the majority.

But the majority in *Powerine* was not influenced by those other courts' decisions, Justice Mosk wrote.

To reach its conclusion—that only a court may award "damages"—the California Supreme Court relied heavily on its 1998 decision in *Foster Gardner Inc. vs. National Union Fire Insurance Co.* (BI, Aug. 10, 1998). In that decision, California's high court found that an insurer's duty to defend a policyholder in a suit seeking damages is limited to civil actions prosecuted in court. In *Foster Gardner*, however, the court did not rule on an insurer's duty to indemnify a policyholder.

The impact of the *Powerine* case could reach beyond California and persuade other state supreme courts to find similarly, Ms. Foggan said. She said that could happen because California's decision is an early one regarding an issue that relatively few state

high courts have taken up. The California Supreme Court's opinion included a considerable amount of explanation in reaching its conclusion, she said.

But David B. Goodwin, a partner at Heller, Ehrman, White &

The California high court's decision already is inconsistent with other states and with its own 1990 finding in *AIU Insurance Co. vs. Superior Court*, said Mr. Goodwin and other attorneys.

In *AIU*, the California Supreme

To mitigate the recent high court decision's effects and obtain coverage, policyholders can now try to persuade their insurers to voluntarily participate in settlements, said Scott DeVries, managing partner in the San Francisco office of Nossaman, Gunther, Knox & Elliott L.L.P. How that will play out remains to be seen, he added.

Or policyholders can force agencies to file lawsuits against them, resulting in increased environmental litigation, he said. But forcing a pollution enforcement agency to sue can result in unintended consequences, such as a court finding more damages than anticipated, he added.

Risk managers, however, consider the court's decision to be consistent with broadly used policy language.

Roger Andrews, president of the New York-based Risk & Insurance Management Society Inc. and director of risk management at Cynthiana, Ky.-based E.D. Bullard Co., said he prefers that courts uphold policy language rather than "socialize" an issue by ruling in favor of public policy regarding pollution cleanup or ruling to help an insured obtain coverage where it is not due.

Ellen Vinck, vp of risk management in San Diego for United States Marine Repair, said she understands how the court reached its strict interpretation of CGL policies. But an accidental spill into a public bay can bring numerous government agencies demanding immediate remediation action, she said.

Policyholders must respond quickly to those demands because even the shortest delays can cause added fines, bad publicity and other problems. Insurance policies need to provide coverage for governmental orders, she added. But with the *Powerine* decision hanging overhead it will now become important for risk managers to assure they have prearranged coverage, Ms. Vinck said.

Numerous major corporations nationwide filed amicus briefs supporting the policyholder in the case. Many of the corporations that filed amicus briefs siding with *Powerine* likely did so because they already settled pollution cleanup demands made by government agencies, said Mr. DeVries, who filed briefs on behalf of Aerojet-General Corp. and Dover Diversified Industries Inc.

"Someone who has been the epitome of a good actor (and settled with government agencies seeking remediation) would have lost their coverage under this decision," he said. "They are the ones who are being punished."

Certain Underwriters at Lloyd's of London et al. vs. Powerine Oil Co. et al., California Supreme Court, No. S084057.

'Someone who has been the epitome of a good actor would have lost their coverage under this decision. They are the ones who are being punished,' says Scott DeVries.

McAuliffe in San Francisco, who represented *Powerine*, disagrees that the decision will serve as precedent for other states.

Court concluded that "damages" include not only money recovered by an administrative agency as reimbursement for cleanup costs that the agency had paid, but also the costs of complying with remedial cleanup injunctions, wrote Justice Joyce Kennard in a dissenting opinion in *Powerine*.

In *Powerine*, policyholder attorneys argued that a state civil code requires that a "plain language" understanding of insurance policies must apply and that understanding of CGL policies does not limit "damages" to those awarded in a lawsuit.

But the court majority was not swayed and said the civil code "seems more applicable to an individual policy, which constitutes a contract reflecting the actual agreement between a given insurer and a given insured...than to the standard policy, which does not," according to the majority opinion.

"Which is a stunning statement, given that there are probably 100 California Supreme Court decisions to the contrary," Mr. Goodwin said.

The court also found that even an "ordinary and popular" interpretation of damages in a CGL policy led them to believe it only applies to those ordered by a court.

Court records show that *Powerine Oil Co.* was in the refinery business since the 1930s. But a financial reversal forced it into bankruptcy and after 1995 the company divested itself of all but a skeleton crew charged with environmental compliance and equipment maintenance.

From 1958 to 1961, the company owned a CGL policy issued by Lloyd's underwriters. The U.S. Environmental Protection Agency subsequently "instituted a proceeding" against *Powerine* for the cleanup of contaminated Superfund sites in Monterey Park and Santa Fe Springs in California, according to the court.

Powerine later sued its insurers, claiming they breached their duty to indemnify. An appellate court ruled that the insurers were not obligated to pay for environmental agency-ordered cleanups.

Chester Street plan OK'd

LONDON—Creditors of Chester Street Insurance Holdings Ltd. have unanimously approved a scheme of arrangement that provides for their payment.

London-based Chester Street, formerly known as Iron Trades Holdings, announced its collapse in January due to increasing asbestosis claims. Chester Street, which insured about 2,000 employers, said its assets of £200 million (\$293.9 million) likely would be insufficient to meet current and future liabilities.

Accounting firm PricewaterhouseCoopers in London was appointed last month as the provisional liquidator of Chester Street.

But Colin Bird, a partner at PricewaterhouseCoopers, said at the time that the accounting firm hoped it could avoid putting the insurance company

into liquidation. Instead, Mr. Bird said, he hoped that creditors would vote in favor of the reorganization plan that PricewaterhouseCoopers proposed in late December.

Under that plan, Chester Street would pay part of each claim—the so-called "initial payment percentage"—and supplementary payments would come from the government-backed guaranty fund the Policyholders Protection Board.

Having secured unanimous backing for the plan, Chester Street can start making payments to creditors as soon as the initial payment percentage has been set, PricewaterhouseCoopers said in a statement. That percentage will likely be set within two months, the statement said.

"This is the best result. This will enable payments in respect

of agreed claims to start being made," said a PricewaterhouseCoopers spokesman. "If the company had gone into liquidation, there would have been no payments to policyholders for years."

Chester Street's asbestosis liabilities arise from the pre-1990 insurance business of the Iron Trades Employers Assn. Ltd., a subsidiary of Iron Trades Holdings that was transferred to Chester Street as part of a restructuring program. The ongoing business of Iron Trades Holdings was sold last February to QBE International Insurance Ltd. of Sydney, Australia.

Iron Trades, originally formed in 1898 as a mutual company, insured U.K. industrial companies, particularly shipbuilding and engineering firms, according to A.M. Best Co.

—By Sarah Veysey

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Bill review can lower medical costs

No charge for service unless company saves

By Craig L. Boilla

As we enter the 21st century, we have all experienced the increasing cost of health care and the impact it has had not only on the bottom lines of our companies but also on our employees' pocketbooks. With the introduction of managed care more than two decades ago, we all



hoped that these vehicles for health care cost containment would reverse the escalating cost of health care and, to some extent, even reduce it.

In retrospect, the reverse transpired. The introduction of preferred provider organizations, health maintenance organizations, exclusive

provider organizations, point-of-service plans and the like helped the health care industry to steer patients to certain facilities and provider groups. At the same time, employer groups enriched their benefits by lowering deductibles, adding first-dollar coverage for physician visits and lowering the out-of-pocket cost for those who used managed care networks.

Twenty years later, we recognize that the discounts obtained through managed care have not been nearly sufficient to offset the cost of the enriched benefits. Insurers face unprecedented loss ratios from premium deficits generated by various

The discounts obtained through managed care have not been nearly sufficient to offset the cost of enriched benefits.

maladies. Many insurers have not been able to survive these losses and have had to withdraw from the marketplace. The remaining insurers are now "cherry picking" the groups they want to cover, and they will continue to increase rates to compensate for losses.

The marketplace has become a battlefield. Insurers have severely tightened the guidelines for both the acceptance of new business and the renewal of their existing blocks of business. The rate increases we have faced have been staggering.

I have worked in the health insurance industry for the past 25 years and realized the trends that were going to raise their ugly heads in the not-too-distant future. In an effort to distinguish myself from my competition, I set out to investigate the effectiveness of medical bill review and cost containment companies. I went in pursuit of that one type of company that addressed the last frontier of cost containment—the negotiation of out-of-network, out-of-area and indemnity claims.

Major insurance companies that own or participate in the ownership of national managed care networks openly admit that, even with the availability of national coverage, their clients continue to have non-network claims that make up, on average, 10% to 25% of total paid claims. Without medical bill review, these claims are paid, in numerous instances, at retail rates. If we presuppose that health care expenses of \$4,000 per employee per year are reimbursed under a representative employer

medical plan for an employer group of 5,000, total annual paid claims may reach \$20 million.

The introduction of medical bill review into the formula can reduce the retail payment of claims considerably. Medical bill review can reduce total paid claims by as much as 8%, or \$1.6 million, annually. This equals a reduction per covered employee per year of \$320, and a reduction per covered employee per month of \$26.66. The impact of medical bill review on the bottom line for many employers is monumental; it can constitute the difference between a profitable and an unprofitable year-end balance statement.

The beauty of medical bill review is that the fee charged for services rendered is not on a capitated basis; the fee is a percentage of savings. There is, therefore, no cost to the plan unless there is a reduction in the cost of the claim. In many instances, a client introduced to the potential savings finds it difficult to believe that there is no cost to the plan if no savings are realized.

Here is how the review process can be explained to the client:

When the claims administrator identifies a claim as being out of the network and falling within certain pre-established threshold parameters, the administrator forwards the claim to the medical bill review company. There the claim is reviewed for unbundling procedure codes, upcoding of procedures, geographic pricing for the provider, gender-specific procedures, duplication, detection of possible fraud, etc. The company will determine ineligible charges and/or amounts that exceed usual, customary and reasonable charges and then reprice the claim.

A more sophisticated medical bill review company will contact the provider to negotiate the claim and secure a signed contract for each successful negotiation that states that the provider will accept the repriced claim as payment in full less any deductible and/or coinsurance that is the responsibility of the claimant. This procedure eliminates any balance billing problems that might fall back as a liability onto the employer or the claimant. This practice reduces provider appeals and eliminates many service problems that create havoc for employees and human resources departments.

Medical bill review companies use several methods to establish the savings realized and, subsequently, the fee charged for services. The first approach is to charge the fee based on the difference between the billed charge and the negotiated savings. The first method severely inflates the savings to include charges that were not going to be paid by the plan in the first place; it is counterproductive and reduces the effectiveness of the medical bill review process. The second approach—the one I recommend—is to calculate the fee based on the difference between the plan's liability and the negotiated savings.

Many medical bill review companies simply gain access to "silent" or "secondary" PPOs. Some states are eliminating this as an option. For example, the state of Texas has already prevented this practice. Other states are expected to follow suit in the near future. The problem with this approach is that if a medical bill review company takes a discount based on this premise, advises the administrator to pay the claim and the provider discovers the discount is not legitimate, then the provider has the option to re-evaluate the claim at a later date and to invalidate the reduction. This creates a unique problem. For example, should this happen with a partially self-funded client and the discovery by the provider is after the termination of one excess risk contract and the beginning of another, who is responsible for reimbursement of the discount taken in error? This

may create a very interesting errors and omissions hearing; let's hope that all parties involved have a policy in place at the time the claim is filed.

A few medical bill review companies have invested in the development of sophisticated proprietary database systems that subject each claim to full analysis. Armed with this statistical information, the bill review company can discuss the relevant coding and pricing with the provider in order to reach an agreement that all can live with.

This more extensive service eliminates the need for access to silent PPOs. This process gives both the employer group and the employee peace of mind, knowing they have paid a fair price for a correct, properly coded medical claim. No other means of repricing completes the entire process and guarantees the patient will not be held responsible for the balance of the bill.

Medical bill review is a win-win-win situation, and it costs the plan absolutely nothing unless savings are realized.

When a claims administrator brings on a new employer group as a client, the administrator enters into a fiduciary relationship with that client. If the administrator does not provide appropriate medical bill review for the client, the administrator has inflated the cost of health care for the client, at the expense of the client and, in most instances, without the knowledge of the client.

The ultimate responsibility for the management of your claims dollars rests with those of us who act as responsible business managers, investing the necessary time to investigate and implement those options in the markets that are available to us. Upon the introduction of the appropriate medical bill review program, you will realize a substantial reduction in paid claims. This will lower the likelihood that you will experience a specific hit and curtail the incidence of aggregate reimbursements from excess risk insurers. The reduction of the loss ratios by excess risk insurers will reduce the rate adjustments you will face in the future.

Medical bill review is a win-win-win situation, and it costs the plan absolutely nothing unless savings are realized.

It must be admitted that it is a very complex undertaking to comprehend completely the numerous differences among medical bill review companies. But it is vitally important to research and analyze these services in order to make the best possible decision about the management of your claims dollars.

I recently developed a request for proposal form that can be used to solicit information from medical bill review companies about the services each company offers. I will be pleased to e-mail this form to you free of charge if you make a request to the e-mail address listed below.

Once you are aware of the differences among medical bill review companies, you will be well prepared to make the correct decision for your organization and for your most valuable resource—your employees.

Craig L. Boilla is regional sales manager for The National Care Network in Grapevine, Texas. NCN introduces reinsurers, third-party administrators, labor organizations, government agencies, self-administered groups and other payers to cost containment programs designed to reduce the liability of their plans. He can be reached at cboilla@nationalcarenetwork.com.

Updated look at risk management rules

"Avoiding Surprises," Second Edition

By Frederic C. Church Jr.

Standard Publishing Corp.

155 Federal St., Boston, Mass. 02110.

617-457-0600

www.standardpublishingcorp.com

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By Michael Prince

You can't bring back the past. But you can update it.

And that's what has been done with a classic risk management book, "Avoiding Surprises." First published in 1982 by Frederic Church, this venerable classic of the field was recently revised and updated to incorporate new developments and changing approaches to risk management.

With an eye toward simplifying what others often complicate, Mr. Church has set forth the basics of the risk management field. Divided into 12 chapters that delve into different areas of the field, the book has at its core two concepts: risk management and calculating an organization's total cost of risk.

But the book is more than one to just skim and put away: It's designed to be a key resource for risk managers. For example, the chapter about identifying assets and exposures contains a seven-

page checklist of various assets that an organization might hold. A risk manager can take this list—which ranges from such items as radio and television antennas to precious metals—and record the value of the asset in the space provided. Of course, many risk managers might already use some sort of asset checklist, but how many are as exhaustive as the one Mr. Church provides?

Another chapter explores the steps involved in setting up a claims management process. That chapter, which includes sample accident reports, also contains a checklist for reviewing claims handled by an outside vendor.

Although all these topics were discussed in the original edition, the new version updates them, and two new chapters have been added to address the rise of enterprise risk management.

Mr. Church states that the role of the risk manager is changing as organizations move to address the total array of risks they face.

"In the future, more companies will place enterprise risk management in the hands of a chief risk officer reporting to the chief executive officer or through a high-level enterprise risk management committee that brings together the knowledge, skill and experience of the risk specialists in the organization," the author writes.

Mr. Church defines enterprise risk management as an approach that comprises operational and legal

risks; political and regulatory risks; and financial and market risks. He then goes into ways to manage financial risks, such as those caused by an interest rate change or fluctuations in commodity prices. These methods include hedging to protect against short-term exposures or using futures contracts, swap contracts or options to reduce financial risks.

"Today's risk manager—particularly those of you who aspire to be your organization's chief risk officer—must understand the political, regulatory, financial and market risk your organization faces," Mr. Church writes.

The book concludes with Mr. Church's personal mantra, derived from his decades in the insurance business, which ends with "get smart, keep smart." His informative, well-written book will help any risk management professional achieve this goal. **BI**



Michael Prince is an associate editor of Business Insurance in New York.

Workers can't be forced to disobey doctor

A workers compensation claimant who can resume some form of employment only by disobeying the orders of his or her treating physician is totally disabled, at least temporarily, regardless of his or her capabilities, according to the Supreme Court of Delaware.

Lolita Gilliard-Belfast injured her right knee in a compensable work accident while working for Wendy's Inc. She was paid disability benefits. Subsequently, she filed a petition to determine whether she was due ongoing total disability benefits. The compensation board determined that Ms. Gilliard-Belfast had sustained an industrial injury to her knee, for which a second surgical procedure was necessary and appropriate. Her treating physicians ordered her not to work prior to the second operation. Nevertheless, the board determined that Ms. Gilliard-Belfast was not totally disabled while she was waiting to have the operation performed. She appealed to the courts, but the trial court affirmed the board's decision.

The appellate court, however, said that the board's decision would place injured workers in a completely untenable position. If a treating physician's order not to work is followed, the court said, the employee risks the loss of disability compensation if the board later determines that the employee could have performed some work. Conversely, the court said, if the treating physician's order not to work is disregarded, an employee who returns to work not only incurs the risk of further physical injury but also faces the prospect of being denied compensation for that enhanced injury. Thus, the court reversed the trial court judgment and returned the case to the compensation board for a decision in favor of Ms. Gilliard-Belfast.

Gilliard-Belfast vs. Wendy's Inc., Supreme Court of Delaware, June 12, 2000 (BI/04/M.-\$10).

Worker on medical leave an 'active' employee

The 4th U.S. Circuit Court of Appeals ruled that an employee on medical leave was an "active" employee covered by a group accidental death insurance policy, because she was working for the employer on a regular basis despite her sick leave.

Annie Tester began working for The Bibb Co. in

LEGAL BRIEFS

June 1993. At the time of her death, she was on medical leave from her position as a creeler weaver. Reliance Standard Life Insurance Co. issued a group accidental insurance policy to Bibb effective August 1993. Ms. Tester's coverage under the policy became effective Sept. 1, 1993, and provided for a death benefit to the designated beneficiary of \$50,000. Employees qualified as a member of a class eligible for this insurance if they were "active, full-time or part-time employees."

On Jan. 8, 1995, Tester took an approved medical leave because of health problems. On Feb. 15, 1995, she died from injuries sustained in an automobile accident. Her husband applied for death benefits under the group policy. His claim was denied on the basis that Ms. Tester was not an "active" employee at the time of her death and, thus, did not have coverage. Mr. Tester sued Reliance Standard under the Employee Retirement Income Security Act. The trial court awarded him the death benefits.

The appellate court concluded that the policy was ambiguous as to the meaning of "active" because it neither defined "active," nor provided criteria for determining when an employee is "active." The court emphasized that the policy did not contain provisions that incorporate the phrases "actively at work" and "active work." The court rejected the insurer's argument that Ms. Tester was out on sick leave and, therefore, did not qualify as an "active, full time employee" because the term "active" requires a present work capability.

"Such an interpretation," the court said, "would lead to absurd results outside of the insured's reasonable expectations." The court said an employee would expect coverage to extend beyond the time periods that he or she is physically at work and to cover those hours and days when he or she is out of the plant due to illness. Thus, the court found that Ms. Tester was an active employee at the time of her death within the meaning of the policy and that her husband was entitled to benefits.

Tester vs. Reliance Standard Life Insurance Co., 4th U.S. Circuit Court of Appeals, Sept. 25, 2000 (BI/03/M.-\$10).

Employee's will pre-empted by ERISA

The will of a plan participant as it related to the distribution of benefits of a pension plan covered by the Employee Retirement Income Security Act was pre-empted by ERISA, according to the 5th U.S. Circuit Court of Appeals.

In September 1996, Donald and Mary Perkins died in a motor vehicle accident. At the time of his death, Donald Perkins was covered under his employer's pension plans.

Donald and Mary Perkins had no children during their marriage; however, they both had children from previous marriages. Both Donald and Mary had executed wills before their deaths giving the survivor the entire estate. A dispute arose over the proceeds from the ERISA plans among their respective children. As a result, Donald's children filed this suit seeking recovery of the ERISA plans' proceeds. The lower court awarded these proceeds to the executor of Mary Perkins' estate. Donald's children appealed.

The appellate court said that, under ERISA, claims for proceeds and benefits due under the terms of an ERISA plan may be brought by the "participant" or the "beneficiary."

Here, the court said, Donald's children were neither participants nor beneficiaries, as Donald had not designated any of his children as beneficiaries under the plans. The court emphasized that, even though Donald had designated his children as beneficiaries in his will, should he and his wife die simultaneously, such instruments purporting to distribute proceeds and benefits covered under ERISA are pre-empted by federal law. The court affirmed the award of the pension benefits to Mary Perkins' executor.

Tucker vs. Shreveport Management Inc., 5th U.S. Circuit Court of Appeals, Sept. 14, 2000 (BI/02/M.-\$10)

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available for \$10 each by sending a check payable to Mayo H. Stiegler, to Business Insurance, 740 Rush St., Chicago, Ill. 60611-2590. Please provide the listed number for each opinion ordered.

Financial modernization a matter of consensus

By RODD ZOLKOS

SAN ANTONIO—An examination of the debate over federal financial services modernization during the 1990s might well provide a classic example of the similarities between the legislative process and sausage making.

Still, according to one insider involved in that legislative process, in the case of the 1999 Gramm-Leach-Bliley Financial Services Modernization Act, the system ultimately worked.

"The legislative process we have is really consensus-making, and until you have consensus, you really can't get legislation through," said Laurie Schaffer, vp and senior corporate counsel at Charles Schwab & Co. in San Francisco and a former counsel to the U.S. House Banking Committee.

In the case of Gramm-Leach-Bliley, a combination of factors over a period of time finally brought about that consensus, said Ms. Schaffer, speaking on a panel at the American Bankers Assn. Insurance Risk Management Conference last month in San Antonio.

Now, with federal law allowing convergence among banks, insurers and securities firms, the next step likely will be the adoption of a dual charter system that would allow federal licensing of insurers, Ms. Schaffer said. She noted that those who crafted Gramm-Leach-Bliley made a point of indicating in that measure's language that insurance regulation remains a state-based function, but added, "You can only take on so much in one bill." "Eventually, federal insurance regulation will come about—driven in part by the banks, driven in part by some of the Internet activity that's going on," she said. "I don't know that you will see it in this Congress; it may take a couple of years."

But Paul Eddy, deputy general counsel at Travelers Insurance Co. in Hartford, Conn., suggested the history of the financial services modernization process might make Ms. Schaffer's estimate on federal insurance regulation a bit unrealistic.

"If Gramm-Leach took 20 years, I think two years might be a little optimistic," he said. Such issues as state auto insurance requirements are very much local matters, Mr. Eddy said.

"There are a lot of very tricky issues in that question," he said, though he added that the banking industry has worked through the same sorts of issues so, "It may well be doable."

Sarah A. Miller, director of the Washington-based ABA's Center for Securities, Trust and Investments, noted that under a dual-charter insurance licensing model offered by the ABA, a company opting for a federal charter would get a national license but would still be required to follow state workers compensation laws, for example.

Recounting the history of Gramm-Leach-Bliley, Charles Schwab's Ms. Schaffer noted that the process was initially delayed for at least 10 years by turf battles between the House Banking and Commerce committees.

But, she said, by 1995 "a lot of pressure had been building." Banks were beginning to find ways to move into insurance and securities even without the legislation, and the market was changing.

"As these pressures were building and loopholes began to be created, you began to see changes in the industries as well," she said.

"There was a lot of bank and insurance company activity before Gramm-Leach-Bliley," agreed Travelers' Mr. Eddy. "Most big insurance companies owned a bank or a thrift. There were a lot of attempts to distribute insurance products by banks."

The initial effort in 1995 failed largely because of the question of banks in insurance, Ms. Schaffer said. At that time, the *Barnett Bank* case, which ultimately saw the U.S. Supreme Court ruling in 1996 that state-chartered banks could sell insurance if allowed to do so by state law, was "still percolating," and insurance agents wanted to maintain state insurance regulation.

By the 1997-98 congressional session, however, the Supreme Court had ruled in favor of Barnett Bank.

"In my perspective, people talk about the Travelers-Citibank merger. That had an impact, but in my opinion, *Barnett* had the bigger impact," on financial services modernization efforts, Ms. Schaffer said.

In light of the *Barnett* ruling, insurance agents realized "this was the last fight," she said. They recognized that financial services modernization was going to happen, and if their interests were to be represented, they had to embrace it, she said.

"In trying to craft legislation, that really did allow full affiliation...I think, for the independent insurance agents, this really did end up being their Alamo in a way," she said.

This time, opposition was led by a grass-roots effort started by small banks. The Clinton administration opposed the measure as well, and while the legislation passed the House, "it was very clear it wasn't going to pass the (full) Congress," Ms. Schaffer said.

Ultimately, in the Senate it was opposition by Sen. Phil Gramm, R-Texas, who objected to Community Reinvestment Act provisions in the bill, that led to its demise in 1998.

"Interestingly enough, those provisions ultimately wound up surviving in Gramm-Leach-Bliley in somewhat modified form, but with essentially the same effect," Ms. Schaffer said. "That's politics."

As the new congressional session began in 1999, "the stars started lining up," Ms. Schaffer said. Various per-

sonnel changes in the Clinton administration, including Robert Rubin's replacement as Treasury secretary by Lawrence Summers, brought the administration into more of a position of support for financial services modernization. Other factors played into the administration's change of heart as well, Ms. Schaffer suggested.

"I perceive that some of the impeachment stuff that wound up happening led the White House to want to pass it because they wanted something as part of the Clinton legacy," she said.

Despite GLB's elimination of the prohibition against bank-insurance company affiliation, it hasn't generated the wave of cross-industry mergers some anticipated.

Alex Frank, managing director at Morgan Stanley Dean Witter & Co. in New York, noted there was considerable bank-bank and bank-securities firm merger activity during the 1990s but, "Interestingly enough, you haven't seen that many insurance companies with securities firms or insurance companies with banks. Who knows? Maybe that's yet to come."

"I do think what you saw in banking and securities is a lot of consolidation within those industries before you saw a lot of consolidation across the industries," Mr. Frank said. There is still room for consolidation within the insurance industry, he said, and that activity may well continue before cross-industry convergence takes off.

In addition to cultural differences and "product fit" issues, the excess capital in the insurance industry is also slowing cross-industry convergence, Travelers' Mr. Eddy suggested.

"With all that capital, it might not be perceived as that attractive an investment, because there is a lot of competition," he said. **BI**

Some traditional coverage misses online needs

By RODD ZOLKOS

SAN ANTONIO—As financial institutions move to do business online, they not only open themselves to new risks, but also to risks not covered by traditional insurance products.

For example, according to Jeffrey S. Grange, vp and global manager of financial fidelity products at Chubb & Son in Warren, N.J., with so-called "cyber crime," a company faces the risk of "theft without taking."

"Theft, as a common law principle, always turns on the unlawful taking of property," he said, and fidelity bond coverages are based on the taking of property.

"That means your traditional fidelity bond is very seriously deficient in that respect," Mr. Grange said.

Speaking at the American Bankers Assn.'s Insurance Risk Management Conference last month in San Antonio, Mr. Grange noted that theft of money and securities might be covered under the traditional financial institution bond, but there is no coverage for loss of confidential or proprietary information.

Many existing computer

crime policies don't address all of the issues of a fully networked environment, Mr. Grange said. Authorized users who exceed their authorized access are generally excluded, and most contracts specifically exclude confidential material or data.

Computer crime policies also don't address machine-to-machine propagation of computer viruses, nor do they respond to business interruption or extra expense, he said.

Because they're typically triggered by a direct physical loss, property coverages won't respond to business interruption and extra expense resulting from technology-related crime.

Mr. Grange noted that, given the Internet's global reach, "That meant that if an institution of any size embraces the technology, they become a global bank. That, of course, brings a whole new measure of risk."

"The other phenomenon is the instantaneous nature of the risk now," he said, noting that damage from attacks on a company's computer system can have an immediate impact on

See Online on next page



160 attend ABA conference

SAN ANTONIO, Texas—The American Bankers Assn.'s 2001 Insurance Risk Management Conference drew approximately 160 attendees to San Antonio, Texas, Jan. 28 through 31.

The theme of this year's conference was "Making an Impact in an Evolving Environment," and much of the discussion focused on such industry developments as e-business and financial services modernization and customer privacy.

The date and site of next year's conference are still being finalized. For more information, visit the association's Web site at www.aba.com.

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Online

Continued from previous page that business' reputation.

The new exposures that financial institutions face in the online environment prompted Chubb to develop a new policy specifically designed to help protect financial institutions against losses resulting from Internet-related security breaches. The company launched the new product, CyberSecurity by Chubb for Financial Institutions, at the ABA conference.

According to Tracey Vispoli, cyber solutions manager at Chubb & Son, the policy consists of six insuring clauses:

- E-theft, which includes insurance protection against compensatory damages if an insured is found liable for the theft of confidential customer information.
- E-service denial or impairment, including loss of business income and extra expenses incurred during the recovery period.
- E-signature, to help protect financial institutions from a direct loss resulting from accepting a customer's electronic signature on secured loan agreements and later finding the signature to be fraudulent.
- E-communication, including protection in situations involving fraudulent e-mail.
- E-vandalism, including em-

ployee acts that destroy data.

• E-threat, which helps protect financial institutions from threats even if they are not carried out. The clause includes coverage for expenses related to hiring independent negotiators or public relations consultants.

Ms. Vispoli noted that financial institutions' customers want them to provide Internet banking services immediately, so the interests of security staffs often are competing with those of the institution's marketing staffs.

And, she noted, from a customer perspective, the irony is that security of online systems is the No. 1 concern, but the No. 2 concern is speed and ease of use.

In terms of the likely sources of attacks, Mr. Grange noted that 81% of online attacks on a company come from inside the company. And Tony Raker, vp-corporate communications/corporate relations at Amsec International in Winchester, Va., cited FBI statistics that estimate losses from internal attacks at \$2.7 million per incident, vs. \$56,000 per incident for attacks from outside a company.

"The enemy has been identified, and it is truly within," said Mr. Raker, whose firm provides security audits to Chubb's CyberSecurity customers.

An insurance and risk management approach to financial insti-

tutions' online business is clearly needed, Mr. Raker said, "Because the legal recourse is very undefined, even here in the United States."

"Risk identification must be a corporate culture goal," he said.

"Safety and soundness and their reputation—for a financial institution, that's core to their business," Mr. Grange said. "Security matters, and it really matters for a financial institution now. If a financial institution isn't secure, they're out of business."

"The good news is that those institutions that can demonstrate they have invested in security have a tremendous competitive advantage," he added. BI

Banks see risks rising

Growth in e-business puts focus on privacy issues

By RODD ZOLKOS



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SAN ANTONIO—With a variety of e-business activities becoming increasingly commonplace for financial institutions, the risks to which those institutions are exposed are expanding dramatically.

Faced with that host of new exposures, banks' efforts to manage their risks must address a range of concerns, including reputational risks, regulatory risks and privacy issues, not just external hackers, according to Brett Moseley, a consultant at PricewaterhouseCoopers in Linthicum, Md.

"A solution should not just focus on one particular risk," said Mr. Moseley, speaking as part of a panel on e-business risk management at the 2001 American Bankers Assn. Insurance Risk Management Conference, held last month in San Antonio.

Mr. Moseley outlined several e-business scenarios that could create exposures for financial institutions.

One such situation is that of a bank introducing an online banking system. In that scenario, Mr. Moseley said, the institution is exposed to the risk of hacker attacks that could severely damage the company's reputation. "These days, that's actually a very real risk," the consultant said.

The solution to that risk is to conduct penetration testing to gauge the effectiveness of system security, Mr. Moseley said.

"Penetration testing is when you hire ethical and skilled hackers...to try to break into your system," he explained. "They have to be people you trust, and they have to know what they're doing."

Done properly, the testing identifies any holes in a system's security measures, Mr. Moseley said. Such testing should be done periodically, he added.

A second scenario posing risks for financial institutions involves third-party companies, hired to provide customer account data, that have access to the institution's network.

Such arrangements involve the risk of attacks to the vendor's system that could lead to damage to the financial institution's network assets. The solution, according to Mr. Moseley, is stronger authentication systems and a segmented corporate network.

Rather than just a user name and password, such mechanisms

as a secure ID, a thumbprint or electronic certification should be required to access the network, and the network's database should be isolated behind security firewalls.

A third risk scenario involves privacy and branding exposure in cases in which the financial institution's site provides links to external transactional sites that appear, to the site visitor, to be part of the bank's site. In such cases, an online customer

'I look at biometrics as sort of an on-off switch. It's sort of like sealing an envelope,' says Stephen A. Schutze.

goes from the institution's site to a third-party site to perform a transaction, though to the customer, it appears as though he or she never left the bank's site.

The risk to the bank is the possibility of damage to its corporate reputation if the external sites are compromised or customer privacy is violated. The solution, according to Mr. Moseley, is making it clear to online customers when they are actually linking to external sites.

But regardless of the steps a bank might take to secure a site, "Even the best security firms will tell you they can't guarantee you'll be 100% secure, so you need some sort of coverage," said David T. O'Neill, vp at The Fidelity & Deposit Cos. in Baltimore.

And, Mr. O'Neill noted, e-commerce security isn't just a matter of installing system firewalls. Insider attacks on systems are a very real threat. "The human element is very important," he said.

In that context, financial institutions with online operations need insurance coverage appropriate for the related exposures, Mr. O'Neill said. "Is the standard (general liability)

policy meant to cover these exposures? I would beg to say not," he said. "What about the D&O policy? That's meant to cover the Ds and Os," he said of directors and officers liability coverage.

The e-commerce coverages coming on the market are designed to cover risks resulting from online business that would not otherwise be covered under traditional policies, such as vital information/intellectual property, reputation, revenues, lawsuits from third parties, "cyber extortion" and computer crime, Mr. O'Neill said.

Stephen A. Schutze, director of eStrategies at the American Bankers Assn. in Washington, noted that one of the major risks of e-business is that "You really don't know who's out there that's trying to grab your transaction."

But there are four elements of security on the Internet—authentication, non-repudiation, message integrity and confidentiality—that together can increase user confidence in online transactions, he said.

Mr. Schutze suggested that biometric methods of authentication, such as retinal scans or thumbprints, will eventually replace the passwords and IDs currently in use.

With those biometric authentication devices, "It's something you are, so it's that much harder to steal than something you know," he said.

For now, cost and public acceptance have slowed the implementation of such authentication methods. But, Mr. Schutze said, "It's coming."

In practice "I look at biometrics as sort of an on-off switch," Mr. Schutze said, with the biometrics used to switch on such devices as digital certificates, essentially Internet credentials based on pairs of large prime numbers designed to prevent repudiation of transactions.

"It's sort of like sealing an envelope," Mr. Schutze said.

The biometric authentication also could activate a digital signature, an algorithm-based number that guarantees the integrity of the message. Or a biometric device could enable encryption that ensures the confidentiality of the transaction.

Taken together, digital certificates and signatures involving biometrics will help prevent identity theft, Mr. Schutze said, noting, "Identity theft is becoming a bigger and bigger problem."

D&O judgments becoming concern

By RODD ZOLKOS

SAN ANTONIO—Directors and officers exposure to litigation has been growing over the past 20 years, but a host of large settlements and judgments in recent years have heightened the risk dramatically, according to one D&O liability expert.

Speaking at the 2001 American Bankers Assn. Insurance Risk Management Conference last month in San Antonio, Dan A. Bailey, a partner at Arter & Hadden L.L.P. in Columbus, Ohio, noted that, until a few years ago, there was a sort of "glass ceiling" on D&O judgments. That threshold, he said, limited the "worst case possible" to \$100 million.

"So in the old days, in terms of evaluating your insurance program, that kind of glass ceiling was kind of the outer limit," Mr. Bailey said.

That has changed over the past two years, however, he said. During that period, D&O losses exceeded the \$100 million barrier in several cases, moving beyond \$1 billion in some cases and reaching the \$2.83 billion mark in a settlement in the shareholder class action against Cendant Corp. and its directors and officers in 1999.

The Cendant case, which stemmed from a lawsuit charging that the defendants had artificially inflated the company's stock price through an accounting fraud, included characteristics common to many of the largest recent judgments and settlements—alleged financial restatements and institutional investors as plaintiffs.

In the Cendant case, "You just had the combination of bad facts and enormous damages, so there just was no ceiling to the settlement," Mr. Bailey said.

In general, "Whenever you see a financial restatement case, you can count on that case being very difficult to defend and probably very expensive," Mr. Bailey said. And, he noted, "We're seeing more of these where the lead plaintiffs are institutional investors."

Though the trend isn't widespread, it seems that it is responsible for some inflation of settlements, Mr. Bailey said.

In addition to an "unprecedented" number of financial restatements and institutional investor plaintiffs contributing to the shattering of the settlement ceiling, "The plaintiffs bar is pushing harder for settlement dollars than they ever were before," Mr. Bailey said.

With more cases being dismissed as a result of the federal Private Securities Litigation Reform Act of 1995, the plaintiffs bar is pushing

harder on those cases they can move forward, according to the D&O defense attorney.

"So you put all those things together, and it all has contributed to this scary dynamic," Mr. Bailey said.

"A case that used to go for \$5 million now is going for \$10 million or \$15 million, because you've got these big ones serving as a benchmark," Mr. Bailey said. "The bottom line is they have pulled up the lower-value cases to a higher settlement value than we have ever seen before."

"The other consequence, the obvious one, is from an insurance standpoint," he said.

"You can't be paying out these kinds of dollars without somebody starting to hurt after a while. So when we talk about price increases, I'm fairly concerned whether the increases we've seen in the past few months—10%, 15%, if that's what (insurers are) getting—will be enough to sustain this book in the long term."

And, Mr. Bailey noted, "I know of at least five or six cases that will be coming out in the next six months that will be in the same \$100 million-plus category, and some of these will be more than \$200 million."

Looking forward, potential problems lurk in the area of information disclosure.

As it is in other business areas, the Internet is creating some potential new risks in the D&O realm, with Web sites and online forums such as chat rooms and message boards presenting particular disclosure problems that must be managed.

And a new Securities and Exchange Commission regulation that took effect last year has created some new potential headaches for directors and officers. That rule, Regulation FD, aims to promote fair disclosure of information to shareholders by eliminating selective disclosure.

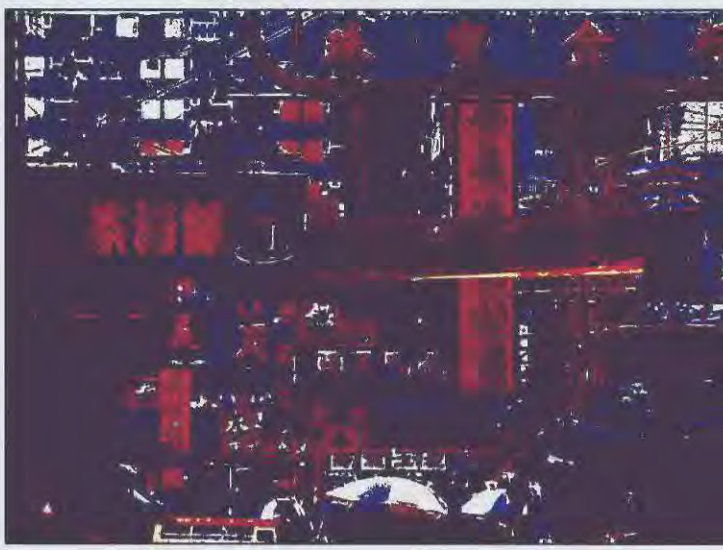
The regulation requires that companies disclosing material, non-public information to securities market professionals or stockholders who could be reasonably expected to trade on that information must simultaneously provide that information to the general public if the exposure was intentional, or they must make it public promptly if the disclosure was unintentional.

While it doesn't provide a direct cause of action, Regulation FD could pave the way for additional D&O suits if the increased volume of information disclosed leads to greater volatility in stock prices, Mr. Bailey suggested. BI

GLOBAL BRIEFS

The final cost to French insurers of the windstorms **Lothar** and **Martin** that battered France in December 1999 has been estimated at 44.3 billion francs (\$6.3 billion). The Federation Francaise des Societes d'Assurance said that 90% of private claims and 80% of corporate claims have now been settled. The FFSA announced that the storms represented the biggest single catastrophe ever borne by the French insurance industry....Chubb Corp. has established a **new operating unit in London**. Chubb Financial Solutions Representative Services Ltd. will structure and execute credit, equity, weather and energy financial products. It will be headed by Richard Harris, formerly managing director of AIG Risk Finance....**Willis Australia Ltd.**, the Sydney, Australia-based subsidiary of London-based broker Willis Group Ltd., has acquired Australian broker Bradstock G.I.S. Gary Seymour, principal shareholder in Bradstock, has joined Willis Australia as managing director. Bradstock specializes in insolvency-related insurance products in the Asia-Pacific region....Lloyd's of London has issued a statement to deny reports in the Swiss press that it was the lead insurer of a **missing pink diamond** worth an estimated 500,000 Swiss francs (\$303,950). The stone was stolen when it was being transported from Geneva, Switzerland, to South Africa. Lloyd's denied reports that it had offered a reward for the diamond and had engaged a team of diamond hunters to try to recover the stone. Lloyd's said that, as a following insurer, it was playing no active role in the recovery effort....Premium volume for Paris-based insurer **Assurances Generales de France** topped 100 billion francs (\$14.3 billion) for the first time in 2000, the group announced. AGF, a subsidiary of Munich, Germany-based Allianz A.G. Holding, recorded consolidated premium volume of 6.21 billion euros (\$5.81 billion) in nonlife insurance for 2000....Guernsey's Financial Services Commission has approved regulations, The Protected Cell Companies (Special Purpose Vehicle) Regulations 2001, that will permit companies to use **protected cells for securitization deals**....**Sirius International Insurance Corp. U.K.** has expanded its presence in the London market. The group has moved to new premises in the London Underwriting Centre to accommodate a new trade credit and political risk underwriting team headed by Matthew Woollam, formerly of Limit Underwriting Ltd....Gerard Heynig has been named chairman of the management board of Warsaw, Poland-based AIG Poland Insurance Co. S.A. Mr. Heynig was previously senior officer for the Benelux countries at AIG Europe S.A....Lloyd's of London-based insurer **Goshawk Insurance Holdings P.L.C.** plans to enter the professional indemnity market. The group has appointed Martin King, previously professional indemnity underwriter at Cotesworth syndicate 1688, as professional indemnity underwriter....Lloyd's of London-based insurer **Cathedral Underwriting Ltd.** has added to its reinsurance team with the appointment of John Hamblin as underwriter. Mr. Hamblin was previously active underwriter of Limit syndicate 566. Cathedral syndicate 2010 has recorded reinsurance premium volume of £26 million (\$38.2 million) since it began underwriting last November, the group announced. It projects total premium volume of £55 million (\$80.8 million) for the 2001 year of account....Stuart Tragheim has been appointed project director of the Assn. of British Insurers' **Raising Standards initiative**. The initiative, launched last October, is aimed at, among other goals, developing a customer-satisfaction standard and working with insurers to help them gain accreditation from the U.K. government's Pensions Protection and Investments Accreditation Board. Formerly, Mr. Tragheim was director of affinity relations at Teachers Provident Society.

Foreigners in China reorient



Aftermath of regulatory crackdown leaves local insurers stronger

By GAVIN SOUTER

NEW YORK—Radical changes in China's insurance environment during the past two years mean that risk managers with exposures there face more-stringent regulations, a brokerage executive said.

Since Chinese authorities began cracking down in 1999 on the frequent breaches of the country's insurance regulations, many foreign risk managers have had to rethink and reconstruct their insurance programs in China, said Yuan-Kee Lee, a

managing director at Marsh Inc. and chief executive of its North Asia operations based in Sydney, Australia.

Instead of virtually extending their global programs to cover Chinese risks, risk managers must now buy most of their coverage from local insurers and negotiate terms with underwriters in China, she said.

While risk managers can still obtain coverage that complements a global program, they can no longer dictate terms to Chinese insurers, she said.

See China on page 17

Equitable agrees to acquisition bid from Halifax

By SARAH VEYSEY

LONDON—The beleaguered Equitable Life Assurance Society—one of the United Kingdom's biggest occupational pension providers—received a possible lifeline last week, after it became the subject of a brief bidding war.

London-based mortgage bank Halifax Group P.L.C. and GE Capital Corp., the Stamford, Conn.-based financial services arm of General Electric Corp., both made offers last week to purchase the operating assets of Equitable and provide the insurer with varying amounts of financial relief to help Equitable meet its liabilities.

On Feb. 5, Equitable's management board accepted the Halifax offer, under which Halifax would make a cash injection of up to £500 million (\$734.5 million) into the company's life insurance reserves and would pay Equitable £500 million to acquire its assets, sales force and certain of its products.

Equitable would use the proceeds as well as existing assets to finance a proposed

scheme of arrangement, or orderly runoff of the company. Equitable has about 450,000 pension policyholders—many of them participants in company pension plans—and manages funds totaling around £34 billion (\$49.95 billion), accounting for about one-tenth of the British pensions market.

Shortly after Equitable accepted the Halifax offer, however, GE Capital made its own offer and sought regulatory intervention to block the Halifax deal so that its bid would be considered.

GE Capital offered to pay Equitable £425 million (\$624.3 million) for its operating assets, and reportedly offered to extend a similar amount of loan support and reinsurance to the insurer's so-called "with-profits fund," which backs the guaranteed annuity rate—or GAR—pensions and other policies. GE Capital also said that if its offer were accepted, it would sell the company's sales force but reopen its life insurance fund to new business produced by GE's other European life insurance operations. It would

See Equitable on page 17

Small rate jumps seen for P&I clubs despite losses

By EDWIN UNSWORTH

LONDON—Shipowners may pay slightly higher liability insurance rates as they renew their coverage this month with



protection & indemnity clubs, after the shipowners mutuals in 2000 experienced their first negative results in a decade, according to Standard & Poor's Corp.

On a consolidated basis, the 17 clubs tracked by the rating agency showed a pretax loss of \$136.5 million in 2000, compared with a \$158.5 million profit in 1999. Their paid loss

ratio rose, to 112% in 2000 from 92% the year before, while the P&I clubs' combined ratio rose to 133% from 126%, according to S&P.

S&P's analysis is part of the rating agency's 2001 Marine Mutual Report, which provides an annual look at the financial strength of P&I clubs. Despite the loss turned in by the group, there were few changes in S&P's latest ratings of 17 P&I clubs.

Rowena Potter, managing director of S&P's financial services group, which compiled the report, said that one reason that rate increases will be moderate is the market's continuing strength. Another is that a perceived threat from competing insurers, which S&P highlighted in last year's report, seems to have abated. The mutuals' main competitors are a handful of insurance companies, including AXA Global Risks S.A., British Marine Luxembourg S.A. and the Dragon syndicate at Lloyd's of London (BI, Feb. 14, 2000).

"Therefore, despite having a negative outlook on the market's operating performance, Standard & Poor's takes a positive view on the fundamentals of the market as a whole," she said.

Of the 17 P&I clubs rated, the ratings of 12 were left unchanged. Four saw their S&P

See P&I clubs on next page

U.K. responds to public farm E. coli risks

By CAROLYN ALDRED

LONDON—A compensation settlement of £2.6 million (\$3.3 million) awarded to a young boy who contracted E. coli after a school trip to a farm highlights the risk management and insurance concerns of farms and municipalities.

Last month's settlement of the case in London's High Court is the latest in a string of multimillion-pound payments that are driving up rates for municipalities and owners of farms open to the public.

This most recent incident also has led the U.K. Health and

Safety Executive to rewrite its risk management guidelines for farms that are open to the general public.

Tom Dowling was 4 years old when he contracted an E. coli bacterial infection, believed to be from a goat, while visiting an open farm operated by Bowmans Farms Ltd. in Hertfordshire in June of 1997. As a result of the infection, the child, who is now 7, sustained severe brain damage and spastic quadriplegia, requiring 24-hour care for the remainder of his life—estimated to be only 25 years. A total settlement of £2.6 million was agreed upon by the claimant's lawyers and in-

surers for the farm and the school's local authority, including about £200,000 (\$293,920) for pain and suffering.

Bowmans Farms Ltd. was sued for "failing to institute a proper hygiene system to provide washing facilities for visiting children and for failing to close the farm to visitors when they were aware of the infection," according to the complaint filed on behalf of the boy. The London borough of Barnet, which governed the boy's school, was also named as a defendant in the lawsuit for failing to check whether the farm was suitable for children after two other children had been infected

by E. coli bacteria on the farm prior to the claimant's accident.

The defendants settled for 95% of the amount sought, splitting the liability at 55% and 40% between the farm and local authority, respectively.

The Dowling lawsuit alleged that signs at the farm warning children to wash their hands were not sufficient for young children who were unable to read them. E. coli is a type of bacteria commonly found in the feces of farm animals, such as cattle, that can be spread by human and animal contact.

Although the farm had in place

See Farms on next page

P&I club ratings

International Group	Location	S&P ratings	
		1/24/01	2/3/00
American Steamship Owners' Mutual Protection & Indemnity Assn. Inc.	New York	BBB+	BBBpi
The Britannia Steam Ship Insurance Assn. Ltd.	London	Api	Api
Assuranceforeningen Gard-gjensidig	Arendal, Norway	Api	Api
The Japan Ship Owners' Mutual Protection & Indemnity Assn.	Tokyo	BBpi	BBpi
Liverpool & London Steamship Protection & Indemnity Assn. Ltd.	Liverpool, United Kingdom	NR	NR
The London Steam-Ship Owners' Mutual Insurance Assn. Ltd.	London	Api	Api
North of England P&I Assn. Ltd.	Newcastle, United Kingdom	A-	BBBpi
The Shipowners' Mutual Protection & Indemnity Assn. (Luxembourg)	Luxembourg	Api	Api
Assuranceforeningen Skuld (Gjensidig)	Oslo, Norway	BBpi	BBBpi
The Standard Steamship Owners' Protection & Indemnity Assn. (Bermuda) Ltd.	Bermuda	AA-	AA-
The Standard Steamship Owners' P&I Assn. (Europe) Ltd.	United Kingdom	AA-	AA-
The Standard Steamship Owners' P&I Assn. (Asia) Ltd.	Singapore	AA-	AA-
The Standard Steamship Owners' Protection & Indemnity Assn. (London) Ltd.	London	A-	BBBpi
The Steamship Mutual Underwriting Assn. (Bermuda) Ltd.	Bermuda	BBBpi	BBBpi
Sveriges Angfartygs Assurans Forening (The Swedish Club)	Goteborg, Sweden	BBBpi	BBBpi
The United Kingdom Mutual Steam Ship Assurance Assn. (Bermuda) Ltd.	Bermuda	AA-	Api
The West of England Ship Owners' Mutual Insurance Assn. (Luxembourg)	Luxembourg	BBBpi	BBBpi

NR=Not rated. "pi" denotes ratings based on published information and not on meetings with the entity.
Source: Standard & Poor's Corp.

P&I clubs

Continued from previous page
ratings raised—the American Steamship Owners' Mutual Protection & Indemnity Assn. Inc. to A- from BBBpi, the North of England P&I Assn. Ltd. to A- from BBBpi, the Standard Steamship Owners' Protection & Indemnity Assn. (London) Ltd. to A- from BBBpi, and The United Kingdom Mutual Steam Ship Assurance Assn. (Bermuda) Ltd. to AA- from Api.

Only Assuranceforeningen Skuld, the Oslo, Norway-based P&I club, had its rating cut, to BBpi from BBBpi. The report says the Skuld downgrade reflects "the continued poor operating performance and potentially weakened corporate profile following another difficult year for the club." S&P added, though, that this downside is partly offset by the club's "strong financial flexibility and good business position."

Commenting on the rate increases that P&I clubs will be seeking at their Feb. 20 annual renewals, Ms. Potter said they are likely to be in the relatively modest range of 7.5% to 10%.

One reason for this is that the

clubs continue to enjoy "extremely favorable" terms on the International Group of P&I Clubs' excess of loss reinsurance program, which last year set rates until 2002. The International Group is currently made up of 15 P&I clubs, which pool their reinsurance coverage for

Increases at the Feb. 20 annual renewals are likely to be in the modest range of 7.5% to 10%, says S&P's Rowena Potter.

large losses.

The report also states that the clubs' free reserves—assets set aside to be used, if necessary, to reduce the need to call on members for additional funds to meet claims—had been increasing over the last few years but took a sudden dip in 2000.

The report says that, while many clubs have continued to build reserves, some have suffered a reversal due to exceptionally poor claims experience, low premium levels or a downturn in investment earnings.

In addition to the loss turned in

by the group, consolidated premiums of the 17 P&I clubs were \$1.88 billion last year, down 7.4% from the year earlier, according to S&P. Gross claims paid stood at \$1.87 billion, up 4.5% from 1999. Investment income dipped 9.4% to \$235.1 million in 2000.

Apart from predicting moderate rate increases this year, the S&P report forecasts that P&I clubs will start to offer more-diversified, customer-driven products. "Clubs and their managers must develop the flexibility to satisfy all owners, and this will probably mean cooperating with other organizations to offer a full range of services," the report says.

It also predicts that information technology will become a key differentiator between clubs. "IT is clearly a tool that can help to put companies ahead of the pack, in terms of claims handling, policy forms, efficiency, expense control and in communication with clients generally," the report says.

Copies of the 2001 edition of the *Marine Mutual Report* are available from Standard & Poor's, Third Floor, Broadgate West, 9 Appold St., London EC2A 2AP; e-mail: insurance_info@standardandpoors.com. The cost is £495 (\$725).

Farms

Continued from previous page
washing facilities and safety fences that separate livestock and the public, as was recommended by the HSE at the time, "this case has been instrumental in the HSE rewriting guidelines" for farms open to the public, said Andrew Wolfe, farms director at Bowmans, which is based in London Colney, Hertfordshire.

HSE Inspector Mike Sebastian confirmed that formal health and safety guidelines for open farms were drawn up by the HSE after the incident. These guidelines were subsequently revised last June and incorporate many of the lessons learned by the HSE investigation team after the Bowmans case.

Mr. Sebastian, who is based in Stoneleigh, Warwickshire, esti-

mates that children account for half of the 10 million-12 million people who visit farms in the United Kingdom annually, which result in about 10 incidents of E. coli infection each year.

Since the incident, Bowmans, which is open to the public every day, has instituted additional man-

agement procedures and upgraded facilities to further reduce the risk of a member of the public contracting E. coli, Mr. Wolfe said.

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Products & Services Guide

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Equitable

Continued from page 15

also turn Equitable's headquarters in Aylesbury, England, into GE's European center for pension administration services.

When Equitable said it would stick with Halifax offer, GE Capital reportedly offered to sweeten the terms of its offer. But when that failed to sway Equitable, GE Capital withdrew its bid on Feb. 8, according to Reuters news service.

The Equitable board described the Halifax offer as more attractive than the GE offers. Key to the Halifax offer was the prospect of receiving funds to help Equitable meet its liabilities under its proposed scheme of arrangement.

A scheme of arrangement is a method under U.K. law that allows financially troubled insurance companies to negotiate settlements of their liabilities to policyholders and other creditors, and to plan for the orderly distribution of their assets.

Equitable's proposed scheme would pay its GAR policyholders a lump sum that would increase the current value of their policies by about 20%, the company said.

Equitable, the world's old mutual life insurer, closed its doors to new business in December 2000, after takeover talks with London-based insurer Prudential P.L.C. broke down (BI, Jan. 1). Equitable began pursuing a possible sale after the House of Lords ruled last July that the insurer owed a group of policyholders at least £1.50 billion (\$2.20 billion). That decision arose from the insurer's 1998 discovery that it had underfunded

about 100,000 guaranteed annuity rate pension plans. The GAR policyholders sued when Equitable tried to pay them lower benefits than it had guaranteed.

In addition to Prudential walking away from the table, a U.K. unit of Dutch insurer AEGON N.V. and Sydney, Australia-based AMP Ltd. both also pulled out of a bidding race for Equitable last month.

Key to the Halifax offer was the prospect of receiving funds to help Equitable meet its liabilities to policyholders under its proposed scheme of arrangement.

The guaranteed annuity rate pension plans are part of Equitable's with-profits policies, which are products that build up a cash value—typically in the form of crediting policyholders with annual bonuses linked to the profitability of the insurer—in addition to underlying benefits. They can include life insurance policies, as well as pensions, savings plans and trusts. Bonuses added to accounts cannot be taken away. Equitable has about 190,000 GAR policyholders, more than half of whom are in occupational plans.

The main other type of savings product offered by Equitable is unit-linked policies. These products also have a cash-value component, but instead of building value through bonuses, a portion of the premium is used to purchase units in funds administered by the insurer, much like mutual

funds. The value of the units can rise and fall with the funds' investment performance.

A key challenge to Equitable will be winning support for its proposed scheme of arrangement from policyholders. If it can negotiate settlements of its liabilities with GAR policyholders and other policyholders, that would enable it to cap its liabilities at around the £1.5 billion mark, which is the

amount the House of Lords said it owed. If it fails to settle with the groups of policyholders, however, its eventual liabilities could exceed that figure and the funds that the Halifax deal would provide.

London-based Lovells, a law firm acting on behalf of Equitable in the proposed sale, described the life insurer's proposed scheme of arrangement—under section 425 of the U.K. Companies Act of 1985—as “groundbreaking.”

Section 425 schemes of arrangement “have been used successfully on many occasions in the context of the non-life insurance industry,” but are rarely used in the life sector, said Robin Spencer, the head of Lovells' insurance restructuring practice.

Rating agencies said that winning support from policyholders for the sale—and scheme of arrangement—would be key to Eq-

uitable's success at meeting its liabilities.

“The main upside (to the deal) is connected to a related proposal to achieve a settlement between GAR and non-GAR policyholders,” said Standard & Poor's Corp. in London. “If this is agreed, Equitable Life will have greater certainty regarding its liabilities and, as a result, will have greater financial strength and investment flexibility.”

If policyholders and creditors approve the scheme of arrangement, Halifax would make an additional cash payment of £250 million (\$367.3 million) into Equitable's closed with-profits fund and would make a further payment of up to £250 million, contingent upon the profitability of the business in 2003 and 2004.

“If a settlement is not achieved, it is possible that Equitable Life's financial strength could deteriorate, reflecting the potential impact of adverse investment markets on the GAR liability of the closed fund,” S&P pointed out.

S&P changed its CreditWatch rating on Equitable to “developing” from “negative” in the wake of the Halifax announcement. “The revised CreditWatch implications reflect the upside potential to the ratings as a result of the injection of sale proceeds into the now closed with-profits fund,” S&P said in a written statement.

Moody's Investors Service in London also said that the proposed scheme would lead to “further improvements in statutory solvency, investment strategy and potentially future investment returns.” However, Moody's noted, “significant uncertainty remains over the long-term future capital-

ization and solvency of Equitable should policyholders not vote to approve the restructuring later this year.”

Halifax already owns U.K.-based life insurer Clerical Medical Investment Group Ltd., and the acquisition of Equitable would more than double its assets under management to £65 billion (\$95.49 billion) from £30 billion (\$44.07 billion).

Moody's said that the acquisition of Equitable would strengthen and diversify Halifax's earnings. It added that the transaction would not expose Halifax to any uncapped liabilities in its own with-profits fund.

The National Assn. of Pension Funds, which represents many companies with pension funds invested in Equitable, called for a company pension scheme specialist to be appointed to the Equitable board amid fears that members of occupational pension plans may be shortchanged by the Halifax deal.

The NAPF pointed out that, if the deal goes through, GAR policyholders would have to relinquish entitlements on future contributions in return for a lump sum.

“The non-executive directors are the people who will have ultimately to pilot any deal through the policyholders and through the courts,” said Alan Pickering, chairman of the NAPF. “This is why we think there should be at least one person (on the board) who can empathize with company scheme members. It will ensure that they are left in no doubt that their interests were represented. Everyone's going to have to compromise.”

China

Continued from page 15

Risk managers who fail to abide by the local rules and attempt to dictate to local underwriters may face severe penalties that could jeopardize their companies' operations in China, Ms. Lee said at a Marsh seminar on China held in New York last week.

Insurance regulation in China has changed dramatically in the past several years, as responsibility for regulating the sector shifted from the People's Bank of China to the China Insurance Regulatory Commission in 1998, Ms. Lee explained.

Before the establishment of the CIRC, many foreign insurance buyers, brokers and insurers used local insurers as fronting companies, reinsuring much of the business out of the country, Ms. Lee said.

The Chinese government disapproved of these actions, mainly because the Chinese insurance industry was not being developed as a result of the increasing foreign investment in the country, Ms. Lee said.

“They want China to have an international-quality insurance industry,” she said.

So, the CIRC in 1999 instituted a crackdown on the insurance industry, shutting down some foreign insurers and brokers that authorities said had breached the 1995 Insurance Law.

Among other things, the law prohibits fronting arrangements and retail brokering.

Marsh's own risk management consulting and reinsurance brokering operation was suspended in the crackdown (BI, June 7, 1999). The suspension was lifted later in the year after Marsh im-

plemented certain changes the CIRC required.

Businesses operating in China now should not risk official censure by flouting the insurance regulations, Ms. Lee said.

In addition to its Beijing head office, the CIRC has seven new branch offices and it plans to open three more, she said.

“So it is very important to be

Underwriters in China are now 'open-minded, they want the business, they understand that you want coverage, and you can negotiate with them,' says Marsh's Yuan-Kee Lee.

compliant with the laws and regulations,” Ms. Lee said.

While the Chinese authorities have not disclosed any penalties they would impose on policyholders that flout the insurance regulations, likely penalties would include cancellation of business licenses, suspension of bank accounts and fines, Ms. Lee said.

The main regulation that foreign investors need to be aware of is that they must buy coverage from local insurers, Ms. Lee said. Exceptions include marine cargo and other coverages that are not available from local insurers, she said.

Of the coverages not available from local Chinese insurers, the most important is earthquake, Ms. Lee said.

The CIRC last year banned local insurers from providing earthquake coverage, in most cases, as a way to aid the state reinsurer, China Re. The reinsurer was encountering difficulties in securing catastrophe coverage in interna-

tional markets because local Chinese insurers were supplying China Re with insufficient underwriting information, she said.

Consequently, policyholders should be able to buy earthquake coverage from foreign insurers without breaching Chinese regulations, she said.

Earthquake and flooding are the two principal natural perils

facing businesses operating in China, Ms. Lee said.

In the last century, three major earthquakes occurred in China, with each one killing more than 150,000 people.

“You must make sure that you understand your earthquake exposure.... The Chinese government has one of the best earthquake research centers, so information is readily available,” she said.

Flooding is a problem that China has suffered for thousands of years, and it is not about to let up anytime soon, Ms. Lee said.

But because of the high likelihood of flood in some areas, it is difficult to secure insurance coverage, she said. “It's very difficult to buy commercial insurance to cover flood because it is not insurance any more in some areas where floods come every year,” Ms. Lee said.

For coverages that are available locally, policyholders should not try to follow previous practices of

dictating the terms and conditions and insisting that the business be reinsured to their chosen foreign carrier, Ms. Lee said.

“That is now prohibited. It doesn't mean that your terms and conditions will not be acceptable, but you have to treat the insurers like underwriters,” she said.

Consequently, policyholders must provide all the information on a risk that they would normally provide to the underwriters of their programs outside of China, Ms. Lee said.

In addition to the regulatory changes over the past several years, the quality of underwriters at the local insurers has improved quite substantially, she said. “They are open-minded, they want the business, they understand that you want coverage, and you can negotiate with them,” she said.

In many cases, policyholders can negotiate a coverage that complies with their global programs, but they can no longer simply demand that coverage as a condition of placing the business with a certain local insurer, she said.

Instead, risk managers should appoint a local lead insurer and develop a relationship with that insurer so that it fully understands the risks, Ms. Lee said.

The geographical limitation of policies is also an issue for policyholders, Ms. Lee said.

Under the Chinese regulations, insurance coverage must be bought from insurers located in the same area as the risk unless the total sum of property insured is 500 million yuan (\$60.4 million) or the total premium exceeds 1 million yuan (\$120,800). And those exceptions only apply to Chinese insurance companies, not the handful of foreign insurers

that have limited operating licenses in China, Ms. Lee said.

Policyholders can use a single insurance company to write coverage for multiple locations, but the insurer must be based in the same town as the policyholder's main location in China, or if the sum of the property insured in that town is more than 50% of the policyholder's total sum insured, she explained.

Another issue for foreign policyholders is reinsurance, as Chinese authorities are now strictly enforcing the requirement that 20% of all premiums must be ceded to China Re, Ms. Lee said.

So, policyholders whose coverage is heavily dependent on facultative reinsurance should ensure that the reinsurance above that provided by China Re is well coordinated, Ms. Lee advised.

“Otherwise, you may find that you have quite a number of reinsurance leaders and claims settlement may take a long time,” she said.

One common concern that risk managers have about China is the risk of nationalization or expropriation of their companies' operations, Ms. Lee said. But Chinese law bans nationalization and expropriation of foreign companies except in “special circumstances,” she said.

The government has not explicitly said what the special circumstances might be, but they would likely include national security issues or issues concerning major civil engineering projects, she said.

And if companies are affected by nationalization or expropriation, the government is compelled by law to compensate businesses. Still, there are no guidelines on what the levels of compensation would be, Ms. Lee said.

Layoffs

Continued from page 1

made in exchange for extra severance pay.

In an apparent alternative to layoffs, for example, stockbroker Charles Schwab Corp. recently announced a plan that would have forced employees to take time off—either using vacation days or as unpaid leave—but Schwab quickly backed off of that approach when questions were raised about its legality.

Although some employers will seek alternatives to terminating jobs, for other companies layoffs may be inevitable. With them come employer worries about disgruntled employees who seek to offset their reduced income by turning to the courts, especially with suits alleging sex, racial or age discrimination.

There are several steps employers can take, experts say, to minimize their potential liability exposure.

Paramount among these is to have objective, valid business reasons for terminating the selected employees, and to conduct frequent analyses of the disparate impact any terminations may have on protected groups, such as minorities, females and employees who are over age 40.

Other steps include planning

spect (see story, page 19).

Employers should heed warning signs that layoffs may become necessary and be prepared, one attorney says.

"It is always better to make those decisions when you aren't in a crisis," said Patricia Gillette, an employer attorney with Heller Ehrman White & McAuliffe in

employers be sure there are valid, well-documented business reasons for cutting particular jobs.

"There's no magic bullet, but if there is an articulated process which fairly evaluates the value of each employee to an organization, then the decisions made can be more easily defended," said employer attorney Steven K. Ludwig, with Fox, Rothschild, O'Brien & Frankel in Philadelphia.

Philip Berkowitz, an employer attorney with Salans, Hertzfeld, Heilbronn, Christy & Viener in New York, said, "The key thing is to treat employees fairly, to have a policy in place which makes clear the employer is making decisions based on appropriate criteria, and that all employees affected are given special severance benefits in exchange for which they sign the release" agreeing not to sue.

Assuming that voluntary retirement programs or attrition are inadequate or unfeasible, some lay-off decision may be less likely to generate liability exposures than

others. Companies that decide to exit certain geographical areas or product lines or functions, for example, are less likely to face the usual bias claims because the terminations involve shutting down an entire operation or unit, rather than choosing specific workers to let go.

A general rule when doing layoffs is to focus first on function, advised Ms. Gillette. A company may decide, for instance, that it either does not need a marketing department or can outsource its functions.

"In that regard, companies can do pretty much what they want to," provided there is no discriminatory adverse impact on one particular group, she said.

Even in these situations, though, there may be a disparate impact on selected classes of workers. If, for instance, an employer lays off only the maintenance department, but all of that area's employees are members of minority groups, "you're really

See Layoffs on next page

'If there is an articulated process in place which fairly evaluates the value of each employee to an organization...the decisions made can be more easily defended,' says Steven K. Ludwig.

ahead; leaving a paper trail; designating more than one person to make termination decisions; complying with relevant federal and state laws; offering generous severance benefits and outplacement services; and treating departing employees with dignity and re-

San Francisco. If a company sees early in the year that it may be having some trouble by midyear, it "should be thinking of a plan now," rather than waiting until financial problems arise, said Ms. Gillette.

Another attorney advises that

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THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS COUNTY DEPARTMENT, CHANCERY DIVISION IN THE MATTER OF THE LIQUIDATION OF ILLINOIS EARTH CARE WORKERS COMPENSATION TRUST NOTICE OF CLAIM FILING DEADLINE AND PROCEDURES

PLEASE TAKE NOTICE, that on October 26, 2000, the Circuit Court of Cook County, Illinois, entered an Agreed Order of Liquidation With a Finding of Insolvency and Injunctive Relief against Illinois Earth Care Workers Compensation Trust ("EARTH CARE"). Nathaniel S. Shapo, Director Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of EARTH CARE ("Liquidator").

TAKE FURTHER NOTICE, that on January 16, 2001, the Circuit Court of Cook County, Illinois, entered an Order Fixing Rights and Liabilities and Providing for the Filing of Claims and the Setting of Claim Filing Deadlines (Fixing Order). Pursuant to the Fixing Order, all rights and liabilities of EARTH CARE and its policyholders, members, creditors and all other persons interested in its property or assets, are fixed as of October 26, 2000, unless otherwise provided in prior or subsequent orders of the Court.

TAKE FURTHER NOTICE, that all persons, companies or entities who have, or may have claims against EARTH CARE, its property or assets, or against an enrollee or policyholder, shall have the right to present and file with the Liquidator proper proofs of claim on or before October 26, 2001 at 4:30 p.m. (C.S.T.).

TAKE FURTHER NOTICE, that pursuant to Section 209(4) of the Illinois Insurance Code, 215 ILCS 5/209(4), any insured under an insurance policy issued by EARTH CARE shall have the right to present the Liquidator with a proof of claim setting forth a contingent claim, subject to the claim filing deadline of October 26, 2001 at 4:30 p.m. (C.S.T.). The final date by which evidence supporting the liquidation of any such contingent claim may be received by the Liquidator shall be October 28, 2002 at 4:30 p.m. (C.S.T.). No such contingent claim shall be allowed for purposes of participating in any distribution of estate assets that may be made at the class "d" priority level, 215 ILCS 5/205 (1)(d), unless such claim has been liquidated and the insured claimant has presented evidence of payment of such claim to the Liquidator on or before October 28, 2002 at 4:30 p.m. (C.S.T.).

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

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIM AGAINST EARTH CARE, ITS PROPERTY OR ASSETS, OR AGAINST AN EARTH CARE POLICYHOLDER OR MEMBER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE OCTOBER 26, 2001 AT 4:30 P.M. (C.S.T.).

Cathleen M. Travis
Special Deputy Receiver

METROPOLITAN TRANSPORTATION AUTHORITY (MTA)
NOTICE is hereby given that the Authority requests proposals from qualified firms to provide the services indicated below. Copies of RFP may be secured from Ms. Michelle Davy, Procurement Services, MTA, 345 Madison Ave, NY, NY 10017-3739 or by calling (212) 878-7261. Each document will cost a non-refundable fee of \$150 (Company checks drawn on an U.S. Depository or Money Order). There will be a \$25.00 fee for each returned item. You may pick up the documents between 9:30am and 4:30pm, Monday to Friday (except holidays) or have them mailed to you. This document will be available on or about February 2, 2001.
RFP # 5-01-01003-0 DUE DATE/TIME 3/13/01, 4:00 PM
FOR: Actuarial & Risk Management Consulting Services.

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Layoffs

Continued from previous page
going to have to be very careful," said Joe Hesselthaler, a principal with Towers Perrin in Philadelphia.

The really tough choices for employers—and the biggest liability exposures—generally arise when layoffs require culling particular employees from ongoing units.

"Obviously, it's easier to defend a decision to stop doing something—to stop a product line or to outsource your accounting function—than it is to defend individual terminations," said Neal Mollen, an employer attorney with Paul, Hastings, Janofsky & Walker in Washington.

"It's much easier to say, 'We don't do that anymore, so we didn't have a spot for you,' than it is to say, 'We're going to continue to do that,' " but instead of six people, the department will have five "and we've selected you as the individual to go," Mr. Mollen said.

To minimize their exposure, employers must use objective criteria in this process, attorneys say.

"I think they have to have well-founded reasons for making distinctions among employees, in particular whom they're going to let go and whom they're going to keep," said Marc E. Weinstein, a plaintiffs attorney with Kolman & Associates in Langhorne, Pa.

"They should have clear criteria as to how the employees are being judged, and then apply those criteria for each employee. And be very cognizant of whether more employees in any particular protected class are being let go than in other classes.

"If it looks like employees in protected classes are being disproportionately affected, then they've got to take another look at the criteria they've used to evaluate employees, to make sure that the criteria are fair," said Mr. Weinstein.

Choosing on the basis of seniority appears to be the least complicated approach, but in some industries that have only recently made an effort to diversify their workforce, that could have a disproportionate impact on the minority and female populations.

But even here, consistency helps, attorneys say.

Peter J. Petesch, an employer attorney with Ford & Harrison L.L.P. in Washington, said if companies adhere to a bona fide seniority system, it "is not going to be discriminatory even if there is a disparate impact on certain groups."

"However, if all layoffs in the past were done based on performance, and now all of a sudden they're being done by seniority... somebody might be able to come up with a creative theory for recovery," said Mr. Petesch.

Another possible approach is to do layoffs on the basis of past performance reviews. But this is not always an entirely adequate solution, either.

For instance, Murray Hill, N.J.-based Lucent is reducing its headcount by 16,000 employees, including 6,000 whose jobs will be outsourced.

Referring to the involuntary layoffs that will be necessary, Paul F. Buckley, treasury director-risk management, said, "The first criterion in that process is performance, but when you get into these kinds of numbers you're actually losing decent performers, too."

Furthermore, the performance reviews themselves may present a problem. "A lot of companies are

fairly laissez-faire as to how they keep performance records," said Rich Koski, a consultant with Buck Consultants Inc. in New York.

Companies should also make sure the reviews they have on file are accurate, without euphemisms. Letting go an incompetent employee who has been getting "fair" or "acceptable" performance ratings even though the employer was in fact unhappy with that person's work could cause problems after termination. Lawsuits can result when somebody who has been given good reviews "all of a sudden becomes terrible overnight," said Mr. Koski.

Ms. Gillette said she generally advises her clients to use a "multi-factored system" and examine several factors, including the worker's length of service, performance record over a set period, experience working in various positions and current skill set.

"And then, to the extent someone has special skills the employer can't live without, that's going to give them a leg up," said Ms. Gillette.

Although the decision must be based on neutral facts, "this is difficult because we're really human beings with biases and prejudices," said L. Steven Platt, a plaintiff attorney with Arnold & Kadjan in Chicago. Most people know enough not to act on them, but "they creep into decision-making anyway," said Mr. Platt, who is also president of the National Employment Lawyers Assn.

Senior management must make a strong commitment to ensure that layoffs are done fairly, and this must be communicated, Mr. Platt said. "My experience is senior managers do have that kind of an outlook," but often "the message gets garbled in the translation" when it seeps down to the supervisory and mid-level man-

agement-level employees who have the power to question managers' termination decisions and have access to performance appraisals, he said.

In addition, "employers might want to consider establishing an appeals procedure," said Liz Snyder, an employment law consultant with Hewitt Associates L.L.C. in Lincolnshire, Ill. "If they have something like that in place,

'If you're inconsistent and if you don't document, your chances of getting sued and the employee prevailing go way up,' says employer attorney Patricia Gillette.

Managers often wind up going after the "irritants in the workforce, the people the managers find they don't get along with," agreed Paul Mollica, a plaintiffs attorney with Meites, Mulder, Burger & Mollica in Chicago. "Employers have to be sensitive as to why managers are selecting out particular individuals."

So employers can defend themselves against such claims of individual bias, experts strongly recommend more than one person make the decision on terminations.

That way, "the employer can be confident there's no animus on the part of one decision-maker towards a protected class," said Mr. Weinstein.

"I always recommend a 'reduction in force committee,' which has the power to review every termination and decision to assure that it's based upon appropriate criteria," said Mr. Berkowitz.

This committee usually includes a representative from the human resources department as well as

at least there's a way to resolve issues that come up in-house instead of taking them directly to outside tribunals," said Ms. Snyder.

Employers' actions also must comply with all relevant federal and state laws. The 1988 federal Workers Adjustment and Retraining Notification Act, for instance, requires employers to provide 60 days' advance notice of plant closings and mass layoffs that fall within its jurisdiction, and there are equivalent state laws as well.

Also, under the federal Age Discrimination and Employment Act of 1967, employees who are over 40 must be given 45 days to sign a waiver agreeing not to sue, and another seven days after they sign the agreement to rescind it.

Employers must also provide these fired employees with statistical data on other employees in comparable positions, both those who are fired and those who are keeping their jobs.

Employers must be careful also about not going overboard and

cutting too many employees. Firing a worker who is over 40 years old, then finding six months later you need the position filled and hiring a recent college graduate, can "be quite problematic in terms of leaving (employers) vulnerable to a lawsuit," said Mr. Kuenstler.

It is also a good idea to maintain as much of a paper trail as possible, said Dennis Coleman, a principal with Unifi Network, a unit of PricewaterhouseCoopers in Teaneck, N.J. "You don't want to make this look in any way that individuals are being singled out other than for sound business reasons."

Ms. Gillette said, "The key issue is consistency and documentation, and if you're inconsistent and if you don't document, your chances of getting sued and the employee prevailing go way up, because juries believe that companies write things down."

She added that "The other thing that people often miss is the emotional component of this, really trying to put yourself in employees' position in terms of the anxiety, the questions that need to be answered, the handholding and then the reassurance to people who are staying that things will be OK—without guaranteeing anything, because things may not be OK."

Another mistake employers make is they "tend to err on the side of cheap," by doing things like offering "really minimal" severance packages, such as asking employees to sign waivers agreeing not to sue in exchange for just two weeks' severance pay, and by not offering any kind of outplacement service, Ms. Gillette said.

"You have to find a way to balance the economic factors with some kind of system that recognizes what employees have given to the company," she said. **BI**

Fair treatment reduces bad feelings

By JUDY GREENWALD

A key, if sometimes overlooked, element in reducing employers' risk of being sued by unhappy former employees is to treat them with at least a modicum of dignity and respect, attorneys advise.

While nobody is happy about losing a job, sensitivity on the part of the employer helps dissipate the anger and hurt pride that often lead to lawsuits, legal experts say.

"The overwhelming majority of people who come to me do so because of the way they were fired," said L. Steven Platt, a plaintiffs attorney with Arnold & Kadjan in Chicago.

This is especially true for long-term employees, said Mr. Platt, who is also president of the National Employment Lawyers Assn. These people, whose social life is frequently enmeshed in their jobs, really do not want to see their employers.

But managers "have an annoying tendency to humiliate people when they have to terminate them" through such methods as having the police escort terminated workers out the building, literally pushing them out the door, giving the workers insulting severance offers, failing to recognize the employees' achievements, or voicing "false criticism" of their work performance, Mr. Platt said.

Employees can understand the need to make cutbacks, and if they are treated with dignity, "there's less likely to be a problem," he said.

It goes beyond following the letter of the law, said Jacques Leger, managing consultant with Watson Wyatt in San Fran-

Employees can understand the need to make cutbacks, and if they are treated with dignity, 'there's less likely to be a problem,' says L. Steven Platt.

cisco. If it feels like "you're being put through a factory of termination, you will remember that and you will act accordingly," he said. "A person who feels assaulted will generally punch back."

Neal Mollen, an employer attorney with Paul, Hastings, Janofsky & Walter in Washington, agreed.

"A major corporation that's going through a significant reduction in force is going to have unhappy folks, but if they feel the process was fair or their perspective has been considered, they may be unhappy with the result but they're much less likely to sue," he said.

Mr. Mollen said one of his cor-

porate clients once let go thousands of employees.

"There were certainly a lot of animosities created and a lot of folks felt they should have stayed rather than the individuals who actually got jobs, but surprisingly few of them brought suit because (the company was)

very careful in designing a process that solicited input from all quarters," he said.

Employees had the opportunity to go through a rigorous process to determine who stayed and they saw how it worked, "so even if they disagreed with the result, they had a hard time assigning what they viewed as an incorrect decision to irrationality or discrimination. They were much more willing to accept that it was just a difference in opinion." As a result, despite the many who lost their jobs, there were only a couple of lawsuits, "which is really a remarkable record," said Mr. Mollen.

The actual leave-taking can be important as well. Some employ-

ers give people up to two weeks to leave the office after they have received their termination notice to "give them a chance to get their house in order," said Joe Hesselthaler, a principal with Towers Perrin in Philadelphia.

But others give employees just a half-hour to clear out the desk, with a big guy twice their size "out in the hallway," he said.

Mr. Hesselthaler said he knows of one case where an employee's mother called her son shortly after he was fired and was told he did not work there anymore. "He didn't have a chance to tell anybody."

Employers should consider the impact of that sort of treatment not only on the terminated employee but on the remaining workers as well, said Mr. Hesselthaler. "What does that say to the rest of the workforce?"

Bear in mind also that some day the employer may want to rehire the employee it terminated, said Mr. Leger. Sooner or later, the economic situation will turn around, and the country is now going through a demographic period where older workers will be needed.

Furthermore, ex-employees already know the company's culture. "Your best new employee may be your ex-employee," said Mr. Leger. But, "if you did something stupid, you're not likely to get him back."

Brokers

Continued from page 1
accounts.

"It depends on the philosophy of the particular risk manager," said Lucille "Lucky" Gallagher, an independent risk management consultant in Denver. "Some feel that they want to deal with just one broker. I did that in my prior years" as vp-risk management for Greeley, Colo.-based Monfort Inc. and ConAgra Red Meat Cos., she said. "The broker functioned as an arm of the risk management department, so I had one broker that I dealt with."

But there are times, she added, when multiple brokers should be tapped, particularly when a risk manager needs an expert in a particular line of business.

"The use of multiple brokers or one broker really depends on the special needs of the client and the capabilities and services brokers provide to solve those needs," agreed David Tibbals, president of D.L. Tibbals Risk Management Consulting Inc. in Marietta, Ga.

He said that while risk managers historically have tended to use a multiple-broker approach, he has seen a move over the past 10 years toward use of a single broker.

Mr. Tibbals attributed that trend to a growing interest among risk managers "in wanting to capitalize on some efficiencies and in wanting the ability to get it all in one shop." This is due in part to the growing sophistication of risk managers, who now have a "pretty good pulse" on the pricing environment and know what they want in terms of programs, he said.

Some observers, however, main-

tain that the trend has been toward fragmentation.

"We have seen that, due to (brokerage) consolidation, more risk managers are looking to split their accounts" as a way to get a better breadth of the marketplace and to keep the brokers "fresh," said John Kelly, president and chief executive officer of regional broker Frenkel & Co. in New York.

Mr. Betterley said that he, too, generally finds that clients today are using more than one broker.

Risk managers themselves are divided on the matter.

"In my opinion, for my company, it is best for us to use more than one major broker," said Randy Thurman, director of risk management for Gaylord Entertainment Co. in Nashville, Tenn. The brokerage business is still a very personal relationship business, he said. "I'm dealing with one—or in some cases, several—members of a brokerage firm that I know, trust and who know my business. If that changes for some reason, I may not feel as comfortable with the person reassigned to me."

Because of that, "my company is better off at all times to have at least two major brokers with the capabilities of handling all of the business that we do," Mr. Thurman said.

Brian D. Casey, director of risk management and loss prevention for Corning Inc. in Corning, N.Y., also advocates a multiple-broker approach. "It's a people business, and people go from one place to another. So to say that you're going to stay with one broker forever, it's kind of hard, especially with all the swallowing up everybody's been doing," he said, referring to brokerage consolidation.

Mr. Casey took the multibroker ap-

proach a bit further in the mid-1990s when he handpicked eight brokers from two rival firms—the former Johnson & Higgins and Aon Group Inc.—and asked them to assume joint responsibility for Corning's global property program.

The main reason that approach worked for two years, Mr. Casey said, was that the team was made up of "a group of young people who clicked and worked well together. Once some of those people started going off in other directions, however, the chemistry fell apart, and it just became awkward," he said.

The use of multiple brokers or one broker really depends on the special needs of the client,' says David Tibbals.

Despite the ultimate failure of the joint-brokered program, Mr. Casey continues to use several brokers for Corning's domestic and global business.

The multiple-broker approach also has worked well for James E. Green, risk manager for Justin Industries Inc. in Fort Worth, Texas.

"It has allowed us to test different products and services, and it gives us a second set of eyes and opinions on risk management issues," he said.

Additionally, "I would like to think that it helps prevent complacency, knowing that, without going through the broker-qualification process, we can move the business," he said.

Indeed, maintaining a competitive spirit among rival brokers seems to

be one of the biggest advantages of maintaining relationships with more than one company, according to several risk managers.

"I have always believed in the competition model—where neither broker has the whole (insurance program), so they always try to outdo each other," said Christopher E. Mandel, senior director-risk management, claims and safety at Tricon Global Restaurants Inc. in Louisville, Ky.

Roger Andrews, general counsel and director of risk management for E.D. Bullard Co. in Provo, Utah, noted that using more than one broker not only allows risk managers to stay abreast of a variety of different product offerings, but also "helps keep brokers sharp and on their toes, knowing that another broker is always there."

On the other hand, Jeffrey W. Pettegrew, vp-risk management and insurance for Westaff Inc. in Walnut Creek, Calif., noted that although encouraging competition can be useful, in a single-broker approach "there are always competing brokers standing at the altar," ready to take on the business if there are problems.

Mr. Pettegrew likened the broker selection process to picking a jockey to ride in a horse race. "Like the broker, a jockey needs to intimately know the horse and the track, and I don't think that several jockeys will help win the race," he said.

"If a risk manager has a special vision, like enterprise risk management or another critical concept, I prefer to work with a single partner that will really grasp the strategy or concept," Mr. Pettegrew said. In addition, "I find that underwriters extend special consideration when they are dealing with a tight, cohesive team. They find

continuity between the broker and myself very valuable to them," he said.

Sherry Pixler, risk manager for Storage Technology Corp. in Louisville, Colo., also advocates the single-brokerage approach.

"The primary advantage for us is having a single broker that is an extension of our risk management department who fully understands the high-tech risks" that the digital information storage giant faces, she said. "We feel like that's a very important aspect of what the broker provides us, because we are so specialized."

"A single-broker approach is not right for everybody, but for us, it has been advantageous," Ms. Pixler said.

Such an approach also worked well for Ray Sibley, risk manager for Washoe County in Reno, Nev.

"I only had to call one person; I didn't have to think about whom I had to call. It's not as if it's a big deal...but it was only one person whenever we had a meeting to talk about issues of what the county was doing. We could run the gamut, because the broker was handling all of it," he said of his experience as the county's risk manager. "If we used more than one broker, we'd have had to schedule different meetings."

For the first time, Washoe County is pooling its risks with the local fire district and school district in an effort to streamline and generate savings. As a result, Mr. Sibley is working on selecting the county's broker.

"We could end up having one broker for all three agencies; we could hire one broker for each line of business of the three agencies; or we could end up with five or six different brokers," he said. "We're looking at several options." **[B]**

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Plans

Continued from page 3

matic difference in network and care access and 47% said there was no real difference.

Given that employers don't see major differences among health plans, it isn't surprising that employers are so price-sensitive when comparing plans, Mr. Sperling said.

Clearly, though, the survey shows employers expect that in the future they will be much more reliant on the Internet and other online methods to purchase and offer health care coverage to employees.

For example, within the next three years, 60% of employers expect to use the Internet for the health plan selection and renewal process—compared with just 9% already doing so today. Correspondingly, the number of employers using paper for this process will fall to 22% from 84%.

For the present, employers see a very practical use of the Internet: providing online benefit summaries to employees. In fact, 57% of respondents labeled this an urgent priority.

In addition, 35% of employers said putting provider cost, location and other access information online was an urgent priority.

In the area of design, just over 20% of employers either have or are considering a defined contribution approach to fund health care coverage.

While there are numerous variations, at the core of this approach is employers agreeing to provide employees with a fixed-dollar amount to purchase a health plan or services. By contrast, in the now nearly universal defined benefit approach, an employer agrees to provide a health care plan with stipulated benefits, such as covering 90% of expenses that participants incur by using physicians in a preferred provider network.

Most employers—85%—who say they are considering a defined contribution plan approach say it is because they want to control program costs, while 70% say the appeal is to return control of health care decisions to employees and 30% say the attraction is to reduce their exposure to lawsuits.

Hewitt's Mr. Sperling predicted the move to defined contribution plans will be incremental as certain key issues have yet to be resolved. For example, under current law, giving employees funds to purchase health care would be tax-ineffective as the contributions would be added to their taxable income.

By contrast, when an employer purchases health care coverage, it can take a tax deduction for the premiums or claims paid, while the employer's cost is not taxable income to employees.

While organizations may find the defined contribution approach appealing, "Before it gains momentum, solutions must be developed to...change tax law to level the playing field between employer-provided coverage and individual coverage," the survey notes.

In addition, for the concept to work in the real world, a third party would be needed to assume administrative, communication and pricing and employee advocacy functions that employers now assume, according to the survey.

Contrary to popular perception, nearly all—92%—of employers believe that their employees are either satisfied or are neutral about the coverage offered by their health care plans.

In addition, while Congress once again is about to consider legislation to expand the rights of health care plan enrollees—making it easier, for example, for them to sue plans if they are wrongfully denied coverage—most employers believe their employees don't have strong feelings about the issue.

Eighty-one percent of respondents believe their employees are neutral about patient protection legislation, while 15% say employees support such an initiative and 4% are against such legislation.

Employers themselves warn they would terminate their health care plans if Congress passes legislation exposing them to liability for medical actions of providers. A whopping 46% said they would discontinue their health care plans if they become exposed to malpractice suits.

In the cost area, the average increase employers expect this year is 12%, with 13% of respondents expecting an increase of at least 20% this year. On average, for individual coverage, employers expect to pass 25% of this cost on to employees and 30% of the cost increase for dependent coverage.

Free single copies of "Health Care Expectations: Future Strategy and Direction," are available from Hewitt Associates, Publication Desk, 100 Half Day Road, Lincolnshire, Ill. 60069; 847-295-5000.

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Modern approach to natural selection?

Last month, a teen-age boy was critically hurt after he and two friends attempted to recreate an outrageous and dangerous stunt they had witnessed on cable television.

There followed, predictably, a lot of finger pointing at the entertainment industry for being so irresponsible as to show outrageous and dangerous stunts on television at any time other than the middle of the night and without stronger warnings to the effect of "do not try this at home."

And next, just as predictably, came the counterarguments that responsibility must rest with the viewer, or with the individual who controls access to viewing—in this case, a parent.

Initially, I agreed with these counterarguments. Upon consideration, though, they seem to be just another way to fault the TV show.

Instead, I see this most-recent controversy as emblematic of a far more insidious problem that is growing in our society, and that is a growing reluctance to call someone an idiot when he or she does something idiotic.

There was a time, not that long ago, when an individual who did something injurious or self-destructive would be met with a reaction not of, "Who made you do this?" but of, "What? Are you stupid?"

Generations of parents have greeted doltish behavior with the stern observation, "And just because your friends jump off a cliff, does that mean you should do it too?" Today's equivalent should be, "And just because you saw it on TV, does that mean you should do it too?"

Maybe it's our newfound notions of political correctness, but we seem less willing today to accept the notion that the responsibility for one's actions rests with the individual. I think it's unfortunate and disturbing that we are less and less willing to lay the blame where it belongs: squarely on the shoulders of those who do something stupid and, as a consequence, wind up hurting themselves or others.

I realize it's not nearly as satisfying to acknowledge that a loved one is a moron or dolt as it is to blame some big entertainment conglomerate for these failings. It's also not nearly as lucrative, the plaintiffs' bar will tell you. But sometimes individuals—especially teen-age boys—do dumb and harmful things—and it's nobody's fault but their own.

The latest brouhaha stems from a television program on the MTV cable network called, aptly enough, "Jackass." The show, which I admit to having seen a few times, appeals to that part of the brain that likes to watch outrageous and dangerous stunts, fire and explosions, public humiliation and really, really dumb things that I would never try myself but am all too happy to witness someone else doing.

In January, an episode of the MTV program was broadcast in which the star of "Jackass" donned a fire-retardant suit that was adorned with pieces of meat and proceeded to lie on a fiery barbecue grill while his colleagues doused him with lighter fluid. It was entertaining—precisely because it seemed so outrageously dangerous and idiotic that no one in his or her right mind would do such a thing.

Unfortunately, though, 13-year-old Jason Lind and his friends in Torrington, Conn., somehow saw the show as instructive. A few days later, they decided to recreate the stunt. Jason was reportedly wrapped only in old clothing when he was set on fire, resulting in critical burns to his legs.

My initial reaction when I heard of this was to exclaim, "What an idiot!" What happened is tragic, but there's no denying the element of stupidity involved. We're not talking about people who are mentally handicapped or who are too young to discern entertainment from reality. This was a trio of 13-year-olds who, frankly, should have known better.

Also bear in mind that this is a show called "Jackass." That, in and of itself, should offer a clue that these stunts are not to be emulated. Furthermore, the show carries the following prominent warning: "Jackass features stunts performed by professionals and/or total idiots. In either case, MTV insists that neither you nor any of your dumb little buddies attempt the dangerous crap in this show...."

But Jason's father apparently is unwilling to admit that perhaps his son and his friends were idiots for trying to create a human barbecue. Or that he himself may have failed to instruct his child in something so elementary as the dangers of fire.

Instead, Eric Lind called on Sen. Joe Lieberman, D-Conn., and both of them are pointing a finger at MTV and its parent company, Viacom Inc., for displaying the show.

According to Reuters, Sen. Lieberman stated: "It is irresponsible for MTV to air these kinds of stunts on a program clearly popular with young teens, to air it at a time when many of them are likely to be watching, and to do so without adequate warnings."

He continued, "There are some things that are so potentially dangerous and inciting, particularly to vulnerable children, that they simply should not be put on TV, and this is clearly one that crosses that line."

But I think that failing to teach our children to think critically about what they see or to take responsibility for their actions is far more dangerous than anything put on TV.

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

Court

Continued from page 1
civil courts, so why shouldn't those involving workers compensation insurance?" Ms. Kammerer said.

Insurers criticized the decision, however, asserting it will lead to more litigation in a state already known for being litigious.

"What we are left with now is the prospect of needless, expensive litigation between insurers and their policyholders," said Doug Widtfeldt, vp of the Sacramento-based Assn. of California Insurance Cos.

Indeed, some California policyholders are "extremely upset and will look at their premiums and their losses and determine where problems are, and, if they find a problem, they will take action," predicted Drew Pomerance, a partner in the Los Angeles firm of Roxborough, Pomerance, Gallegos & Nye, who represented the employer in the case.

The case centered on whether Section 11758 of the California Insurance Code, which grants insurers immunity from antitrust law for sharing information used for ratemaking purposes, also shields insurers from civil liability for allegations of negligence and breach of the implied covenant of good faith and fair dealing.

In April 1994, Schaefer Ambulance Service Inc. filed a bad-faith lawsuit seeking class-action status on behalf of about 300,000 employees in the state that purchased workers comp insurance from the SCIF between Jan. 1, 1984, and Dec. 31, 1992, and which, during that time, faced claims litigation from one or more of their injured workers.

Santa Ana, Calif.-based Schaefer alleged SCIF had misallocated and then misreported employers' financial information to the Workers Compensation Insurance Rating Bureau, which determines premium rates for SCIF policyholders. In calculating the premium, the WCIRB considers a variety of factors, including an employer's experience modification factor. This factor involves a comparison of the expected losses of all employers to the actual incurred losses plus reserve estimates of the insured employer at issue.

SCIF forwards financial data to the WCIRB in "unit statistical reports" for each policyholder. Each report contains three columns of information: indemnity, medical, and defense expense, or allocated loss expense. Only the financial information reported in the indemnity and medical expense columns is used to compute an employer's experience modification factor. Medical-legal reports requested by the employer or insurer that are not prepared by the attending physician are recorded as defense expenses. SCIF, however, reported

such costs as medical expenses to the WCIRB, the suit alleged. As a result, the employers' experience modification factor was artificially inflated, which in turn led to higher premiums.

In 1993, the Department of Insurance issued regulations clarifying how insurers should report medical-legal expenses to the WCIRB. The regulations stated that medical-legal expenses should not be included in medical expenses.

Schaefer further alleged that SCIF refused to provide access to individual claim files or let employers audit or monitor how the insurer represented them in various workers comp actions.

Employers thus were prevented "from auditing, questioning, or in any manner attempting to determine whether SCIF performed reasonably in administering the claims of the insureds and to prevent an insured from discovering SCIF's intentional or negligent manipulation of the reserves and misreporting of financial information to the WCIRB," court papers stated.

In response to SCIF's motion

'What we are left with now is the prospect of needless, expensive litigation,' says Doug Widtfeldt.

seeking to dismiss the class-action suit, the case was stayed for several years while Schaefer pursued administrative remedies through the workers comp system.

On Aug. 9, 1994, the WCIRB determined that SCIF had improperly reported expenses for medical-legal reports as medical, not defense, expenses, and ordered SCIF to submit revised reports for Schaefer Ambulance and several other employers.

SCIF appealed the WCIRB's decision to the Classification and Rating Committee of the bureau, which upheld WCIRB's determination. SCIF then appealed the decision to then-Insurance Commissioner Chuck Quackenbush.

An evidentiary hearing was held in December 1995 before an administrative law judge, who received numerous documentary exhibits and heard two days of testimony from the parties' expert witnesses. On May 8, 1996, the administrative law judge issued a proposed decision, affirming the WCIRB decision. The commissioner adopted the proposed decision on May 28, 1996.

In September 1996, after the stay on the civil case had been lifted, SCIF filed a petition for writ of mandate, asking the trial court to direct the commissioner to vacate his order. On March 16, 1999, the court denied the petition and entered judgment in May 1999. SCIF

then moved for judgment on the grounds that the action was barred by Section 11758 of the state's insurance code, but the trial court denied the motion. In May 2000, the Court of Appeal affirmed the trial court decision. SCIF then petitioned the California Supreme Court to review the issue.

But the high court agreed with the lower courts, stating: "While the question is close, we conclude Section 11758 does not immunize SCIF from civil liability under these circumstances."

Paul Glad, a partner in the Sa Mateo, Calif., office of Sonnenschein, Nath & Rosenthal, who represented SCIF in the case, said he will petition for rehearing on behalf of the insurer.

"What the Supreme Court's decision says is that Schaefer may now go forward and sue the State Fund in tort for the alleged misreporting of medical expense data to the rating bureau. The real question now is whether State Fund's claims-handling conduct rises to the level of damages, which a trial court will have to decide. In ACIC's view, the misreporting of this data was not bad-faith conduct by State Fund or any other insurer," said Mr. Widtfeldt.

"It's unfortunate because this entire matter could have been resolved administratively if the Department of Insurance had rejected the proposed decision of the administrative law judge in 1996, and extricated the issue to new administrative proceedings for the fashioning of a universal remedy. So-called 'damages' could have been ascertained by the Department and the experience rating formula revised on a prospective basis. This would have benefited Schaefer and other similarly situated employers on a going forward basis whose premiums may have been affected by insurer reporting errors," he said.

"It all comes down to accountability," said Jeff Pettegrew, vp-insurance and risk management at Walnut Creek, Calif.-based Westaff Inc.

"When premiums are a product of the data that's promulgated by insurers and submitted to a rating bureau, the insurer has a good faith duty to adhere to claims-handling best practices," he said.

"And, in my opinion, as California has ever-increasing work comp premiums which are continuing to impact profitability, our courts are simply not going to stand by and allow insurers to disregard their fiduciary responsibility."

Hence, "I expect we're going to see more court opinions in a similar regard," he said.

State Compensation Insurance Fund vs. Superior Court of Orange County; Schaefer Ambulance Service Inc. et al., real parties in interest, California Supreme Court; No. SO82133, filed Feb. 1, 2001.

Privacy expansion proposed

WASHINGTON—Some Senate Democrats want to expand new medical records privacy regulations to grant individuals a federal right to sue health care providers and others for violating the confidentiality of records.

The new privacy regulations, which the Department of Health and Human Services issued in December after Congress failed to meet the deadline for drafting its own set by the Health Insurance Portability and Accountability Act of 1996, call for civil and criminal penalties of up to

\$250,000 in fines annually and up to 10 years in prison under certain circumstances. The rules, however, do not allow for a private course of action.

During a hearing Thursday on implementation of the rules, Sen. Edward Kennedy, D-Mass., and some other Democratic members of the Senate Committee on Health, Education, Labor and Pensions called for giving patients whose medical information is illegally disclosed a federal right to sue.

"Experience shows that a private right of action is an effective

deterrent against violations. Often, it is the only way to provide adequate compensation when deterrence fails," said Sen. Kennedy.

The rules, which entities such as hospitals, health plans and physicians have until Feb. 26, 2003, to comply with, have come under fire from employers and others for being overly complex and costly.

Privacy groups, however, hold that the rules do not go far enough to protect sensitive medical information.

—By Mark A. Hofmann

Rights

Continued from page 1

- Patients should have a rapid medical review process for denial of care.
- The review process should ensure that doctors are allowed to make medical decisions and that patients receive care in a timely manner.
- Federal remedies should be expanded to hold health plans accountable.
- Patient protection legislation should encourage, not discourage, employers to offer health care.

In his letter to Democratic lawmakers, the president called for a bipartisan approach to patients' rights legislation, and he noted that, as governor of Texas, he had worked with lawmakers from both parties to "enact some of the strongest patient protection laws in the country." He said he believes "that, following an independent medical review of a health plan's decision to deny care, patients who have been wrongly denied" should be able to sue the plan in federal court.

"I cannot support a plan, however, that encourages unnecessary or frivolous litigation," wrote President Bush. He noted that expensive litigation that drives up health care costs could price some consumers out of the market for health coverage. "I believe it is possible to provide patients with a meaningful remedy when they have been wrongly denied care, without causing other Americans to lose coverage. A responsible remedy for patients should protect employers from the high costs of being subject to multiple causes of action in multiple venues and should provide a reasonable cap on damages."

"I do not believe that any bill currently before the Congress meets all of these principles," President Bush said, in a clear reference to McCain-Kennedy proposal.

Employer representatives gave President Bush's proposals a guarded thumbs up.

"I read the principles as clearly indicating that the McCain-Kennedy bill would not be acceptable, because it clearly doesn't meet the standards (President Bush) has set forth," said James Klein, president of the American Benefits Council in Washington. Mr. Klein said the details of what the president would do remain unknown.

"The fact that the president has linked his principles to the understanding that we should not be exacerbating the problem of the uninsured is a very important benchmark against which we should measure any proposals," he said.

"We are relieved that he has not embraced the very open-ended liability in both federal and state courts, and also, I think, he recognizes that it's very difficult to insulate employers completely from liability," said Kate Sullivan, director-health care policy for the U.S. Chamber of Commerce. "He recognizes that there should be appropriate caps on damages. Those are all positive, but we are concerned that he does

have liability in there, he does have benefit mandates, and those are things that will increase the cost of coverage. If you increase the cost of coverage, people wind up being uninsured."

The McCain-Kennedy bill attracted no praise—guarded or otherwise—from employers.

The measure tracks the Norwood-Dingell bill closely in many respects. Like that measure—which passed the House in 1999 only to die last year in a conference committee that could not reconcile it with a narrower Senate measure—the McCain-Kennedy bill would create a new system of liability when illegal denial of coverage resulted in personal injury or death.

And like previous managed care regulation proposals, the new measure would mandate a variety of coverage guarantees, such as emergency care access and continuity of care "for those with ongoing health care needs," according to a description of the bill that was posted on the Web site of one of the measure's co-sponsors, Sen. John Edwards, D-N.C.

Disputed coverage decisions would be subject to external review by independent medical experts. According to Sen. Edwards, a patient would have to exhaust all internal and external appeals before being able to take a plan to court. The one exception to the provision would be when "death or irreparable injury has already occurred prior to completion of the appeals process."

States that have their own patient protection statutes could seek certification from the secretary of the Department of Health and Human Services that their laws are "substantively equivalent" to the federal standard, or they could simply enforce the federal standard or have the federal government enforce it within their boundaries. State laws deemed "more protective" of patients' rights than the federal law would be allowed to stand.

Cases involving medically reviewable decisions, including traditional malpractice claims, would continue to be heard in state courts, where they would be subject to the penalties provided by state law, including punitive damages.

Cases involving administrative decisions would be heard in federal court, with a specific ban on punitive damages. Although the measure would ban punitive damages in federal cases, it would allow the assessment of a civil monetary penalty of up to \$5 million in cases where plans acted with bad faith and flagrant disregard of a patient's rights.

Sen. Edwards' document says that employers would be protected against "any liability, unless they directly participated in making the decision on a claim for benefits which resulted in personal injury or death." According to the document, the bill lists a "number of areas that are not to be considered 'direct participation.'" These include selecting a plan, choosing what benefits to cover under the plan, or "advocating with the health plan on behalf of a beneficiary for coverage."

The chairman of the board of the American Medical Assn., Dr. D. Ted Lewers of Easton, Md., said in a written statement that "this new legislation resolves the most-serious issues. It protects patients from managed care abuses, protects employers from frivolous lawsuits and protects state laws already in place. It's a win-win for everyone."

Employers, however, wasted no time blasting the McCain-Kennedy proposal.

"It's about the same—just as bad as where we left off," said Mr. Klein of the American Benefits Council. "There still would be unlimited liability in state courts and under some actions brought in federal court, (and) there would still be uncapped economic and non-economic damages. It would expose employers and health plans to extraordinary vulnerability that would discourage employers from sponsoring health coverage."

"From the NAM's standpoint, it is worse than Dingell-Norwood. It creates multiple bites at the apple. It creates the possibility that an employer or an HMO could be sued in both federal and state courts," said Neil Trautwein, director-employment policy for the National Assn. of Manufacturers in Washington. "We really don't think they've given much in the tort reform. A \$5 million cap on federal punitive damages does not equal tort reform."

"The key sticking issue that remains is the question of employer liability," said Henry Saveth, an attorney with William M. Mercer Inc. in New York. "I think that the Bush administration in general, and Health and Human Services Secretary Tommy Thompson in particular, have a very good understanding of employer concerns about potential liability for things that may go wrong under their health plans. They really understand what employers are worried about. Norwood clearly got the message; McCain did not."

Helen Darling, a senior consultant with Watson Wyatt Worldwide in Stamford, Conn., said that neither proposal addresses a critical question.

"It seems that everybody's getting into the act and saying, 'Let's do more of everything.' The key question is, who's gonna pay for it?" she asked, noting that employers' health care costs have been steadily climbing.

"The irony is that, on top of the already millions of uninsured, with the rate of increase coming in, we will have people dropping out of the ranks of the insured" because employers will be forced to drop more-expensive coverage, Ms. Darling said. "And what's really important is coverage and affordability for everybody."

"Ultimately, we will have a patients' bill of rights, but the issue was made politically more difficult by the introduction of so-called bipartisan measure during the week that Bush had designated as focusing on taxes," predicted Mr. Saveth. "It's also questionable if McCain helped his own cause by stepping on Bush's issue for the second time this year, the first time being campaign finance reform." **BI**

purported to provide at the time they were promulgated."

- Enforcement of regulatory requirements should be timely, impartial and professional, with penalties proportional to the violations at issue.

- A level playing field, in which insurers are subject to the same regulations as their competitors, such as financial services firms providing similar products.

- Technology, with regulators embracing the use of new technologies "by insurers in every aspect of their business."

In his letter to Ms. Sebelius, who is Kansas' commissioner of insurance, Mr. Vagley noted that the AIA had agreed with former NAIC President George Nichols III not to participate publicly in the debate over optional

federal chartering during the year 2000, and "instead, focus our efforts on NAIC-based reforms." He noted, though, that the regulatory debate has now extended to Congress, where a new House committee has jurisdiction over insurance, banking and financial services, and that an optional federal chartering bill developed by the banking industry is likely to be introduced.

Consequently, the AIA "must be actively and aggressively involved in this debate, both to assure that our principles of sound regulation are embodied in any legislation that is considered and to guard against adverse proposals that may be advanced by others. We urge the NAIC to be involved in this debate as well," Mr. Vagley said in his letter. **BI**

UPDATES

401(k) balances up 18%: Study

Continued from page 2

The organizations attributed the growth to increased contributions and strong equity market performance.

Although the average balance at year-end 1999 amounted to \$55,502, 42% of participants had account balances of less than \$10,000, while 15% had account balances greater than \$100,000, the analysis found.

EBRI/ICI attributed the variance to factors such as the age of 401(k) plan participants, how long they had been at their jobs and their contribution behavior.

The median, or midpoint, account balance among active 401(k) plan participants was \$15,246 at year-end 1999.

The figures in the EBRI/ICI analysis do not include amounts left with pre-1999 employers or rolled over into individual retirement accounts.

EBRI and ICI have collaborated for the past four years in the collection of data on 401(k) plan participants from some of their members that serve as plan record-keepers and administrators.

The report includes year-end 1999 information on 10.3 million active participants in 32,675 plans with a combined \$573.4 billion in assets. This accounts for 11% of all 401(k) plans, 26% of all 401(k) plan participants, and about 35% of all assets held in 401(k) plans in the United States.

Groupama executives exit

PARIS—French mutual insurer Groupama-GAN has lost two top-level executives in as many weeks.

Alexis Ruset, chairman of the group's reinsurance subsidiary Sorema, resigned in late January, citing personal reasons. Mr. Ruset was replaced by Groupama's chief operating officer, Jacques Giraud.

Last week, Emmanuel du Boullay, head of transportation and international insurance at Groupama, announced his resignation. He will be replaced by Michel Beauchesne, the group's head of auditing.

Mr. Boullay said that the impact of the December 1999 windstorms on the group's financial position prevented Groupama from giving priority to international development. Mr. Boullay said that he felt his talents would be put to better use elsewhere.

Groupama is still completing the integration of Group des Assurances Nationales, the former state-owned insurer that it acquired in July 1998. The French government was forced to sell the insurer after the European Union ruled that France could no longer subsidize GAN (BI, Sept. 22, 1997).

Last year, Groupama's chairman, Bernard Delas, left the group suddenly (BI, June 19, 2000).

Management buys N.Y. brokerage

NEW YORK—Frenkel & Co. Inc. has a new owner—senior management.

The New York-based brokerage announced a management buyout last week, led by Robert Shunk and John Kelly. Mr. Shunk will continue as chairman of Frenkel, while Mr. Kelly has taken on the new title of president and chief executive officer.

Frenkel also announced a new executive team, including: R.P. Wolf, executive vp, general counsel and secretary; Gary E. Smith, executive vp and chief operating officer; Martin Elkinson and Michael Feinstein, executive vps; and Michael Glazer, chief financial officer.

Since 1985, Frenkel had been owned by its employees through an employee stock ownership program. Mr. Kelly said the ESOP was "preventing us from having the capital structure" necessary to undertake a focused acquisition program and remain independent. "By removing the ESOP, we will have the capital base to be very competitive in the acquisition market" and be better able to establish various joint-venture partnerships with third parties, he said.

In a statement, Mr. Kelly added that Frenkel plans "to maintain our history of independence, while continuing to expand our product offerings and provide clients with the high level of service they have come to associate with the Frenkel name."

Terms of the management buyout were not disclosed.

Based on 1999 brokerage revenues of \$35.1 million, Frenkel was the 33rd largest broker of U.S. business in *Business Insurance's* annual broker rankings. Frenkel also is a member of worldwide broker network Assurex International.

Briefly noted

London-based CGNU P.L.C. is selling its New Zealand subsidiary, **State Insurance Ltd.**, to Sydney, Australia-based NRMA Insurance Group Ltd. The deal, which values Wellington-based State Insurance at about \$405 million New Zealand (\$181.2 million), is expected to be completed in the first quarter. CGNU announced last week. CGNU will retain its other New Zealand property/casualty insurer, Auckland-based NZI Insurance New Zealand Ltd.... Washington state Insurance Commissioner Mike Kreidler has announced he will delay implementation of a rule requiring health insurers to provide coverage for contraceptives. The rule, which was to take effect this July, will now be imposed in January 2002. The commissioner said he supports the rule but found its implementation flawed.... Starting March 1, Philadelphia-based Independence Blue Cross will reduce monthly premiums by up to 9% for 60,000 **Medicare health maintenance organization enrollees** in five Pennsylvania counties. Premiums are being reduced because of legislation Congress passed late last year that pumps more federal money into Medicare HMOs, the company said.

AIA

Continued from page 2

ments under which insurance companies that operate in multiple jurisdictions should be subject to "one-stop, nonduplicative regulation and uniform laws governing market conduct activities, agent licensing, claims practices, solvency, liquidation and other activities where an ongoing regulatory role is in the consumer interest."

AIA further holds that, in such areas, "regulations should focus on the issues that really matter to the insurance-buying public, and not impose excessive and often-meaningless requirements that remain in place long beyond whatever limited benefit they

FOR THE RECORD

Excerpts from BI's Daily Online Updates, Feb. 5 - 9, 2001

AON POSTS GAINS "Significant improvement" in its operating segments contributed to Aon Corp.'s revenue and profit growth in 2000, the company said. Brokerage and consulting revenues at the Chicago-based brokerage giant increased 7%, to \$5.14 billion, in 2000. Corporatewide revenues, which include investment income and revenues from Aon's underwriting operations, increased 6%, to \$7.30 billion. As expected, Aon took an \$82 million special charge against its fourth-quarter earnings as part of the comprehensive business transformation plan it announced last year (BI, Dec. 18, 2000; Nov. 6, 2000). Including the special charge, net income increased 35% for the year, to \$474 million. Aon's benefit consulting unit, Aon Consulting Worldwide, reported a 17% revenue increase in 2000, to \$770 million. Revenues from insurance brokerage—including Aon's retail, wholesale and reinsurance brokerage units—and other services increased 5% in 2000, to \$4.37 billion.



AIG SEES DOUBLE-DIGIT GROWTH American International Group Inc. in 2000 achieved gains in both revenues and net income. AIG posted revenues of \$45.97 billion in 2000, a 13.1% increase over the prior year. Net income rose 11.5%, to \$5.64 billion, including net realized capital losses. Excluding the net capital losses, AIG's income was \$5.74 billion, up 14.8% from 1999. Among the insurer's operations, property/casualty net written premiums increased by 8%, to \$17.53 billion, last year. Of this total, U.S. commercial business—AIG's largest property/casualty segment—showed the smallest increase, rising 6.1% to \$8.81 billion. Foreign property/casualty premiums rose 7.3%, to \$5.76 billion, while the smaller mortgage guarantee and personal lines segments reported greater growth. AIG's property/casualty combined ratio was 96.73% last year, marginally worse than the 96.35% it recorded in 1999. Commenting on AIG's U.S. property/casualty results, AIG Chairman Maurice R. Greenberg said the insurer "benefited in the fourth quarter from the broad strengthening of commercial property/casualty rates.... Stronger rates

are evident across virtually all classes of business, and we believe rates will continue to firm."

REINSURANCE TRADING SITE An Internet-based reinsurance platform designed to provide a neutral site for reinsurance negotiations was launched last week. Reinsurance buyers and brokers can use the site, www.eREINSURE.com, to submit programs and solicit quotes via e-mail messages that directs reinsurers to the site, said Igor Best-Devereux, chief executive officer of Salt Lake City-based eREINSURE.com Inc., which operates the site. After examining programs, reinsurers may request additional information, make amendments and submit quotes, he said. Details of a specific risk are made available only to those reinsurers that a buyer or broker wishes to contact, Mr. Best-Devereux said. The Internet site eliminates the need to send multiple copies of a risk to reinsurers and simplifies and reduces the cost of the transaction, he said.

POLLUTION COVERAGE FOR LENDERS Chubb Corp. and brokerage Environmental Warranty Inc. are offering coverage to replace a financial institution's basic due diligence investigation of real estate prior to making a loan. The coverage, called collateral impairment and environmental liability insurance, is underwritten by Warren, N.J.-based Chubb and marketed by West Hartford, Conn.-based Environmental Warranty. Lenders may buy the coverage to protect against financial losses that result when a loan is in default and the property that has been provided as collateral is contaminated by pollution. The coverage is designed to replace Phase 1, or preliminary, site assessments, which typically cost between

\$1,500 and \$2,500. The policy term is up to 20 years, with limits ranging from \$1 million to \$5 million, and premiums ranging from \$250 to \$1,500.

SWISS RE RESTRUCTURING Zurich, Switzerland-based Swiss Re Group plans to consolidate its European nonlife business into a single organization by merging its Bavarian Re division with its Europe division. Following the merger, Bavarian Re will be renamed Swiss Re Germany. Stefan Lippe, currently chief executive officer of Bavarian Re, will become head of Swiss Re's nonlife business group, while Rudolf Kellenberger, current head of nonlife operations, will devote himself fully to his duties as Swiss Re's deputy chief executive officer. Michel Lies will continue to lead the restructured Europe division. In addition, Anton Wittl was appointed chief executive officer of Swiss Re Germany.

PACIFICARE INCOME DROPS Rising health care costs led to a steep drop in net income for PacifiCare Health Systems Inc. last year, the company said. PacifiCare reported net income of \$161 million for 2000, a decline of 42.3% from the year before. For the fourth quarter, net income fell 81.9%, to \$12 million, from the same period in 1999. Santa Ana, Calif.-based PacifiCare attributed the declines to rising health care costs in its commercial and Medicare business. Those cost increases were driven by increased utilization under hospital and physician contracts that had shifted from capitation-style reimbursement to per diem, fee-for-service or risk-based arrangements, the company said. Total revenues in 2000, however, increased 15% to \$11.5 billion. Fourth-quarter revenues were \$2.9 billion, also up 15% over 1999. In releasing its results, the company announced a new growth strategy, which will include offering a preferred provider organization plan, beginning in 2002. PacifiCare's membership totaled about 4 million at the end of last year, a 9.6% increase over 1999. Commercial membership grew 11.7%, the company said.



BRIEFLY NOTED Humana Inc.'s financial outlook improved dramatically last year, with net income in 2000 of \$90 million, compared with a loss of \$382 million the year before. Revenues increased 3.9%, to \$10.5 billion.... Patricia H. Roberts has been promoted to executive vp and chief operating officer at General Star Management Co., the surplus lines subsidiary of General Re Corp. Ms. Roberts will be responsible for all of General Star's underwriting operations.... General Re Corp. has agreed to sell a controlling interest in Gen Re Securities Holdings, its derivatives trading arm, to Roberto Mendoza, a senior partner at Goldman Sachs & Co., and Peter Hancock, the former chief financial officer of J.P. Morgan & Co. Inc. General Re will retain a minority interest in the firm.... The board of directors of St. Paul Cos. Inc. has approved a \$500 million share repurchase program. The new program is in addition to the \$89 million remaining under a previous program. Since 1998, the St. Paul, Minn.-based insurer has spent \$1.11 billion on share purchase programs.... Employers Reinsurance Corp. has named longtime ERC executive John Connolly as senior vp-strategic initiatives. He will work with ERC President and Chief Executive Officer Ron Pressman on growth strategies for the Overland Park, Kan.-based reinsurer. Additionally, the General Electric Co. unit appointed three other current ERC or GE employees to new posts: Tony Hill, as global chief actuary; Bob Jones, as global services leader; and Andrea Pearson, as global claims leader.... James N. Stanard, chairman, president and chief executive officer of catastrophe reinsurer Renaissance Re Holdings Ltd. has been named the Bermuda Market Leader of the year by the Bermuda Insurance Institute. Brian Hall, the former chairman of Johnson & Higgins (Bermuda) Ltd., is the recipient of the BII's 2001 Lifetime Achievement award. Both awards will be presented at the BII annual dinner on March 10.

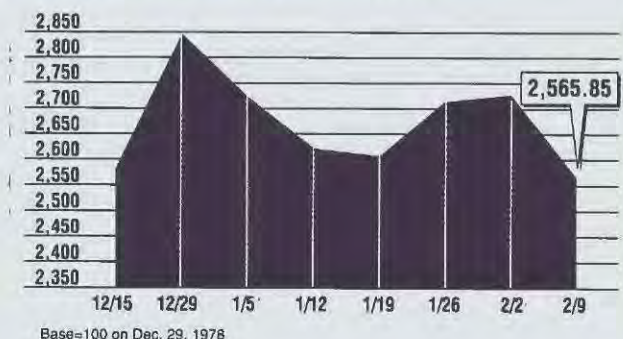
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BI Industry Stock Report FEB. 5, 2001, THROUGH FEB. 9, 2001

BROKERS			Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)					
Aon Corp.	NYS	36.28	4.52	5.93	42.31	20.69	35.16		Harleysville Group	NDO	27.50	2.33	-5.98	30.63	11.63	595									
Brown & Brown	NYS	37.05	8.84	5.86	37.05	15.63	122		HBB Group Inc.	NYS	38.75	0.00	0.00	40.63	21.50	0									
Clark Bards Holdings	NDO	11.25	-6.25	-11.11	17.88	8.50	15		HCC Insurance Holdings	NYS	23.97	3.54	-11.02	27.19	10.94	736									
E.W. Blanch Holdings Inc.	NYS	13.25	5.16	-24.01	56.94	12.44	964		ING Groep N.V.	NYS	73.50	-3.31	-8.27	83.94	46.81	507									
Gallagher Arthur J. & Co.	NYS	27.99	3.69	-12.02	34.25	11.53	1418		IPC Holdings Ltd.	NDO	22.19	0.00	5.65	23.88	9.75	243									
Hibb, Rogal & Hamilton	NYS	37.45	9.18	-6.08	42.13	25.63	123		Hartford Financial Services	NYS	65.23	2.32	-7.64	80.00	29.38	5965									
Kaye Group Inc.	NDO	12.38	-0.50	59.68	12.50	5.00	103		John Hancock Financial Services	NYS	35.35	-1.26	-6.05	38.25	13.44	3695									
Marsh & McLennan	NYS	115.13	4.79	-1.60	135.69	70.50	4902		LaSalle Re Holdings Ltd.	NYS	18.88	0.00	0.00	19.39	10.88	0									
BROKERS AVERAGE			4.44	3.19					Lincoln National	NYS	45.76	0.68	-3.28	56.38	22.63	4324									
INSURERS/REINSURERS									MAIC Holdings Inc.	NYS	17.00	-1.45	1.87	22.00	10.00	77									
ACE Ltd.	NYS	37.71	-0.63	-11.14	43.94	14.06	4267		Market Corp.	NYS	169.00	1.31	-6.63	183.25	115.50	93									
Accel International Corp.	NDO	0.20	0.00	-32.64	1.13	0.10	0		MBA Insurance Group	NYS	73.49	3.65	-0.86	76.19	36.31	2012									
Acceptance Insurance Cos.	NYS	5.04	0.60	-4.00	6.94	2.75	31		Meadowbrook Insur. Group	NYS	6.60	-1.49	-18.77	8.38	3.94	40									
AEGLON N.V.	NYS	37.15	-0.27	-10.35	43.00	31.50	694		Mellife	NYS	32.45	-2.84	-7.29	36.63	14.25	5668									
AFLAC Inc.	NYS	63.20	5.86	-12.45	74.94	33.56	4935		Mutual Risk Mgmt. Ltd.	NYS	14.71	-11.86	-3.14	23.75	12.31	735									
Allmerica Financial Corp.	NYS	57.40	-3.97	-20.83	74.25	35.06	1691		Navigators Group	NDO	13.38	-0.47	0.47	14.13	8.63	24									
Allstate Corp.	NYS	41.40	2.86	-4.96	44.75	17.19	12328		NYMAGIC Inc.	NYS	18.00	1.41	-4.64	19.25	12.25	14									
Ambac Financial Group	NYS	56.79	3.35	-2.61	59.31	25.91	2786		Ohio Casualty Corp.	NDO	8.47	-19.35	-15.31	17.88	6.13	2337									
American Financial Group	NYS	26.85	1.97	1.08	29.00	18.38	926		Old Republic Int'l	NYS	26.72	1.31	-10.25	32.06	10.63	1953									
American General	NYS	77.26	1.52	-5.20	83.44	45.63	3557		Partner Re Ltd.	NYS	51.65	3.51	-15.33	62.50	29.25	1112									
American Intl Group	NYS	86.68	0.34	-12.06	103.75	52.38	19065		Penn-America Group Inc.	NYS	8.10	-0.61	6.23	9.75	6.98	11									
American Safety Insurance	NYS	7.10	0.00	15.92	7.25	3.25	52		PMA Capital Corporation	NDO	17.56	-0.35	1.81	19.13	15.19	43									
Argonaut Group	NDO	17.19	-16.16	-18.15	21.25	14.44	166		Philadelphia Cons. Holding	NDO	26.25	1.35	-6.50	31.25	14.13	1105									
AXA-UAP Group	NYS	65.30	-3.09	-9.07	81.50	58.25	1892		PKRE Corp.	NYS	19.50	11.11	15.56	19.50	11.88	254									
Baldwin & Lyons Inc.	NDO	24.75	6.17	6.45	28.75	15.25	4		RellaStar Financial Corp.	NYS	53.94	0.00	0.00	53.94	23.75	0									
Berkley W.R. Corp.	NDO	39.25	9.50	-16.82	47.63	14.00	3298		RenaissanceRe Holdings Ltd.	NYS	80.60	3.20	2.92	83.00	35.88	565									
Berkshire Hathaway Inc.	NYS	68900.00	-1.57	-2.96	74900.00	668.00	1		RJI Corp.	NYS	44.00	-2.65	-1.54	46.16	26.25	35									
Capitol Transamerica Corp.	NAS	13.00	0.48	4.52	13.25	10.00	12		St. Paul Cos.	NYS	48.12	0.25	-11.40	57.00	21.31	4798									
Chubb Corp.	NYS	74.90	1.63	-13.41	90.25	43.25	6570		SCOR	NYS	48.35	-1.08	-3.78	53.75	38.38	26									
CIGNA Corp.	NYS	110.75	-6.54	-16.29	136.75	60.75	7056		SAFECO Corp.	NDO	25.75	4.30	-21.67	36.88	18.00	6001									
Cincinnati Financial Corp.	NYS	36.69	2.62	-7.27	43.31	26.19	1233		SCOPIE Holdings Inc.	NYS	25.20	1.41	6.57	36.94	18.31	NA									
Citigroup	NYS	54.05	-2.54	-5.85	59.13	35.34	48893		Seibels Bruce Group	NDO	0.78	-10.74	38.84	2.25	0.53	121									
CNA Financial Corp.	NYS	37.84	1.73	-2.86	41.94	24.56	517		Selective Ins. Group	NDO	25.00	13.31	-3.09	25.88	14.75	339									
CNA Surety	NYS	13.45	0.00	-5.61	14.94	10.38	165		Tokio Marine & Fire	NDO	51.38	0.74	-9.87	61.00	45.00	94									
EMC Insurance Group Inc.	NDO	11.38	1.11	-3.19	13.13	6.81	6		Torchmark Corp.	NYS	33.99	-2.05	-11.57	41.19	18.75	2894									
ESG Re Limited	NDO	2.44	2.63	32.20	6.50	1.72	85		Transatlantic Holdings	NYS	98.85	1.41	-6.64	107.06	68.75	49									
Enhance Financial Services	NYS	13.51	2.82	-12.49	17.00	8.63	589		Trenwick Group Inc.	NYS	22.15	-6.89	-10.73	27.13	12.00	610									
Everest Reinsurance	NYS	62.73	5.43	-12.42	74.75	21.25	1723		Union American Corp.	NDO	6.58	0.96	11.70	7.75	4.50	3									
Fremont General Corp.	NYS	3.20	21.67	13.78	8.25	1.50	1067		United Fire & Casualty	NDO	21.63	-4.95	-9.49	25.00	15.50	62									
Gainco Inc.	NYS	3.30	-2.37	25.71	6.38	2.19	113		Unirun	NDO	38.00	1.00	-6.46	41.94	27.19	375									
									UNUM Corp.	NDO	27.89	-6.00	3.78	30.44	11.94	12380									
									Vesta Insurance Co.	NYS	7.99	2.44	57.63	8.39	4.13	657									

BI Insurance Index



Top advancing issues: PacifiCare Health Systems Inc., Fremont General Corp., Selective Insurance Group. Leading decliners: Ohio Casualty Corp., Argonaut Group, Seibels Bruce Group. Most active issue: Citigroup. The BI Index dropped 0.6%; the Dow Jones 30 Industrials decreased 0.8%; the S&P 500 went down 2.6%, and the NYSE Composite dropped 1.1%. Average P/E: Brokers, 21.6; Insurers/reinsurers, 28.7; and HMOs, 18.3.

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