

Business Insurance

June 5, 2006

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\$5

Late News

Forecast predicts 17 named storms

Seventeen named storms will form during the Atlantic hurricane season that began last week, the Tropical Meteorological Project at Colorado State University predicts. In a forecast that mirrors earlier predictions made in December 2005 and April, the team predicts that nine of the named storms will grow into hurricanes. Of those, five will become intense hurricanes. The predicted activity remains well above the 50-year average recorded during 1950-2000 but significantly below last year's record 28 named storms.

Snowbarger named acting PBGC head

Vincent K. Snowbarger, a former Republican congressman and Kansas state lawmaker, has been named acting executive director of the Pension Benefit Guaranty Corp. Mr. Snowbarger, who has served as deputy director of the PBGC since November 2004,

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Max Re restates to correct accounting.

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Asbestos reform revisions

- The fund would compensate people with asbestos-related illnesses that stem from the Sept. 11, 2001, terrorist attacks and last year's hurricanes.
- Medical criteria that claimants must meet would be tightened.
- Existing asbestos trust funds could retain 10% of their funding to cover claims processed during the transition to the new system.

◆ Sen. Arlen Specter, R-Pa., is trying to win support for his asbestos compensation reforms.

Revised asbestos fund bill may be effort's last chance

By MARK A. HOFMANN

WASHINGTON—The chief sponsor of a plan to create a national trust fund to replace the litigation-based system for compensating victims of asbestos-related diseases says he will drop his effort if the Senate rejects recently introduced amended trust fund legislation.

Senate Judiciary Chairman Arlen Specter, R-Pa., and Sen. Patrick Leahy, D-Vt.—the committee's ranking minority member—unveiled a new version of the Fairness in Asbestos Injury Resolution Act late last month. Among other things, the revised bill would allow people exposed to asbestos from the Sept. 11, 2001, terrorist attacks on New York's World Trade Center as well as those exposed by last year's Gulf Coast hurricanes to seek

compensation from the proposed \$140 billion trust fund. The revised measure also would tighten some of the medical criteria that claimants must meet before they can seek compensation and would let existing asbestos compensation trust funds retain at least 10% of their funding to cover claims processed during the transition between the current system and the new trust fund.

According to Sen. Specter, many of the changes stemmed from concerns raised by critics of the original bill and proposed amendments to it. The original bill appeared likely to undergo extensive amendments before opponents blocked consideration of the FAIR Act by raising a budgetary point of order (*BI*, Feb. 20). Sen. Specter

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California comp rates dropping, but stabilizing forces emerging

By ROBERTO CENICEROS

SACRAMENTO, Calif.—At its recent workers compensation renewal, SCAN Health Plan got firsthand experience of the softening market for workers comp risks in California.

The Long Beach-based Medicare health maintenance organization was offered a guaranteed-cost program from Wausau Insurance Cos. that came in at \$400,000 less than the projected price of the loss-sensitive program that it had with its longtime insurer, St. Paul Travelers Cos. Inc., according to Deborah Shulman, SCAN's director of risk and insurance management.

SCAN decided to opt for the cheaper program and enjoy an accelerating trend. More employers

are moving to guaranteed-cost programs as pricing drops, said James E. Little, chairman and chief executive officer of Employers Direct Insurance Co. in Agoura Hills, Calif. Just a few years ago, many employers went into loss-sensitive programs because they had few alternatives.

But substantial price decreases recently seen in California could be bottoming out, Mr. Little said. Signs indicate that savings derived from reforms California adopted in 2004 have now worked their way through the system and pricing will stabilize.

But for now, SCAN's lower insurance costs are not an isolated incident. Last week, California In-

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Supreme Court to revisit issue of appropriate punitive awards

Tort reform backers hope for more clarity

By MARK A. HOFMANN

WASHINGTON—Tort reform advocates hope that the Supreme Court will use an Oregon case to clarify further when a punitive damage award is so disproportionate to underlying compensatory damages as to become unconstitutional.

The case, *Philip Morris vs. Mayola Williams*, stems from a Feb. 2 Oregon Supreme Court decision that upheld the award of \$79.5 million in punitive damages to the widow of a smoker who had died of lung cancer in 1997.

Mayola Williams' husband, Jesse, had been a three-pack-a-day smoker. Ms. Williams sued Philip Morris, now part of Altria Group Inc., for alleged fraud and ultimately received an award of \$521,000 in compensatory damages and \$79.5 million in punitive damages.

The U.S. Supreme Court sent the matter back to Oregon courts in 2003 as a result of its decision in *State Farm vs. Campbell*. In that case, the court majority held that punitive damages in excess of single-digit multiples of underlying compensatory damages are in most cases so disproportionate to the real damages that they cross the legal border that separates constitutional from unconstitutional.

In its decision upholding the award, Oregon's high court noted that the standards in both *State Farm vs. Campbell* and in the landmark 1996 decision in *BMW vs. Gore*—in which the Supreme Court held for the first time that punitive damages awards could be so disproportionate as to violate the Constitution—were not absolute, but rather guidelines.

"Single-digit ratios may mark the boundary in ordinary cases," wrote Associate Justice W. Michael Gillette for the Oregon Supreme Court. The *Philip Morris* case, though, "is by no means an ordinary case,"

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Employers in Manitoba face a duty to re-employ injured workers.

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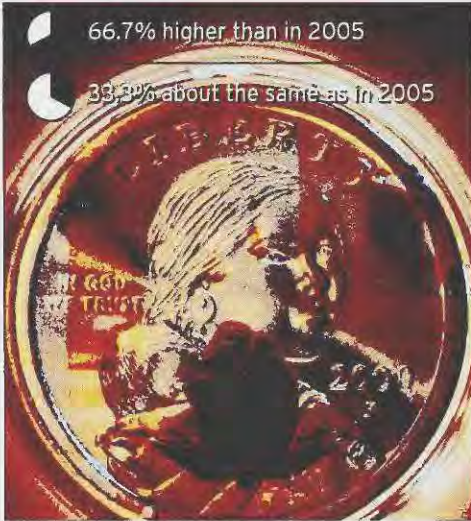
Higher costs hit earnings of managed care companies
But employers' premium hikes expected to hold steady or drop slightly.
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For punitive damages, how much is too much?
The Supreme Court must further clarify the limit on awards, an editorial says.
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Based on claim costs so far, will your company's health care costs change in 2006?



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

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS
Business Insurance (ISSN 0007-6864) Vol. 40, No. 23, is published weekly by Crain Communications Inc., 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Periodicals postage is paid at Chicago and at additional mailing offices. POSTMASTER: Send address changes to Business Insurance Circulation Department, 1155 Gratiot Ave. Detroit, Mich. 48207-2912. \$5 a copy and \$97 a year in the U.S. \$130 in Canada and Mexico (includes GST). All other countries, \$230 a year (includes expedited air delivery). Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 40012850, GST No. 136760444, Canadian return address: 4960-2 Walker Road, Windsor, ON N9A6J3. Printed in U.S.A. Copyright © 2006 by Crain Communications Inc.

Max Re restates after accounts probe

Reinsurer says finite deals transfer risk, but changes still needed

By RUPAL PAREKH

HAMILTON, Bermuda—Max Re Capital Ltd.'s decision last week to restate results for several years is another indication of many companies' heightened cautiousness about all accounting aspects of finite risk transactions.

Hamilton, Bermuda-based Max Re earlier this year announced it was conducting an internal accounting probe to determine whether three finite risk retrocessional contracts written in 2001 and 2003 were booked properly (*BI*, April 3). While the results of that review—conducted by the reinsurer's audit and risk management committee—found that the three contracts in question did not violate federal accounting rules and contained enough risk transfer to meet Financial Accounting Standards Board criteria to be accounted for as reinsurance, Max Re says the review prompted management to re-evaluate

other accounting aspects of the contracts, resulting in the restatement.

In a conference call with investors last week, Keith S. Hynes, Max Re's executive vp and chief financial officer, noted that the restatement of earnings for the years 2001 through 2005 relates to two separate accounting issues, the first being whether the contracts should have been divided into retrospective and prospective components.

"During the course of the review, we concluded that each of the retrocessional coverages was finalized subsequent to its inception date. In accordance with FAS 113, these contracts should have been bifurcated into retroactive and prospective components be-

Max Re-statement

Net income/(loss), in millions:		
Year	Original	Post-restatement
2005	\$6.7	\$6.3
2004	133.7	135.3
2003	120.6	118.6
2002	(5.8)	(5.8)
2001	2.5	(11.5)

cause they were completed late, whereas we had accounted for each contract entirely on a prospective basis," Mr. Hynes said.

Bifurcating the three contracts accounted for all of the changes in net income and shareholders equity reported due to the restatement, Mr. Hynes noted.

In an interview, Mr. Hynes said the second accounting issue related to a contractual feature which had originally been accounted for on a net basis, but, after the review, the company deemed it should have been recorded on a gross basis. Mr. Hynes declined to disclose the nature of that feature.

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Aon diversity chief receives APIW honor

Group recognizes Doyle's work to advance women in industry

By GLORIA GONZALEZ

Seeking to create an environment where women can openly and honestly discuss their difficulties in climbing the corporate ladder, Corbette Doyle co-founded a Web site called WomenOpinions.com, where women discuss key work/life balancing issues.

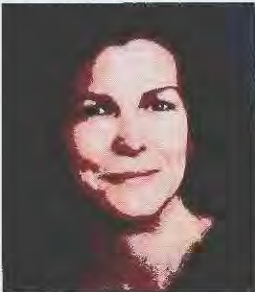
The site gathers responses from women that will be part of a series of books that Ms. Doyle, chief diversity officer of Chicago-based Aon Corp. and chair of

president of the APIW and a partner with law firm Edwards & Angell L.L.P. in New York.

Ms. Doyle is the 30th recipient of the annual award from the APIW, an organization devoted to the advancement of professional insurance women, and she will be honored at a June 8 reception at the Marriott Marquis in New York.

Dedication to diversity

Ms. Doyle's commitment to the advancement of women began long before she was chosen as Aon's first ever chief diversity officer earlier this year. She has been a guest speaker at several leadership conferences, discussing women in the workforce and the challenges they face, and she launched the Web site more than two years ago to provide a forum for women to discuss these issues.



Ms. Doyle

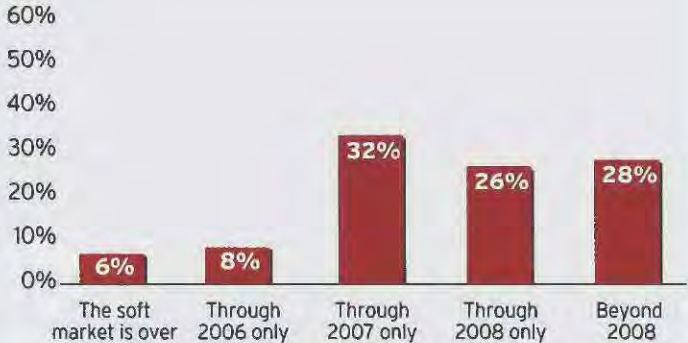
This commitment to promoting the advancement of women in the corporate world is a key reason why Ms. Doyle was selected as the Insurance Woman of the Year by the Assn. of Professional Insurance Women.

"That is a very important part of Woman of the Year...that they've demonstrated support for other women in the industry," said Laurie A. Kamaiko,

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Insurer CEOs rate market conditions

How long do you expect the softening market to continue?



Market to remain soft through end of 2007, insurer executives say

By SALLY ROBERTS

The soft market is here to stay at least for the foreseeable future, according to a group of insurer executives surveyed by American Re-Insurance Co.

But while many of the insurers expect their financial results to be the same or worse this year than last as a result of the soft market, the survey suggests they are still getting an adequate return on policyholder surplus and most expect to keep their combined ratios relatively low.

Princeton, N.J.-based American Re surveyed 61 chief executive officers and senior executives of regional and middle-market national insurers who attended its 12th annual CEO Roundtable Forum last month.

The survey found that a vast majority of executives, 86%, believe the soft market will continue through 2007. Of these, 32% said the soft market will last only through 2007, while 26% said it will last through 2008

and 28% said it will endure beyond 2008.

When asked what they believed were the major factors enabling the soft market, executives pointed to the weak resolve of senior management to achieve adequate returns first, followed by aggressive competition fueled by new capacity and strong recovery of financial markets, which may foster cash flow underwriting.

But while most of the insurers last year indicated their financial results would be "better" compared with the previous year, 67% of the insurers responding to this year's survey expect the same or worse results.

Of those, 40% described their financial outlook for the 2006-2007 period as the same compared with the previous period, while 27% said poorer. In the 2005 survey, 35% described their outlook as the same, while only 11% said poorer.

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BI's 'Women to Watch' to list industry's leaders

Business Insurance will publish a special report on "Women to Watch" in the Oct. 9 issue of the magazine and invites readers to nominate outstanding women working in insurance, risk management and employee benefits worldwide.

While the insurance industry historically has been led by men, more and more women are taking on leadership roles. To explore this trend, *Business Insurance* will explore how professional opportunities for women have evolved.

As part of the report, *BI* will

profile women executives who are doing outstanding work in insurance, reinsurance, risk management, employee benefits and related fields, such as law and consulting. In October 2000, *BI* produced a similar special issue recognizing contributions—past and present—that women have made to these fields. This year, the magazine will look at women who are currently in leadership positions.

Business Insurance editors will review nominees and select a group of leaders for the list of

women to watch. Among the criteria for inclusion are: recent professional achievements, influence on the marketplace and contributions to the advancement of women in business. The list is open to women leaders worldwide.

To nominate outstanding women in insurance, risk management and benefits, please visit www.BusinessInsurance.com/WomenToWatch and fill out a brief nomination form. The deadline for completing the form is Friday, Sept. 1.



REGIS COCCIA

Editor

Hurricane predictions mostly on the money

June 1 marked the official start of the Atlantic hurricane season, and after the devastating events of 2004 and 2005, many people are wondering what's in store this year.

Will we see another monster such as Katrina? Will another fierce storm wipe out New Orleans? Will this be the year that a big hurricane makes landfall north of the Carolinas? An awful lot of human lives—and dollars—are riding on the answers to these questions.

Much of this is of course unknowable, but that hasn't stopped a team of researchers from Colorado State University, directed for the past 22 years by Professor William Gray and now led by his associate, Philip Klotzbach, to predict how many tropical storms will form and how many intense hurricanes will develop in a given year. Part of their research stems from measurements of sea surface temperatures and historical meteorological records. The numbers on the forecasts, if not the geographic coordinates, are intriguing.

But just how accurate are the Colorado State team's forecasts? To find out, I researched the past several years and matched the prediction at the start of hurricane season with the actual result observed following the season's end in November.

It turns out the Colorado State team's forecasts at this point in the year have been pretty much on the money, except for 2005—the most destructive year on record. The team issues revised forecasts during the hurricane season, but for comparison's sake, I chose only those forecasts issued in late May.

In 2002, the team predicted 11 named storms, six hurricanes and two intense hurricanes (wind speeds exceeding 111 mph); that year actually saw 12 named storms, four hurricanes and two intense ones. For 2003, the team said there would be 14 named storms, eight hurricanes and three intense ones; in fact, they pegged it, except only seven hurricanes formed. 2004's forecast called for 14 named storms, eight hurricanes and three intense hurricanes. Those numbers were right, except for the intensity—six intense hurricanes occurred.

For 2005, the year of Dennis, Katrina, Rita, Wilma, Alpha, Beta and Gamma, the team predicted 15 named storms, eight hurricanes

and four intense hurricanes. Not quite. There were 23 named storms, 13 hurricanes and seven intense ones. Katrina was the worst-ever insured catastrophe, with losses exceeding \$34 billion and estimated to reach \$60 billion.

According to the Colorado State team's latest forecast, 2006 will see 17 named storms, nine hurricanes and five intense hurricanes. Where they'll hit and how much damage they'll cause is anybody's guess.

Regardless of these prognostications, it's clear that hurricanes have become more frequent and more damaging in the last 14 years. Seven of the 10 costliest insured windstorms in the United States have occurred since 2004. Not coincidentally, coastal development has also put a lot more people and property in harm's way.

After Katrina, many people were quick to point fingers and blame the federal government, state officials, local politicians and of course, the insurance industry. There's ample evidence that the government could have done more to mitigate the loss of life and property, and residents themselves could have better understood what their policies did—and did not—cover. Awareness of flood risk and participation in the National Flood Insurance Program could have helped tens of thousands of people who lost virtually all their possessions. But few bought the coverage, and many who didn't have been shocked to learn that homeowners' policies exclude flood peril.

Lost amid the din is the fact that insurance companies are helping rebuild areas that were devastated—a role that property insurers play almost everywhere there is catastrophic loss. While the denial or slow payment of claims has grabbed headlines, many forget that thousands of insurance agents, brokers and company personnel in the Gulf lost much of their belongings, too.

I sincerely hope we never see another human tragedy like that, but we probably will in the near future. If Professor Gray's team is correct, we'll see another above-average hurricane season in 2006. We'll have to wait and see where the storms hit. Far more important questions to answer now, though, are "Will we be ready?" and "What have we learned since the last time?"

AIG, Chubb to pay \$50 million in D&O suit

TORONTO—American International Group Inc. and Chubb Corp. may pay a total of \$50 million to settle a lawsuit against former directors of Hollinger International Inc. and leave Hollinger's excess insurers potentially responsible for covering all future claims against the directors, an Ontario Superior Court judge has ruled.

The settlement, which would exhaust the limits written by New York-based AIG and Warren, N.J.-

based Chubb, would resolve the claim that minority shareholder Cardinal Capital Management L.L.C. of Greenwich, Conn., made against Chicago-based Hollinger, which publishes the Chicago Sun-Times daily newspaper. Cardinal claimed that the former directors ignored the alleged financial misconduct of former Hollinger Chief Executive Conrad Black.

Other lawsuits over Mr. Black's alleged financial misconduct are

pending against Hollinger, a unit of Toronto-based Hollinger Inc. The settlement would force Hollinger to seek coverage for those claims from its excess insurers. Those insurers—ACE Ltd., Zurich Insurance Co. and Royal Insurance P.L.C.—opposed the \$50 million settlement.

The settlement, though, still must be approved by a judge in Delaware, where Cardinal's lawsuit was filed.

—By Dave Lenckus

Greenbrier: Reducing health care cost increases

Continued from page 4

select the right doctor and hospital ahead of time, Mr. Sheehy said.

To do that, health care provider quality information will have to become much more widely available and transparent, the two executives said.

While there has been provider resistance to the collection and dissemination of such information, "transparency is coming.... The provider community is increasingly recognizing that is important," Mr. Hanway said.

Providers recognize that they could deliver better care if quality care-related information was more widely available, he said.

And some providers could benefit financially if payment rates were linked more closely to the quality of services delivered. "It makes sense to doctors," Mr. Sheehy said.

At the same time, there are steps employers can take in the design of their plans to encourage employees to lead healthier lifestyles. For example, CIGNA asks employees to fill out health care risk appraisals

and employees receive financial incentives if they stop certain behaviors, such as smoking, uncovered by the assessments.

"It is not disease management. It is dealing with diseases before they occur. We need to get the employee engaged much earlier in the process...so we can avoid those (medical) problems later on," Mr. Sheehy said.

Both CEOs say that by attempting to reduce the number of uninsured, government has an important role to play in cost control efforts. One approach—recently enacted in Massachusetts—is to require all state residents to have health care insurance coverage and for the state to subsidize premium costs for lower-income individuals.

Additionally, employers that don't pay a reasonable percentage of the cost will have to pay an annual assessment of \$295 per employee.

The state's goal is to have 95% of state residents enrolled in health plans over the next three years, up from about 90% now. The measure,

which was passed earlier this year, could have implications beyond the Bay State.

The Massachusetts law could be a "testing ground" for coverage expansion ideas, Mr. Sheehy said.

Mr. Hanway, though, notes that he is hopeful, but skeptical, about whether the Massachusetts law will achieve the goal—near-universal coverage—that its proponents say is possible.

"There are lots of unanswerable questions," he said, not the least of which is whether affordable policies can be offered given some of the requirements, such as complying with numerous state benefit mandates.

Both chief executives agree, though, that despite some initial bugs, enrollment in the prescription drug benefit program offered through Medicare has proceeded very well. The role of health care insurers in the program has been positive as they have the market clout to negotiate the best prices from drug manufacturers, Mr. Sheehy said.

Agents & Brokers directory deadline nears

The 35th annual Directory of Agents & Brokers will be published in conjunction with the July 17, 2006, issue of *Business Insurance*. The directory information will be available only to *BI* subscribers in a searchable database in the directory area of our Web site, www.businessinsurance.com.

The July 17 issue will contain a ranking of the largest Agents & Brokers based on the information supplied for this directory.

Companies that would like to be included should request a questionnaire by June 16 by contacting Kevin Edison at kedison@businessinsurance.com.

Editor Regis Coccia can be reached at rcoccia@businessinsurance.com

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Cail now for details. **Business Insurance Europe** will unpack its regular biweekly publishing schedule beginning this September – it's a trip you won't want to miss!

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Editorial

Captive formations are to states' advantage

CAN THERE BE too many captive insurance domiciles in the United States?

That's a question that some might raise as the roster of states with captive statutes continues to increase.

Twenty-two states now have captive laws on their books, with many of those states having enacted captive measures in the last half dozen years or so.

And that number could go even higher soon. A captive measure now is pending in the New Jersey Legislature, while the Ohio Department of Insurance, as we report on page 4, also is drafting a bill.

Given the number of states with captive laws, are the latest states moving to adopt measures wasting their time?

We don't think so. To our thinking, it would be a welcome development if every state allowed insurance captives to be formed within its borders. After all, why should an employer that wants to form a captive be forced to go to a state other than the one it is based in just because its home state lacks a captive law?

There is no logic to that, and states—judging by the growing number of domestic domiciles—clearly understand that.

That so many states have captive laws reflects how states have become savvy about the captive industry. This is a business states clearly relish, given the economic benefits—chiefly creation of high-paying jobs—it brings.

Regrettably, it has taken the states a long time to recognize that it is to their advantage, and that of businesses in the states, to allow captive formations.

Indeed, it wasn't that long ago that a U.S. company, if it wanted to form a captive, had no choice but to do so offshore. Fortunately, that no longer is the case.

Of course, enacting captive legislation is no guarantee that a state will attract captives. In fact, two states—Colorado and Tennessee, the pioneers in the domestic captive movement—have seen their captive rosters shrivel over the two decades due largely, we think, to state regulators who did little to promote their states as captive domiciles.

Fortunately, there are plenty of states that do want this business and those with good laws and a consistent and fair approach to regulation have seen their efforts rewarded with a swelling number of captives.

Schillerstrom



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Court must draw a clear line on punitive damages award

THE SUPREME COURT'S decision to review an Oregon punitive damages case gives the justices another welcome opportunity to spell out the circumstances under which punitive damage awards are deemed to be so disproportionate to underlying compensatory damages as to violate the Constitution.

In two decisions in the past decade—*BMW vs. Gore* and *State Farm vs. Campbell*—the court did just that. In the 1996 *BMW vs. Gore* decision, the court held that punitive damages could be so disproportionate that they violated constitutional rights, but didn't give a ratio that would separate the constitutional from the unconstitutional. Three years ago, in *State Farm vs. Campbell*, the justices said that,

in general, a punitive damages award more than nine times that of the underlying compensatory damages would cross the line.

Of course there was a catch—and an understandable one at that. The court declined to draw a bright line that would apply to all cases. As a result, lower courts strayed from the high court's guidelines under a variety of circumstances, including situations where courts found that the defendant had engaged in "reprehensible conduct." The case the court agreed to hear—*Philip Morris vs. Mayola Williams*—gives the justices another chance to clarify just what circumstances apply.

The case in question involves a \$79.5 million punitive damage award tacked on top of

a compensatory award that ultimately amounted to \$521,000. The Oregon Supreme Court upheld that award, holding that the defendant had "engaged in a massive, continuous, near-half century scheme to defraud the plaintiff and many others."

The high court agreed to decide whether such conduct can override the constitutional concerns and whether juries can punish defendants for harm done to individuals who are not party to a suit. Both are critical questions that deserve clear answers.

There is a certain risk for tort reform advocates as the high court hears this case. No one knows exactly where any member of the court will come down in any particular case, and

that's particularly true regarding Chief Justice John Roberts and Associate Justice Samuel Alito in this case. There is a chance that the court's two newest members, despite generally pro-business records, will see no constitutional justification for any limits on state punitive damage and could, in the process, basically reverse both precedential decisions.

That's a considerable risk that could set punitive damages award reform efforts back a decade. But few opportunities come risk-free. Since the justices have already accepted the opportunity presented to them by the Oregon case, we hope they use it wisely to further clarify when enough is enough where punitive damages are concerned.

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ADVERTISING: Boston: 617-292-4856; Chicago: 312-649-5276; Irvine CA: 949-255-5355; New York: 212-210-0133

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By Corby Peltó

Perspectives

Insurers' oversights unfair to policyholders

As a 20-year insurance industry veteran who has held a variety of titles, from line-level positions to senior management roles, I have gained about as broad a perspective and understanding of the insurance industry as most insiders.

When people ask me what I think about insurance companies from a quality and ethical perspective, I confess to them that I don't like what I see and that more needs to be done to correct decades of inefficiency, ineffectiveness and impropriety.

Although insurance company executives often blame greedy attorneys and other external factors for driving up insurance costs for their policyholders, it is equally true that insurance companies share significant blame for those rising costs. It is high time that insurers be held accountable for their oversights and failures to improve quality and curb costs.

Insurance companies should be accountable for controlling costs

and minimizing exposure for their policyholders.

As evident in the ongoing government criminal probes, the insurance industry has operated within an environment that has enabled relationships and the steering of clients to overshadow objective measurements and deliverables to policyholders.

Along with an unproductive industry environment, insurance policy contracts have not adequately assured insurance company performance commitments to the policyholder.

In essence, insurers have gotten away with a "pass the buck" strategy that has enabled them to force policyholders to pay for the insurance company's inefficiencies and failures.

Buyers of insurance should realize that insurance companies will find a way to earn their profits one way or the other. When an insurer is not accountable for minimizing costs and exposures for their policyholders, the real losers are the policyholders.

Insurance companies often pro-

mote how effectively and efficiently they investigate and manage insurance claims. However, there are far more shortcomings in the way that the industry operates in the claims arena than there are strengths.

Over the years, insurance companies have drifted further and further

has steered quality people away from the industry.

Insurance companies do not consistently investigate claims in a thorough or timely manner, and the lag time from date of accident to investigation completion is poorly managed. It is no wonder that claimants

The professionally educated and trained claims adjuster has too often been replaced by clerks who lack the technical, analytical and communication skills that are necessary to be effective in this role.

away from the time-tested practices than most claims veterans would agree are necessary in delivering a sound claims operation.

The professionally educated and trained claims adjuster has too often been replaced by clerks who lack the technical, analytical and communication skills that are necessary to be effective in this role. The treatment of claims adjusters in sweatshop environments has hurt results and it

seek out attorneys as often as they do.

Some executives may feel their companies no longer benefit in taking a recorded statement from a workers compensation claimant, or they don't believe it matters whether a claimant is contacted within one day versus several days after a loss occurred.

These leaders were never claims adjusters, nor do they understand the benefits of claims investigations

and the tools necessary to control claim costs.

Although it is true that insurance companies have created various deductible plans as a way to reduce insurance premiums for their clients, this is just another way to pass the buck.

Because insurance companies lack confidence in the outcomes of their claim investigations, they have a tendency to inflate or manipulate reserves in order to create a safety net for their uncertain financial forecasts. Such practices certainly do not benefit the policyholder.

Although there are companies operating in the marketplace that aggressively attack the cost structures and deficiencies that impact policyholders, don't expect these reformers to have much of an impact in this arena. After all, it is far easier to defend an entrenched position than it is to attack one.

Corby Peltó is president and chief executive officer of Minneapolis-based Peltó Group Inc., a claims management and consulting company.

Workers comp doesn't cover injury at company picnic

The Supreme Court of Tennessee denied an employee's claim for workers compensation arising out of an injury occurring during a company-sponsored picnic.

Phyllis Young began working for Taylor-White L.L.C. in 1999. In September 2002, the employer sponsored a company picnic that was held outside of work hours at a public park. The employer informed employees about the picnic by posting signs on its plant's bulletin boards and by word of mouth.

Ms. Young attended the picnic with a friend, who was also an employee. She participated in a number of games at the picnic, and she was injured when she fell while participating in a three-legged race.

Neither employees nor management were required to attend the picnic. There were no adverse consequences if an employee signed up but did not attend. Ms. Young filed for and was awarded workers compensation for her injury. The employer appealed.

The appellate court said that although a disc jockey hired by the employer to organize the picnic games encouraged Ms. Young to participate in the race, neither mere encouragement nor the offer of a nominal cash prize was enough to transform what would otherwise be a voluntary activity into one within the course of employment.

The court concluded that because the race was not within the course of her employment, Ms. Young's injury was not compensable. The trial court decision was reversed.

Young vs. Taylor-White L.L.C., Supreme Court of Tennessee, Oct. 20, 2005 (BI/01/Ju.-\$10)

Product distribution a single occurrence

The distribution of an allegedly defective product was a single occurrence for the purpose of determining whether a per occurrence limit or aggregate limit applied under a commercial general liability insurance policy, according to the Supreme Court of South Carolina.

The product liability case arose from the sale of Parex, a synthetic stucco distributed by CGD Inc. The defective stucco allegedly caused water intrusion that damaged many properties. The property owners brought a class-action suit against CGD. The company was covered under a CGL policy issued by Owners Insurance Co. The policy defined "occurrence" as an accident, including continuous or repeated exposure to substantially the same general harmful conditions. If distribution of the stucco to various buyers is considered one occurrence, the policy's per occurrence limit of \$1 million applied; if each sale was an occurrence, the aggregate limit of \$2 million applied. The insurer brought this suit in federal court seeking to have the court declare that the policy did not cover the multiple water intrusion suits.

The federal trial court said the question of which limit applied should be decided by the Supreme Court of South Carolina.

The Supreme Court of South Carolina said that the case involved the distribution of inherently defective goods, and not the defective distribution of otherwise satisfactory goods. According to the court, there was no indication CGD defectively

distributed the product in question. Further, the court said that the policy here provided coverage for an "occurrence." Because the distributor had taken no distinct action giving rise to liability for each sale, it concluded under this policy definition that placing a defective product into the stream of commerce was one occurrence.

Owners Insurance Co. vs. Salmonsen, Supreme Court of South Carolina, Nov. 7, 2005 (BI/01/My.-\$10)

Benefit curtailment supported by record

An Employee Retirement Income Security Act long-term disability administrator's decision to discontinue a participant's benefits was sufficiently supported by the record, according to the U.S. Court of Appeals for the Fifth Circuit.

Lois Albert worked as a tax supervisor at American General for approximately 25 years. Ms. Albert participated in the employer's long-term disability plan, which was administered by the Life Insurance Co. of North America.

In August 2000, Ms. Albert went on medical leave after undergoing surgery to remove a portion of her right lung. In October 2000, she returned to work. However, her condition worsened and she again departed from work. She applied for and received short-term disability benefits under the ERISA plan.

She also applied for long-term disability benefits, but her application was denied. She appealed and

the insurer reversed its decision and awarded her benefits. Four months later, however, Ms. Albert was subjected to a battery of tests after which the insurer determined that she was no longer entitled to long-term benefits. Ms. Albert brought suit in federal court but lost. She appealed.

The appellate court concluded that the plan administrator's decision to discontinue Ms. Albert's benefits was supported by the record and, thus, there was no abuse of discretion. According to the court, the evaluator selected by the administrator conducted a functional capacity examination of Ms. Albert and concluded that she was capable of performing her job as a tax analyst.

Furthermore, the court noted that a doctor who performed an independent medical examination of Ms. Albert found no physical reason or obvious cognitive reason why she could not perform her job duties.

The court emphasized that even though Ms. Albert legitimately disputed the evidence, the administrator's decision to deny her long-term disability benefits was not required to be supported by indisputable evidence. The trial court decision was affirmed.

Albert vs. Life Insurance Co. of North America, 5th U.S. Circuit Court of Appeals, Dec. 2, 2005 (BI/03/My.-\$10)

Going, coming rule not applicable in suit

A truck driver's trip to his home fell under the exception to the general "going and coming" rule, ac-

cording to a Kansas appellate court.

On Sept. 30, 2002, Chris A. Sumner, a truck driver for Meier's Ready Mix Inc., died as a result of a one-vehicle accident.

Although Mr. Sumner was driving a company truck at the time of the accident, the parties stipulated that at the time of the accident, he was engaged in a personal errand with no business purpose. As Mr. Sumner was driving between deliveries for his employer, he received word that there was an emergency at his home.

His company's assistant manager gave him permission to go home and Mr. Sumner was killed in an accident while driving there. It was established that the employer allowed Mr. Sumner to keep its truck at his residence at night. Mr. Sumner's wife filed for and was awarded workers compensation death benefits.

However, the Workers Compensation Board reversed that decision and Mr. Sumner's wife appealed.

The appellate court said that Mr. Sumner routinely kept the company's truck at his home between his shifts.

In this particular instance, the court said, there was no time to make the second delivery that day. Thus, the court said that Mr. Sumner's trip to his home fell within the going and coming exception rule because the employer's policy in allowing Mr. Sumner to take the company truck home furthered the employer's interests.

The board's decision was reversed.

Sumner vs. Meier's Ready Mix Inc., Court of Appeals of Kansas, Jan. 13, 2006 (BI/05/My.-\$10)



Perspectives

Preparing employees for disasters

Catastrophe response plans should not overlook 'people risks'

By Guy Sapirstein

Recent catastrophic events such as Hurricane Katrina and potential catastrophes, such as pandemic influenza or future natural disasters, have confronted risk managers and the insurance industry with unparalleled challenges.

Forecasts for the upcoming hurricane season, as well as other data on the global climate, suggest that the trend toward costly natural disasters will continue and even increase. Among the implications of this trend for businesses is the elevated risk for business interruption and financial loss.

In preparing for business interruption risks, one of the most overlooked and underappreciated factors concerns the impact of employees. A recent benchmarking study conducted by Continuity Insights magazine and KPMG Advisory Services revealed that 35% of respondents identified "people issues" as the "weakest link" in their continuity plans, strategy and recovery efforts.

In comparison, "technology risks" were endorsed as "weakest" by only 19% of the respondents.

Ignoring "people risks" can result in decreased production flow, and a cascade of events that could threat-

en both the company and other dependent organizations such as suppliers and customers.

To help address the issue, companies need to consider the field of human impact preparedness, which is based on an understanding of the life cycle of a disaster and how people respond during the different phases in that life cycle. That understanding has implications for the assessment and measurement of recovery from disaster.

The metric many companies use to assess disaster recovery is the time it takes to resume operations. While this measure is important, it ignores some fundamental aspects of human reactions to disasters.

Recovery from disaster is not linear; rather, it begins with what L.M. Zunin and D. Myers, in their book "Training Manual for Human Service Workers in Major Disasters" describe as "heroism," but after a relatively short while people enter the phase of "disillusionment," which can last weeks, months or even years.

During this phase, psychological reactions become more negative as people despair that their life circumstances are not improving. In this stage we see poor motivation, problems with retaining staff and reduced productivity.

These effects can be mitigated, however, if companies create a plan specifically addressing the needs of their employees throughout the entire life cycle of the disaster.

Effective mitigation of disasters always includes preparation. The process of human impact preparedness includes three components: organizational assessment, human

The assessment also should focus on individuals in specific positions and their personal strengths and weaknesses in the face of potential crises or disasters. While some people will feel threatened by this process, it would be wrong to avoid dealing with potentially problematic issues.

• Human impact planning is a

Companies need to consider the field of human impact preparedness, which is based on an understanding of the life cycle of a disaster and how people respond during the different phases in that life cycle.

impact planning, and exercises and training.

• Organizational assessment should be comprehensive and it should encompass any or all levels of an organization. The assessment should cover four major areas: a review of existing plans, including human resource policies and procedures; evaluation of existing resources and partnerships; communication and information flow; and organizational culture.

strategic planning process used to prepare for the inevitable consequences of disasters. Many of the activities found in a human impact plan might already exist within a company, but they are typically scattered across departments, with poorly designed procedures, roles and responsibilities.

The development of a human impact plan organizes and centralizes these policies and procedures. It also coordinates them with all other

internal or external crisis preparedness plans. This process covers a variety of different areas that will ultimately ensure that the "people risks" to the organization will be mitigated.

The process of human impact planning necessitates a thorough understanding of the human reaction to stress and disasters, as well as accounting for the entire life cycle of a crisis. The process is collaborative in nature and is implemented in organizations of all types and sizes.

• Exercises and training should be developed to enhance the levels of preparedness. They should be experience-based—such as simulation and table-top drills—information-based and include periodic reviews and refresher courses.

Hoping for the best outcome is not a strategy; preparedness is. Risk managers and insurers should begin to encourage and guide companies to engage in human impact preparedness as a means of mitigating the potential effects of disasters on their workforce.

Guy Sapirstein is a principal at Concord, N.H.-based Organizational Resilience International L.L.C., a trauma and crisis management consultant.

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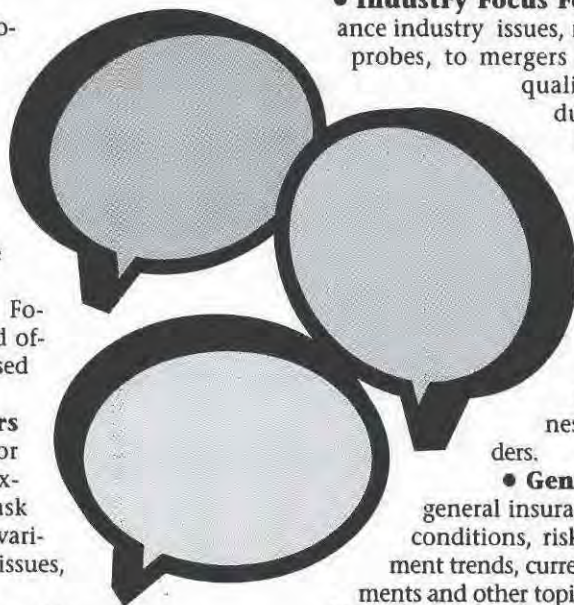
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Business Insurance accepts articles from experts in commercial insurance, risk management and employee benefits management for publication in its Perspectives section.

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They should not present case studies or promotional information.

All articles for the Perspectives page should address the concerns of the corporate buyer of insurance; i.e., the risk management or employee benefits manager. Material written for only the concerns of brokers or underwriters is not appropriate.

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• Send us a letter describing the topic you would like to address. You might want to suggest alternative topics. For each topic, briefly describe

what you want to say and accomplish in the article.

• You will receive from us an acceptance or declination of your article idea.

• If accepted, we will respond with comments and request the full article, which generally should be 800-900 words in length.

• All articles are to be accompanied by color photograph of the author and a brief biography.

• We will notify you of any questions we have about your article or any substantial editing we think is necessary.

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RiskMeter enhances reporting capabilities

BOSTON—CDS Mapping L.L.C., a provider of online property risk mapping, has enhanced its Internet application RiskMeter Online, which allows underwriters to identify property locations. The application's enhancements include the addition of six states—Arkansas, Kentucky, New Mexico, Oklahoma, Tennessee and Utah—to its Distance to Fire Station report,

bringing the total number of states to 41. By entering an insured location's address, the application determines the distance to the three closest fire stations and provides a detailed report that includes the names of the closest stations and staffing information. For more information, contact James Munson, director of consulting services, at 860-854-6125 or jmunson@cdsys.com. More information can also be obtained by visiting www.riskmeter.com.

AAIS files liability endorsement options

WHEATON, Ill.—The American Assn. of Insurance Services, the national advisory organization that develops policy forms and rating information, has filed several endorsement options under its commercial liability program. The endorsements are effective Jan. 1, 2007, and include the following: an exclusion for certain personal and advertising injury claims against policyholders that provide Internet services or access; an exclusion for errors or omissions committed in association with rendering services as a Web site designer or consultant; and a professional services exclusion that applies to the rendering of or

failure to render professional services as a pharmacist, among others. For more information, contact Rick Maka, director of marketing, at rickm@aaisonline.com.

ACE launches program for U.K. travelers

LONDON—ACE European Group, a division of ACE Ltd., has introduced an injury and travel insurance package for large corporations in the United Kingdom. ACE Businessclass Premier includes customized accident, health and travel insurance as well as risk consulting and other services. The program provides emergency assistance, security and travel advice, legal assistance services, and accident and health risk consulting. The package offers coverage for directors; partners; employees, including expatriates; employees' families; customers; and shareholders. In addition, the company also can provide accompanying coverages that include visitors' personal accident and image protection benefits, which covers the costs of hiring a public relations firm and image consultant to manage the release of information arising from the accidental death of an employee, visitor or other person lawfully at the premises.

For more information, contact the company at 44-207-173-7288 or businessclasspremier@ace-ina.com.

Buck Consultants offers communications tool

NEW YORK—Buck Consultants, an independent subsidiary of Affiliated Computer Services Inc., has developed a benefit communications program for employers. The Total Rewards InSight tool brings together an organization's total compensation information for the company's various audiences, such as recruits, employees, executives, human resources plan sponsors and the board of directors. Available online, employers can manage and deliver messages to these various employees from a single location. It provides employees with personalized data for all of their benefits and compensation programs, including total accumulated compensation from employer-sponsored incentive, retirement and equity plans. Some of the featured data includes a summary of benefit plan information, listing current plan enrollments, contributions and participation levels; retirement and wealth modeling tools; and a valuation of human resources programs, among others. For more information, contact the

company at 866-355-6647 or communication@buckconsultants.com.

CRC offers coverage for dietary supplements

CHICAGO—CRC Insurance Services Inc. has launched a products liability insurance program for the dietary supplement industry. The program is designed to cover dietary supplement manufacturers, importers, exporters, distributors, wholesalers and multilevel marketers. The coverage includes vendors legal liability, premises liability and employee benefits liability. The available limits are \$1 million per occurrence, \$2 million general aggregate and \$2 million products and completed operations aggregate. For more information, visit the company's Web site at www.crcins.com.

We'd like to report on new risk management and employee benefit products and services offered by your company. Send information about your new offerings to: Carrie A. Peinado, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; telephone: 312-649-5313; fax: 312-649-7801; e-mail: cpeinado@businessinsurance.com.

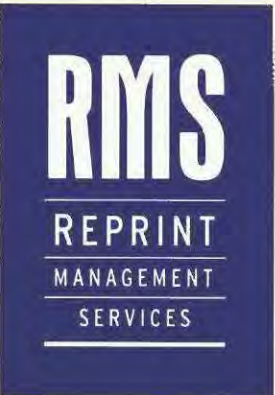


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Adequate warning is helpful before switch to CDHP

Long transition period creates less ill will

By JEREMY SMERD

In the summer of 2002, John Mackey, founder and chief executive officer of Whole Foods Market Inc., took a long walk in the woods to clear his head. Among the issues foremost on his mind was his company's rising health care costs.

Four-and-a-half months later, in October, Mr. Mackey completed the 2,175-mile Appalachian Trail; he also decided that beginning January 2003, Whole Foods would become one of the first large employers to switch exclusively to a high-deductible health plan. For Mr. Mackey, a libertarian who believes strongly in individual responsibility, the new plan represented the best way to force employees to be mindful, cost-conscious health care consumers.

But the transition was not wrinkle-free. Despite a short but intensive campaign by Mr. Mackey to educate employees about the pending change and its rationale, the top-down decision ran counter to Whole Foods' democratic culture, upsetting employees who regularly vote on company policy, from how to display produce to whether to hire someone in a store.

"The change was going to happen anyway, which was a little challenging because that does not go with the Whole Foods Market philosophy of having a shared stake," said a company spokeswoman. "But because the plan had to be implemented so quickly, that's the way it was."

The effort to change health plans provided an intense lesson for Whole Foods: How a company transitions to a new plan is as important as making the change.

Analysts say large employers have learned from the experience of others in recent years and, as a result, are taking longer between when they decide to drop all other health plans in favor of a high-deductible plan and actually implementing the change. A longer time frame may help change employees from passive consumers of medicine to active consumers of their health care.

"For everybody, it's a change from the traditional plan," said Tom Billet, a senior benefits consultant with Watson Wyatt Worldwide. "It's not easy. For the employee, it requires more thought and research. But that's the idea."

Enrollment in high-deductible plans is growing rapidly. United-Health Group Inc., for example, said it experienced an 80% year-over-year increase in the number of businesses offering consumer-driven health plans beginning in 2006, with 11% of its large employers making it their only health care plan.

"We're seeing that mostly the large companies, those with over 2,000 employees, are looking at a year of just education before throwing them into a full-blown CDH model," said Dr. Amit Gupta, president of Fiserv Health CareGain, a technology company that helps design consumer-driven health care programs.

Executives at Deere & Co., the company known for its John Deere farm equipment, told its 13,500 U.S.-based nonunionized employees last July that the company would be abandoning its current health plan in favor of high deductibles and health savings accounts partially funded by the company. The news was not a complete surprise, since the company's CEO, Robert Lane, has been a staunch supporter of President Bush's effort to expand the tax benefits of the accounts.

Early warning

What was noteworthy, however, was Deere's time frame for making the change: Rather than enrolling at the next opportunity, in January 2006, the company said it would make the wholesale switch in January 2007, 18 months after its initial announcement.

"If you give them 60 days' warning, they can't possibly imagine how they're going to survive," said Duane Olson, Deere's benefits manager. "Eighteen months—that's a catalyst, isn't it? Once it costs you money, what do you do? You try to figure out, 'What are my benefits? What is it going to cost me? What are my choices?' Now people are asking doctors what their costs are."

The shift in time frames is due, in part, to disenchantment with high-deductible plans among employees, according to a survey published last year by McKinsey & Co. The survey found that 56% of employees whose companies had switched to a consumer-driven plan were less satisfied with their health insurance. Employers, meanwhile, have raved



Whole Foods founder John Mackey's decision to implement a high-deductible health plan was announced only a short time before the new plan went into effect.



about the cost savings they've attained by making the switch.

To bridge this satisfaction divide, large companies are bringing back wellness and preventive programs that may have failed in the past, Dr. Gupta said. "Getting people more engaged in incentives is growing because employers want to get people used to the idea of getting rewarded for healthy behavior," he said.

Five years ago, Deere canceled an employee assistance program because only 0.6% of employees used the free financial, counseling, and child and elder care services the company offered. As part of the transition to a high-deductible plan, the company brought back the program with expectations that 8% to 10% of employees would use it.

"I've had more employees tell me that this new plan is the final catalyst: 'If I keep smoking it's going to cost me money,'" Mr. Olson said.

Deere has supported these programs with online learning modules, newsletters and meetings open to workers and their spouses.

Other common incentives, Dr. Gupta said, include deductions in premiums for nonsmokers or bonuses for those who sign up for wellness programs with the intent

"The whole concept of working at Whole Foods is about empowerment. I think in this case they felt employees needed to have their input heard, too."

Amy Moore
Whole Foods Market Inc.

of encouraging people to use separate accounts to pay for health services. Such programs, like high-deductible health plans, encourage people to make use of free preventive medicine that could eventually help them keep their own health care costs to a minimum.

Like other companies offering high-deductible plans, Deere will offer 100% coverage for all preven-

Whole Foods Market, one of the first large companies to make high-deductible coverage its sole health care offering, continues to tweak its plan to meet employee needs.

tive health care, as defined by the U.S. Preventive Services Task Force. That includes screenings for common cancers, heart and vascular disease, a variety of infectious diseases, depression and drug abuse, diabetes and a host of other common diseases that are more costly to treat than prevent.

Union support

It is especially important for Deere to make the transition to high-deductible health care. The company would like to enroll its 8,700 unionized employees in the same health plan when their contracts are up for renewal in 2009. Union workers are currently enrolled in a plan with no premium and a small co-pay for visits to the doctor and prescription drugs.

Bobby Garlan, a vp of Local 74 of the United Auto Workers in Ottumwa, Iowa, said the possibility of a change in health plan has not yet been discussed, but that any change would be of great concern to his members. Though UAW officials say Deere has traditionally enjoyed good relations with its labor force, the stakes for a smooth change are nonetheless higher for companies with unionized employees.

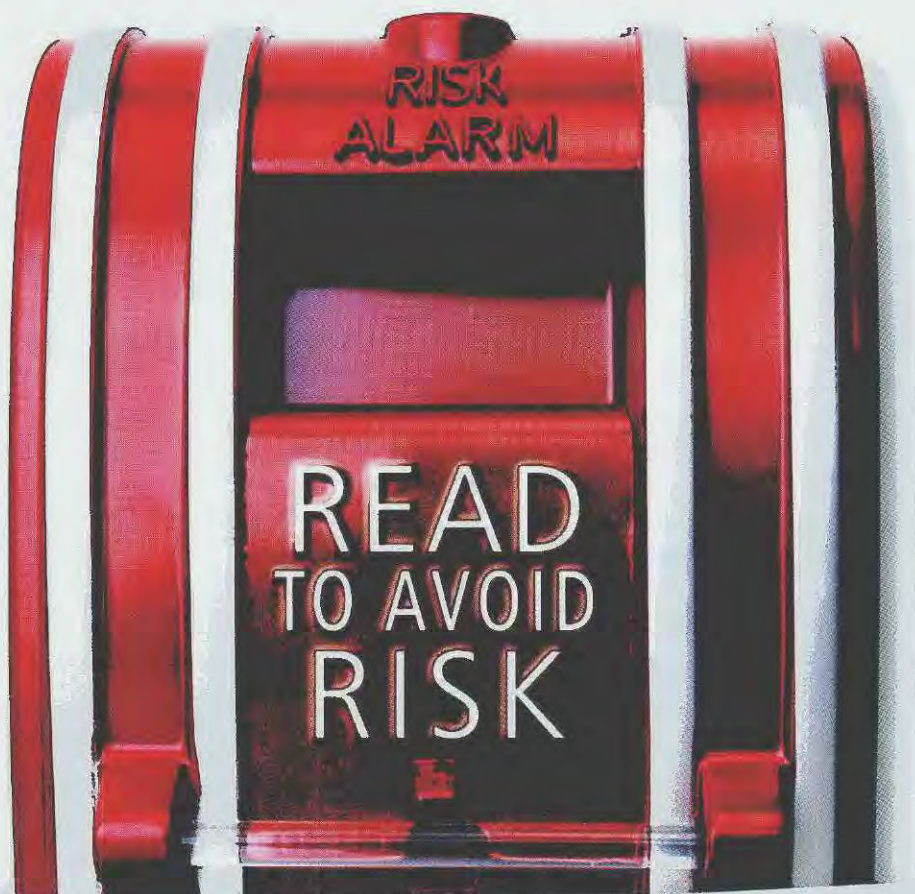
For both employee and employer, the change to a radical new health plan, Mr. Olson said, "can't be a leap of faith. There's too much at stake."

This was a point executives at Whole Foods quickly learned from their employees. After making the change to a high-deductible plan in January 2003, Mr. Mackey and his executives arranged for a company-wide referendum on their entire benefits package, including whether to continue using a high-deductible plan.

"The whole concept of working at Whole Foods is about empowerment," said Amy Moore, the company's benefits manager. "I think in this case they felt employees needed to have their input heard, too."

Executives once again explained the rationale for the plan. It went something like this: Whole Foods had quickly grown to become the world's largest natural foods supermarket chain, but its health care costs had grown faster.

Four out of 10 employees chose to forgo the company's health care plan, mainly because they were young—the average employee age



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COMMENTARY

Senior Editor Sally Roberts

Quality concerns make a comeback

Anyone who has been in the insurance industry long enough will be well aware that certain subjects have a way of gravitating toward the spotlight every few years as if they are on a rotating cycle. Issues such as whether the insurance industry should be state or federally regulated or whether we should adopt a Canadian-style single-payer health care system come to mind.

So it should come as no surprise that the issue of quality service—or lack thereof—is once again a major topic of discussion in the risk management community.

At this year's Risk & Insurance Management Society Inc. conference in Honolulu, outgoing President Ellen Vinck stated very clearly that risk managers are still discontented with the service they receive from their insurance providers—especially when it comes to the insurance placement process.

Almost 60% of the risk managers RIMS recently surveyed, she said, do not get an insurance quote 30 days prior to their policies expiring and only 5% reported receiving a policy within 30 days of binding. The vast majority wait between 90 and 120 days for the product, she said.

Ms. Vinck noted that this data was shared with the industry executives who attended RIMS' quality forum held in March at RIMS headquarters in New York.

Although the press was not invited to the forum, I was told that the two-dozen risk managers, regulators and senior executives of the world's largest brokerages, insurers and industry associations who attended the forum agreed that a working group should be developed to help improve quality in the insurance placement process.

It's déjà vu all over again. It doesn't seem that long ago that I was sitting among 100 or so industry representatives at Willis Group Holdings' then-Nashville, Tenn.-based corporate headquarters when risk manager after risk manager got up to the podium and complained about poor quality service from their insurance providers.

That was 1993. And what developed from that meeting was the Quality Insurance Congress, which, of course, dissolved in 1999 after failing to generate con-

tinued strong support from the insurance industry. Think "quality scorecard."

While policy accuracy and timeliness may have only been one aspect of the quality improvement effort the QIC was seeking to address, I hope RIMS' renewed effort in this area does not follow the same path. One, however, cannot help but be cynical about it and, at best, be cautiously optimistic. Consider, for instance, the pivotal role slow policy issuance played in the World Trade Center coverage dispute. That litigation arose largely because no final policy was issued before the Sept. 11, 2001, terrorist attacks, even though Willis placed the coverage before the July 2001 closing of Silverstein Properties Inc.'s 99-year lease on the complex.

One would think that after such a well-publicized example of what can happen when a policy is not issued promptly after binding that the industry would shape up. But apparently it hasn't.

I don't get it. Why is this not standard operating procedure within the industry if the ultimate consumer, the one paying for the product, is asking for it? If risk managers can get all the information needed for submission to their brokers on time (and that is an important first step) then the insurers have no excuse for not issuing a quote or policy within the requested time frame.

But I'm preaching to the choir here. The real question is whether risk managers are going to stick to their guns this time, or will this be just another exercise in futility?

When I asked RIMS President Michael Liebowitz recently why he thinks this time is going to be different, he said that given recent industry compensation investigations and the issues of disclosure and transparency, the timeliness and accuracy of policy issuance is the next logical step.

"If we don't demand it, some regulator is going to demand it," he said. "They're going to make it part of the process."

"I think risk managers are going to say: 'We're the buyers, we're entitled to this level of service and you need to give us this level of service and if you do not, someone else is going to tell you that you have to do it.'"

Senior Editor Sally Roberts can be reached at sroberts@businessinsurance.com

Muslim head scarf ban unfair: Court

By JUDY GREENWALD

PHOENIX—Alamo Rent A Car L.L.C. was liable for religious discrimination when it terminated a Muslim employee who insisted on wearing a head scarf during the Ramadan holiday, a federal court said.

Bilan Nur, who immigrated to the United States from Somalia in 1998, was terminated by Alamo in December 2001 after she refused to remove her scarf while working in its Phoenix office.

Ms. Nur was told she could wear the scarf while she was in the back office but had to remove it when she went to the rental counter in the front of the office.

This "was not a reasonable accommodation," said U.S. District Court Judge Roslyn O. Silver in her May 26 opinion in *Equal Employment Opportunity Commission vs. Alamo Rent A Car L.L.C.* Tulsa, Okla.-based Alamo is now a subsidiary of Vanguard Car

Rental U.S.A. Inc.

Judge Silver also disagreed with Alamo that accommodating Ms. Nur would have posed an undue hardship. Although Alamo managers "concluded that accommodating Ms. Nur's request to wear a head covering at the rental counter might have imposed a cost on Alamo because it would have opened the floodgates to others violating the uniform policy, Alamo has not supplied any basis for concluding that those opinions were anything other than pure speculation," said the opinion.

Additionally, the managers' conclusion "was based on a faulty understanding of Title VII's protections against dissemination based on religious beliefs, that is, that accommodating Ms. Nur's religious beliefs would have required Alamo to forego enforcement of the uniform policy against any employee," said the opinion.

An Alamo spokesman had no comment.

EEOC trial attorney David Lopez said the decision is significant because "it's very rare for a plaintiff to win a case on the pleadings. Usually, religious discrimination is a factual issue that needs to go to a jury." Here, however, "the court recognized there was a very clear violation of the antidiscrimination laws and we prevailed."

Mr. Lopez said the decision is also significant because it was the first of several post-9/11 backlash cases filed by the EEOC. He said Ms. Nur had been permitted to wear her scarf during Ramadan in 2000. The only difference in 2001, he said, is that it followed the Sept. 11, 2001, terrorist attacks.

Mr. Lopez said the EEOC will seek back pay and emotional distress and punitive damages at a subsequent hearing, which has not yet been scheduled.

Plans: Long transition period needed

Continued from page 14

at Whole Foods is 36—and healthy.

This meant that those who regularly used health care signed up. That group included older employees or those with families, and, of course, employees with chronic illnesses. The result was that the healthy contributed little to the company's health care pool of money, while the sick spent regardless of cost. The rising costs threatened other core company benefits, such as deep discounts on food.

In October 2003, employees passed the consumer-driven plan by a wide margin, Ms. Moore says. That year, medical-claim costs dropped 13% and about 90% of employees

had money left over in their health reimbursement accounts. Hospital admissions dropped 22%. Since then, health care cost increases for the company have slowed to a pace below national rates, which show growth of 8% to 10% annually. The slowed pace comes despite the company's explosive expansion to 39,000 employees, up from 24,100 in 2002, Ms. Moore said.

The company continues to tweak its plan to meet the needs of employees. Recently, Whole Foods began to offer employees disease management programs for people with diabetes, cardiac problems and asthma. The programs are not unlike those

that John Deere recently brought back.

"If you want people to be smart consumers, you need to give them the tools and resources to do it," Ms. Moore says.

The change in plan, and the company's response to its employees, seems to be working. Whole Foods employees recently voted to keep their consumer-driven plan as the plan of choice. They will vote again in 2009.

Jeremy Smerá is a staff writer for *Workforce Management*, a sister publication of *Business Insurance*.

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Manitoba amends comp regulations

Employers must allow injured to return to jobs

By GLORIA GONZALEZ

WINNIPEG, Manitoba—Employers in Manitoba next year will have to comply with a new obligation to re-employ injured workers under changes to the province's workers compensation legislation.

Following a trend that began almost a decade ago in Ontario, Manitoba amended its workers compensation law last year to specify that employers have an obligation to allow injured employees to return to work or provide similar employ-

ment after they recover from their injuries. The legislative changes also require employers to take steps to accommodate injured workers.

Employers are generally supportive of these types of legislative changes because they can help reduce insurance costs, but they do have concerns about implementation, observers say.

The amendments to the Workers Compensation Act in Manitoba require employers to re-employ their injured workers following a workplace injury or illness, subject to certain conditions. In general, employers with 25 or more full-time or regular part-time workers must re-employ any injured employee who worked for the company for 12 continuous months prior to the injury.

Depending on their level of recovery, workers may have the right

to be re-employed in the position they held on the date of the injury or in a similar alternate position with comparable earnings. In addition, the work or the workplace may have to be modified to accommodate the effects of the injury, as long as the accommodation does not cause an undue hardship for the employer. These provisions take effect Jan. 1, 2007.

Under the previous workers comp legislation, employers did not have a duty to rehire injured workers, noted David Scott, vp-rehabilitation and compensation services for the Workers' Compensation Board of Manitoba, which provides workers compensation coverage that is financed by employer-paid premiums.

"It didn't come up often, but when it did, workers were frustrated

by that because they lost a job because of being hurt," he said.

Employers that fail to comply may be subject to a penalty up to the value of the worker's net average earnings for the year prior to the injury, although they do have some termination rights in certain circumstances, Mr. Scott said. For example, if the employee was laid off as part of a general staff reduction, the employer could avoid any potential liability, he said.

In addition, a provision in the legislation allows for an employer, worker or industry to be excluded from the re-employment obligations by regulation. The WCB has not yet determined whether any such exemptions would be granted, Mr. Scott said.

See MANITOBA / page 18

Health, productivity plans more common in United States

By SARAH VEYSEY

Most multinational companies have developed a health and productivity strategy for employees in the United States, but few of those companies extend the programs to their operations in other countries, according to a survey by Watson Wyatt Worldwide.

The Arlington, Va.-based firm surveyed 90 multinational companies on their use of health and productivity plans or intention to develop them within the next two years.

next two years; in the Asia/Pacific region, 21% of respondents had a strategy and 30% intend to develop one within two years; in Europe, 16% had a plan and 28% intend to develop one; and in Latin America, 15% had a plan while 21% will develop one.

"Outside the United States, multinationals have been somewhat insulated from increasing health care costs, but they may find that things are changing. As many countries consider reducing state-funded health benefits, multinationals will find that well-implemented health programs will help keep costs down and productivity up worldwide," Bob Wesselkamper, director of international consulting at Watson Wyatt in Chicago, said in a statement.

Health and productivity strategies are more commonly used in the United States than in other territories because the "sheer cost of providing supplemental benefits" there currently "dwarfs" the costs of providing such benefits in other countries where state-backed social security systems currently provide many health benefits, noted Francis Coleman a senior consultant at Watson Wyatt in New York.

An integrated approach to health, productivity and disability can help companies save money, he noted.

In the future, he said, multinationals with operations outside of the United States likely will increase their use of health and productivity plans there too, because of the increasing costs caused by aging populations and the desire of many governments to shift the burden of paying for medical claims from the state to the private sector.

Improving performance

Percentage of respondents who believe they can improve health and productivity in regions to a moderate or great extent:

- In the U.S., 77%
- In Canada, 50%
- In Asia Pacific, 48%
- In Europe, 44%
- In Latin America, 38%

Source: Watson Wyatt Worldwide



A powerful May 27 quake on the Indonesian island of Java has killed more than 6,000 and caused widespread property damage.

Java quake kills thousands; insured damage under \$100M

By MICHAEL BRADFORD

YOGYAKARTA, Indonesia—A 6.3 magnitude earthquake that took thousands of lives on Indonesia's Java island also caused widespread property damage in the region.

The quake struck just after dawn on May 27 near Yogyakarta, killing at least 6,000 and injuring tens of thousands as homes and other buildings collapsed.

Property damage, while heavy, will not be massive for insurers. Insured damage is expected to cost less than \$100 million, according to a spokesman for AIR Worldwide Corp., a catastrophe modeling company based in Boston.

Among the commercial losses is damage at a production facility of Dutch baby food company Royal Numico N.V. The plant will be closed for two to three months, Royal Numico said in a statement. The company said it has enough product on hand to last the next eight weeks. Beyond that, "Numico will explore all internal and external sourcing options to limit the effect of this dis-

ruption on its Indonesian consumers," according to the statement.

Numico said repair and startup costs, along with other expenses, will amount to €15 million to €20 million (\$19.1 million to \$25.6 million), net of insurance proceeds. Loss of sales in the second quarter is expected to amount to around €8 million (\$10.2 million).

Jan Bennink, chief executive officer of Numico, said in the statement that the plant's management quickly set up an emergency center after the quake to offer aid to employees and their families.

Around 13,000 houses and several public facilities were destroyed by the quake, according to Indonesia's Ministry of Culture and Tourism.

Several hotels and the Adi Sutjipto Airport sustained damage. Among the cultural sites that were damaged are Plaosan Temple and Prambanan Temple, the ministry said.

The government of Indonesia has broad experience in dealing with such crises, the ministry in a statement. "However, Indonesians are still astonished by the disaster."

Updates

Glencairn opens Russian unit

Glencairn Group Ltd. has opened an office in Moscow. The London-based broker said in a statement that the establishment of Glencairn L.L.C. was part of its "ongoing development in this rapidly growing economy."

Ksenia Yamova, who previously worked for Aon Corp. in Russia, will be general director of the office, and Andrey Runov, who previously was with Ingosstrakh Insurance Co. Ltd., will be deputy general director.

Mapfre plans to restructure

Spanish insurance group Mapfre Mutualidad said it plans to change its corporate structure and expand its international presence. The Madrid-based insurer said it intends to integrate all of its activities under its listed holding company, Corporación Mapfre, which would be renamed Mapfre S.A. Mutual policyholders of Mapfre Mutualidad will have their capital returned. Rating agency Standard & Poor's Corp. said its AA ratings of the company remained unchanged because "the impact on the group's overall capitalization is likely to be minimal." In addition, A.M. Best Co. said its A+ rating of Mapfre would remain unchanged.

Aon launches three insurance facilities

Aon Ltd., the London-based arm of Aon Corp., has launched three facilities to help captive companies and European corporations have greater stability in their insurance buying. Aon said its captive reinsurance stop-loss facility would provide clients with risk transfer for many lines of business, enable them to cap their total aggregate retained risk exposure and provide capacity of up to £16.5 million (\$30.8 million). The primary property damage and business interruption package will provide capacity of up to £37.5 million (\$70.1 million) with a flexible attachment point, Aon said in a statement. And Aon's new excess property damage and business interruption line slip will provide captives and corporations with capacity of up to £155 million (\$289.6 million), with a £25 million (\$46.7 million) attachment point, the broker said.

Benfield sets up Australian office

Benfield Corporate Risk, the primary brokerage unit of London-based Benfield Group Ltd., has opened an office in Perth, Australia. The office will focus on developing specialty business in the energy, power and mining sectors, Benfield said in a statement.

Manitoba: Employers support re-employment provision for injured workers

Continued from page 17

Certain provinces and the federal government have legislation that gives workers the right to return to their jobs after a workplace injury, but Ontario is widely seen as the leader of the movement to amend workers comp legislation to specifically outline employers' responsibilities to their injured workers. In Ontario, the Workplace Safety and Insurance Act of 1997 specified that employers with 20 workers or more, except in exempted classes, had a duty to re-employ injured workers who had worked for the company continuously for at least one year on the date of the injury.

The WCB of Manitoba will have to conduct fairly extensive education on its provisions as the board in Ontario did when the province made its changes, said Michael Zacks, acting director and general counsel for the Office of the Employer Adviser, an independent agency of the Ontario Ministry of Labor that helps employ-

ers manage their workplace safety and insurance costs.

Manitoba has embarked on a consultation process to inform employers of their new duties under the amended legislation, which included several information seminars in April and the requested submission of written comments. The main questions raised by employers during these sessions related to the level of accommodation an employer must undertake before claiming undue hardship and the termination provisions, WCB's Mr. Scott said.

Determinations of whether an accommodation presents an excessive hardship will be made on a case-by-case basis, though observers expect the standard to be high.

"It's a pretty high bar for an employer to prove that an accommodation would seriously affect their business," said Anne P. Nicoll, a principal with Mercer Health & Benefits L.L.C. in Toronto.

In general, employers support re-

turn-to-work initiatives, although there may be some instances where employers and their employees are at loggerheads over return-to-work issues, observers say. In some cases, employers have told injured workers that they would not be allowed to return to work, and these legislative changes will help avoid those situations, they say.

Employers support these provisions because the faster they can return their employees to work, the lower their insurance premiums will be, said Kevin MacNeill, a lawyer with the labor and employment practice of Heenan Blaikie L.L.P. in Toronto. "Some employers view that as making good sense to get employers back to work as quickly as possible."

A key issue for employers, though, is working with board officials to help them understand the practical realities of implementing these new laws to ensure that they have the intended effect, said Ian Howcroft, a vp of the Ottawa-based Canadian Manufactur-

ers & Exporters, a trade association that represents more than 2,000 employers in Canada, including employers in Manitoba. "I think they try to be responsive, but at times some of their responses are not as complete as they need to be," he said.

Another issue for employers is that not all the provinces have re-employment requirements and those that do often have different provisions in their legislation. "What we want to do is to have alignment as much as possible as long as alignment is done in a practical manner," Mr. Howcroft said. "Whenever possible, we'd like to see that alignment, but we don't want people to adopt the most onerous, most complicated system."

While the duty of the re-employment provision creates a duty that employers previously did not have in workers comp legislation, employers always had a duty to accommodate under human rights legislation. Most employers, therefore, do not view these amended workers comp laws as

an unnecessary burden because they have been complying with accommodation requirements for years, said Sherri Helmka, executive director of the Kitchener, Ontario-based Employers' Advocacy Council, which represents and advises employers in the province on workers comp and other issues.

Employers often can comply with the duty to accommodate by taking simple steps to modify the person's workspace such as moving equipment into different positions, Ms. Helmka said. "Accommodation doesn't mean hundreds of thousands of dollars," she said.

Employers should have good programs in place to help employees return to work and help them reintegrate into the workplace, Ms. Nicoll said. They should also have a documented system for handling worker injuries because they may need to demonstrate to the board that they have a viable program in place, she said.

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AND IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that, by an order dated 27 March 2006 made in the above matter the Court directed that a meeting (the "Creditors' Meeting") of the Scheme Creditors (as defined in the scheme of arrangement hereinafter mentioned) of the above named company (the "Scheme Company") for the purposes of considering and, if thought fit, approving (with or without modification) a scheme of arrangement proposed to be made between the Scheme Company and its Scheme Creditors (the "Scheme") be held on 23 May 2006 at the offices of Clifford Chance LLP, 10 Upper Bank Street, London E14 5JJ, commencing at 15:00 (London time).

The Creditors' Meeting was duly opened at the above mentioned date and location. However, in the days leading up to the Creditors' Meeting certain reinsurance policyholders of the Scheme Company asserted that they had very significant claims against the Scheme Company and expressed concern as to how their claims would be valued under the proposed Scheme.

Given the significant impact which the Scheme will have on both the Scheme Company and its Scheme Creditors, the Scheme Company concluded that more time was required to understand the nature of these claims and to discuss with policyholders their concerns about how those claims would be treated under the Scheme. The decision was therefore taken to adjourn the Creditors' Meeting. Once the position becomes clearer, the Scheme Company will notify Scheme Creditors of the date and location of the reconvened meeting through the appropriate channels. The Scheme Company will in any event announce those details on the Website www.nrg-solvmentscheme.co.uk

Furthermore, in light of the adjournment of the Creditors' Meeting, the hearing on the Scheme Company's application under Chapter 15 of the US Bankruptcy Code to the US Bankruptcy Court, which is scheduled for 12 June 2006, will accordingly be adjourned. The revised date for this hearing will be arranged once the reconvened Creditors' Meeting has been scheduled.

Notice of the Creditors' Meeting and the statement required to be provided to creditors pursuant to Section 426 of the Companies Act 1985, together with Voting Forms and Forms of Proxy have been circulated to known Scheme Creditors as well as brokers and other intermediaries. Copies of these documents, as well as the Information Memorandum (incorporating the Estimation Methodology), the Scheme and blank Forms of Proxy and Voting Forms may be obtained by attending at, or on written application to, the Scheme Company, c/o NRG Victory Management Services Limited at the above address, marked for the attention of Martin Baker or Ms Lyn Davies during normal business hours on any day (other than a Saturday or Sunday or public holiday). They may also be downloaded and printed from the Website www.nrg-solvmentscheme.co.uk. Any policyholder who has any questions concerning the action he is required to take should contact the Scheme Company c/o NRG Victory Management Services Limited (Attention: Martin Baker or Ms Lyn Davies), Charter House, Park Street, Ashford, Kent TN24 8EQ, United Kingdom. Tel: +44 (0) 1233 722600; Fax: +44 (0) 1233 722 601; email: scheme.manager@nrgv.co.uk



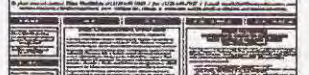
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Managed care: Organizations struggle to attain membership growth

Continued from page 4

prising, said Bradley Ellis, director at Fitch Ratings in Chicago. "The compression held off longer than we expected," he said. "It may be a very short-lived blip. Fundamentally, I think the sector is still in good shape."

Despite the reduced earnings, medical cost increase rates are expected to remain fairly stable or even decline slightly, according to the insurers. "Commercial medical cost trends now look like they will run a little better than what was initially contemplated in our 2006 pricing," said Jim Bloem, chief financial officer of Humana, which is projecting 2006 cost increase rates in the 6% to 7% range and premium increases in line with these trends.

Buddy Pizel, chief financial officer of Los Angeles-based Health Net Inc., said commercial premium yields have been very strong and that the company has revised its full-year 2006 guidance to state that commercial premiums will be up about 8% this year while costs will be up between 7.5% and 8%.

"Medical cost trends are probably going to decelerate a little more before they start to turn around," Mr. Ellis said. Even premium rate increases in the 7% to 8% range, while lower than previous years, are "clearly unsustainable," he added.

Next year, though, cost trends may begin to drift higher as traditional methods of controlling costs, such as changing benefits structures, lose momentum, said Joseph

Major managed care organizations: First-quarter 2006 results

Ranked by net income. Dollar figures in millions.

Company	Net income Q1 2006	Percent increase (decrease)	Revenues Q1 2006	Percent increase (decrease)
UnitedHealth Group	\$899.0	21.0%	\$17,586.0	36.5%
WellPoint Inc.*	731.8	19.6	13,819.7	26.3
Kaiser Permanente	448.0	(18.4)	8,600.0	10.5
Aetna Inc.	401.7	3.1	6,234.7	15.0
CIGNA Corp.	352.0	(19.3)	4,107.0	(5.5)
Coventry Health Care Inc.	120.9	6.9	1,938.7	19.3
Humana Inc.	83.7	(21.6)	4,704.4	38.9
Health Net Inc.**	76.6	NM	3,186.6	9.4

* Does not include first quarter 2005 earnings from WellChoice Inc., which was acquired by WellPoint in December 2005.

** Net income comparison to prior year period not meaningful because Health Net posted net income of \$21.3 million in the first quarter of 2005.*

Source: Company reports

Marinucci, credit analyst with New York-based Standard & Poor's Corp. "There's probably some upward pressure that's likely to emerge into '07," he said.

Medical costs have lessened partly because of moderating pharmacy cost trends, insurers say. A push by insurers and employers—propelled by incentives such as lower copayments—to encourage employees to use generic drugs and expiring patent protection for some of the most commonly prescribed medications have helped drive down pharmacy costs.

Health Net's pharmacy costs, for example, were up about 7.5% in the

first quarter, with the insurer expecting further moderation in the second half when some drugs lose their patents. Previously, the carrier projected the pharmacy cost increase trend to be in the 8% to 9% range in 2006.

While UnitedHealth Group Inc. continues to lead the managed care sector in terms of revenues, the Minnetonka, Minn.-based insurer is in the midst of a regulatory probe related to its stock-option practices (BI, May 22). There is some concern that these issues may become a distraction for upper management, but analysts do not believe it changes any fundamental factors

for the company. "It's a concern, but operationally we still view these companies as very financially sound, UnitedHealth in particular," Mr. Marinucci said.

A key issue that managed care companies need to focus on is achieving membership growth, analysts say. While several companies reported small membership gains, both Health Net and CIGNA continue to struggle in this area. Health Net said it expects commercial enrollment to remain essentially stable in the second quarter and then grow about 1% to 2% for the rest of the year. "I know you've heard that from us before," Health Net's Mr.

Pizel said during the company's first-quarter conference call. "We're more confident now, based on a more rational pricing environment, increased traction with brokers, increased sales and marketing investments and better products."

Membership figures for the major managed care organizations continue to be bolstered by mergers and acquisitions. Health Net, for example, increased its enrollment by 112,000 members due to its March acquisition of the health plan assets of Long Beach, Calif.-based Universal Care Inc., keeping first quarter enrollment essentially flat rather than an expected drop of 3% to 4%.

UnitedHealth and Indianapolis-based WellPoint Inc. have distanced themselves from the rest of the sector both in terms of revenue and membership volume and observers are wondering if pressure will mount on the next tier of health care carriers to seek acquisitions. Observers are contemplating if Aetna and CIGNA will feel compelled to pursue acquisitions to keep pace with their two larger counterparts, Mr. Marinucci said.

Insurers are likely to focus on acquisitions of product-specific companies such as consumer-driven health plan providers and specialty drug companies, or targeted, regional acquisitions rather than large acquisitions such as WellPoint's acquisition of New York-based WellChoice Inc. "We just think the size of the acquisitions is going to be reduced," said Fitch's Mr. Ellis.

Doyle: Heightened diversity efforts help strengthen company's talent base

Continued from page 3

dustry knowledge and experience.

As chief diversity officer, her primary responsibility is developing Aon's global diversity strategy.

Promoting diversity within Aon's ranks is "a critical part of our talent management strategy," Ms. Doyle said. "We are very much focused on recruiting very talented women and people of color in the industry."

This entails, in part, recruiting women and minorities from companies outside of the mainstream insurance industry. Aon, for example, recently announced the appointment of Kathryn Hayley as chief executive officer of Aon Consulting U.S. Ms. Hayley previously worked at Deloitte Consulting L.L.P.

"That's one of the strategies we're embracing, recruiting from outside our industry where that's viable," Ms. Doyle said. Ms. Hayley's hiring was "a really important step in the right direction."

Identifying talented employees within Aon and providing the necessary training and mentoring for them to move up the company ranks is another key part of the broker's diversity strategy, Ms. Doyle said. Currently, Aon is identifying the top 30 women in its global operations and rolling out a talent-development strategy that includes hands-on skill training and

executive mentoring that will enable these women to take on higher levels of responsibilities. "We are very focused on building a mentoring culture," Ms. Doyle said.

One of the probable challenges that Aon faces, based on the experiences of other companies tackling diversity issues, is retaining women of child-bearing age, she said.

To address this issue, Ms. Doyle is leading efforts at Aon to revamp the broker's flexible work program to build an environment where employees feel they can take advantage of flexible schedules.

"Clearly, retaining women is a critical issue," Ms. Doyle said. "You need to allow them to continue to build their careers and progress in these years where they can't commit to 60-hour workweeks."

Making a commitment

Aon has made a significant commitment to diversity, as demonstrated by its willingness to put Ms. Doyle in the position of chief diversity officer, diverting some of her attention away from an important business unit, said Ellen Thrower, a professor and the executive director of the School of Risk Management, Insurance and Actuarial Science at St. John's University's Peter J. Tobin College of Business in New York. It's a commitment

Facing work/life balance head-on

Corbette Doyle's interest in insurance arose when she was an economics major at the State University of New York at Oswego, exploring which industries would most value her research skills. "Like most of my counterparts, I fell into it," she said.

She became a research analyst at Utica National Insurance Group in Utica, N.Y., where she found multiple opportunities in the underwriting and research and development fields. She parlayed that experience into a position in the research department of Willis Group Holdings Ltd., eventually becoming the co-chair of the London-based broker's health care industry practice.

She joined Chicago-based Aon Corp. in July 1993 to help the company build its national health care practice and was promoted to chief diversity officer when Aon embarked on its diversity initiative about

five months ago. In addition to her new responsibilities as chief diversity officer, she will continue to oversee the broker's health care practice.

Ms. Doyle, who holds the Associate in Risk Management designation and Chartered Property Casualty Underwriter designations, also graduated first in her class with a master of business administration degree from Vanderbilt University in Nashville, Tenn. She lives in Nashville with her husband, Tim Gaetano, who is a songwriter, and her two daughters.

Ms. Doyle praises her husband for helping her achieve a good work/life balance that enables her to pursue her career interests, while still tending to her family's needs.

"I know that has been the bedrock of my success," she said.

—By Gloria Gonzalez

ment she hopes that other insurance companies will emulate, she said.

"She is an incredible expert in the entire health care area, and taking on this role as chief diversity officer sends a powerful signal about how important Aon is taking this issue," she said.

Because of her longtime commitment to diversity, Ms. Doyle was a natural choice for the position at Aon, which has made diversity a focal point in its efforts to strengthen

its talent base and its capability to serve its clients, said Gregory Case, president and chief executive officer of Aon.

In her position, she reports directly to Mr. Case and the two frequently have candid discussions about what the company needs to do to succeed in its diversity initiatives, he said.

"We view Corbette as a key architect and key catalyst to make that happen," he said. "She brings great expertise and great enthusiasm."

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California: Substantial workers comp price decreases could be coming to an end

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Insurance Commissioner John Garamendi advised insurers to decrease their pure premium rates by 16.4% for policies incepting July 1. Since July 2003, the commissioner has called for six workers comp rate decreases totaling 55%.

Lower system costs stemming from reforms adopted in 2003 and 2004 and falling accident frequency justify the reductions, Mr. Garamendi said.

But while the commissioner had reduced his benchmark rates by almost half since 2003, insurers, on average, lowered their filed rates by only one-third, according to a Moody's Investors Service report published in May and titled "California's Workers' Compensation Insurers Are Profitable—and Worried."

And last week the State Compensation Insurance Fund said it would reduce its rates by 10% for July 1, renewals, not the 16.4% called for by the commissioner.

Still, rates continue to drop and buyers are seeing favorable deals.

SCAN's Ms. Shulman said she would have preferred to stay with St. Paul Travelers, because of a long-standing relationship with the insurer. She had poured resources into reducing her losses so that

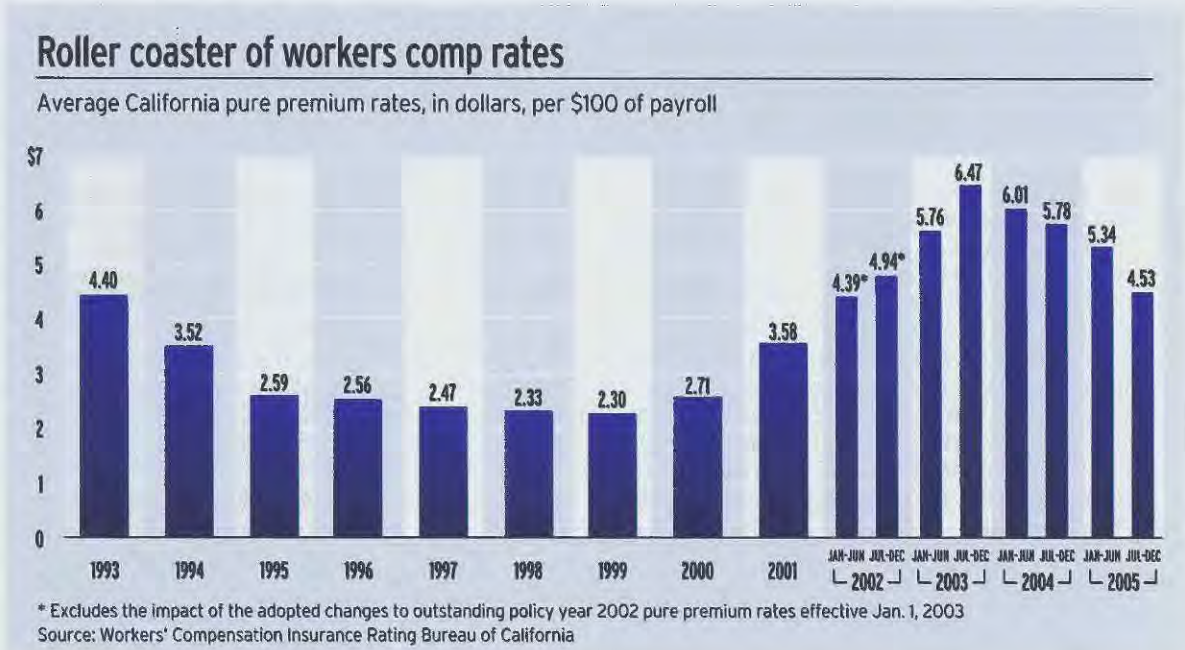
SCAN Health Plan, with 850 employees, mostly in California, could obtain better pricing when it sought to renew its loss-sensitive program.

But the price of the guaranteed cost policy offered by Wausau was too low to turn down, Ms. Shulman said. So it made smart business sense to purchase the coverage.

Middle market insurance buyers have seen recent renewals with "pretty aggressive rate reductions" as insurers have offered them 15% to 25% price cuts on top of past reductions, according to Steve Paulin, senior vp at Sullivan Curtis Monroe Insurance Brokerage in Irvine, Calif., which specializes in middle market business.

Policyholders also have a few more purchasing choices than they had before reforms began working through California's market, Mr. Paulin said. Yet the number of insurers selling coverage in California has not increased dramatically since many pulled out of the state or went out of business before the reforms took effect, he added.

Additionally, several national, multiline underwriters are reluctant to sell only workers comp coverage to prospective California clients, Mr. Paulin said. They view the state's workers comp environment



as too unstable and will only provide workers comp policies when they can balance their books by selling several coverage lines to each client.

Other insurers, however, are eagerly expanding in California, according to Moody's.

Berkshire Hathaway Inc., for example, increased its direct written premium to \$523.6 million in 2005, or 3.7% of the nation's largest mar-

ket. Berkshire's direct written premium in the state is up from \$63.3 million in 2004 and \$15.4 million in 2003, according to Moody's.

While some insurers are bullish on the state, others remain skeptical and some of those insurers have contingency exit plans ready, the Moody's report states.

The State Compensation Insurance Fund held a 41% market share at the end of 2005, compared with

a 22% share in 1999, which suggests private insurers still are not flooding the state with capital, according to Moody's.

Some insurers remain skeptical because lawyers, doctors and injured employees continue to seek to roll back some of California's reforms, observers note.

Commissioner Garamendi said

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Roundtable: Continuing soft market predicted

Continued from page 3

Only 25% of the respondents in the 2006 survey said they expect their results to be better this year, compared to 41% last year.

Despite desires to maintain underwriting discipline, this confirms "that they see a softening market and they are going to be a participant in that soft market," said Dom Addesso, president of American Re direct treaty in Princeton, N.J.

But while there might be a desire among the insurers to retain business on their books, there is still a feeling that the business is producing adequate returns, the survey suggests.

Forty-six percent of the stock company respondents, for example, predicted that their target return on equity or policyholders' surplus would be in the 10% to 15% range in 2006, while 27% said between 5% and 10% and another 27% said their returns would be greater than 15%.

A majority of the executives from mutual companies—57%—predict their return on equity or policyholders' surplus will be in the 5% to 10% range, and 31% predict a return of between 10% and 15%.

"While people are predicting the same to poorer results, taken in tandem with (these predictions), it would suggest they still feel their returns are at adequate levels going into '06," Mr. Addesso said.

In addition, 76% of executives from stock companies said they are targeting a combined ratio of below 95% for 2006-2007, while another 19% said they are targeting combined ratios in the range of

Execs see room for improvement

Areas where insurer executives say their companies can improve (survey allowed multiple responses)

Issue	2006	2005	2004	2003
Policy processing	1st (35%)	1st, tie (28%)	3rd, tie (28%)	2nd (28%)
Marketing	2nd (27%)	1st, tie (28%)		
Strategic focus	3rd (25%)			
Claims processing/claims management		1st, tie (28%)		
Underwriting capability			1st (35%)	
Planning			2nd (30%)	
Strong capital position		3rd, tie (28%)	1st (38%)	
Underwriting capability				3rd (34%)

Source: American Re-Insurance Co.

95% to 100%.

Among mutual companies, 26% said they are targeting a combined ratio of below 95%, while 67% said they are targeting a ratio in the range of 95% to 100%.

When asked to rank the three most critical issues facing the primary insurance industry today, natural catastrophes topped the list for the first time, followed by the ability to file and use adequate rates due to state regulations and then restrictive state regulations.

In 2005, respondents ranked low interest rates and capital market returns first, followed by restrictive state regulation and the ability to file and use adequate rates due to state regulation.

"While we didn't necessarily drill down to the executives to determine what the (natural catastrophe) issues were to them individually, I'm sure the issues are the predictions from the scientific commu-

nity and the potential for tightening capacity and pricing," Mr. Addesso said.

When asked about the most critical issues faced by their individual companies, executives ranked maintaining underwriting discipline and price adequacy first, followed by managing their cost structure and the cost and coverage of their reinsurance programs.

In the 2005 survey, maintaining underwriting discipline also was ranked first, but it was followed by managing their distribution channels, followed by managing their cost structure.

When asked the order of priority in which Congress needs to act on certain issues, respondents ranked general tort reform first, followed by reforming Sarbanes-Oxley and asbestos liability reform.

The survey results are available at American Re's Web site, www.amre.com.

Ohio: Considering captive bill

Continued from page 4

state in the central Midwest has an up-to-date captive law.

One Midwest state—Illinois—does have a captive law, but the state currently has just three captives. Illinois, among other things, imposes a \$2 million capital and surplus requirement on captives, several times higher than many other domestic domiciles.

Enactment of captive legislation in Ohio, though, is not imminent and still must receive the endorsement of Gov. Bob Taft.

While the executive branch is aware of the captive drafting effort and has seen a draft bill, it has not yet endorsed a measure, Ms. Womer Benjamin said.

Still, captive legislation would stand a good chance of passage in Ohio since state captive experts say they are not aware of any opposition to the concept.

Revamping statutes

The Ohio captive effort comes as several other states—eager to attract captives—have recently enhanced their existing statutes. Last year, for example, Montana and Nevada capped the maximum premium taxes captives licensed in those states pay, while Utah eliminated its captive premium tax.

In addition, Delaware revamped its 20-year-old statute to not only cap premium taxes, but to set up a new sliding premium tax structure to reduce the tax burden on smaller captives.

This year, state captive legislative activity has been a mixed bag. On the one hand, Alabama legislators

in April passed legislation that allows the formation of captive insurers in the state. The impetus of that measure was a 2004 hurricane that raked the state, causing significant increases in property insurance rates. A state force found that allowing captives to be formed in the state could better help state businesses to fund coverage.



Ohio Gov. Bob Taft has not yet endorsed a measure in the Legislature that would create a captive domicile in the state.

On the other hand, a captive bill proposed in Connecticut won unanimous approval in the state Senate, but the legislative session ended before the bill could be considered by the House.

Captive legislation has been introduced in New Jersey, but no action has yet been taken on the measure. The New Jersey bill is modeled after the statute in Vermont, the world's third largest domicile with 546 captives.

PHOTO: REUTERS PHOTO ARCHIVE

Max Re: Several years restated

Continued from page 3

The restatement is expected to have the cumulative effect of reducing shareholders equity at the end of 2005 by \$18.3 million, Max Re said. That is well within the reinsurer's original estimate of a restatement adjustment from these contracts reducing retained earnings at Dec. 31, 2005, by no more than \$50 million.

The restatement will most significantly impact Max Re's 2001 results, which will be adjusted downward by \$14 million and push the reinsurer into a loss for that year. Prior to the restatement, Max Re's profits fell 71.3% to \$2.5 million in 2001, largely due to losses from the Sept. 11, 2001, terrorist attacks.

Under FAS 113, introduced in 1993, a U.S. cedent can account for a contract as reinsurance only if it transfers significant risk—but some ambiguity remains surrounding exactly how much risk must be transferred, as well as accounting for those risks (see related story).

Several companies in the past year—including ACE Ltd.; American International Group Inc.; Convergium Holding Ltd.; MBIA Inc.; Odyssey Re Holdings Corp.; and RenaissanceRe Holdings Ltd.—have restated earnings in the wake of increased attention by regulators and other officials to the use of nontraditional insurance products. Many of those restatements, however, stemmed from breaches of FASB accounting rules for insufficient risk transfer and regulatory scrutiny, including subpoenas from the U.S. Securities and Exchange Commission and other parties.

"A lot of those other companies were notified by the SEC that they had to look at their accounting...there was no need for subpoenas (at Max Re) because they are very open about their books," said Cliff Gallant, an analyst with Keefe,

Bruyette & Woods Inc. in New York. "They are aware that their credibility is very important to their shareholders...being as proactive as they have been, and the fact that the financial impact was relatively minor bodes well for them," Mr. Gallant added.

"We did a very thorough review," and although the contracts in question did meet established risk transfer rules, "we concluded that we could more appropriately account for them," Max Re's Mr. Hynes said in an interview.

Mr. Gallant added that "Maybe Max Re benefits from the experience of others" that were targeted by authorities as part of broad finite risk-related investigations.

"The various investigations have piqued everyone's interest in terms of full and fair disclosure," said Elliott M. Kroll, partner and chair of the insurance and reinsurance group at Herrick Feinstein L.L.P. in New York. Recent probes over nontraditional products are increasingly prompting "a very careful and cautious approach" to how companies account for and disclose any insurance or reinsurance contract, he said.

It still remains unclear whether Max Re will face regulatory scrutiny related to its accounting. "We've advised the SEC of our internal investigation and they have not given us an indication of what sort of course of action they may take," Mr. Hynes said in the interview. A spokesman for the SEC declined to comment.

Following the restatement announcement, Chicago-based Fitch Ratings noted it does not expect that the A financial strength ratings of Max Re or its subsidiaries will be affected by the outcome of the company's internal investigation.

"Fitch does not consider these events thus far to be material to Max Re's ratings. It is important to note

To bifurcate insurance accounting or not? FASB asks the question

NORWALK, Conn.—The Financial Accounting Standards Board is inviting comment from risk managers, policyholders and other industry constituents regarding the potential bifurcation of insurance and reinsurance contracts into insurance components and financing components.

FASB in a statement said its call for comments stems from the organization's concern over transparency in the financial statements of policyholders, insurance and reinsurance companies as they relate to finite risk contracts and other types of deals, which include terms or features "that significantly limit the actual amount of risk transferred."

Current insurance accounting standards under Norwalk, Conn.-based FASB apply mainly to financial reporting by insurers and reinsurers, with little guidance offered on how policyholders should account for insurance contracts. Furthermore, insurance and reinsurance contracts often have a combination of insurance and financing components, but are accounted for simply as "insurance contracts," FASB said.

Bifurcation—a method which has been under consideration by a

working group at the National Assn. of Insurance Commissioners—would divide the accounting for finite risk transactions so that the risk-transferring portion would be treated as insurance and the financing portion would be treated as a deposit. FASB said it seeks to determine whether bifurcation would improve financial reporting by providing the users of financial statements better, clearer data about the economic substance of insurance arrangements.

"FASB is encouraging the active participation of all constituents in this process, however, we are particularly interested in hearing from noninsurance company policyholders—including smaller and private companies," said Jeffrey Cropsey, FASB project manager, in the statement. "Bifurcation could have a significant impact on the way some insurance contracts are accounted for and we want to ensure that all parties have an opportunity to carefully consider the issues and express their points of view," he said.

The deadline for comment is August 24. For more information, visit www.fasb.org.

—Rupal Parekh

that the company initiated the investigation internally and voluntarily contacted the SEC. Furthermore, Max Re has not to date received any subpoenas or information requests related to finite risk reinsurance," Fitch said in a statement.

One day after announcing its restatement, Max Re filed its 10-Q for first-quarter 2006, posting a 93.4%

jump in profits to \$72.9 million due to "solid underwriting performance coupled with strong investment returns." Max Re said it plans to submit its restated 10-K filing with the SEC no later than mid-June.

The reinsurer's shares closed last week at 23.77, 7.9% higher than on Tuesday, the last closing before Max Re announced the restatement.

Asbestos: Legislation's last chance

Continued from page 1

has repeatedly denied that the fund, which would be paid for by defendant companies, their insurers and existing asbestos compensation trust funds, would expose the federal government to any fiscal liability.

Sen. Specter made clear that he would cease pushing for the fund if his colleagues spurned his efforts again.

"If this amended bill is rejected, I do not see the...Senate Judiciary Committee revisiting this issue," he said as he introduced the revised FAIR Act—S.3274—on May 26. "I cannot conceive of a more strenuous effort being directed to this subject" than the one that began more than three years ago, he said. "Let me make clear that this is the last, best chance."

The Risk & Insurance Management Society Inc. welcomed the move.

"RIMS supports Sen. Specter's efforts to resolve the asbestos litigation issues in a manner that provides timely benefits to the victims, allows employers to stay in business and insurers to budget for these losses over the life of the program," said G. Terry Fleming, RIMS director-external affairs, in an e-mail statement.

Insurers, which would be responsible for slightly more than \$46 billion of the benefits ultimately paid out by the fund, praised Sen. Specter's efforts but refrained from embracing the amended approach. Insurers uniformly opposed the earlier versions of the bill.

"We currently are looking at the details of Chairman Specter's revised asbestos trust fund bill, which runs to over 400 pages, in order to fully understand what these revisions would mean in practice," said Julie Rochman, a senior vp with the American Insurance Assn. in Washington.

Ms. Rochman said the insurer group is "pleased Chairman Specter remains strongly committed to resolving the asbestos litigation crisis, and (we) look forward to working with him and other interested parties to further address the many fundamental flaws in the original proposal. Clearly, any trust fund must totally eliminate leakage of claims back into the tort system, and must contain fair but rigorous criteria for claimants to ensure that only those who are truly sick from asbestos exposure receive compensation from such a fund. These and other issues must be fully resolved in order for the trust fund to be workable and receive our support."

"We appreciate Sen. Specter continuing to search for a solution to this problem," said Ben McKay, acting head of the Property Casualty Insurers Assn. of America's Washington office. "However, it's my understanding that the new bill still lacks certainty, finality and affordability, which we see as integral to any workable solution. We're going to continue to stay engaged—this is a crucially important issue."

Smoker: Tort reform advocates await punitive damages decision

Continued from page 1

he added.

The tobacco manufacturer, "with others, engaged in a massive, continuous, near-half century scheme to defraud the plaintiff and many others, even when Philip Morris always had reason to suspect—and for two or more decades to absolutely know—that the scheme was damaging the health of a very large group of Oregonians—the smoking public—and was killing a number of them," Justice Gillette wrote. "Under such extreme and outrageous circumstances, we conclude that the jury's \$79.5 million punitive damage award comported with due process, as we understand that standard to relate to punitive damage awards."

Philip Morris appealed the state court decision to the U.S. Supreme Court, which agreed on May 30 to hear the appeal based on two questions: whether highly reprehensible conduct overrides the constitutional limits and whether due process guarantees permit a jury to punish a defendant for the effects of its conduct on people who are not parties to the suit.

A prominent tort reform advocate called the case "a big one."

"It is the first post-*State Farm* punitive damages case that the court has agreed to review," said Robin Conrad, senior vp of the National Chamber Litigation Center Inc., which handles litigation for the U.S. Chamber of Commerce in Washington. "That's really been a long time in coming."

Ms. Conrad cited the issue of whether a jury can punish a defendant for "what we call the harm to others" as "particularly problematic." She also said that despite the formula in the *State Farm* decision, "we've seen lots of examples of federal courts and state courts still not getting it right."

Victor Schwartz, general counsel of the American Tort Reform Assn. and a partner in the Washington office of Kansas City, Mo.-based Shook, Hardy & Bacon L.L.P., said that the high court's decision to review the case represented the "third wave after *State Farm*."

During the first wave, the court remanded a number of cases—including *Philip Morris vs. Williams*—to the lower courts for review, he

said. "They looked like they were going to be a good enforcer of their decision."

But in the second wave, the high court "let stand decisions where clearly *State Farm* had been breached and the lower courts were able to get away with not following the decision," said Mr. Schwartz. Some used "reprehensible conduct" as the reason for ignoring the guideline and others allowed consideration of out-of-state conduct in determining a state court award, he said. Still others allowed "pain and suffering awards to be inflated," thus increasing the base upon which the punitive damage award could be based and remain within the 9-to-1 ratio, he said.

"Wave three is this case—the policeperson is back on the beat" and will look at the enforcement of the 9-to-1 ratio, said Mr. Schwartz.

He cautioned, though, that the review is not without its perils. Two defenders of constitutional limits on punitive damages—the late Chief Justice William Rehnquist and former Associate Justice Sandra Day O'Connor—will not hear this case. Their replacements—Chief

Justice John Roberts and Associate Justice Samuel Alito—could tip the balances. If the two new members of the court, "while being empathetic with the need to curb punitive damages, feel limits are not in the Constitution," they could join Associate Justices Antonin Scalia, Clarence Thomas and Ruth Bader Ginsburg, with the result that "*State Farm*, as an enforceable right, could be lost."

And that's just what Robert Peck, president of the Center for Constitutional Litigation in Washington, which numbers among its clients the Assn. of Trial Lawyers of America, would like the court to do.

Mr. Peck, who represents Mrs. Williams, said that while no one knows exactly why the court decides to review a case, "the court has been getting inundated with petitions from disappointed defendants after a punitive damage award has been upheld. They probably feel an obligation to make clear what we think they've already said and we think the Oregon Supreme Court got it right" in holding that there was no bright line.

Travelers faces bad-faith suit over Katrina claim payment

By JUDY GREENWALD

NEW ORLEANS—Travelers Property & Casualty Co. and several of its employees are facing a bad-faith lawsuit over the insurer's alleged refusal to pay in full claims stemming from damage sustained by a New Orleans hospital during Hurricane Katrina.

The May 23 lawsuit, which was filed in U.S. District Court in New Orleans, seeks \$28.7 million from Travelers, a unit of St. Paul, Minn.-based St. Paul Travelers Cos. Inc.

The lawsuit says the insurer has so far refused to pay more than an initial payment of \$700,000 under its all-risk policy in connection with repairs to St. Charles General Hospital.

The lawsuit was filed by Winter Haven, Fla.-based Building Concepts & Design Construction Inc., which under a November 2005 contract with the policyholder, Preferred Continuing Care-New Orleans L.P., agreed to handle the complete insurance claim and repair damage to the facility.

The hospital was sold to New Orleans-based Touro Infirmary in January, according to the suit, and the contractor agreement with BCDC was reaffirmed. Meanwhile, the

168-bed facility remains closed.

"Despite several inspections by so-called 'adjusters,' numerous correspondence between the parties, and despite numerous documents establishing 'proof of loss' to defendant, Travelers has only tendered an advance in the amount of \$700,000, which is wholly inadequate to repair the property in question," says the lawsuit.

Travelers' \$700,000 payment "is arbitrary, capricious and in bad faith considering numerous inspections of the property in question and the various documents establishing proof of loss," the suit states.

In addition to Travelers, defendants named in the suit are Travelers employees Norman Taylor, adjuster; William Schoenborn, vp; William Schaefer, vp of major claims; and Rick Sparks, whom the lawsuit described as a company representative.

The lawsuit says Mr. Taylor interacted with BCDC President and Chief Executive Officer Stephen D. Vaughan "in an aggressive, abusive and shockingly unprofessional manner."

It contends that Mr. Schoenborn accused Mr. Vaughan "of being a Florida contractor looking for any work available and added that Travelers encountered many out-of-state contractors trying to take advantage of the work available in New Orleans."

According to the lawsuit, the \$28.7 million sought reflects \$6.5 million necessary to complete repair of the insured property, \$14.6 million in penalties—including double damages—and \$8.4 million in attorney's fees, less the \$700,000 already paid.

A Travelers spokeswoman said the insurer cannot comment specifically on pending litigation.

Mr. Vaughan said, "Travelers has just totally ignored the claim" despite "by now literally hundreds of calls. They don't respond, they don't do anything. So we finally ended up suing them."

"New Orleans desperately needs hospital beds," said BCDC attorney Jacques F. Bezou, of the Covington, La.-based Bezou Law Firm.

"We feel that the lawsuit is legally efficacious and we will prevail," he said. "The environment in Louisiana right now, especially in New Orleans, is very antagonistic toward insurance companies—with good reason—and if Travelers is foolish enough to go to trial in this case, good luck to them."

California: Comp rates fall, but stabilization seen

Continued from page 21

last week that his Department of Insurance actuaries suggested he call for an 18.9% pure premium rate decrease for policies incepting in July. But he opted to recommend the 16.4% rate cut instead because outstanding court challenges to California's reforms could increase costs.

Additionally, the commissioner said he has heard of delays in providing benefits to injured employees and "a growing chorus of complaints from seriously injured workers who have suffered as the amount of compensation and treatment they receive has been slashed."

Insurers also will learn in July

whether three proposed ballot initiatives seeking to rollback reforms have garnered enough signatures to qualify for the November election. Moody's also notes that by year's end, California may have a new governor and new insurance commissioner along with "a vastly different workers comp system."

And as rate reductions continue, they are reviving memories of several years of rate reductions that began in 1995 and drove many insurers out of the market, the Moody's report states.

The potential for "irrational competition" in the name of market share does exist, Mr. Paulin said. But for now, the rate reductions insurers

Late News

Continued from page 1

replaces Bradley Belt, who in March announced that he would step down. The PBGC has a nearly \$23 billion deficit, the result of taking over several hugely underfunded pension plans in the past several years.

Feds charge ex-CFO of Ohio comp bureau

Federal prosecutors last week charged Terry Gasper, a former chief financial officer for the Ohio Bureau of Workers' Compensation, with taking kickbacks for doling out the organization's investment business. The racketeering charge filed against Mr. Gasper in federal district court in Cleveland stems from an ongoing investigation into coin investments and allegations of misconduct involving millions of dollars in OBWC investment funds, prosecutors said. Federal prosecutors alleged in a statement that he received from investment brokers the use of an ocean-front condominium in Florida, a \$25,000 investment and a \$9,000 tuition check made out to a college attended by his son.

Group health costs up 10% to 15% for most

Most employers renewing their group medical insurance over the past six months experienced 10% to 15% average cost increases, according to a survey of benefits brokers released Wednesday. The 105 respondents to the twice-annual survey conducted by the Council of Insurance Agents & Brokers said 70% of employers with more than 500 employees, 80% of those with 51 to 500 workers and 60% of employers with 50 or fewer employees experienced the 10% to 15% renewal increases. Survey respondents also said that most employers are continuing to try to control medical premiums by shifting costs onto employees with higher deductibles and copayments and higher out-of-pocket maximums.

PBGC finalizes rule on premium filing

The Pension Benefit Guaranty Corp. has published a final rule requiring sponsors of defined benefit pension plans to submit their premium filings to the agency electronically. According to the rule, which takes effect July 1, sponsors of large plans—those with at least 500 participants—will have to file premiums electronically for plan years beginning on or after Jan. 1 of this year. All other plan sponsors will have to meet the new requirement for plan years beginning on or after Jan. 1, 2007.

SEC charges ex-PMA chairman

The U.S. Securities and Exchange Commission last week filed a complaint against Frederick W. Anton III, former chairman of Philadelphia-based PMA Capital Corp., charging him with passing on insider information in 2003. The complaint seeks a civil penalty of \$1.1

million from Mr. Anton, a judgment permanently barring him from serving as an officer or director of any publicly held company and a permanent injunction enjoining Mr. Anton from further SEC violations.

UnitedHealth unit debuts report card

UnitedHealthcare of Colorado last week released its first-ever quality report card ranking the quality of care and affordability of 20 of its contracted hospitals throughout Colorado. The report card, which uses measurement criteria established by the Agency for Healthcare Research and Quality and the Leapfrog Group, measures 150 medical procedures, including colon surgery, viral infection and chest pain, Cesarean section, knee and hip replacement, and obesity procedures. Each procedure's quality rating was based on patient volume, complication and mortality rates, failure to rescue or death from complications, intensive care unit physician staffing and computer-assisted order entry.

Popularity of CDHPs growing: GAO report

Consumer-directed health plans are becoming more popular, according to a report by the Government Accountability Office. The report found that between 5 million and 6 million enrollees and their dependents received coverage under such plans by January, compared with 3 million who did so by January 2005. But even 6 million people covered by either health reimbursement arrangements or health savings accounts represent only a small share of the 177 million who have private health insurance coverage, according to the GAO.

Integro sets up marine practice

Integro Ltd. has formed a Southeastern marine practice in Atlanta. Heading the inland and ocean marine practice for the Southeast region is Timothy I. Rea, a former senior vp and Southeast marine practice leader for Marsh Inc. "Timothy is arguably one of the best marine experts in the country and has worked with a significant number of industry leaders within this highly specialized market sector," said Frank Kinnett, managing principal and head of the Atlanta office.

At BusinessInsurance.com

New Online Poll: At your midyear renewal, do you expect your property insurance rates to: decrease by more than 10%, decrease by less than 10%, stay flat, rise by more than 10%, rise by less than 10%?

Items in the Late News column originally appeared in BI's Daily News feature on www.businessinsurance.com. Visit the BI Web site to sign up to receive BI's Daily News by e-mail.

BI Stock Index [5/30 - 6/2]

Up-to-the-minute data for all 85 companies that comprise the BI Stock Index can be found at www.businessinsurance.com

Percentage change of BI Stock Index vs. key indicators

BI Stock Index	
2899.13	0.55
Dow Jones	
11247.87	-0.27
S&P 500	
1288.22	0.63

Source: FinancialContent Inc. (<http://financialcontent.com>)

Largest gains

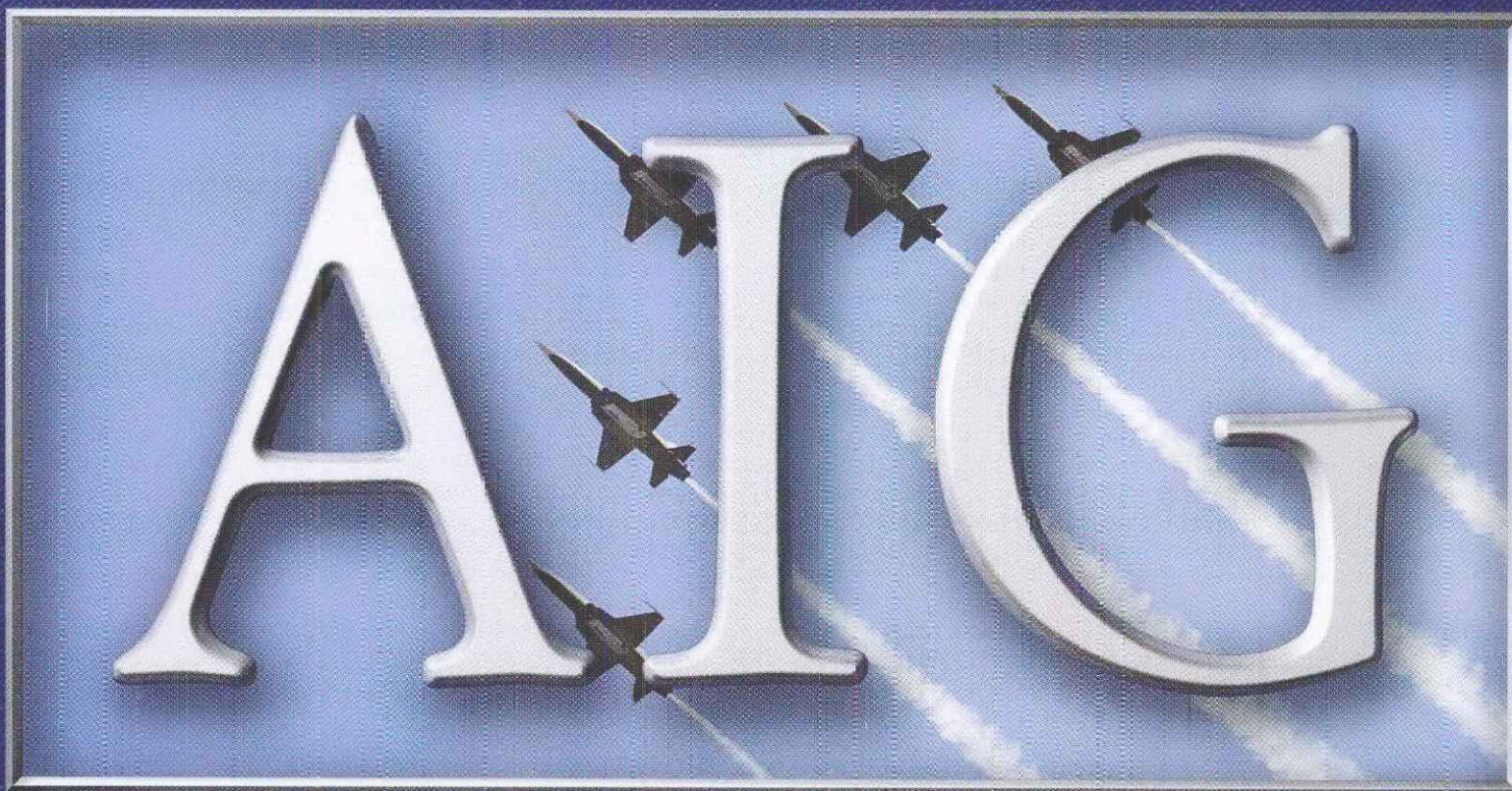
Alleghany Corp.	10.89%
UnitedHealth Group	8.95%
Aetna Inc.	5.62%
CIGNA Corp.	5.14%
Health Net Inc.	5.11%

Largest losses

Vesta Insurance Group	-10.00%
Hilb Rogal & Hobbs	-3.60%
USI Holdings Corp.	-2.20%
Clark Inc.	-2.20%
AEGON N.V.	-1.76%

Weekly change by market segment

Brokers	-0.31%
Insurers/Reinsurers	0.71%
Managed Care Organizations	3.29%



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