

Business Insurance

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

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Aon promotes LeStrange to head Americas broker unit

CHICAGO—Aon Corp. announced last week that Kenneth J. LeStrange has assumed the role of chairman of Aon Risk Services Cos. Inc. Americas, Aon's commercial insurance brokerage unit based in Chicago.

Mr. LeStrange, 42, replaces Richard A. Riley, who has assumed the role of vice chairman of Aon Group Inc., with various responsibilities within the brokerage. Mr. LeStrange, former president of Am-Re Managers Inc., the alternative risk transfer

See Updates on next page

Bermuda tax status under fire

U.S. insurers protest that loophole gives Bermuda companies unfair advantage

By GAVIN SOUTER

WASHINGTON—Lobbying efforts by four major U.S. insurers to eliminate alleged tax advantages held by Bermuda rivals are triggering congressional and regulatory concern.

U.S. senators and members of the Treasury Department last week voiced concern about potential tax advantages held by Bermuda-based companies with U.S. subsidiaries.

Given the interest by Congress, legislation to change the tax code could be introduced and passed this year, some U.S. insurer executives say.

Any changes in tax treatment, howev-

er, are likely to be virulently opposed by Bermuda insurers and reinsurers that have U.S. subsidiaries.

Those companies say the so-called "tax loophole" should not be viewed in isolation and they argue that when other issues, such as taxable ceding commissions and excise taxes, are factored in, any advantage they might have is significantly reduced.

In some cases, the U.S. affiliates are paying more U.S. taxes today than they did before they were bought by Bermuda-based parents.

Efforts to penalize Bermuda-based insurers and reinsurers are protectionist and contrary to a spirit of free trade, ex-

ecutives of the Bermuda companies say.

Industry analysts say it's hard to pin down what advantage Bermuda-based companies have over companies based in the United States. In addition, they say, if Congress closes one "loophole," the Bermuda insurers and reinsurers could probably find an alternative way to regain any advantage.

Lobbying to eliminate only the tax advantages held by companies in Bermuda and other tax havens could leave the U.S. insurers open to a charge that they are ignoring tax advantages held by insurers in other countries. Given the complexity of tax treaties already in place with some of

See Bermuda on page 24

Four U.S. insurers are charging that Bermuda offers an unfair edge to companies there writing U.S. risks.



Pension reform moves forward

Clinton opposes tax vehicle

By JERRY GEISEL

WASHINGTON—Pension reform legislation that would provide a significant boost in benefits that could be funded through employer plans is on its way to a congressional conference committee.

The House of Representatives last week on a 257-169 vote approved a series of pension reforms that are tucked into a broader measure that would cut certain taxes and raise the minimum wage. The Senate had earlier passed a tax cut/minimum wage bill with pension provisions that largely mirror those in the House bill.

While the House vote keeps pension reform alive, the future of the broader bills to which it is attached is uncertain, due to intense Clinton administration opposition.

Shortly after last week's House vote, President Clinton vowed he would veto the legislation if it comes to his desk

loaded with tax breaks.

While the administration wants Congress simply to raise the minimum wage, congressional Republicans are willing to do so only as part of broader tax cut legislation.

Unless that impasse can be broken, employers could very well see pension reforms they favor pass Congress but then get a veto—again. Last summer, Congress passed a huge tax cut bill containing pension reform provisions, which President Clinton then vetoed.

"My fear is that the fate of pension provisions will be decided by unrelated provisions, as they were last year," said Frank McArdle, a consultant with Hewitt Associates L.L.C. in Washington.

Still, some observers say a compromise could be easier to achieve this time.

The tax bill President Clinton vetoed last year would have cut taxes by roughly \$800 billion

See Pensions on page 26

Doctor groups seek more bargaining clout

By ROBERTO CENICEROS

Physician-sponsored legislation under consideration at the state and federal levels could drive up health care costs and hamper buyer-backed data-collection efforts aimed at quality improvement, health care payers fear.

While somewhat different in each state, the measures generally would exempt self-employed doctors from federal antitrust laws when banding together to negotiate contracts. Such an exemption would be allowed if a state provides oversight of the contracts negotiated between doctor groups and payers.

Legislation also has been introduced in the U.S. Congress that would permit antitrust exemptions without requiring any

state oversight.

Obtaining an antitrust exemption would permit self-employed physicians to, for example, band together to negotiate as a group with health insurers, self-insured employers or other third-party payers over the amounts physicians are paid for patient care. They could also jointly bargain over such issues as their obligations under utilization review and quality-reporting requirements without violating federal antitrust law.

Joining forces in such a manner currently is prohibited by federal antitrust law.

The legislation introduced at the federal level would amend antitrust law to give doctors who band together similar treatment under the law as is currently afforded

See Antitrust on page 4



Survey tracks legislation

Deregulation spreading

By MEG FLETCHER

Measures that would deregulate rate and form filing requirements for commercial risks are still trucking through state legislatures, though proposals to tighten policyholder exemptions are creating some speed bumps.

Many agents and regulators are raising barriers, such as minimum premium requirements for "exempt commercial policyholder" status, in an effort to protect unsophisticated corporate buyers from losing most regulatory oversight.

"There seems to be a general realization this year, among insurers as well as agents, that setting thresholds too low, which may result in unanticipated future (policyholder) losses, could prompt a backlash against deregulation," said Wesley Bissett, vp-state govern-

See States on page 25

States take the initiative

Deregulation of commercial lines rate and form filing requirement



■ Legislation or regulations enacted or adopted in 1998 and 1999
 ■ Legislation or regulations pending in 2000
 ■ Both pending and enacted legislation or regulation

Source: Alliance of American Insurers

GRAPHIC BY JOHN HALL

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Updates

Aon promotes broker exec

Continued from previous page

unit of American Re-Insurance Co., continues his role as chairman of Aon's alternative market operations.

"Ken is a very successful leader with a proven record for growing and developing organizations," Michael O'Halleran, president and chief operating officer of Aon Corp., said in a statement. "We are confident that Ken will intensify our drive for organic growth, which is a key opportunity for Aon."

Cover backs up comp claims

SACRAMENTO, Calif.—A cut-through reinsurance deal with Centre Insurance Co. will ensure the payment of workers compensation claims incurred by Superior National Insurance Group companies following the Calabasas, Calif.-based group's seizure earlier this month by the California Insurance Department.

According to a statement by California Insurance Commissioner Chuck Quackenbush, claims made against Superior National policies prior to the seizure will be paid out of the company's assets. If the department is unable to rehabilitate Superior National and it is liquidated, California comp claims under Superior National policies will be paid through the state's guaranty fund.

California regulators seized the company March 3 after determining that four of its units were "severely underinsured" and insolvent by a total of \$247.1 million. Last week, the department obtained conservation orders placing Superior National's operations under the department's control.

In his statement, Mr. Quackenbush emphasized that Superior National policies remain in effect. He added that in addition to ensuring the payment of claims, the reinsurance agreement should smooth the transition of the insurer's management to the California department and make the company more attractive to potential buyers.

Aetna's future is questioned

HARTFORD, Conn.—A Memphis-based investment adviser, Southeastern Asset Management Inc., that has bought 8.5 million shares—about a 6% stake—in Aetna Inc., has had "conversations with third parties" concerning proposed corporate transactions, according to a Securities and Exchange Commission filing made last week.

Southeastern's \$444.3 million purchase of the Aetna stock, which makes it one of the firm's largest shareholders, was also revealed in its SEC Schedule 13-D filing. A Southeastern spokesman had no additional comment.

An Aetna spokeswoman would not comment on press reports that Southeastern has suggested auctioning Aetna off on a piece-by-piece basis or that Aetna's board is expected to discuss such an approach.

Meanwhile, Oldwick, N.J.-based A.M. Best Co. has placed Aetna's affiliated operating companies under review with developing implications. Best said this reflects the uncertainty surrounding Aetna's future ownership and organizational structure as well as the impact on its market position, operating performance and financial flexibility.

Separately, the spokeswoman said that Aetna, in response to a query, has acknowledged that, for several years after its founding in 1853, it apparently insured the lives of slaves.

But the company has no plans to make reparations, as requested by New York attorney Deadria Farmer-Paellmann, said the spokeswoman. "We concluded that our stance on diversity and quality and fairness issues is such since then that it more than outweighs what we may or may not have done 150 years ago."

Insurer settles Medicare case

WASHINGTON—CIGNA Corp. unit Connecticut General Life Insurance Co. will pay about \$8.9 million to the federal government to settle allegations that it overbilled Medicare in its role as a Medicare contractor.

The government alleged that Connecticut General overcharged the Medicare program over a number of years. As an example, the government cited such acts as Connecticut General charging for the copying of two sheets of papers when the insurer was, in fact, copying on two sides of one sheet of paper.

The settlement "constitutes a cost-effective resolution of differences in calculating past administrative costs," CIGNA said in a statement.

Department of Health and Human Services Inspector General June Gibbs Brown said in a statement that when Medicare contractors "don't play by the rules, it threatens the integrity of the entire program."

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Errors & omissions

- Due to incorrect information supplied to *Business Insurance*, a March 6 story indicated that Ernst & Young L.L.P. plans to sell its risk management and benefit consulting operations as part of an agreement with a French computer services company. Ernst & Young says those practices—which it calls its human resources and insurance risk management consulting practices—are not part of the proposed sale.

Coverage denial overturned

By ROBERTO CENICEROS

RIVERSIDE, Calif.—Having regulatory responsibility for contaminated groundwater is not the same as ownership of the groundwater, negating insurers' denial of coverage based on an "owned property exclusion," a California appeals court ruled.

The ruling demolishes a key argument asserted by insurers fighting to deny coverage for the state of California's cost of cleaning up the infamous Stringfellow Acid Pits. Hundreds of millions of dollars in past and future cleanup

costs incurred by the state are at stake.

A trial court in Riverside, Calif., had ruled that the state's "ownership" of the water underneath the former hazardous waste dump site meant that insurers that had provided the state with general liability coverage could avoid paying for cleanup costs.

The insurers had argued that damage to owned property is excluded under their liability policies, just as an automobile liability policy would not pay for damage to a policyholder's own automobile.

In *State of California vs. The Superior Court of Riverside*, however, a three-judge panel for the California Court of Appeal for the 4th Appellate District, unanimously set aside the "owned property exclusion" granted by the lower court.

"The state owns the groundwater in a regulatory, supervisory sense, but it does not own it in a possessory, proprietary sense," the appellate court found. Therefore, it is apparent the owned property exclusion does not apply, the ruling stated.

See Cleanup on page 26

Voters reject bad-faith law

California initiative would have allowed third-party suits

By JOANNE WOJCIK KOCHANIEC

SACRAMENTO, Calif.—Super Tuesday turned out to be superb for insurers and tort reform advocates in California, where the electorate overwhelmingly voted to repeal law that would have permitted third-party bad faith insurance lawsuits in the state.

Propositions 30 and 31 were defeated by nearly a 2-1 margin, with approximately 68% of voters deciding against implementing S.B. 1237 and A.B. 1309, both of which had been suspended pending the outcome of last Tuesday's vote. S.B. 1237 would have permitted third-party bad faith suits against insurers, while A.B. 1309 would have prohibited the filing of such suits by businesses and would have limited property damage suits to those involving auto accidents.

Proposition 30 and 31 opponents called the vote a victory for consumers, who would have had to pay higher insurance premiums had the measures been

implemented.

"Repeal of the new bad-faith laws imposed by the 1999 California Legislature is a big win for consumers," said Peter Gorman, associate vp of the Alliance of American Insurers' western region in San Francisco.

"By rejecting these propositions, voters were saying that they do not want to pay higher insurance premiums or see the court system become clogged with frivolous lawsuits brought by trial attorneys, who stood to gain the most from these initiatives," said Roger Schmelzer, vp of regulatory affairs for the Indianapolis-based National Assn. of Mutual Insurance Cos.

"It shows some of the misconceptions within the Legislature," which apparently paid more attention to lobbying by trial lawyers than to the wishes of its constituency when it passed the laws, observed Shirley Knight, assistant state director of the California

See Bad faith on page 25

Increases outstrip medical charges: Study

Employer costs to rise 9.7%

By MICHAEL PRINCE

Health care providers are raising their charges by about 3% in 2000, but health insurers are charging employers more than triple that amount, a survey released Thursday shows.

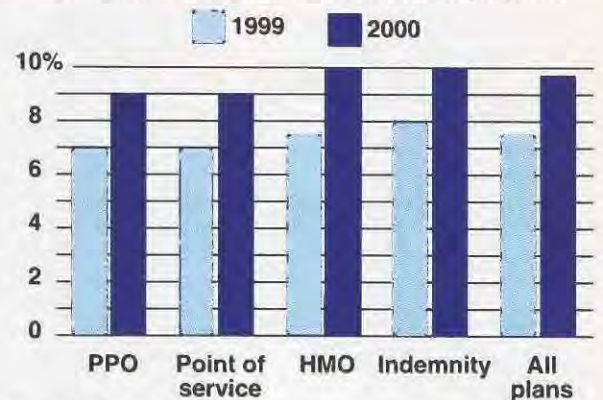
Employers' health care costs are jumping by an average of 9.7% this year, up from a 7.5% increase reported for 1999, states the Fifth Annual Survey on Purchasing Value in Health Care. The yearly survey is conducted jointly by Watson Wyatt Worldwide, the Washington Business Group on Health and the Healthcare Financial Management Assn.

Looking at the different types of plans, prices for health maintenance organizations rose the fastest, by 10% in 2000, compared with a 7.5% increase last year. Point-of-service plans and preferred provider organizations are charging employers 9% more in 2000, compared with 7% increases the year before.

See Costs on page 26

Cost hikes continue

Median rate of cost increases for employer plans



Source: Watson Wyatt Worldwide

GRAPHIC BY JOHN HALL

Inside

- It's reasonable to ask workers to pay a percentage of health care costs, this week's editorial says. **PAGE 8**

- A successful workers compensation pool for municipalities and other entities requires effective loss control, claims handling and program administration. **PAGE 17**

- Opening arguments in the *Jaffray vs. Lloyd's* fraud case begin amid intense media interest. **PAGE 19**

- Reinsurance disputes are governed by contract law, rather than insurance law, under European conventions, the U.K. House of Lords rules. **PAGE 19**

- Publisher Kathryn J. McIntyre isn't surprised that some parties have finally protested to Congress about the tax advantages of Bermuda-based entities, but she is surprised by the identity of the protesters. **PAGE 25**

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Southwest jet's hard landing likely to create total hull loss

BURBANK, Calif.—The hard landing of a Southwest Airlines Inc. jet in Burbank, Calif., on March 5 could lead to the airline's largest loss ever.

After landing, Flight 1455, which originated in Las Vegas, failed to stop before reaching the end of the runway at Burbank-Glendale-Pasadena Airport. The jet crashed through a runway barrier and plowed across a busy boulevard. The jet struck a car and sent debris flying into other vehicles before coming to rest on the boulevard, Hollywood Way, just short of a Chevron gas station.

While rain had fallen in Burbank earlier that day, the runway at the time of the incident was dry, according to a Southwest spokeswoman.

Two of the jet's 137 passengers, the flight captain and a motorist suffered minor injuries, a Southwest spokeswoman said. Other passengers began reporting aches and pains a day or two later, she said.

Officials closed Hollywood Way for hours after the incident, while crews

cleaned up spilled fuel, removed 9,000 gallons of fuel from the jet and used two cranes to move the jet onto airport property.

The jet, a 15-year-old 737, is valued at \$17.4 million. The airline late last week still was investigating the incident and could not comment on hull damage, the spokeswoman said.

The loss, though, likely will be the largest ever for the 29-year-old airline, which has never had an incident that has caused a passenger fatality, another spokeswoman said.

Insurance market sources said early estimates of hull damage exceed \$10 million, which means adjusters likely will classify the hull a total loss. The entire loss probably will be at least a few million dollars higher, though, due to cleanup and liability costs, market sources said.

Southwest's global insurance is led by Associated Aviation Un-

derwriters, a Short Hills, N.J.-based underwriting consortium. The airline's London coverage is led by Lloyd's underwriters managed by ACE London Underwriting Ltd. Southwest has \$1.5 billion of liability limits.

Willis Group Ltd. placed the coverage. *By Dave Lenckus*



PHOTO: AFP
Cranes lift the Southwest Airlines 737 back onto the airport property.

Contracts can transfer risk: Broker

By RODD ZOLKOS

SCOTTSDALE, Ariz.—Many companies overlook the role that risk management can play in ensuring that contracts meet risk transfer requirements, according to one expert.

"A lot of organizations automatically run any contract by their legal department, but they don't automatically run them by the risk management department," said Ilene Roberts, a vp with Riggs, Counselman, Michaels & Downs Inc. in Baltimore. "You need both."

Ms. Roberts discussed contractual risk transfer and the risks posed by poorly drawn contracts last month at the American Bankers Assn.'s annual insurance risk management conference in Scottsdale.

Contract situations that need a risk management/insurance review include any contracts with insurance requirements, any contracts with hold-harmless or indemnification agreements, as well as any contracts or situations that should have such provisions, Ms. Roberts said.

"It's really important to understand that there are lots of situations where there is no contract or it's (only) a one-page work order," she said.

Even in those cases, however, it's important for risk management to review the agreement and make sure the company is protected from exposures that might

See Contracts on page 12

Quake risk capital deal

HAMILTON, Bermuda—Lehman Re Ltd., a unit of Lehman Brothers Holdings Inc., has completed a \$150 million risk securitization deal covering portions of its California earthquake exposure.

In its first capital markets deal since being formed nearly two years ago, Bermuda-based Lehman Re has arranged coverage that will be triggered if insurance industry losses from California quakes hit \$22.5 billion during a 22-month period ending at year-end 2001.

To launch the transaction, Lehman formed a Cayman Islands-based special-purpose company, Seismic Ltd. As of March 6, Seismic had sold \$145.5 million in debt and \$4.5 million in preferred shares to investors and had entered into a swap agreement with Lehman Re, according to Paul VanderMarck, senior vp with Risk Management Solutions Inc., a Menlo Park, Calif., company that provided risk analysis for the deal.

If aggregate industry losses from covered earthquake events reach the trigger point during the 22-month period, Seismic investors will pay Lehman Re in increments of \$15 million, or 10% of the total offering, for each \$1 billion of industry loss exceeding \$22.5 billion, Mr. VanderMarck explained. Lehman Re will receive the full \$150 million if industry losses hit \$31.5 billion.

The 22-month notes—on which investors' full principal is at risk—will pay investors 4.5% over the London Interbank Offered Rate and have been rated BB+ by Standard & Poor's Corp. and Ba2 by Moody's Investors Service. Lehman Brothers and Swiss Re Capital Markets acted as co-lead managers for the offering.

Lehman Brothers formed Lehman Re in June 1998 with \$500 million in capital. Lehman officials could not be reached for comment on the Seismic deal.

—By Douglas McLeod

Ex-Oxford CEO to lead venture Online benefits portal launched

NEW YORK—A former managed care executive is giving small businesses a new way to buy health insurance online.

Internet venture BenefitPort last week launched a Web site, www.benefitport.com, that enables brokers to obtain quotes and secure health insurance coverage for small-business clients.

"This is the premier marketing organization in the health insurance space," said Stephen Wiggins, the chairman of BenefitPort and the former chairman of Oxford Health Plans. Mr. Wiggins announced the e-business portal at a press conference in New York.

Through the BenefitPort site, a broker can obtain price quotes and detailed information about health, life, dental and vision insurance policies from more than 50 insurers. And, in selected states, brokers can purchase policies for their clients through the site.

BenefitPort combines the operations of

general agencies with Internet technology. To date, the company has purchased five regional general agencies. In total, these agents work with more than 17,000 brokers and generate more than \$1 billion in premiums a year, the company said. This broker network now can use the BenefitPort Web site to transact business. Non-affiliated brokers also can use the Web site, the company said.

To obtain quotes on business, a broker enters information about a client, its employees and its coverage needs. The system then displays all the policies that fit the assigned parameters.

The number of suitable policies can be further reduced by adjusting the parameters, such as deductible amounts or employee co-pay percentages.

The broker can select all or some of the policies for a detailed comparison and can fax or e-mail this information to a client through the Web site.

Data may spark reform Work comp data base may spur system changes

By MEG FLETCHER

CAMBRIDGE, Mass.—New, objective data from a multistate benchmarking program for workers compensation claims and benefits is already improving the quality of public policy discussions in several participating states.

The data, which was compiled and analyzed through the Workers Compensation Research Institute's CompScope program, helps workers comp stakeholders—such as employers, workers, insurers and administrators—to pinpoint system concerns so they can develop state-specific improvements, according to experts participating on a panel discussion during the WCRI's annual issues and research conference earlier this month.

The current version of WCRI's "Detailed Benchmark/Evaluation" database, which is the centerpiece of the CompScope program, contains data from eight states on 4.5 million claims with injury dates from 1994 through 1997. Those states are California, Connecticut, Florida, Georgia, Massachusetts, Minnesota,

Pennsylvania and Texas.

How several states have used the CompScope data was the subject of a presentation at the WCRI meeting.

Stakeholders in Pennsylvania, for example, are using CompScope results as a tool for collaborative problem-solving when data from 1994 to 1996 revealed little improvement in the percentages of workers' claims that received their first wage-loss benefit payment within 21 days of injury.

Meanwhile, stakeholders in California and Massachusetts are looking at health care-related cost data from CompScope to evaluate the effects of prior reforms on costs. Specifically, they found that vocational rehabilitation provider costs in California have increased despite the imposition of caps in 1993. In Massachusetts, 1993 reforms may help explain a drop in medical costs in the state.

In addition, stakeholders in Pennsylvania and California are using data to focus policymaker and business action on additional areas for reform. For example, CompScope data showed that defense at-

torney costs rose 20% annually in Pennsylvania and that the frequency and cost of permanent disability claims continues to be an issue in California.

"We are just beginning to scratch the surface," in terms of the useful data CompScope can provide, said Carol A. Telles, a senior WCRI analyst.

CompScope's methodology enhances comparability across states by developing a similar mix of claims for each state based on industry, injury and wage.

Specifically, CompScope can bench-

See Data on page 22



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Business Insurance appoints new sales, editorial staff

Business Insurance has hired two new salespeople as well as a new editorial staff member.

Karen Cosco and Allison Sidorsky have joined as district managers in the sales department of *Business Insurance* in New York, while Sarah Veysey has joined the magazine as an associate editor in London.



Ms. Cosco

Ms. Cosco, 30, most recently was East Coast sales manager for Technology & Learning magazine, published by Miller Freeman Inc. in

New York. Before that, Ms. Cosco was Midwest advertising sales manager for Bank Investment Marketing magazine, a publication of Securities Data Publishing in New York. She also served as an account executive for Brooks Community Newspapers in Norwalk, Conn.

Ms. Cosco holds a bachelor of arts degree in international relations from Wheaton College in Norton, Mass.

Ms. Cosco, who will be responsible for advertising sales for Florida and Connecticut and selected accounts in New York City, can be reached at 212-210-0138.

Ms. Sidorsky, 26, was an account manager for Publicitas/Globe Media Inc. in New York before joining *Business Insurance*.

There, she was responsible for

selling advertising for Tennis, Cruising World and Sailing World magazines.

Prior to that, she was regional account executive for Cruising World and Sailing World magazines. She also served as an account executive for B101.5/WRX 103.7 radio in Providence, R.I.

She holds a bachelor of science degree in communication from Roger Williams University in Bristol, R.I.

Ms. Sidorsky—who will handle



Ms. Sidorsky

selected sales accounts in New York, as well as Philadelphia, Washington D.C., Maryland, Virginia and the Carolinas—can be reached at 212-210-0135.

“Both new sales managers bring a strong sales background to *Business Insurance*. I am confident that their knowledge will be a great asset to them in working with current and prospective clients,” said Martin J. Ross, associate publisher and advertising sales director.

Ms. Veysey, 25, most recently was a staff writer for the Financial Times World Insurance Report, as well as a reporter for several other insurance periodicals published by the Financial Times in London.

Prior to that, she was a staff writer for Reactions magazine in London.

She received a bachelor of arts degree with honors in modern European studies from Loughborough University in Loughborough, England.

Ms. Veysey can be reached in London at 207-457-1422.

“Sarah’s reporting talent and her knowledge of insurance and risk management issues make her an excellent addition to our editorial staff and greatly bolster the strength of our London bureau,” said Editor Paul D. Winston. **BI**



Ms. Veysey

Antitrust

Continued from page 1
ed to collective bargaining units, such as labor unions, under the National Labor Relations Act. President Clinton and U.S. Attorney General Janet Reno oppose the bill, which is before the House.

The legislative efforts have sparked fierce political battles, pitting employers and insurers against doctor organizations.

The biggest concern voiced by opponents of the measures is that allowing doctors to join together to increase their bargaining clout with health care payers will lead to higher costs.

Doctors say, however, that they need to organize to level the playing field, because health insurers now use their leverage in terms of controlling access to patients to dictate contract terms to self-employed doctors.

Managed care plans are squeezing payments to doctors to make up for the predatory pricing that the plans have employed to improve their competitive position, the doctors groups contend.

Supporters of the legislation also contend that patient care is at stake, because managed care utilization controls choke doctors’ ability to provide appropriate care.

“We have seen some extraordinarily audacious contracts, contract demands and negotiation practices,” said Kim Ross, vp for public policy for the Texas Medical Assn. in Austin, which led the fight for the antitrust legislation in Texas. “This was our reaction to it, based on a doctrine the American Medical Assn. developed in response to a grass-roots concern,” he said of the legislation enacted in Texas.

Texas currently is the only state that has adopted such legislation. Gov. George W. Bush signed it into law last year (*BI*, June 28, 1999). The rules under which Texas’ law will be implemented are still under development, however, so the direct impact on payers remains unknown.

The TMA’s Mr. Ross has advised the California Medical Assn. and other state groups on antitrust exemption legislation for physicians. He said the District of Columbia, Illinois and Georgia also are making serious efforts to pass similar laws, while other states are awaiting the outcome of federal legislation.

Unlike proposals in some states, the Texas law does not compel either party to come to the bargaining table, and negotiations between doctors and payers are non-binding.

Legislation recently proposed in California, however, would require binding arbitration in a situation where a doctor group and health plan could not agree to terms.

See Antitrust on page 6

Unfair

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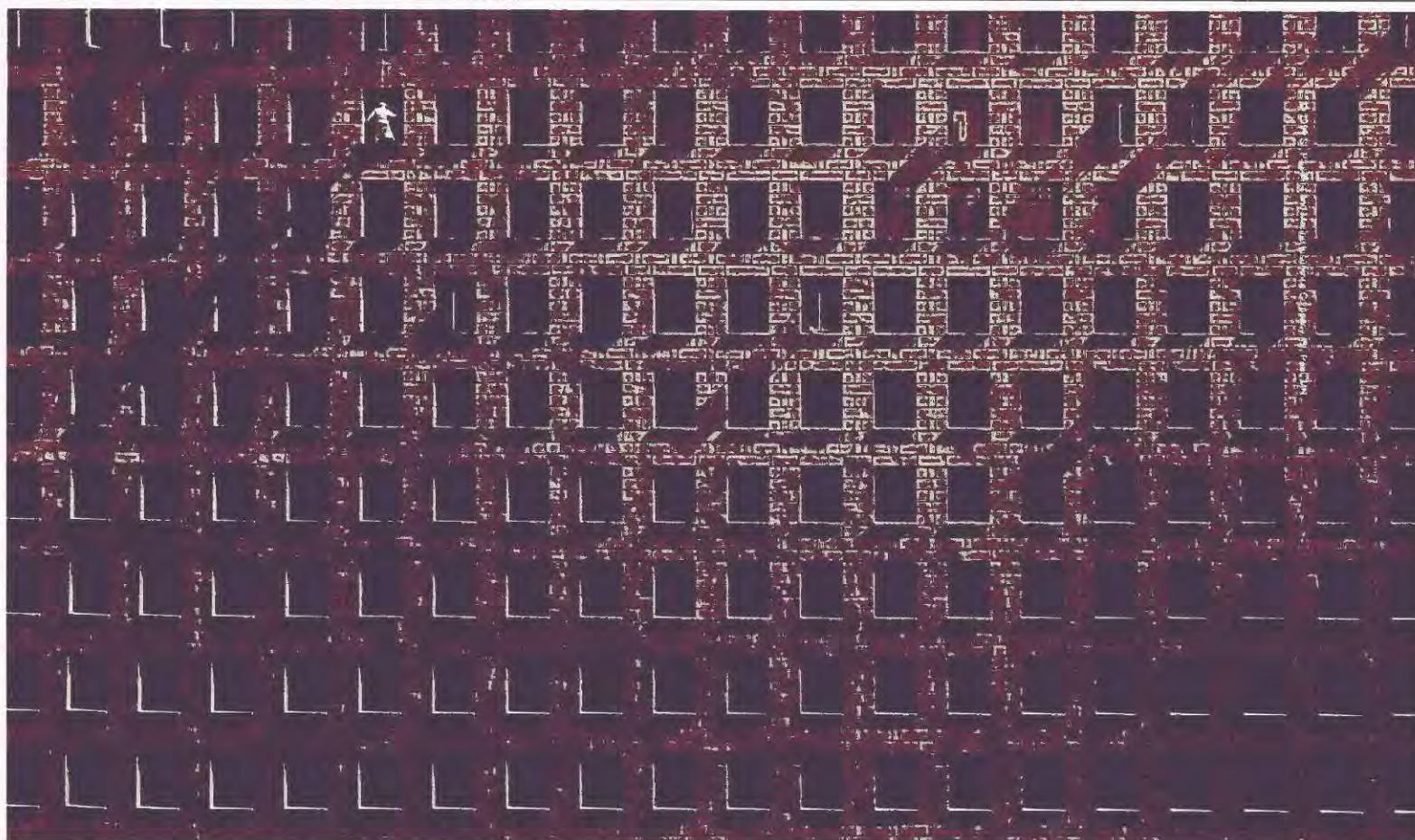
Codification Seminars

May 2-3, 2000
Omni Inner Harbor Hotel
Baltimore, Md.

May 16-17, 2000
Chicago Marriott O'Hare
Chicago, Ill.

Deloitte & Touche Partner Mark Parkin and Senior manager Steve Butters present two days of intensive instruction in the NAIC's *Codification of Statutory Accounting Principles* which becomes effective **January 1, 2001**.

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Antitrust

Continued from page 4

Sen. Jackie Speier, D-San Francisco/San Mateo and chairwoman of the Senate Insurance Committee, last month introduced S.B. 2007, the "Quality in Health Care Contracts Act," into the California Senate.

The bill from Sen. Speier would allow doctors, when private negotiations fail, to designate the California Medical Assn.—or other non-profit organizations—to represent them in negotiations with health care payers.

Under the bill, doctors could negotiate fees, utilization review criteria and procedures, as well as their obligations under quality assurance programs and treatment audits.

The proposals in California and other states rely on provisions in current federal law that allow exemption from federal antitrust laws if a state provides supervision. For example,

under S.B. 2007, California's attorney general would have to approve or modify contract terms between doctor groups and payers. In the event of an impasse, the bill calls for the attorney general to order an arbitrator to settle the dispute.

The Texas law also relies on its attorney general for supervision, while other states considering antitrust exemptions could also call upon an insurance commissioner or other state agent to oversee contracts.

The federal legislation, H.R. 1304, sponsored by Rep. Tom Campbell, R-Calif., would not require state supervision of contracts.

The federal legislation, like most state proposals, also contains language prohibiting doctors from striking or boycotting; it does "not confer any right to participate in any collective cessation of service to patients not otherwise permitted by law."

While some observers interpret that as saying that the measure will bar all strikes or boycotts, the language contains loopholes that would allow doctors to participate in such actions, said a spokesman for the Washington-based Health Care Leadership Council, which represents businesses in the health care industry. For example, the spokesman said, doctors could attempt to deny services to health plans, rather than to patients.

The legislative movement has strong opponents, however, especially health maintenance organizations.

The measures, if passed, would permit physicians to "engage in anti-competitive practices, resulting in increased costs and lower-quality care for consumers," according to a press release from the California Assn. of Health Plans, an HMO trade association in Sacramento. "It would give physicians the right to form a cartel, which is a measure of power that no other group has."

Other business and employer groups also have voiced opposition, said Larry Boress, executive director of the Chicago Business Group on Health, an employer coalition.

Such legislation is not based on consumer protection, as doctors have maintained, Mr. Boress said. "Clearly, the whole focus is on power and politics and protecting doctors in their ability to practice independently," much as they did under fee-for-service plans, he said.

Mr. Boress also said such legislation could put quality improvement efforts at risk, if access to treatment data becomes a bargaining issue.

It could be "a real problem"—and a setback for employers and purchasing coalitions—if doctors, through new-found negotiating clout, decide they don't want to release information about their practice decisions, Mr. Boress said.

More health plans are producing report cards on satisfaction, access, utilization and disease management based on treatment data, said Dr. Seth Garber, a principal for William M. Mercer Inc. in Seattle. Consequently, he said, unless a doctor group has a monopoly in a certain area, it would be hard for the group to buck consumer demands for more reporting on quality issues.

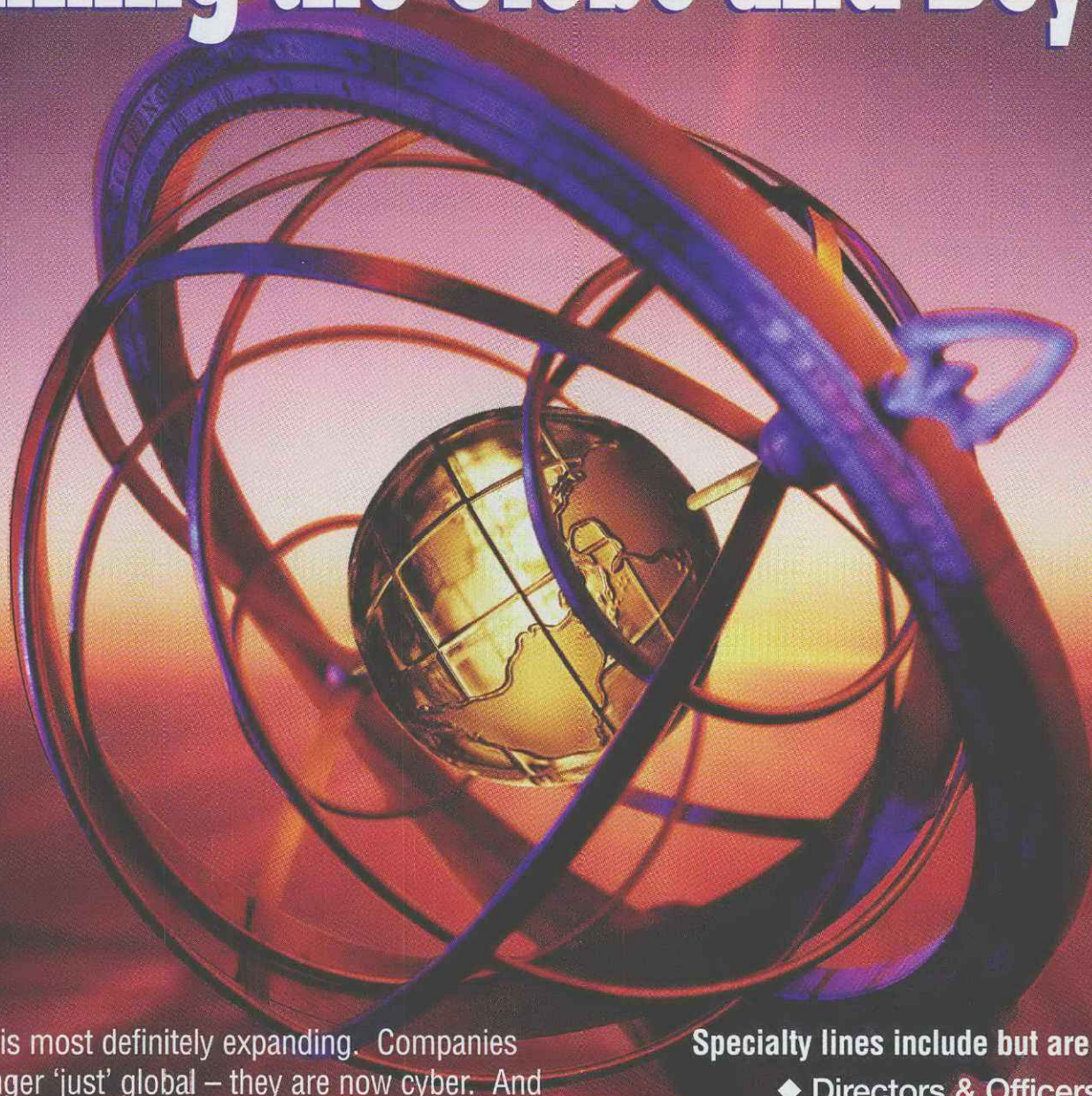
Negotiations between doctor groups and health care payers, therefore, are most likely to focus on price, Dr. Garber said.

Either way, if doctors' push for antitrust exemptions is broadly successful, that would certainly drive up health care costs, said Eileen Raney, national practice leader in Los Angeles for Deloitte & Touche L.L.P.'s integrated health care group.

Some employers facing higher costs from this and other legislative developments might decide to quit sponsoring health care benefits, she said. The doctors' effort could also move the health delivery system back to a PPO model with few managed care protections or price discounts. **BI**

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Opinions

Overreaction to cost shifting

IT IS HARDLY unreasonable for employers to ask employees to bear some of the burden of rising health care costs.

That's what makes the strike by union engineers of the Boeing Co. over the company's request that they share in the cost of their health care—for the first time—seem so irrational and petty. Even with the premium contributions proposed by the aircraft manufacturer, the workers' out-of-pocket expense for their health care benefits still is far less costly than for many other workers nationwide.

In short, the union engineers apparently have no idea how good they've got it.

Other Boeing unions and labor organizations around the country are rallying to the side of the engineers, but embracing such an unreasonable bargaining demand does little for the credibility or negotiating position of labor.

There may be other matters keeping the Society of Professional Engineering Employees in Aerospace from reaching an agreement on a new contract with Boeing, but the issue of employee contributions toward health care premiums should not be the deal-breaker they make it out to be. Taking such a strong position over such mild cost-sharing is an overreaction and is out of step with the reality of rising health care costs in corporate America.

As health care cost hikes accelerate, after years of stable rates, many employers are going to pass on some of this added expense to employees. Such moves will be even more likely at companies like Boeing that, until now, have paid 100% of health care premiums for some workers.

Boeing's last proposal before talks broke down called for the union engineers, among other things, to continue to pay nothing toward their health care premiums in the first year of the contract, 5% of the premium in the second year and 10% in the final year. Non-union workers at Boeing already pay 10% of the cost of their health care coverage.

Even at the level of 10%, the engineers are getting quite a bargain for such important protection. In addition, such mild cost-sharing requirements are unlikely to seriously erode the wage gains the workers are also seeking.

Asking workers to contribute something toward their premiums not only helps spread the burden of



rising costs, but also makes sense from the standpoint of giving employees a greater appreciation of the enormous cost of medical care and the value of the benefit that the employer provides.

Without any sense of how much their coverage actually costs, there is a risk of employees making poor treatment choices, engaging in unnecessary utilization and driving up the cost of their plan even further.

Compared with industry norms, the 10% premium contributions requested by Boeing are still extremely generous and are far below the national average for large employers, which is more than three times greater than what Boeing is seeking.

A recent survey by William M. Mercer Inc. bears this out.

According to the survey's findings for large employers, employees in health maintenance organizations paid, on average, 34% of the premium for family coverage in 1999. For preferred provider organizations, employees contributed an average of 36% for family coverage.

Boeing's engineers should recognize how good they've got it, and labor groups should pick their battles more carefully.

Letters

Coverage battle will resonate with buyers

To the editor: I want to commend *Business Insurance* for alerting its readers to the case of *Reliance Insurance Co. vs. VE Corp.* (BI, Feb. 28). There, a U.S. magistrate in Philadelphia refused to enforce a version of the total pollution exclusion. In reaching this conclusion, the magistrate applied law handed down by the 3rd U.S. Circuit Court of Appeals.

The opinion of the 3rd Circuit (121 F.3d 895) tells a story that should resonate with risk managers.

The policyholder requests insurance

for a specific exposure, explaining why it needs the coverage. Before the first renewal, the policyholder reiterates its needs and again requests the coverage. Then, as the 3rd Circuit put it, "despite these communications," the underwriter changes the terms of the insurance. The underwriter fails to seek approval of the change from the state insurance regulator.

The policyholder receives the renewal policy six months after the renewal date. These and other allegations led the court to conclude that VE Corp. could

have a reasonable expectation of coverage.

This case teaches a great deal about what insurance buyers should demand from their vendors in coverage documentation.

I recommend that anyone transacting insurance read the full 3rd Circuit opinion as well as the magistrate's findings of fact and conclusions of law.

Kenneth S. Wollner
Managing Director

Globe Midwest Risk Management L.L.C.
Southfield, Mich.

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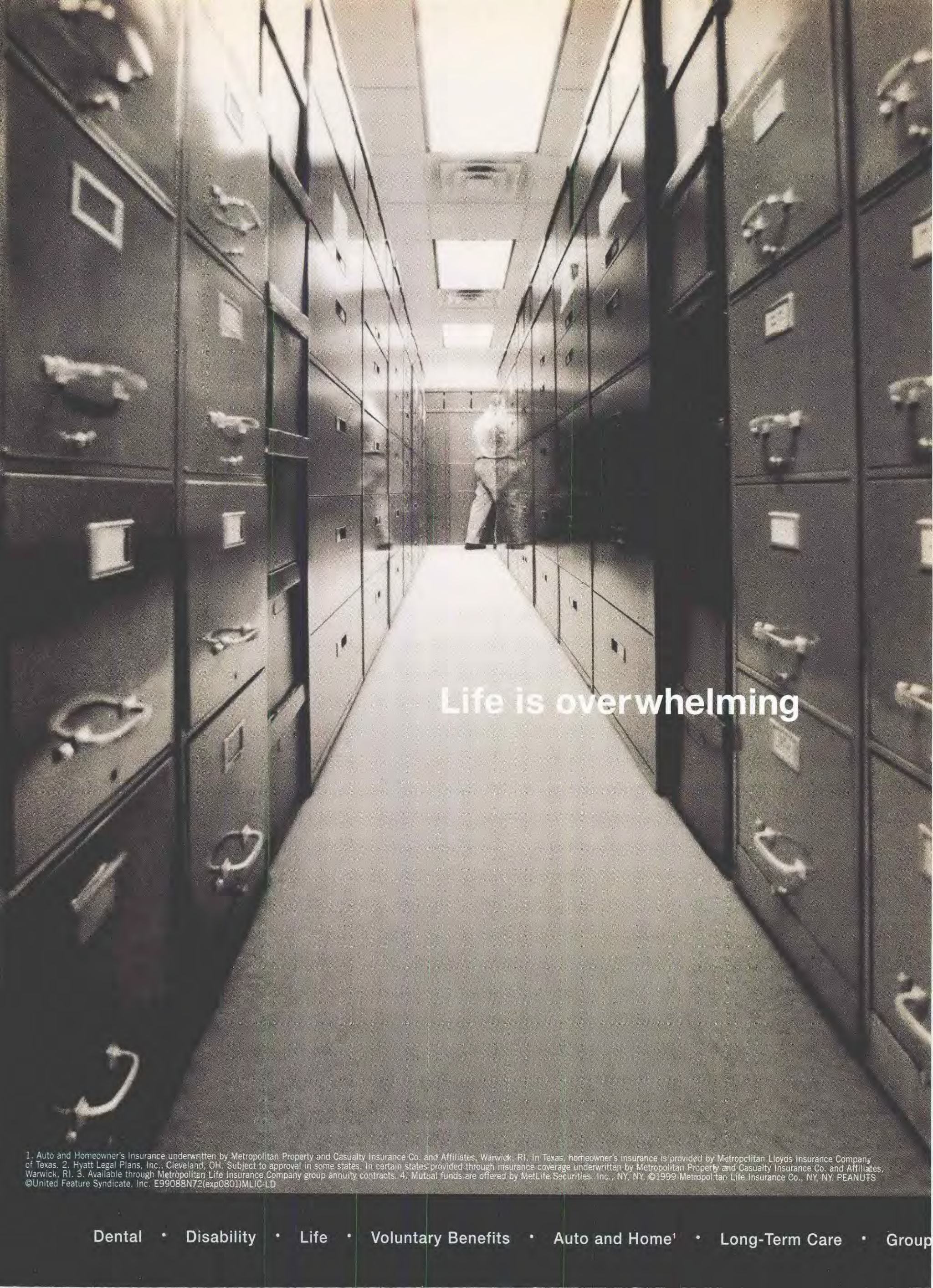
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Contracts

Continued from page 3

emerge from the contractual arrangement, Ms. Roberts said.

In entering into a contract with another company, "there are two ways to get you into their insurance," she said. "One is through contractual liability insurance. The second way is as an additional insured."

Both approaches have flaws, she said, "so the thing to remember is you want both. You want an indemnity provision in the contract, and you want to be named as an additional insured."

Ms. Roberts said she frequently sees companies making such mistakes as using incorrect or outdated terminology in their contractual risk transfer agreements, failing to include additional-insured requirements or entering into con-

tracts that lack indemnity agreements or whose agreements are inadequate.

Another common mistake is allowing an indemnity agreement with provisions that may be feasible today but won't be a year down the road. "Try to remember to think long term," Ms. Roberts said. "Don't put things in that may not be attainable two or three years from now."

Ms. Roberts said she also often sees vague or undefined requirements, and she advises risk managers to "try to be specific."

Moreover, Ms. Roberts said, she frequently encounters contracts that mistakenly require an insurer to give notice of modification or non-renewal of the contract counterparty's coverage.

"I see that a lot," she said. "And insurance carriers will not provide notice of modification or non-renewal, simply because insurance policies expire."

Consequently, the contract must hold the counterparty responsible for providing updated insurance information, Ms. Roberts said.

Among the recommendations Ms. Roberts made to the risk managers was to conduct insurance reviews of contracts before they're signed. "After it's signed, it's too late."

'Don't put things in (an indemnity agreement) that may not be attainable two or three years from now,' says Ilene Roberts.

She also recommended that risk managers avoid contradictory clauses in contracts and unattainable requirements, and that they ensure that contract requirements accurately reflect the intent of the parties to the contract.

Ms. Roberts also drew attention to contractual risk transfer for environmental exposures, for which many policies are written on a claims-made basis. "If they're going to carry claims-made coverage," she said, "make sure there is a requirement that they carry it for a number of years after the project is completed."

Ms. Roberts emphasized that it's critical that a company designate someone in the organization to monitor the contractual insurance requirements and the insurance information provided by the contract counterparties.

"Please don't forget that one," she said. "That is one of the most overlooked issues."

"It's amazing how many people will sign contracts and throw them in a drawer and nobody's seen them since until somebody has a claim," she said. **BI**

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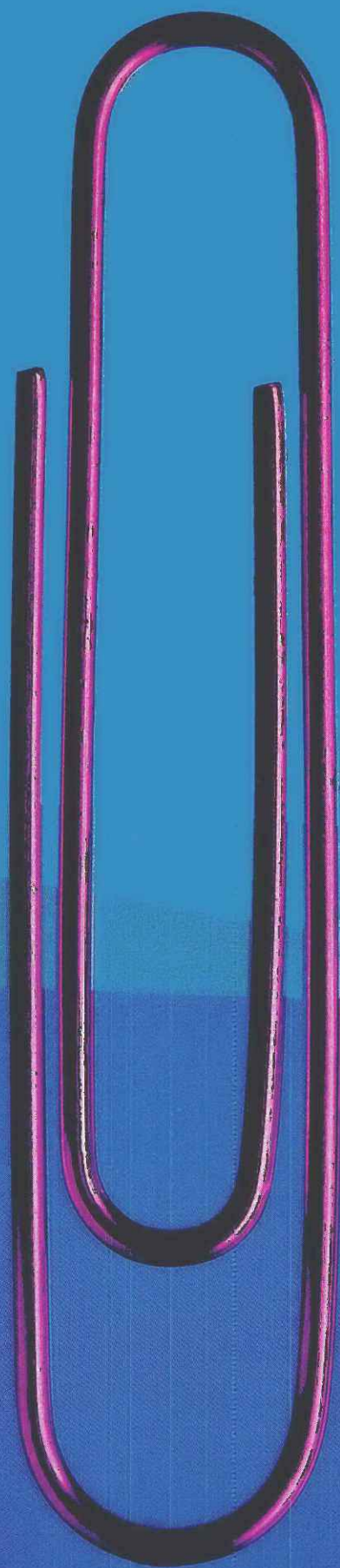
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Several facets to success of comp pool

By Paul M. Jahn
and Edward C. Bonaccorso

RUNNING A SUCCESSFUL workers compensation pool for municipalities and other public entities takes a multifaceted approach that includes effective loss control, claims handling and program administration.

Effective loss control, centered on training and educating supervisors and workers, is crucial. Claims handling must be caring, compassionate and focused on returning employees to work. Also crucial to a successful pool is sound program administration, which includes underwriting, information systems and member services. All these pieces must work well and work together.

Effective loss control

Providing loss control services to public employers can be more challenging than doing so in the private sector. Usually, there's no one person solely responsible for loss control within the municipality.

In a municipality, there can be several key officials—including the mayor or supervisor, the head of the department of public works and the school superintendent—and they are often accountable only to the voters. Loss control professionals must provide town officials with good information about safety and loss control so that they can make well-informed decisions.

Typically, municipal work consists of a variety of essential tasks, including running sewage treatment plants, paving roads, digging up pipes, collecting trash, enforcing laws and putting out fires. These are high-risk jobs, and, to complicate matters, most department of public works employees perform in multiple capacities. One day these DPW workers may be paving a road, and the next they may be clearing brush.

As most municipalities don't have in-house loss control experts, they depend entirely on outside guidance. Loss control professionals should conduct audits to pinpoint strengths and weaknesses, organize safety committees and provide vital training and education. They also should perform loss analyses to identify accident trends.

Most public employers should have safety committees made up of employees and managers. The safety committee should serve as the focal point for loss control efforts. It should review accidents and communicate safety information to the rest of the organization's employees.

Continuing training and education constitute the foundation of better loss control. Individual meetings with municipal officials, and regional meetings that feature guest speakers, interactive CD-ROMs and videotapes all should play a role. Loss control specialists should also provide specialized training as needed. For example, workers who handle chlorine in water and sewer plants need hazardous-materials training, while those who dig trenches and work in confined spaces must know how to prevent cave-ins.

Loss control representatives need to convince supervisors of the importance of using safety equipment, and the supervisors, in turn, must get workers on board. Because of tight budgets, municipalities are often behind private employers in purchasing and providing safety equipment.

But DPW workers may need eye and hearing protectors, hard hats, gloves, safety vests, steel-toed boots and back belts. Workers who use jackhammers need special anti-vibration gloves. Loss control specialists must show that safety is always a wise investment.

Vehicle safety is another key loss control consideration. DPW trucks should be equipped with radios, strobe lights and arrow signals to indicate that other vehicles should change lanes. Dump trucks need motorized dump-body covers that prevent loose debris from flying off and endangering other drivers. All vehicles, including police cars, should undergo regular safety inspections.

All these tangible items are important, but perhaps the most crucial factor is intangible: changing the way the employers and employees think and feel about safety. When they realize that safety programs benefit them directly, they change their behavior and make

safety a constant priority.

Compassionate claims handling

In handling workers comp claims, it's crucial to emphasize caring and to minimize bureaucracy. An injured worker may feel isolated and may worry about how she or he will be treated by the employer, the workers comp insurance provider and perhaps even the health care providers. When you treat injured workers well, explain their rights, pay benefits promptly and stay in close touch; the vast majority are eager to cooperate and return to work. You must start out assuming every claim is legitimate—unless proven otherwise—and that the employee deserves good service.

Giving employees and employers the best claims service costs more, but the investment pays disproportionate dividends. The higher administrative expense is dwarfed by the savings yielded by earlier return to work and reduced litigation.

Registered nurses should serve as the primary contact with injured employees. The nurse case manager should closely monitor treatment, communicate with medical providers and the employer, and serve as an expediter and problem solver.

It's important for injured workers to believe that someone cares about them, that someone is on their side. The nurse should serve as the injured worker's advocate. Because the workers comp system is highly bureaucratic, employees appreciate having someone to guide them through the claims and medical processes.

The nurse personally knows all about the worker's claim—the injury, the prognosis, the medical treatment and the possibility of alternate duty. This is much different from a system where the employee is talking to an adjuster who is simply accessing computer records and doesn't have personal involvement or medical knowledge. The nurse is dealing with "John Smith's injury," not with "claim No. 19-6431b." A nurse should contact claimants promptly in every lost-time case and in selected medical-only cases. Employers and supervisors should be reminded that prompt reporting of injuries is crucial.

The best place to heal is at the workplace. Nurses should play an essential role working with public employers to set up modified job duties that let employees stay productive. An injured police officer could be assigned to the evidence room or a desk job, for instance. Nurses should also alert the loss control staff when an injury indicates an unsafe working condition, and they should inform investigators when they suspect malingering or fraud.

Nurses who manage contact with employees free up the adjusters to do what they do best: directing investigations, meeting the legal requirements of the claims process and handling paperwork. Using nurses as the primary contact serves as an early-warning system for malingering. While about 90% of cases are legitimate, some people will try to take advantage of the system. Disputed claims require more attention, often result in litigation and potentially produce much higher claim costs. The presence of the nurse allows problems to be spotted much earlier in the process.

A red flag should be raised when something in the medical claim does not add up. The claimant may receive an unusual course of care, may not respond to proven methods of treatment or may change doctors frequently. Occasionally, a doctor may even alert the nurse that he believes the complaints are exaggerated.

When malingering is suspected, the case analysts become more involved. This frees up nurses for non-suspicious cases and allows case analysts to focus more of their efforts on the few claims that require more investigation.

Case analysts should focus on anti-fraud measures and thorough preparation for litigation. They should assess cases and drive the investigations while working with state officials to investigate and prosecute workers comp fraud.

With this system, legitimate claimants are treated well, receive benefits and return to productive work promptly. They also find that workers comp is part of their employee benefits package, not a bureaucratic hassle to be endured. Individuals inclined to abuse the system develop a healthy fear of the consequences of abuse.

Strong administration

Strong administration is the final piece that makes a pool succeed. A municipal pool is a non-profit bearer of risk. As is the case with any bearer of risk, the technical and administrative staff provide the infrastructure. They are the people who run the computer systems, underwrite the risks, handle marketing, manage finances and provide member services. Without good people in these positions, the pool can't be successful.

If a municipal pool is of sufficient size, it should have a dedicated administrative, claims and loss control staff, preferably working onsite. A dedicated staff helps the organization take on a "soul." Without that soul, you won't get the care that brings the greatest benefit to the membership.

By implementing this multifaceted approach, our program, the Public Employer Risk Management Assn., has achieved great success in reducing losses. PERMA is a self-insured pool that serves more than 400 municipalities, volunteer fire districts, school districts, water districts and other public bodies in New York state.

Most PERMA members are small and medium-sized towns and villages. The smallest member is a water district with one employee; the largest has hundreds of employees.

Founded in 1982, PERMA initially used an outside third-party administrator for loss control and claims handling. In 1989, PERMA contracted with a professional management firm to operate the pool. By 1992, a dedicated staff had been assembled, from two contractors, to provide all management-related services, including claims administration and loss control.

Because of an extensive loss control program and superior claims handling, PERMA members now have fewer and less expensive claims.

Each PERMA member has an annual loss control evaluation that covers management involvement and support, education and training, hazard control and accident investigation. Members receive a numerical grade, with 600 the top score.

From 1995 to 1999, the average score improved more than 100%. Currently, the average score is above the 500 points necessary to receive the full 20% risk management discount.

And here are the most important statistics: from 1995 to 1998, accident frequency dropped by 35%, and accident severity decreased by 44%.

PERMA's hands-on, caring claims handling has paid off, too. From 1991 to 1995, PERMA's average claim was \$3,738 lower than the average workers comp claim in New York state. Additionally, during those five years, the average lost-time claim at PERMA was \$12,402—\$8,980 lower than the New York state average of \$21,382.

Often, as a program grows, results deteriorate. But PERMA has continued to reduce losses while it has grown from 53 members and \$4 million of premiums in 1992 to 400-plus members and \$16.4 million of premiums in 1998.

PERMA's experience shows that the benefits of the practices outlined in this article aren't merely theoretical. When implemented, they work to reduce injuries, get workers back on the job sooner and cut costs.

BI



Mr. Jahn



Mr. Bonaccorso

Paul M. Jahn is claims manager with the Public Employer Risk Management Assn. Inc. in Albany, N.Y., and vp of Governmental Entities Management Services Inc., based in Cambridge, Mass. Edward C. Bonaccorso is loss control manager with PERMA and vp of GEMS. They can be reached at pjahn@perma.org or ebonaccorso@perma.org, respectively.

Workers comp experts see pressures for change

Business Insurance, March 13, 2000 / 21

INTERNATIONAL

Jaffray

Continued from page 19

question. According to Mr. Goldblatt, senior figures at Lloyd's "did not have any honest belief in the representations they made about the state of the market" when they recruited new members. Mr. Goldblatt said that if the court finds that names were misled when they joined the market in the 1980s, such misrepresentation could have occurred only as a result of incompetence or deliberate intent on the part of market leaders.

Mr. Goldblatt acknowledged that Lloyd's would argue that keeping the looming asbestosis crisis a secret would have been impossible, but he said that the culture at Lloyd's made it possible to do so. "Lloyd's is a contradiction. It is a gossip shop, but it is also a place at which secrets, at syndicate level, are kept very close to the chest. There are things about which you do talk and things about which you don't talk, things which will damage your business," Mr. Goldblatt said. He claimed that the true extent of the asbestosis problem was deliberately concealed from names to ensure that they would not desert the market.

Mr. Goldblatt argued that the gravity of the impending asbestosis problem was known at Lloyd's as early as 1980. He pointed to the fact that, in August 1980, a group of Lloyd's underwriters set up the Asbestosis Working Party, an information repository. Although the AWP was not an official Lloyd's body, Mr. Goldblatt claimed that it did have close links with some senior figures within Lloyd's. The AWP gained access to attorneys' reports of asbestos-related claims from the United States, but it did not attempt to calculate the future impact asbestosis would have on the Lloyd's market, according to Lloyd's.

Mr. Goldblatt said that the AWP had a relationship with Lloyd's then-Deputy Chairman Murray Lawrence and the Lloyd's audit committee until "at least 1981." Until the 1982 Lloyd's Act, the Lloyd's audit committee carried out the internal audit of the market. Mr. Goldblatt also noted that, until 1982, the AWP and the audit committee always had at least one

member in common.

The names also allege that Lloyd's was drastically under-reserved to deal with the asbestos-related claims that plagued the market in the 1980s and early 1990s. Mr. Goldblatt cited a 1985 report by Jim Bannister of the Risk Research Group Ltd. that suggested Lloyd's would need £4 billion (\$6.31 billion) in reserves to meet asbestos-related losses alone. Mr. Goldblatt said that, at this time, Lloyd's had set aside just £2 billion (\$3.16 billion) in general reserves to cover all of its exposures.

Lloyd's has denied the names' allegations of fraud and is expected to begin its counter-arguments the week of March 20.

If Lloyd's wins the case, it will be able to collect the £51 million (\$80.6 million) the names are estimated to owe for asbestos-related debts. If

the names are victorious, however, they will be able to sue Lloyd's for damages. Other names that agreed to R&R would not be allowed to file lawsuits alleging fraud as the judge presiding over this case has barred further asbestos-related actions in the United Kingdom.

Standard & Poor's Corp. last week said that while such damages would be "manageable," Lloyd's reputation could, nevertheless, be hurt by the court case.

"The fact is there are only about 200 names pursuing the organization for damages. That represents less than 1% of the total number of names in the Lloyd's market in the late 1980s," said Dominic Skeet, associate director at S&P in London. "The financial impact of Lloyd's losing the case should be relatively modest, and this alone would be unlikely to affect Standard & Poor's

overall strong A+ credit rating for Lloyd's."

Mr. Skeet said, however, that while the damages would not affect the market's financial strength, the high profile of the court case might harm its reputation.

"The case is expected to last over the next three to six months and will attract a lot of media attention, potentially causing uncertainty among investors and policyholders," he noted.

The extent to which the publicity generated by the case affects the long-term position of Lloyd's very much depends on whether it wins or loses the Jaffray case, according to Mr. Skeet. "At this stage the publicity can only really be bad because it is dredging up a lot of old allegations which the media had a lot of interest in prior to R&R but which had subsequently diminished," he

said.

If Lloyd's wins the case, however, he said he believes that it will be able to put the problems of the past firmly behind it. "Lloyd's could make a big play of the fact that this period is well and truly consigned to the past," he said.

Meanwhile, Lloyd's is facing four years of consecutive losses, from 1997 to 2000, according to the ratings agency Moody's Investors Service Inc. Moody's predicts that Lloyd's will see a loss of £149 million (\$240.6 million) for 1997, which closed at year-end 1999 under the market's three-year accounting system; a loss of £771 million (\$1.3 billion) for 1998; a loss of £775 million (\$1.25 billion) for 1999; and a loss of £496 million (\$783.5 million) for 2000. Moody's said it could forecast no guarantee of Lloyd's returning a profit for 2001. **BI**

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Bermuda

Continued from page 1

those countries, Congress is unlikely to force through changes if foreign insurers from, say Switzerland, are brought into the debate.

The four U.S. insurers pushing for a change in the tax code are Chubb Corp.; Hartford Financial Services Group Inc.; Liberty Mutual Insurance Co.; and Kemper Insurance Co.

The four insurers say that U.S.-owned companies are at a disadvantage compared with U.S. insurers and reinsurers owned by Bermuda par-

ents, because they are able to reinsure much of their business with their Bermuda parents and the investment income earned on reserves to pay claims on that business accumulates tax-free because Bermuda does not have an income tax. U.S. companies, in contrast, say they have to pay a 35% tax on their investment income.

"We can't compete on a level playing field with a company that does business in the U.S. but doesn't pay the U.S. taxes," said William Malchodi, senior vp and director of taxes at The Hartford in Hartford, Conn.

The Hartford has calculated that, even factoring in the expense of mov-

ing the premiums offshore, Bermuda-owned affiliates still could enjoy a 9% cost advantage over U.S.-owned insurers and reinsurers on risks with a five-year tail.

The Bermuda-owned companies enjoy a real competitive advantage over U.S.-owned rivals, agreed Robert Marzocchi, vp-tax at Chubb in Warren, N.J.

"We just want the playing field to be level. If Congress believes it's OK to keep the laws the way they are, they should be willing to allow U.S. companies to do the same thing," he said.

Both Chubb and Hartford have Bermuda affiliates but they are wholly owned foreign corporations and pay U.S. taxes, the two companies say.

The insurers are proposing that Congress should add a new section to the Tax Code.

In one version circulating in Washington, a proposed draft of the section states that where a domestic insurer or reinsurer reinsures U.S. risks with a foreign reinsurer that controls the domestic company "then the investment income of the domestic person shall be increased for each year during the term of the reinsured policy by an amount equal to the product of the average of the applicable federal mid-term rates... and the reserves of such domestic person... which relate to the U.S. risks ceded."

The new section would effectively impose U.S. taxes on the investment income earned on the reserves for long-tail business. Because the proposal specifically targets reinsurance, it is not expected to affect captives based in Bermuda.

The "loophole" was discussed extensively at a congressional hearing last week.

At a Senate Finance Committee hearing, Sen. Daniel Patrick Moynihan, D-N.Y.; Lindy Paull, the Joint Committee on Taxation's chief of staff; and John Talisman, acting assistant secretary of the Treasury Department, all expressed concern over the tax advantage of Bermuda insurers.

"We've met with different industry

representatives about it and we are looking at what are the necessary, appropriate steps," a Treasury spokesman said.

If the U.S. insurers' proposal gets backing in Congress it could be pushed through as part of a tax bill; as legislation that concerns tax havens or tax loopholes; or as a "pay for" attachment to any bill that would require some form of increased tax revenues to compensate a decrease in revenues in other legislation, said Mr. Marzocchi at Chubb.

'I don't know why companies that believe in free trade would want to put up barriers,' says Brian Duperreault.

The changes could be successfully adopted this year, depending on the format they take, though the presidential election could slow down the effort, he said.

The Bermuda insurers that are most likely to be affected by any legislative changes are: ACE Ltd., which bought the U.S. property/casualty operations of CIGNA Corp. in 1999 and Westchester Specialty Group Inc. in 1998; XL Capital Ltd., which bought NAC Reinsurance Corp. in 1999; and Everest Reinsurance Holdings Inc., PXRe Corp., White Mountains Insurance Group, and Trenwick Group Inc., all of which announced plans to move or completed holding company redemestications to Bermuda last year.

The Bermuda-based companies strongly reject the assertion that they hold a significant advantage over U.S.-based companies.

Transfer pricing rules that stipulate that reinsurance transactions must take place at "arms length" ensure that a fair ceding commission is paid for the business that is reinsured. That ceding commission is paid to the U.S. affiliate, which then pays tax on the commission as income, the Bermudians say.

Additionally, a 1% excise tax is paid on any premiums reinsured outside of the United States, they say.

"Under the proposal, a U.S. insurer with a Bermuda parent would be forced to pay higher taxes on reinsurance transactions than their U.S.-owned competitors," said Paul Giordano, general counsel for XL Capital.

Also, the reinsurance should not be characterized as a "loophole" as the risk is being transferred to the Bermuda company with no guarantee that the business will be profitable, he said.

Mr. Giordano would not disclose how much business NAC Reinsures with XL.

The Bermuda parents pay a fair ceding commission and they take on the risk, agreed Brian Duperreault, chairman, president and chief executive officer of ACE.

"There is no free lunch," he said.

ACE has reinsured little business of its U.S. affiliates, but if it did it would be a means of utilizing its capital effectively, Mr. Duperreault said. This is no different from the reason some U.S.-based companies reinsure their own risks through inter-company reinsurance pools, he said.

In addition, he said, the former CIGNA companies owned by ACE now pay U.S. income taxes, whereas for several years prior to the purchase they were losing money and did not pay substantial taxes on the business.

"Since they have come under our ownership we have created taxable income," Mr. Duperreault said.

In general, the proposals subvert free trade, he said.

"I don't know why companies that believe in free trade and open competition would want to put up barriers,"

Mr. Duperreault said.

Companies that redomesticate to Bermuda pay significant taxes when they do that and the related reinsurance business is already governed by the IRS rules, said Raymond Barrette, president of White Mountains in Hanover, N.H.

"It's a bit of a tempest in a teapot," he said.

Even if the changes to the tax code were put in place, Bermuda would still be an attractive place to move to, said Janet J. Burak, senior vp and general counsel at Everest Re, which registered a new holding company in Barbados and opened its main office in Bermuda.

"If (the proposals) came into effect, it may have some implications for us but we look at Bermuda as an important market with a flexible regulatory environment," she said.

Analysts say it is difficult to assess what advantage the Bermuda-owned companies have.

The IRS provisions that govern reinsurance with affiliates and the excise tax combine to reduce much of the advantage of having tax-free investment income, said Weston Hicks, an analyst at J.P. Morgan in New York.

The real advantage that Bermuda-owned companies could use is to extensively reinsure their risks and thus reduce the need to have such large amounts of capital in their U.S. affiliates. The excess capital could then be "dividend" to the Bermuda parent and grow tax free, he said.

Other insurers with parents based outside the United States, in say Germany and Switzerland, do the similar transactions, and legislation there also allows them to set aside tax-free catastrophe reserves, Mr. Hicks said.

To address that inequality, however, numerous tax treaties with foreign governments would have to be renegotiated and legislation forcing such changes is unlikely to pass Congress, he said.

The ceding commission paid by Bermuda parents to their U.S. affiliates does not fully offset the tax advantages of reinsuring the business to Bermuda, said Elizabeth Farrell, an assistant vp at A.M. Best & Co. in Oldwick, N.J.

Bermuda companies can rightly argue, however, that if Congress takes away their tax advantage it should also take away advantages that other foreign-owned insurers and reinsurers in the United States have, she said.

For example, Switzerland only imposes a 20% tax rate on the investment income of insurers based there, Ms. Farrell said.

Congress could be going down a "slippery slope" if it tries to penalize foreign insurers and reinsurers for not paying U.S. taxes, said Jon Harkavy, vp and general counsel in the Arlington, Va., office of captive and risk retention group manager Risk Services L.L.C.

Foreign governments may react by imposing retaliatory taxes on U.S. companies with affiliates in those countries, he said.

Even if the proposals are passed by Congress, Bermuda companies could likely find an alternative way to regain a tax advantage, said Donald Watson, a director at Standard & Poor's Corp. in New York.

For example, he said, two of the Bermuda companies could agree to reinsure each other and credit each other with an appropriate amount at the end of each year to ensure that the reinsurance reproduces the effect of reinsuring their own affiliates.

As of yet, few companies have reinsured much business back to Bermuda, said Jay Cohen, an analyst at Merrill Lynch in New York.

"The Bermuda companies have not been aggressive in reinsuring business back to Bermuda so it has not as yet given them a meaningful advantage," he said.

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Commentary

Sour grapes spark Bermuda outcry

As Bermuda-based companies started buying U.S. entities and several U.S. reinsurance companies moved their holding companies to Bermuda, I wondered how long it would take someone to say: "Hey, wait a minute. This isn't fair. They don't pay the same taxes that U.S. companies do."

I suspected that the "someone" would be an Internal Revenue Service accountant who hates "tax havens" and who lies awake at night counting the U.S. tax dollars flying offshore with every transaction done with a Bermuda-based company.

I never, however, imagined that the "someone" who would raise a fuss over the tax advantages of doing business from Bermuda would be four leading U.S. insurance companies, one of which has been an outspoken proponent of free trade and open markets.

As we report on page 1, Chubb, the Hartford, Liberty Mutual and Kemper have run to Congress asking for a tax code change to close what they contend is a nasty tax advantage held by Bermuda-based entities.

The tax advantage is easy to understand: To the extent that a Bermuda-based company reinsures the business of its U.S. subsidiaries, the loss reserves held in Bermuda grow tax-free.

However, the Bermuda-based company has to charge an arm's length premium for the reinsurance, the premium is subject to a 1% excise tax, and the U.S. subsidiary pays tax on the appropriate ceding commission paid by the Bermuda company.

The insurers lobbying Congress to close this tax advantage contend that the tax advantage of reinsuring to Bermuda could be 9% for business that runs off in five years on a break-even basis. So the U.S. insurers want U.S. tax law amended to tax as U.S. income any income from U.S. risks that is reinsured with a tax-haven affiliate.

Why should the U.S. insurers stop with Bermuda? How about going after the advantage held by insurance holding companies in countries that have a lower tax rate

than the United States?

This whole Bermuda bashing for tax advantages sounds like sour grapes to me.

Indeed, would the major accounts that have left these four U.S. insurers to buy insurance from ACE and XL Capital—the two leading Bermuda-based companies that have bought substantial operations in the U.S. market—please raise your hands?

The fact that Chubb, a company that has extensive international operations and has promoted free trade, is among the insurers crying foul really amazes me. The arguments the insurers use for "correcting a competitive tax imbalance for business insurance" are almost laughable for their hyperbole. For one, the insurers argue that this "unfair competition is unhealthy and upsets the marketplace and ultimately harms policyholders."

I can't imagine how policyholders are hurt, especially if any of that estimated 9% savings is shared with the policyholder. Indeed, the insurers seem to acknowledge that when they say: "If this loophole is left untouched, companies from tax-haven countries will utilize these unpaid taxes to either improve their bottom lines or undercut U.S.-owned insurers in their own marketplace."

The real hair-raising danger cited by the insurers calling for more U.S. taxes to be paid by these alleged tax-haven rascals is: "Left unchanged, there could be continued U.S.-owned insurer flight to Bermuda, leaving the U.S. with fewer tax dollars, a smaller labor force and less secure insurance capacity."

Yes, maybe more insurers will incorporate holding companies in Bermuda, and there could be some loss of tax dollars to the U.S. Treasury, but it's beyond my imagination that this will in any appreciable way shrink the U.S. labor force or create less secure insurance capacity in the United States.

There's a wonderful irony in these whining insurers raising the prospect of "less secure insurance capacity in the United States" if the Bermuda-based companies keep this tax advantage. For those too young to remember, it was U.S. insurers' flight from writing liability insurance for Fortune 500 companies that gave birth to ACE and XL Capital.

If Chubb, the Hartford, Liberty Mutual and Kemper, as well as other U.S. insurers, had written the insurance that Fortune 500 companies needed in the mid-1980s, ACE and XL never would have been capitalized by their policyholder-owners and grown into the formidable competitors they are today.

Publisher and Editorial Director Kathryn J. McIntyre's commentary appears fortnightly. She can be reached at kmcintyre@crain.com.

States

Continued from page 1

ment affairs for the Independent Insurance Agents of America in Alexandria, Va. (BI, Feb. 28).

No such backlash has yet emerged, though, said a spokesman for the Washington-based American Insurance Assn.

But, Patricia Borowski, division vp for the National Assn. of Professional Insurance Agents, also in Alexandria, said she is aware of some discussions hinting at seeking a federal solution to the growing "patchwork quilt" of state commercial lines deregulation proposals and laws.

Currently, though, there appears to be broad support across most industry segments for state-based deregulation of rate and form filing requirements for commercial lines risks, the AIA spokesman said.

"By removing much of the regulatory red tape from the commercial rate and form filing process, states give insurers the flexibility to custom-design coverages," said Rita Nowak, assistant vp of property/casualty for the Alliance of American Insurers in Downers Grove, Ill. "In this way, traditional insurers can be more competitive with alternative risk mechanisms and offshore entities. The increased competitiveness also benefits policyholders, who get more individualized, customized service," Ms. Nowak said.

In addition, members of the Risk & Insurance Management Society Inc., many of whom expect to readily qualify for ECP designation, "support the concept of reducing unnecessary regulation... with the caveat that the definition of risk manager and the (ECP) thresholds" be similar across state lines to help companies with multi-state operations, said Lance Ewing, chairman of RIMS' external affairs team and director of insurance and loss prevention for GES Exposition Services in Las Vegas.

Uniformity, however, is certainly lacking in the nearly two dozen deregulation proposals that state legislatures have either adopted or proposed over the past two or so years (see chart, page 1).

During 1998 and 1999, more than a dozen states enacted or adopted such legislation or regulations, including

Virginia, which adopted limited deregulation of some large-deductible workers compensation plans (BI, June 21, 1999).

Meanwhile, 10 states have similar commercial lines deregulation measures pending this year, according to the Alliance.

Those states include Virginia and South Carolina, whose legislatures recently approved measures that are expected to become law.

One reason the state measures vary widely is that they were based on at least four different proposals, including one outlined in a 1998 white paper by the National Assn. of Insurance Commissioners. Other draft proposals were crafted by the National Conference of Insurance Legislators and various industry groups.

While the NAIC model rate and

RIMS supports 'the concept of reducing unnecessary regulation,' as long as steps are similar across state lines, says Lance Ewing.

form filing law is nearing completion, a companion regulation will be discussed during the association's spring meeting in Chicago this week. The proposed regulation defines an exempt policyholder as one that meets at least two of the following criteria:

- Net worth of more than \$50 million;
- Net revenues/sales of more than \$100 million annually;
- Five hundred employees per individual company or 1,000 per holding company;
- Procurement of insurance through a risk manager who is either employed or retained by the policyholder;
- Aggregate premiums of more than \$500,000;
- Status as a non-profit or public entity with an annual budget or assets of at least \$45 million; or
- Status as a municipality with a population of more than 50,000.

In developing commercial lines deregulation proposals, state legislatures typically have chosen from

among such criteria, and industry groups have sought to have some influence on which criteria are included.

State agents' associations, which operate autonomously, receive advice on such policy matters from their national operations.

The IIAA last month approved a policy statement that endorses different treatment for rates and forms. It states that the competitive marketplace is the most-efficient and effective regulator of rates but that a state insurance regulator should retain the authority to intervene upon a finding that a particular market is non-competitive; that a rate is excessive, inadequate, or unfairly discriminatory; or that a rate is unreasonably low and has the effect of substantially lessening competition or creating a monopoly.

In addition, "forms should be subject to a greater level of regulatory review and oversight because of the harm that can result to the insurance consumer if a form is confusing, misleading or provides inadequate coverage. Regardless of the size of the insured, the regulator should retain the authority to intervene when a particular form is unfairly discriminatory, deceptive, misleading or not in the public interest," the IIAA said in a statement.

The PIA national organization also informed its state agent affiliates of its desire for comparatively high thresholds for exemption from most regulations, including an \$100,000 aggregate annual premium requirement.

Observers say the influence of agents' lobbying efforts has been demonstrated twice recently.

The Virginia Legislature sent to the governor a bill that would increase the minimum annual premium criteria for ECP status to \$100,000 from \$75,000. Meanwhile, a bill pending in Kentucky—where the NAIC's current president resides—was recently modified to dramatically increase the aggregate premium criteria for ECP status to the NAIC-recommended \$500,000 from \$75,000.

The degree to which state proposals differ was underscored last year when Oklahoma enacted a law that exempted from commercial rate filings any risk with \$10,000 in combined annual premiums. **BI**

Bad faith

Continued from page 2

for the state office of the National Federation of Independent Business in Sacramento.

"We have always felt that, in California, the scales have been tipped toward trial lawyers," she said. "We already have a mechanism in place to handle complaints" by consumers over insurance claims-handling practices.

The Insurance Department, which opposed the legislation and supported its repeal, has a hot line that responds to consumer complaints.

"The plaintiffs lawyers attempted

to create a feeling of dislike for insurers that nobody bought," said John Sullivan, president of the Sacramento-based Civil Justice Assn. of California.

Based on the outcome of the vote, "people felt that insurers did handle claims fairly," he said, adding that voters also did not like the idea of paying higher premiums to help pay to fight the frivolous lawsuits the measures would likely have triggered.

"The decisive vote sends a strong message to lawmakers that Californians believe their insurance companies treat their customers fairly when handling claims," said Jack S. Ramirez, president and chief executive officer of the National Assn. of Independent

Insurers in Des Plaines, Ill. "We are confident this resounding victory will take the issue of third-party bad faith off the table in California for the foreseeable future."

Supporters of the laws view the loss as a minor setback in a never-ending battle against insurers that stonewall.

"We've built a really solid foundation for whatever our next step will be," said Kelly Hayes-Raitt, consumer advocate for the Los Angeles-based Yes on 30 campaign, which was backed by the Consumer Attorneys of California, the American Assn. of Retired Persons, the California Nurses Assn., the California Teachers Assn. and the Consumer Federation of California, among others. **BI**

Tankers under federal law: Court

By MARK A. HOFMANN

WASHINGTON—Federal—rather than state—rules generally govern the operations of oil tankers, the Supreme Court ruled last week.

In its unanimous decision in *United States vs. Locke*, the high court ruled that the state of Washington could not impose its own rules for the operation of oceangoing oil tankers as part of its effort to prevent oil spills.

After the Exxon Valdez spill in Alaska in 1989, Washington state adopted its own rules regarding such matters as accident reporting and crew training. The federal govern-

ment argued that the Washington state rules were pre-empted by federal law and improperly affected operations outside state waters. A federal appeals court held that Washington state had the right to set its own standards, leading to the Supreme Court's review.

States can set their own liability standards for oil spill damage and can regulate their own harbors and waterways, provided that there's no conflict with federal law, Associate Justice Anthony Kennedy wrote for the court. But federal law mandates "uniform national rules" regarding such matters as design and operation, both of

which the Washington law addressed.

Business groups, including the U.S. Chamber of Commerce, had been watching the case because of its impact on pre-emption of state laws. The National Chamber Litigation Center Inc., which handles legal work for the chamber, had filed a brief, arguing that the usual legal "presumption against pre-emption" of state laws by federal statute does not apply in cases where there is a substantial federal interest in national uniformity.

United States vs. Locke, U.S. Supreme Court; No. 98-1701, Decided March 6, 2000.

Pensions

Continued from page 1

lion over a 10-year period. The legislation the House passed last week, by contrast, would cut taxes by \$122 billion over a 10-year period, while the Senate bill would give \$76 billion in tax breaks, also spread out over 10 years.

There is broad support in Congress for the pension reforms, many of which are based on a bill introduced last year by Reps. Ben Cardin, D-Md., and Rob Portman, R-Ohio.

"The pension provisions have had strong support in Congress all along," Mr. McArdle said.

Employer groups also stand behind the pension provisions.

"This is a very good and comprehensive package," said James Delaplane, vp-retirement policy at the Assn. of Private Pension & Welfare Plans in Washington.

Provisions in the House legislation that would increase pension benefits include measures that would:

- Gradually raise the maximum annual salary deferral an employee could make to a 401(k) plan to \$14,000 in 2004 from \$10,000 currently.

In addition, an employee age 50 or older could contribute beginning in 2001 an additional \$1,100 above the 401(k) maximum salary deferral limit. That additional so-called "catch-up" contribution would continue to increase until it hit \$5,600 in 2004.

This provision aims to help women who return to work after raising families make up for years in which they were outside the workforce and were not contributing to savings plans.

- Boost to \$200,000 from \$170,000 the employee compensation that could be included in calculating pension benefits. Such a change would add thousands of dollars to the benefits of higher-paid employees.

Take the case of a company that agrees to contribute to its profit-sharing plan an amount equal to 15% of each employee's salary. An executive earning \$200,000 this year would receive a contribution of \$25,550, or 15% of the \$170,000 maximum. Under the House bill, the executive

would receive a contribution of \$30,000.

Critics of the bill say the increased compensation limit shows how the bill tilts in favor of the higher-paid.

Others note, though, that prior congressionally ordered cuts in the compensation limit have forced companies to offer more benefits to executives in non-qualified, unfunded pension plans. If such plans fail, the executives could lose benefits promised under the non-qualified plans.

By increasing the compensation limit, "there is greater security for employees' benefits," Mr. McArdle said.

- Increase to \$40,000 from \$30,000 the annual per employee contribution that can be made to defined contribution plans, while raising to \$160,000 from \$130,000 the maximum annual benefit that can be funded through defined benefit plans.

The package also contains administrative cost-cutting items that would:

- Allow employers to use the same basic non-discrimination test—known as the "200%/2 percentage points test"—on savings plans with both pretax and aftertax features.

Current law requires employers to use a different test if their plan has aftertax contributions, though the Internal Revenue Service recently announced it would examine whether there are ways to simplify non-discrimination testing for plans that have both aftertax and pretax features.

- Permit an employee who moves between the private and non-profit sectors to transfer funds between 401(k) and 403(b) plans. Such transfers currently are prohibited.

- Allow employers to prove through "facts and circumstances" that their plans do not favor higher-paid employees even though the plans have not passed IRS non-discrimination tests. The treasury secretary would develop guidance on this issue.

- Exempt the first \$100,000 of a retiree's accrued pension benefits from federal minimum distribution rules. Those rules, which generally require retirees to take a distribution to generate tax revenue, are complex and difficult to administer.

In addition to boosting benefits and cutting administrative costs, however,

the bill would modestly increase some employers' pension costs by mandating new, faster vesting schedules. Under the measure, the slowest "cliff" vesting schedule employers could use would be one in which benefits are first and fully vested after three years of service. The slowest graded schedule would be one in which benefits are 40% vested after three years of service and 100% vested after six years.

Currently, the slowest cliff vesting schedule employers can use is one in which benefits first and fully vest after five years, and the slowest graded schedule is one in which benefits are 20% vested after three years, with vesting continuing at a rate of 20% per year until benefits are fully vested after seven years of service.

The bill also would make clear that the cost of employer-provided retirement education plans should be included in employees' taxable income.

Pension provisions in the House and Senate bills are in many cases identical, but some differences exist.

For example, while the House bill would gradually raise the maximum 401(k) deferral limit to \$14,000, the Senate bill would bump it to \$15,000.

The Senate bill also would allow, after a few years, employees age 50 and older to make slightly larger "catch up" contributions compared with the House bill.

The Senate bill would let employers shift to the Pension Benefit Guaranty Corp. responsibility for locating missing participants in their defined contribution plans. The PBGC's missing participant program can be used now only by employers terminating defined benefit plans.

Finally, the Senate bill—but not the House bill—would index the pension benefit cashout limit to inflation. Currently, an employer can automatically terminate a former employee from its pension plan and give him or her a lump sum only if the cash value of the benefit is \$5,000 or less.

Many employers prefer such cashouts, which relieve them of the responsibility and cost of continuing to provide pension plan reports to former employees and the need to pay termination insurance premiums on their behalf to the PBGC. **BI**

Cleanup

Continued from page 2

The appellate court decision, however, does not end the coverage dispute. The coverage battle will return to the trial court.

The insurers' loss on appeal represents a significant setback for them, because the lower court's decision had emboldened them to dig in and continue litigating rather than negotiate with the policyholder, according to David L. Mulliken, a partner in the

San Diego office of Latham & Watkins, who filed an amicus brief on behalf of several private companies involved in the litigation.

The insurer's "position had hardened significantly because of the trial court ruling," he said. "They figured the wind was at their back and they were going to hang tough."

The state of California purchased liability policies from several insurers, including units of American International Group Inc. and underwriters in the London market, Mr. Mulliken said. Attorneys representing the in-

surers did not return telephone calls.

Private companies for years had dumped millions of gallons of industrial waste into the Stringfellow facility, resulting in millions of dollars in property damage and bodily injury claims against companies that used the site for waste disposal. Five years ago, however, a court found the state was mostly liable for its cleanup.

State of California vs. The Superior Court of Riverside, California Court of Appeal for the 4th Appellate District, No.E025472.

Costs

Continued from page 2

While employers are seeing nearly double-digit increases, providers are raising per-unit prices by only 3% this year, the survey states.

Higher costs for prescription drugs, greater utilization of drugs and "use of new expensive technology to replace less expensive older technologies," make up most of the difference, explained Rich Ostuw, global health care practice director in Watson Wyatt's Stamford, Conn. office and a co-author of the survey. "The rest of the cost increase is going toward improving the financial performance of health plans," the survey states.

Mr. Ostuw estimates that 1%-2% of the increases received by health plans stems from an attempt to boost profit margins, after years of cutting prices to gain market share.

The survey also shows that employ-

ers and providers believe cost pressures are hurting quality of care.

The survey found that 39% of employers and 60% of providers agree with this assertion. In contrast, only 9% of health plans say quality has been hurt by cost pressures.

In response to the rising costs, both employers and health plans are passing them along to others. Ninety-nine percent of health plans indicated they are passing cost increases on to employers, reinforcing the idea that health plans are looking to boost profit margins, Mr. Ostuw said.

In addition, 70% of employers passed higher costs to employees. But the fact that almost one-third of employers are not asking employees to contribute more "says a lot about what employers face between controlling their costs and trying to maximize employee satisfaction," he said.

For employers, the next most-common strategy cited was absorbing the cost increases, cited by 57% of em-

ployers, followed by changing coverage for certain services, cited by 38% of employers. As for health plans, the next commonly cited strategy was to improve medical management, 94%, and then change coverage for some services, as 59% of plans noted.

As past surveys showed, employers chiefly consider costs and access to providers in evaluating health plans. Looking at all sizes of employers, 85% use cost data, while 75% look at access to providers in selecting plans.

Quality data, though, is less important for employers. Only 41% use a plan's accreditation status in picking a plan, and 29% look at Health Plan Employer Data & Information Set measurements, the survey states.

The survey was based on responses from 503 employers, 953 health care providers and 69 leading health plans.

Copies are available for \$20 from Watson Wyatt Worldwide, 1-800-388-9868; www.watsonwyatt.com.

Updates

RIMS Capitol Hill fly-in set

NEW YORK—The Risk & Insurance Management Society Inc. will hold its second annual "RIMS on the Hill" fly-in in Washington March 29-30.

Risk managers attending the event will concentrate on three main issues, said Dan Barry, RIMS' director of government affairs. The issues are the Occupational Safety and Health Administration's controversial ergonomics proposal, managed health care reform and medical records privacy, said Mr. Barry.

Risk managers attending will visit congressional offices during the event to make known their concerns about these and other issues. More than 60 individuals currently plan to attend, and registration is still open.

In addition, RIMS representatives are scheduled to present the organization's comments and concerns about the ergonomics proposal at the Department of Labor's public hearings in Washington at the end of the month.

Reconciliation of patient bills

WASHINGTON—Senate and House negotiators working to iron out differences between managed care reform bills passed by their respective legislative chambers have reached agreement in three areas.

Negotiators agreed last week to guarantee access to pediatric care by permitting parents enrolled in managed care health plans to name pediatricians as their children's primary physicians; to guarantee access to emergency room services; and to prohibit managed care health plans from discriminating against non-physician providers solely on the basis of their licensure.

Sen. Edward Kennedy, D-Mass., a member of the conference committee, issued a statement praising the agreement but calling on his colleagues to speed up the process, noting that more than 20 issues divided the two measures. For example, the House bill would greatly expand the legal liability of managed care plans—and, in some cases, the employers that sponsor them—for coverage decisions, while the Senate bill would not.

"Unfortunately, we have not yet even begun to discuss the most contentious issues—assuring that all patients, and not just some patients, are protected; providing an effective and independent external appeal process; and holding health plans accountable when they kill or injure patients," said Sen. Kennedy in his statement.

IRS bars retiree flex deal

WASHINGTON—Retirees cannot make pretax contributions from their pension benefits to pay for health care coverage offered through their former employers' flexible benefit plans, the Internal Revenue Service said last week.

The IRS "coordinated issue" paper was prompted by the practice of "certain entities" of marketing arrangements that allowed retirees to reduce their monthly pension checks to pay retiree health care premiums through Section 125 flexible benefit plans, the IRS said. Such an approach would effectively reduce the cost of coverage for retirees, as they would be using pretax—not aftertax—dollars to pay for coverage.

The IRS said, though, that the statutory authority that allows employees to reduce their salaries and make pretax contributions—as part of a flexible benefit plan—to pay for health care premiums does not extend to pension distributions made to retirees.

It isn't known how many employers have set up such arrangements.

Bill would ease agency onus

WASHINGTON—The House of Representatives passed legislation last Thursday that would repeal a 1999 law that required accelerated payment of taxes on capital gains from the sale of small businesses, including insurance agencies.

Prior to the change, agency owners could account for money received from the sale of the business in installments over a period of years, paying taxes on each individual installment. The 1999 law, however, requires that taxes be paid on the full capital gains in the year of the sale, even if the payments from the sale are spread out over several years.

The provision to repeal the 1999 law was approved by the House as part of a tax reduction/minimum wage increase measure. Although the bill has bipartisan backing, President Clinton has vowed to veto the legislation, as he favors legislation that only would raise the minimum wage.

A spokesman for the Independent Insurance Agents of America said that, even if the repeal bill is rejected, it will resurface as part of other tax legislation later this year.

Briefly noted

The Oregon Supreme Court on March 4 rejected insurance industry and regulatory challenges to a November 1999 ruling that coverage restrictions in fire insurance policies must be set out in a separate and appropriately headlined policy provision. The court has barred exclusionary language contained in provisions with titles that imply that only an explanation of covered losses follows (*BI*, Nov. 22, 1999). . . **MMI Cos. Inc.**'s stockholders have approved a proposed merger with The St. Paul Cos. Inc. Pending regulatory approval, the deal is expected to close early in the second quarter this year. . . Richard M. Miller Jr. has been named president and chief executive officer of **Willis of Tennessee Inc.** in Nashville. Frank White, who held the position, remains chairman of the Nashville office until June 30, when he plans to retire. Willis of Tennessee has 90 professionals and is known for its strength in construction, health care, employee benefits and leisure industries. The Tennessee division generates more than \$200 million in annual premium and fee revenue for the brokerage.

House considers asbestos plan

WASHINGTON—The House Judiciary Committee last week began what likely will be a long and arduous process as it considers the Fairness in Asbestos Compensation Act of 2000.



Rep. Hyde

The measure, sponsored by Judiciary Committee Chairman Henry Hyde, R-Ill., would create a new Office of Asbestos Compensation under the Department of Justice. The office would administer an asbestos compensation fund paid for by defendants in asbestos-related suits.

Claimants would be able to seek compensation from the fund, if deemed medically eligible, rather than pursue remedy through state and federal courts.

Action on the bill had been postponed several times in recent weeks. Members of the Judiciary Committee are sharply divided on the bill, and roughly 100 amendments had been prepared as of last week.

Va. plant explosion probed

RADFORD, Va.—Investigators last week were combing the wreckage left by the explosion of a Radford, Va., auto parts plant to determine the cause of the fatal blast.

Three workers were killed and six others were injured in the March 5 accident at New River Castings, a subsidiary of Troy, Mich.-based Internet Corp.

Radford Fire Chief Lee Simpkins said a New River representative estimated during a press conference that damage would total between \$30 million and \$50 million. An Internet spokesman could not confirm the estimate or that a New River employee had given it.

"We haven't put a dollar amount on it," the spokesman said. "It's just too early."

He said insurance is expected to cover the damage.

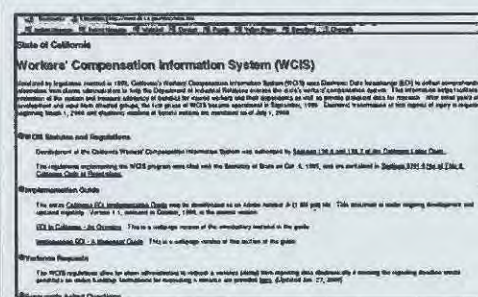
Union tobacco suits dismissed

NEW YORK—Agreeing with a series of prior decisions, a New York trial court judge has dismissed suits brought against cigarette makers by more than a dozen unions seeking to recover money spent by the unions' health plans to treat smoking-related illnesses.

The 14 suits, which sought to recoup money spent by union health and welfare trust funds, charged that the cigarette makers fraudulently hid the dangers of smoking, Justice Charles Edward Ramos states in his opinion.

Justice Ramos rejected that argument and dismissed the suits, ruling that not only were the suits barred by the statute of limitations, but also that injury to the health funds was too remote from the actions of the tobacco industry.

"To allow the funds to maintain actions that are entirely dependent upon harm suffered by others would cause chaos in the judicial system, especially in light of the fact that the participants and beneficiaries could bring suits on their own behalf," wrote Justice Ramos. In reaching his conclusion, the justice relied on similar rulings from other courts, including five federal appeals courts.



California comp moves online

SAN FRANCISCO—California regulators have launched a new workers comp information system, allowing them to accept claims data from insurers and self-insured employers electronically.

The first paper report to be replaced by the electronic filing system is the Employer's Report of Occupational Injury or Illness, Form 5020. This form must be filed for every workplace injury that results in lost work time or that requires medical treatment beyond first aid.

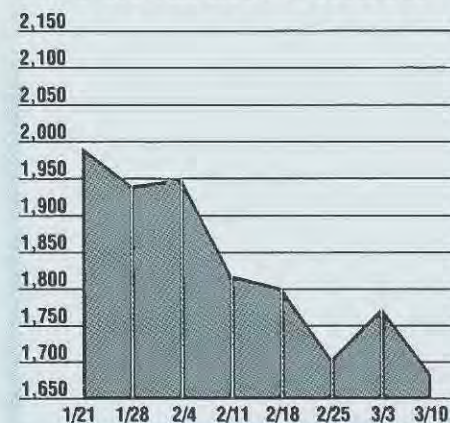
More information is available at the California Department of Industrial Relations' Division of Workers Compensation's Web site at www.dir.ca.gov/dwc/wcis.htm.

Information in brief

The Senate voted last week to expand the 1920 Death on the High Seas Act to allow families of victims of airline crashes that occur within U.S. territorial waters—up to 12 miles from shore—to pursue claims against the airlines under state law. The Senate pro-

vision also would allow families of victims of crashes that occurred farther out to sea to sue in federal court for loss of "care, comfort and companionship," rather than simply the value of lost wages. . . . New York-based Metropolitan Life Insurance Co. will acquire all the outstanding shares of Conning Corp. not already controlled by MetLife for \$12.50 per share in cash. . . . Standard & Poor's Corp. lowered the financial strength rating of health, credit and personal accident reinsurer European Specialty Reinsurance (Bermuda) Ltd. and its affiliates to BB+ from BBB. The downgrade reflects ESG's continued weak earnings, reduced capital as well as concerns over internal control mechanisms and its early departure from its original business plan, an S&P statement said. . . . Oil Insurance Ltd. posted profits of \$351 million in 1999, 28% lower than 1998 earnings, which included a one-time \$171 million gain due to accounting changes. . . . A.M. Best & Co. assigned the FM Global Group an initial rating of A+. FM Global was formed last year through the merger of highly protected risk property insurers Allendale Mutual Insurance Co., Arkwright Mutual Insurance Co. and Protection Mutual Insurance Co. . . . New York-based Financial Security Assurance Holdings Ltd., parent company for financial guarantee insurer Financial Security Assurance Inc., said last week that it is in discussions with a party concerning the company's possible sale. . . . Melissa Shelk was promoted to vp-federal affairs at the American Insurance Assn. Ms. Shelk, who served as legislative director for Sen. Robert Byrd, D-W.Va., before joining the AIA in 1989, represents the Washington-based insurer trade group on liability, tax and transportation issues. . . . Virginia lawmakers approved legislation that would bar municipalities from suing firearms makers for the costs of dealing with gun violence. . . . Moody's Investors Service Inc. downgraded its financial strength rating of Warren, N.J.-based Chubb Corp.'s property/casualty operating companies to Aal from Aaa. Moody's cited Chubb's lack of earnings growth, concentration of earnings in executive protection and high-end personal lines business, and exposure to natural catastrophes. . . . Richard H. Booth has succeeded Gordon W. Kreh as chairman of HSB Group Inc. in Hartford, Conn. Mr. Booth became president and chief executive officer of HSB in January following Mr. Kreh's decision to retire. . . . Itasca, Ill.-based broker Arthur J. Gallagher & Co. has acquired a majority interest in Sydney, Australia-based reinsurance broker MBR Pty. Ltd.

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: CNET Investor (investor.cnet.com) Boulder, Colo.

PCS catastrophe options

As of March 10	Call spread	Price bid/ask	Call spread	Price bid/ask
National Annual 2000			California Annual 2000	
60/80	5.0/—		150/155	0.1/0.3
100/150	7.5/—			
150C	6.0/—		Western Annual 2000	
190/195	0.3/0.5		150/155	0.2/0.4
200/250	3.7/—		300/350	0.4/—
Midwest June 2000			Eastern September 2000	
10/20	0.8/3.3		40/60	1.5/—
20/30	0.4/1.5		80/100	1.0/—

Total volume: 0 Total open interest: 792

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price	P/E	Div.	Yield	52-week
	pence		pence	%	high-low
Legal & Gen	149	12.9	4.1	2.8	237-130
Royal & Sun	315	58.8	24.7	7.9	633-303
Brokers					
Lmbt Fenchurch	142	14.0	4.2	3.0	145-58
JLT	257	10.8	13.3	5.1	286-166

Note: Prices are March 10 closings; other numbers from March 9.

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

BI Industry Stock Report MARCH 6, 2000, THROUGH MARCH 10, 2000

BROKERS					INSURERS/REINSURERS					HEALTH MAINTENANCE ORGANIZATIONS				
Company	Price	Weekly % change	Year to date % change	Year to date High	Company	Price	Weekly % change	Year to date % change	Year to date High	Company	Price	Weekly % change	Year to date % change	Year to date High
Aon Corp.	NYS 21.56	-9.45	-46.09	46.66	20.69	4895	8.00	-9.86	-12.33	13.38	8.00	12	23.00	1.94
Clark Bardees Holdings	NDO 14.50	-2.52	0.87	21.00	11.63	23	4.06	-20.73	-41.44	20.06	4.00	604	47.00	16.05
E.W. Blanch Holdings Inc.	NYS 50.38	0.50	-17.76	71.75	44.50	542	11.81	-4.06	-27.31	24.75	10.75	1332	18.56	-8.05
Gallagher Arthur J. & Co.	NYS 47.69	-4.63	-26.35	66.25	45.13	233	23.88	-10.12	7.00	35.88	20.50	1418	30.00	-5.33
Hibb, Rogal & Hamilton	NYS 27.69	-1.99	-1.99	29.13	15.56	92	5.69	-7.14	-22.88	21.75	4.69	1786	1.75	7.69
Keye Group Inc.	NDO 7.69	-9.56	-9.21	11.88	5.00	21	2.06	3.13	-40.00	17.25	1.69	1615	15.44	-1.98
Marsh & McLennan	NYS 74.56	-6.36	-22.08	104.75	61.75	3198	5.75	4.55	6.98	6.94	3.94	141	20.69	-3.78
Brown & Brown	NYS 33.00	0.19	-13.87	40.63	29.31	118	12.63	-1.94	-11.40	21.38	11.63	92	53.31	-0.52
BROKERS AVERAGE		-3.64	-15.04				22.56	-8.14	-33.27	42.25	22.56	549	19.13	-4.67
ACE Ltd.	NYS 15.13	-8.33	-9.36	35.25	14.06	7411	12.19	-3.47	-7.58	25.13	8.00	729	69.13	-1.07
Accel International Corp.	NDO 0.88	-9.61	-12.50	2.88	0.50	75	48.81	-0.89	-19.98	63.94	47.44	605	30.19	-9.89
Acceptance Insurance Cos.	NYS 3.94	-7.35	-31.52	17.06	2.75	194	12.56	1.01	-15.55	22.50	9.75	687	12.81	-8.07
AEGON N.V.	NYS 66.50	-1.02	-30.37	104.00	63.00	633	30.50	-1.61	-35.62	66.44	29.38	4876	5.75	-17.88
Aetna Life & Casualty	NYS 56.00	4.80	0.34	99.88	38.50	7259	11.75	-12.15	-28.79	19.88	10.88	107	18.00	-4.00
AFLAC Inc.	NYS 35.13	-4.10	-25.56	56.75	34.00	5394	25.06	-7.39	-37.34	57.50	24.00	3958	32.97	4.25
Allmerica Financial Corp.	NYS 36.25	-9.09	-34.83	64.81	35.06	1140	17.19	-9.16	-18.88	29.05	16.63	167	12.31	-11.66
Allstate Corp.	NYS 17.94	-7.42	-25.45	40.75	17.81	22496	116.00	-9.46	-25.16	193.00	111.50	175	5.38	8.86
Ambac Financial Group	NYS 41.50	-2.64	-20.48	63.00	36.88	2424	39.31	2.11	-25.56	71.88	36.31	2968	41.94	-3.59
American Financial Group	NYS 20.31	-0.61	-22.98	38.38	18.38	470	5.50	-12.00	-16.19	17.13	4.75	51	20.44	-1.80
American General	NYS 47.25	-8.47	-37.73	82.19	47.25	3825	9.75	1.30	13.04	17.44	3.31	197	58.69	-0.53
American Intl Group	NYS 83.00	-5.01	-23.24	114.50	78.56	23861	12.63	-10.83	-10.26	16.00	8.75	50	58.69	-0.53
American Safety Insurance	NYS 6.75	-2.70	3.85	10.00	6.00	90	8.75	-10.18	-3.79	19.50	12.00	178	58.69	-0.53
Argonaut Group	NDO 18.00	-0.35	-9.43	27.94	16.88	319	11.63	-3.13	-27.63	21.00	10.89	1095	58.69	-0.53
AXA-UFAP Group	NYS 62.38	4.50	-12.15	73.63	53.75	472	11.13	-1.11	-18.35	20.69	10.63	1650	58.69	-0.53
Baldwin & Lyons Inc.	NDO 16.50	-4.00	-25.42	24.05	16.38	28	31.25	1.63	-3.66	43.63	28.38	288	58.69	-0.53
Berkley W.R. Corp.	NDO 15.00	-2.44	-28.14	29.13	14.25	537	7.44	-8.46	-4.03	11.44	6.63	74	58.69	-0.53
Berkshire Hathaway Inc.	NYS 41300.00	-8.32	-26.38	81100.00	41300.00	6	17.38	-6.55	-12.58	21.13	16.00	195	58.69	-0.53
Capitol Transamerica Corp.	NAS 11.81	-1.56	17.39	16.00	9.38	67	14.56	1.75	0.43	25.50	10.81	98	58.69	-0.53
Chubb Corp.	NYS 45.31	-4.86	-19.53	76.38	43.25	3196	14.31	2.23	10.10	21.88	9.94	133	58.69	-0.53
CIGNA Corp.	NYS 63.75	-10.53	-20.87	98.63	63.31	4021	3.44	-14.06	-48.11	10.88	2.81	4764	58.69	-0.53
Cincinnati Financial Corp.	NYS 26.88	-15.52	-15.69	42.50	26.19	2193	25.38	-7.73	-35.25	49.81	23.75	4661	58.69	-0.53
Citigroup	NYS 48.94	-8.42	-12.12	60.13	38.30	47262	36.13	-2.86	-11.62	43.19	30.00	143	58.69	-0.53
CNA Financial Corp.	NYS 26.06	-3.02	-33.07	45.31	24.56	934	14.94	-0.42	18.32	22.00	11.00	112	58.69	-0.53
CNA Surety	NYS 11.00	2.33	-15.38	15.56	9.75	171	26.81	-5.09	-21.14	38.81	26.81	139	58.69	-0.53

Top advancing issues: SCOR, Vesta Insurance Co., Seibels Bruce Group. Leading decliners: ESG Re Ltd., Unico American Corp., MAIC Holdings Inc. Most active issue: Citigroup. The BI Index fell 5.1%; the Dow Jones 30 Industrials decreased 4.2%; the S&P 500 went down 1.0%, and the NYSE Composite fell 1.8%. Average P/E: Brokers, 17.0; Insurers/reinsurers, 16.2; HMOs, 9.7.

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

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