

Business Insurance

March 20, 2006

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\$5

Late News

ZFS shares up on talk of merger with St. Paul

Shares of Zurich Financial Services Group Inc. rose 5% on Friday amid rumors of a merger of the Zurich-based insurer and St. Paul Travelers Cos. Inc. ZFS' stock closed at 316.75 Swiss francs (\$241.03), while St. Paul Travelers' shares dipped 2.5% to \$41.89. Representatives of Zurich, Switzerland-based ZFS and St. Paul, Minn.-based St. Paul Travelers both declined to comment.

Chubb leads coverage for Nortel settlement

Chubb Corp. leads the directors and officers liability insurers that have agreed to pay \$228.5 million to Nortel Networks Corp. shareholders that sued the communications equipment giant for allegedly misstating its financial results. Two groups of shareholders sued Nortel for separate causes of action in different years. The settlement would resolve both lawsuits—pending court, securities regulatory and stock exchange approvals—according to Nortel.

See **LATE NEWS**/page 31

Florida suit revisits Marsh fraud scandal

State sues over bid rigging despite broker's settlement

By SALLY ROBERTS

TALLAHASSEE, Fla.—Marsh & McLennan Cos. Inc. is once again being accused of bid rigging and client steering by state regulators, but this time it is fighting back.

Florida Attorney General Charles J. Crist Jr., in a joint action with Tom Gallagher, chief financial officer of the Florida Department of Financial Services, sued MMC last week in state court in Tallahassee, Fla., charging the brokerage and three of its subsidiaries with numerous violations of Florida's Racketeer Influenced and Corrupt Organizations Act and antitrust statutes.

Similar to charges alleged by officials in other states, Messrs. Crist and Gallagher allege MMC illegally engaged in bid rigging and manipulated insurance markets to obtain

improper commissions.

MMC blasted the suit last week, saying that the state of Florida signed a legally binding document releasing all claims against Marsh as part of its \$850 million settlement with New York Attorney General Eliot Spitzer.

But the state holds that it has the authority to seek full restitution for any Florida entity that was harmed by Marsh's alleged illegal conduct regardless of any settlements that were reached.

"It's clear that this company took advantage of its clients," Mr. Crist said in a statement. "Florida citizens and companies were cheated out of the best rates on insurance and did not receive the honest professional advice they paid for."

See **MMC** / page 30

Mass. employer tax would fund uninsured

Lawmakers eye play-or-pay bill

By JERRY GEISEL

BOSTON—Massachusetts is moving closer to becoming the first state to impose a tax on employers that do not offer health insurance coverage to their employees.

While many details are being worked out by a legislative conference committee, the proposed law would impose an annual \$295 per employee tax on employers that have 11 or more employees and that do not provide health care coverage. The revenues raised by the

tax would be used to help fund coverage for the uninsured.

The plan is a compromise engineered by Speaker of the House Salvatore DiMasi, D-Boston, and Senate President Robert Travaglini, D-Boston, after state legislators were unable to resolve differences in measures earlier proposed by the two Massachusetts political leaders.

Speaker DiMasi's bill, which the House approved last year, would have imposed a payroll tax on all but very small employers. The tax would have been 5% of payroll for employers with 11 to 99 employees and 7% of payroll for employers with at least 100 employees. Em-

See **MASSACHUSETTS** / page 30

Shifting gears on health care

Key changes in Chrysler Group's benefits program announced by President and CEO Tom LaSorda, left.

- Salaried employees' health care premium increases to be linked to rank and base salary.
- Current and future pre-Medicare retirees to share some premium increases based on their exit salary.
- Medicare-eligible retirees to have health care retirement accounts to which company will contribute.



Chrysler to link benefit premiums to salaries, rank

By GLORIA GONZALEZ

AUBURN HILLS, Mich.—Chrysler Group's decision to base some employee health insurance premiums on pay and to set up health reimbursement accounts for Medicare-eligible retirees may encourage more employers to make similar changes.

The Auburn Hills, Mich.-based car manufacturer, which is struggling to control health care costs that have doubled since 2000 and are expected to hit \$2.3 billion this year, announced last week that it will introduce salary-based health care premium contributions for nonunion salaried active employees and pre-age 65 retirees and an HRA for nonbargained, Medicare-eligible retirees effective Jan. 1, 2007.

Under the program, each active salaried employee's health care premium increase will be based on the employee's rank and base salary level. Currently, on average, active employees pay \$950 annually in health insurance premiums. Under the new plan, midlevel managers, for example, will pay, on average, an additional \$450 in 2007, while top executives will contribute an

extra \$1,500.

Chrysler says that, on average, there will be no change in premiums paid by professional-administrative employees.

Additionally, current and future pre-Medicare retirees will share a percentage of health care premium increases based on the exit base salary of the individual retiree, beginning Jan. 1, 2007. For example, retirees who left the company at an income below \$50,000 will pay half of premium increases due to health care inflation, while employees who exited earning \$171,000 or more will pay 100% of the inflationary premiums. Currently, pre-65 retirees contribute, on average, for both family and individual coverage, about \$3,300 annually toward premiums.

Chrysler Group President and CEO Tom LaSorda described the changes as necessary and equitable.

"Our solution addresses the need to be competitive and recognizes that, while employees need to pay more for their health care, cost increases should be borne equitably, based on an employee's

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Inside



TWISTERS STRIKE
Midwest tornadoes cause widespread claims.

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TORT COSTS UP
U.S. tort system expenses continuing to rise.

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SPOTLIGHT

CLAIMS MANAGEMENT

Buyers seek consistency in TPA performance; complex claims call for special expertise.

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BI RANKING

Largest Third-Party Administrators

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A pre-loss plan can minimize business interruption and position an organization to collect insurance proceeds.

MARCH 20, 2006

Claims management in a post-Hurricane Katrina environment



Arnold Mascali is senior vice president and counsel for Horizon Consulting Group Inc., Aon's property-loss consulting division. He assists clients with the preparation and presentation of catastrophic property-loss and business-interruption insurance claims. Arnold can be reached at arnold_mascali@horizoncgi.com.

With the 2006 hurricane season only months away, now is a good time to reflect upon property claims management lessons learned and take action to better protect against future events. Hurricane Katrina struck a devastating blow to such a wide geographic region that some organizations suffered significant damage at numerous locations. Disaster plans that anticipated a response to only one or a few locations proved grossly inadequate. To better prepare for the 2006 hurricane season and other potential catastrophes, many companies should redesign their claims management plans to facilitate an optimal initial response, effectively coordinate recovery efforts and maximize the identification and collection of insurance funds.

To minimize unforeseen exposures, risk managers need a thorough understanding of the property and business interruption coverage purchased and how that coverage impacts their organization's specific operations. For example, does the policy provide true extra expense, that is, coverage for the costs above the charges normally incurred by the insured to continue operations following a peril? Some policies in place during Hurricane Katrina limited this coverage to costs that mitigated or reduced a business interruption claim. In circumstances in which a business interruption claim is unlikely without true extra expense coverage – e.g., a retailer that has coverage for the selling price of its damaged goods – some costs incurred as a result of Hurricane Katrina may not be reimbursable.

Armed with a detailed knowledge of the policy, the risk professional can make prudent business decisions prior to and following a loss. A good way to evaluate potential financial exposures is to stage a hypothetical loss at a particular location, estimate the costs that might be incurred at current prices and analyze the theoretical impact on business income during the period required to repair or replace the "damaged" property. A broker or loss

consultant could provide a staging worksheet to assist with this exercise. The risk professional would then be in a better position to predict which costs or losses should be covered by the policy and which might not be insured.

Reaction time is critical following a loss. The policyholder is charged with the obligation to mitigate its loss as soon as practical after an insured event. Losses usually escalate with time, and insurance companies may refuse to pay for costs incurred solely due to delays in responding appropriately under the circumstances. Searching for contractors after a catastrophe, bargaining with unknown "experts" and relying upon virtual strangers to assess damage and make recovery recommendations are not cost-effective claims-management strategies.

Well-conceived claims-management plans should include prior coordination with all necessary professional resources, including an emergency restoration company retained to respond within 24 hours of any peril at all insured locations. Many Gulf Coast organizations were unable to stem their losses following Hurricane Katrina because of the dearth of available labor and qualified professionals. Those companies that had prior agreements with reputable and experienced consultants and restoration contractors were first in line for assistance and, consequently, were among the first to re-establish operations and limit their business-interruption losses.

The best mitigation efforts start before a loss, not after. Although no two events are alike, a pre-loss plan can minimize the period of business interruption and position an organization to collect all insurance proceeds to which it is entitled.

Go to www.aon.com/focus to receive "Aon Focus" by e-mail.

On-site medical treatment can help contain rising health care costs

In an era of unrelenting medical cost inflation, employers must embrace cost-saving strategies. One alternative, on-site medical centers and pharmacies, can deliver net value to employers with sufficient numbers of employees in a single location to warrant the capital investment. The typical on-site medical center offers routine medical care, immunizations, and support for wellness and disease management activities. To evaluate feasibility, employers must assess local employee demographics, medical and drug utilization patterns and plan design. Once feasibility is proven, a competitive bidding process is used to weigh alternatives and select the best business partner. For more information, visit www.aon.com/focus.

New global risk map identifies emerging exposures in international filmmaking

Filming in foreign countries can be risky business. Crime, kidnapping, terrorist threats, disease and other critical risks can hinder or debilitate film production. Based on global surveys and in-depth research, an updated Risks in Global Filmmaking Map will be published on March 21 to help filmmakers and their corporate partners make informed business decisions about the threats and exposures in countries around the world. To view the most recent version of the map, visit www.aon.com/focus.

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Inside

New OSHA head expected to take cooperative stance

Employers welcome the appointment of Edwin G. Foulke Jr. as safety agency head. Page 4

Hospitals' captive use slows, but growth continues

While less popular than they once were, health care captives continue to grow. Page 4

NAIC sets Dec. 9 deadline for reinsurance proposal

Insurance regulators close in on agreement over collateral issue. Page 4

Time to turn the page on Marsh scandal

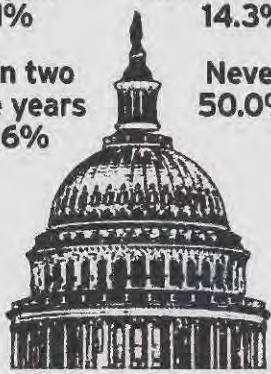
Officials should enforce the Marsh settlement not file new suits, an editorial says. Page 8

Online poll - [3/13 - 3/17]

When will Congress approve legislation creating an optional federal charter for insurers?

Within one year 7.1%
After more than five years 14.3%

Within two to five years 28.6%
Never 50.0%



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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Ride Along Enclosed in Edition 07

Insurers brace for tornado claims

Twisters cause widespread damage across swath of Midwest

By RUPAL PAREKH

Insurers are processing thousands of claims stemming from the recent barrage of deadly tornadoes that battered several Midwestern states, with insured losses expected to total tens of millions of dollars.

Initial reports pegged the number of storms—which hit Arkansas, Illinois, Kansas, Missouri and Oklahoma the hardest—at more than 100, though National Weather Service officials have yet to confirm the actual number of tornadoes that struck the region. Around a dozen deaths in the various states have been blamed on the storms.

The Property Claims Services unit of Jersey City, N.J.-based In-

surance Services Offices Inc. declared the incident a catastrophe, which means PCS expects insured losses to total at least \$25 million.

Arkansas alone last week estimated it would suffer a total of \$25.5 million in insured losses from the storms, according to a spokeswoman for the Arkansas Insurance Department. Insurance departments in other affected states did not release insured loss estimates last week.

In Illinois, the Springfield area on Mar. 12 was struck by twin F2-strength twisters. The storms, packing winds of up to 120 mph, tore roofs off homes and businesses and downed power lines. In Springfield and



Construction workers in Curran, Ill., begin repairs after a roof was blown off a local building by a tornado that touched down March 12.

See TORNADOES / page 6

Court reverses position on pension service credit for pregnancy leave

By JUDY GREENWALD

SAN FRANCISCO—Employees who received less credited service time while on pregnancy leave compared with other disabled workers—before that inequality was addressed by the Pregnancy Discrimination Act—cannot regain that lost time retroactively, says a federal ap-

pellate court in a decision that overturns both a lower court ruling and its own precedent.

The plaintiffs in the case were four current and former AT&T Corp. employees—who had each taken partially uncredited pregnancy leave before the Pregnancy Discrimination Act's 1979 effective date—and their union, the Communications Workers of America.

According to the decision, a 1994 U.S. Supreme Court decision, *Landgraf vs. USI Film Products*, established that unless there is a "clear expression of intent by Congress,"



pellate court in a decision that overturns both a lower court ruling and its own precedent.

The March 8 decision by the 9th U.S. Circuit Court of Appeals in San Francisco in *Hulteen vs. AT&T Corp.* dismisses the case against AT&T in its 2-1 ruling.

The appellate court says a 1991 decision in a similar case, in which a plaintiff was granted the extra time, could no longer be used as precedent because of an intervening U.S. Supreme Court decision that prohibits applying federal law retroactively.

Service time is used to calculate the amount of pension pay-

ments, eligibility for early retirement and seniority for layoffs, among other benefits, according to the decision.

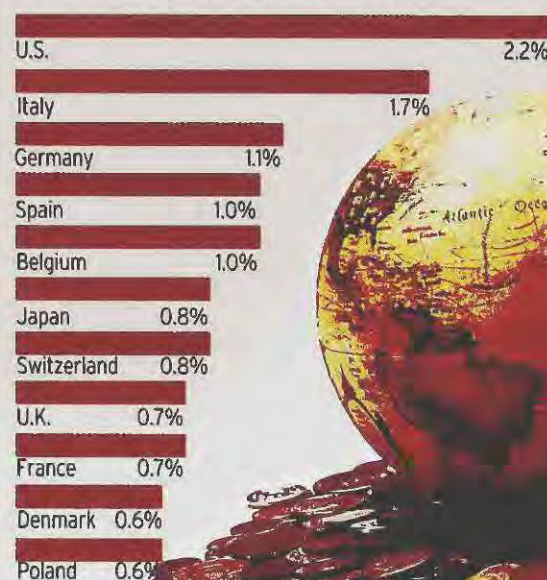
To grant plaintiffs the same benefits as their post-PDA colleagues would be a "seemingly equitable resolution of the case" but would require "that we do indirectly what we cannot do directly—make the PDA retroactive," says the decision.

The court notes that, in its comparable 1992 decision in *Pallas vs. Pacific Bell*, it ruled that

See PREGNANCY / page 29

Leading the world in litigation

Tort costs as a percentage of GDP in 2003



Source: Towers Perrin

U.S. tort costs rise, lag economic growth

Faster increases expected

By MARK A. HOFMANN

U.S. tort costs increased 5.9%, to \$260.1 billion, in 2004 and are likely to grow at a somewhat faster rate through 2007, according to a study released last week by the Tillinghast unit of Towers Perrin.

The 2004 growth rate represented a slight increase over 2003's 5.5% growth rate but remained below 2004's economic growth rate of 6.6%, which was somewhat unusual, the report said. "Since 1950, tort cost growth has exceeded gross domestic product (GDP) growth by an average of two to three percentage points," Tillinghast not-

ed in the study, "U.S. Tort Costs and Cross-Border Perspectives: 2005 Update."

Nevertheless, U.S. tort costs as a percentage of GDP "exceed those of other industrial countries by a sizeable margin," according to the report.

In a comparison of 2003 data, Tillinghast found that U.S. tort costs amounted to 2.2% of GDP, the highest percentage of 11 countries surveyed. Tort costs in Poland and Denmark amounted to 0.6% of GDP, the lowest in the survey. Italy, which ranked closest to the United States, posted tort costs that represent-

See TORT / page 6

Editorial

Don't open new fronts in compensation battle

IN THE SAME WAY THAT Eliot Spitzer appears to have moved on from his investigations into the compensation practices at Marsh & McLennan Cos. Inc. and some other brokerages, it is time for other state prosecutors and officials to move on, too.

As we report on page 1, Florida's insurance regulator and attorney general have now filed suit against Marsh—well over a year after Mr. Spitzer filed a similar suit—accusing Marsh of bid rigging and client steering.

The allegations first raised by Mr. Spitzer suggested serious wrongdoing at Marsh and several other of the world's largest brokerages. Placing clients' business on the basis of how much money a broker can squeeze out of accounts rather than in an effort to obtain what is in the best interest of the clients is a blatant and reprehensible abuse of the insurance placement process. Any brokerages that let such schemes develop and any individual brokers that participated in such schemes should be brought to account.

But in the case of Marsh, that has already happened. Individuals accused of conspiring in the schemes have been charged and/or fired, and numerous other employees who had nothing to do any bid rigging or client steering have lost their jobs as the broker has

downsized in the wake of the scandal.

In addition, Marsh cleared house at the top, implemented new business practices, eliminated contingent commissions and, last but not least, set up an \$850 million fund to compensate clients hurt by the alleged fraud.

Clients in Florida were entitled to tap that fund. If they felt that the offer was insufficient, they also were entitled to pursue Marsh on their own.

Mr. Spitzer did a great service to the commercial insurance buyer by laying out the evidence he had accumulated against Marsh and others, and any suggestion that the reasons behind his action had more to do with his own political ambition than his concern for the fate of commercial insurance policyholders is utterly irrelevant.

One does have to ask, though, why officials in Florida are coming so late to the game.

State officials everywhere would do better to concentrate on ensuring that brokers are living up to the changes they promised in the settlements they signed—as 34 states seem to have done by adopting Marsh's settlement—rather than tramping down trails that have already been blazed by others.

Time to even the tort cost field

TORT REFORM ADVOCATES often claim that the peculiarities of the U.S. civil justice system put U.S. companies at a competitive disadvantage to their foreign counterparts. That argument appears to have gotten a boost by the findings of a recent study by Towers Perrin's Tillinghast unit.

As we report on page 3, Tillinghast's "Tort Costs and Cross-Border Perspectives: 2005 Update" found that U.S. tort costs, when measured as a percentage of gross domestic product, are far higher than those of many other industrialized countries. In fact, at 2.2% of GDP, U.S. tort costs are considerably higher than those of the country with the second-highest tort costs—Italy, where tort costs amount to 1.7% of GDP—and way above those of such international competitors as France, the United Kingdom and Japan, all of which have tort costs well below 1% of GDP.

While the Tillinghast report is careful to

point out that tort costs are only one factor to consider when analyzing international competitiveness and that other factors such as worker productivity and taxes may have a greater impact, we can't help thinking that U.S. tort costs constitute at least part of a competitive drag.

Fortunately, they are also a factor that can be controlled through well-crafted legislation aimed at curbing abuses of the tort system in such areas as punitive damages and class actions. The black-and-white comparison of the relative costs of the U.S. tort system with those of other countries should help spur further efforts to reform.

No one is saying that those costs alone are hurting the ability of U.S. companies to compete globally. But it's also no stretch to say that such costs—costs that can and should be controlled—are doing nothing to help our competitive advantage.

Schillerstrom



Letters

Dublin draws fine line on reinsurer regulation

To the editor: The March 6 *Business Insurance* report by Sarah Veysey on the implementation of reinsurance regulation in Ireland and its impact on the Dublin captive arena, "Dublin managers readying for law to mandate funds for reinsurers," was a thorough article in which Ms. Veysey covered the issues comprehensively.

Traditionally, Ireland took the generally internationally accepted position of treating reinsurance as a principal-to-principal business as far as regulation was concerned; thus, the authorities had a much lesser role in

terms of oversight than for consumer-based business. In the past few years, Ireland's international reinsurance sector has grown dramatically, not least in the captives sector, and for that reason it was decided to accelerate the pace of regulatory implementation, catalyzed by the reinsurance directive.

Ireland's authorities do, though, recognize that there may be different risk profiles and activities relevant to reinsurance captives compared to other reinsurance entities and thus have decided that the minimum guarantee fund for a reinsurance captive establishing in Ireland under the terms of the reinsurance directive will be €1 million (\$1.2

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—BusinessWeek

In *BusinessWeek* magazine's recent comparison of Web sites and information tools offered by the top three national health insurers, Aetna received the highest marks. According to their article, they "found the richest set of offerings at Aetna's site." And Aetna's online survey to help members evaluate and manage their health was said to be "the most comprehensive." To learn more about how our information can help your employees make better health care decisions, call your broker, Aetna representative, or visit us online at aetna.com.

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Largest Employee Benefit TPAs

TPAs that specialize in employee benefit claims administration*

Company	2005 revenues from self-insured clients
Fiserv Health Inc.	\$282,000,000 ¹
The Principal Financial Group/National Accounts	\$170,378,904
CoreSource Inc.	\$152,900,000
Alicare Inc.	\$50,000,000
CenBen USA Inc.	\$47,742,000
Zenith Administrators Inc.	\$47,000,000
American Administrative Group Inc.	\$43,000,000
HealthPlan Holdings Inc.	\$38,000,000
Group Resources Inc.	\$32,500,000
Corporate Benefit Services of America Inc.	\$31,400,000

*Ranked by 2005 revenues from self-insured clients. ¹BI estimate
Source: BI survey

TPA: Risk managers search for consistency

Continued from previous page

Mr. Stangle wants "the same things that most people would look for," he said. "What kind of management systems have you got? What kind of systems are in place to do an investigation, to handle the oversight? What do you do in the area of managed care, i.e., bill review, utilization review, preferred provider organization, case management? And, obviously, what is the capability of their systems?"

In addition to wanting efficient claims processing, clients are also demanding metrics for measuring their claims management programs' effectiveness and they want

help making additional improvements, said David A. North, president and chief executive officer for Sedgwick Claims Management Services Inc. in Memphis, Tenn. Employers, for example, want to be able to measure the return on investment they might derive from adding managed care or investigative services to their claims management arsenals, Mr. North said.

They also want data that will help them dig further into cost drivers in specific geographic regions, he added. At least 75% of clients also seek a single TPA that can service multiple lines such as workers compensation, auto liability

and general liability.

Clients want TPAs that can "slice and dice" through their claims and explain how their losses compare with those of other employers, and they want advice on how to improve, said Dorian Smithson, senior vp in Philadelphia for ESIS Inc., an insurance services company that is a unit of ACE USA.

Risk managers also may want to consider TPAs that can provide more than claims adjudication services as the employers change or expand, Ms. Smithson said. They are looking for "someone that can provide you with a full complement of risk management services, to help you with pre-loss management, claims and medical management, benchmarking and consultative services," she said.

In California, more employers are

At a TPA, "You would think that there would be the same guidelines and standards and supervision, but it really comes down to the person working the files."

Susan Pettineo
Pritchard Industries Inc.

demanding TPAs that can create tailored medical provider networks, said Dave De Wenter, executive vp and chief operating officer for broker and consultant Keenan & Associates in Torrance, Calif. Workers compensation reforms signed into law in 2004 allowed California employers to direct employees into provider networks beginning in 2005; now employers want TPAs that can provide state-approved networks with medical specialists capable of treating the specific injuries their workers suffer most, Mr. De Wenter said.

In their proposal requests, employers increasingly also want to know whether TPAs can help them manage worker absences and integrate occupational and nonoccupational disability benefits, Mr. De Wenter added. "That is becoming a big thing," he said.

Risk managers also look for TPA attributes fitting the specific industries they operate in.

For example, Sharon L. Spencer, risk manager for Nursefinders Inc., an Arlington, Texas-based temporary medical care staffing company, wants her medical malpractice claims management TPA to employ plenty of nurses. Nurses are important for a TPA because they can quickly read through a patient's medical treatment history and apply an insider's knowledge in determining how viable a claim might be.

When shopping for a new TPA, Ms. Spencer said that she investigates, among other things, the specific practices the TPA would employ when determining how much

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Largest property/casualty TPAs

TPAs that specialize in property/casualty claims administration*

Company	2005 revenues from self-insured clients
Gallagher Bassett Services Inc.	\$328,800,000
Specialty Risk Services L.L.C.	\$208,400,000
ESIS Inc.	\$183,800,000
Cambridge Integrated Services Group Inc.	\$158,100,000
Crawford & Co.	\$89,084,806
The Frank Gates Cos. Inc.	\$55,000,000
GAB Robins North America Inc.	\$53,068,000
Risk Enterprise Management Ltd.	\$41,200,000
York Insurance Services Group Inc.	\$38,129,000
Helmsman Management Services L.L.C.	\$35,808,274

*Ranked by 2005 revenues from self-insured clients.
Source: BIsurvey

TPA: Risk managers search for consistency

Continued from page 12

to reserve for certain claims. Ms. Spencer said she also wants to help determine the criteria for claims review.

Among the problems risk managers say they encounter are high levels of turnover among adjusters and a lack of consistency in how claims are handled. The quality can vary widely from adjuster to adjuster, they note.

TPAs can be "extremely inconsistent," said Susan Pettineo, risk manager for Pritchard Industries Inc., a building services company based in New York. One adjuster handling Pritchard's claims in one state does

a great job, while another adjuster in another state is disappointing, even though they both work for the same company, Ms. Pettineo said. "You would think that there would be the same guidelines and standards and supervision," she said, "but it really comes down to the person working the files."

Ms. Pettineo said she is currently reviewing her TPA arrangements, and she wants to see biographies for the claims adjusters who would work her account. That would help her determine their experience and training level, she said.

Before contracting with a new insurer or TPA, it is a good idea to per-

sonally interview their claims adjusters, as well as delving into the company's practices, Ms. Pettineo added.

Kathy Murphy, safety and risk supervisor in the operations department for the Legoland California theme park in Carlsbad, Calif., agreed that claims management can vary, depending on the individual, even within the same TPA. While auditing her TPA's handling of workers compensation claims, Ms. Murphy said she recently found the case of an employee with a neck injury who needed surgery immediately; otherwise, he could have become paralyzed. But the TPA was taking its time in approving the necessary surgery, and only her intervention sped up the process.

Her personal audits also found a case in which her TPA was paying one employee double the temporary disability payments to which the individual was entitled. In another case, she checked a claims adjuster's notes by going online and found an incorrect medical diagnosis attributed to a doctor. That could potentially have led to placing the employee in a role that would have aggravated the individual's injury.

But large TPAs such as ESIS and Sedgwick stress that they are pouring more resources into formal adjuster training programs to help ensure greater consistency among claims handler practices and to reduce turnover. Insurers traditionally fund such training programs, they note, but the practice ebbed some years ago and the TPAs now find themselves meeting the need.



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Largest TPAs by clients

Ranked by number of self-insured clients*

Cambridge Integrated Services Group Inc.

4,662

Gallagher Bassett Services Inc.

2,907

Crawford & Co.

1,901

CoreSource Inc.

1,693

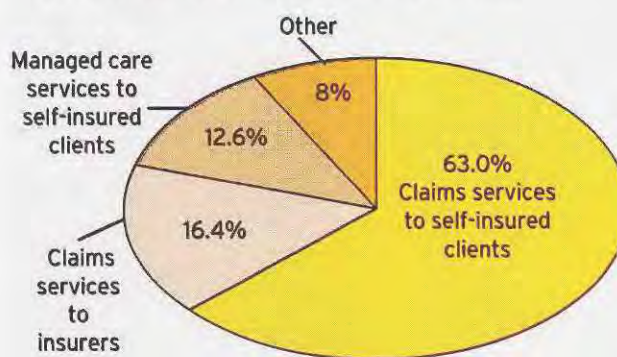
Fiserv Health Inc.

1,200

*Companies that specialize in FSA claims administration were not included
Source: BI survey

Breakdown of revenues

Top 10 companies' revenues by services provided



Source: BI survey

Most prevalent claims

Percentage of all companies that provide the following types of claims administration

Workers compensation	60.0%
General liability	57.6%
Auto	51.3%
Health insurance	46.3%
Property damage	38.8%

Source: BI survey

Largest claims administrators

Ranked by 2005 revenues from claims handled for self-insured clients

Rank	Company/Address	Phone/Fax/Web site	Parent company	2004 revenues from self-insured clients	2004 claims paid for self-insurers	Total clients	Claims staff	Principal officer
1	Sedgwick Claims Management Services Inc. 1100 Ridgeway Loop, Memphis, Tenn. 38120	901-415-7400 Fax: 901-415-7406 www.sedgwickcms.com	Sedgwick CMS Holdings Inc.	\$361,583,400	\$4,066,844,156	365	3,535	David A. North, president/CEO
2	Gallagher Bassett Services Inc. The Gallagher Centre, 2 Pierce Place, Itasca, Ill. 60143-3141	630-773-3800 Fax: 630-285-4000 www.gallagherbassett.com	Arthur J. Gallagher & Co.	\$328,800,000	\$4,100,000,000	2,907	N/A	Rich McKenna, president
3	Fiserv Health Inc. 5500 Wayzata Blvd., Suite 500, Minneapolis, Minn. 55416	763-549-3350 Fax: 763-549-3368 www.fiservhealth.com	Fiserv Inc.	\$282,000,000 ¹	\$7,000,000,000 ¹	1,200	1,477	Jim Cox, group president
4	Broadspire Services Inc. 1601 S.W. 80 Terrace, Plantation, Fla. 33324	800-726-8898 Fax: 954-452-4074 www.choosebroadspire.com	Platinum Equity L.L.C.	\$209,764,000	\$1,833,847,993	344	2,401	Dennis Replogle, president/CEO
5	Specialty Risk Services L.L.C. Goodwin Square, 225 Asylum St., 16th Floor, Hartford, Conn. 06103	888-236-4684 Fax: 860-520-2503 www.specialtyriskservices.com	The Hartford Financial Services Group Inc.	\$208,400,000	\$2,300,000,000	919	753	A. Joseph Boures, president
6	ESIS Inc. 436 Walnut St., Philadelphia, Pa. 19106	215-640-1056 Fax: 215-640-5556 www.esis.com	ACE Ltd.	\$183,800,000	\$2,500,000,000	739	1,383	David Patterson, president
7	The Principal Financial Group/National Accounts 1275 N.W. 128th St., Suite 100, Clive, Iowa 50325	877-273-0900 Fax: 515-235-9280 www.principal.com	N/A	\$170,378,904	\$2,579,395,071	670	849	Dave Blanford, Jim Charling, vps
8	Cambridge Integrated Services Group Inc. 340 Pemberwick Road, Second Floor, Greenwich, Conn. 06831	800-662-1170 Fax: 440-914-2591 www.cambridgeworldwide.com	Scandent Group	\$158,100,000	\$2,599,000,000	4,662	1,689	Chris Sinclair, executive chairman/CEO
9	CoreSource Inc. 400 Field Drive, Lake Forest, Ill. 60045	847-604-9200 Fax: 847-615-3900 www.coresource.com	Trustmark Insurance Co. Inc.	\$152,900,000	\$3,251,000,000	1,693	1,253	Mark Schmidt, president
10	Crawford & Co. 5620 Glenridge Drive N.E., Atlanta, Ga. 30342	800-241-2541 Fax: 404-845-3142 www.crawfordandcompany.com	N/A	\$89,084,806	\$1,520,381,842	1,901	N/A	Thomas W. Crawford, president/CEO

¹ BI estimate
Source: BI survey

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Businesses call on public adjusters to help them with loss claims.

Public adjusters: Advocates for policyholders

Continued from page 11

adjustment is the quantification and defense of the amount claimed, based upon clearly quantifiable damages," Mr. Knox said. "Adjustment is where we can identify and quantify the value down to the smallest degree, and, based upon the facts, the loss is argued and settled—not based upon 'what you want vs. what I want.'"

"If we're looking at the policy in total, just like the insurance company is, we're able to pull out the things in the policy that give you more than you thought you had," said Mr. Burr. "We look at it at little broader than they will. There are all

sorts of extra coverages that, a lot of times, just get lost."

"I've got a claim right now that is over 2,500 pages of just the building detail," noted Mr. Knox. "It's for a 455-unit apartment complex in Gretna, La. That's just the physical damage."

One client of Young Adjustment said her employer turned to a public adjuster because the stress of trying to keep a business running in the aftermath of a hurricane left little room for dealing with the insurance claims process. "We were hit with Hurricane Charley on Aug. 13, 2004," recalled Diane Gorman, a practice administrator at Charlotte

Heart & Vascular Institute in Port Charlotte, Fla. "We were hit very hard; we were just decimated. We were reeling, just trying to take care of their patients."

Ms. Gorman said that "we realized very early on" that dealing with insurance claims while trying to keep the practice running would be extremely difficult. The six-physician practice has an administration team but no risk manager, she said. "We felt that a public adjuster might be the way to go. They work with the insurance companies, and they know more than we would ever know," Ms. Gorman said.

Charlotte Heart & Vascular hired Young Adjustment, and the first claims checks began arriving within a couple months of the hurricane. The claims process continues, Ms.

"If we're looking at the policy in total, just like the insurance company is, we're able to pull out the things in the policy that give you more than you thought you had."

Dick Burr
Young Adjustment Co. Inc.

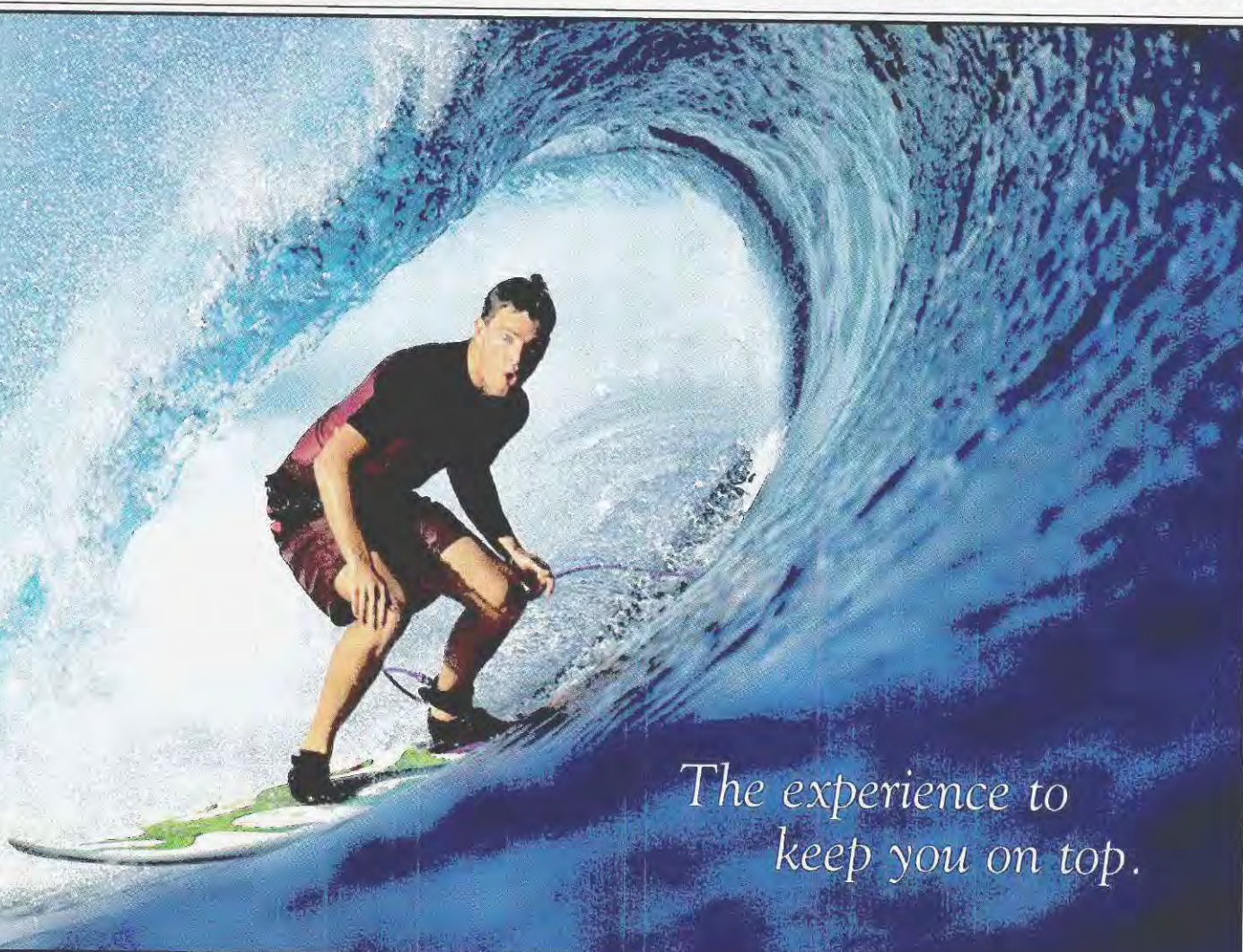
Gorman said, and she added that the practice is "very happy" with the public adjuster. "They treated us very well," she said.

"We definitely have represented large companies that have professional risk managers. But if a company is big enough, they'll usually have a staff of people too, and they won't turn to public adjusters," explained Mr. Burr.

Mr. Knox agreed that a typical client "would not have a full-time risk manager, in most cases."

John Eager, senior director of claims for the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America, said that "what happens is, in a larger business, many times they have a risk manager, and the risk manager will handle the claim with the insurer." But smaller businesses don't have full-time risk managers, and sometimes their claims disputes are handled through arbitration or mediation, he said. "If it resolves your loss, then you're fine. If you still cannot resolve it, you always have the option of finding a third party," which could be a public adjuster, he said.

"From a FM Global standpoint, we don't see public adjusters very often," noted Michael Hagen, vp and chief adjuster for Johnston, R.I.-based Factory Mutual Insurance Co., which does business as FM Global. "The client may have a risk manager; they may not. Usually the reason they hire them is they have a staff shortage. They feel like they don't see claims very often; they will want someone to help them,



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Lance Ewing (L) and Chris Mandel, RIMS past presidents.

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Public adjusters: Advocates for policyholders

Continued from page 18

anyone to help them," he said.

Mr. Hagen stressed that "it would be rare to have any antagonism" between insurer claims adjusters and public adjusters. "FM Global adjusters will work with anybody who's designated by the insured. In every case, FM Global tries to develop a relationship with our clients that includes pre-loss meetings and training seminars. After the loss happens, our adjusters get out there right away and advise the insured what they need to do immediately, and, ultimately, we get them information about what's necessary in preparing the claim. We think, for the most part, it's unnecessary for an insured to have a public adjuster helping them."

"I don't think there's antagonism; there's a level of respect," said Bud Trice, vp at Crawford & Co. in Atlanta, an independent adjuster that works for insurers and self-insureds. The differences tend to arise in "gray areas, such as where it's going to be X number of dollars to replace the roof or Y number of dollars," said Mr. Trice.

"The public adjuster generally will prepare his or her case and say, 'This is what I believe the loss is.' In some respects, the public adjuster does a lot of the legwork that the insurance company would other-

"In some respects, the public adjuster does a lot of the legwork that the insurance company would otherwise have to do."

**Bud Trice
Crawford & Co.**

wise have to do," said Mr. Trice. He acknowledged, though, that because the public adjuster operates on a contingency basis, there's often a degree of "skepticism" about the claims presented.

The contingent fee is "really what the market provides," explained

Mr. Burr. Some states regulate fees; others do not, he said. "It used to run about 10%," but, for some larger commercial losses, the percentages can be driven down, he said.

Public adjusters say that in 2005 insurers did not try to settle claims for less than usual even with the crush of last year's record hurricane season. Insurers were stretched extremely thin, though, because of the sheer volume of claims.

"I don't think they're more conservative; they're just having a very difficult time dealing with the magnitude of loss," said Mr. Knox. "The biggest challenge is the great number of claims that insurers are faced with adjusting and paying," he said. "It's not unusual on commercial claims to have four, five or six adjusters already who have been assigned to the claim and then removed."

"One of the main problems is that companies are just not staffed like they used to be," said Mr. Burr.

"I think that, in the last decade, insurers have reduced claims staff in an effort to economize," agreed Mr. Knox.

Largest multiline TPAs

TPAs that offer both employee benefits and property/casualty claims administration*

Company	2005 revenues from self-insured clients
Sedgwick Claims Management Services Inc.	\$361,583,400
Broadspire Services Inc.	\$209,764,000
CompManagement Inc.	\$89,000,000
Acordia Inc.	\$63,771,900
Cannon Cochran Management Services Inc. dba CCMSI	\$47,544,000
The Loomis Co.	\$26,934,800
Keenan & Associates	\$24,750,000
F.A. Richard & Associates Inc. dba FARA	\$18,331,000
GatesMcDonald	\$15,000,000
CAS-Claims Administrative Services Inc.	\$12,568,106

*Ranked by 2005 revenues from self-insured clients
Source: BI survey

Liability claims need broad skills, outside expertise

By SALLY ROBERTS

When it comes to resolving a complex liability claim, a claims professional's job is to fairly compensate the policyholder party while making sure the insured pays out no more than it is obligated to.

As such, detailed, complex and often time-consuming claims investigations are required to determine which party is at fault and whether to settle a case or defend it in court.

This means claims professionals need to have not only working knowledge of all aspects of the investigations from legal venues to medical reports but they also need to know when to call in outside experts. And unlike a property claim or a business interruption claim, where an outside appraiser or outside counsel may occasionally be brought in if there's a dispute, complex liability cases often involve a host of outside experts from various professions, from engineers to doctors to economists.

But the biggest difference between adjusting property claims and liability claims, experts say, is that with property claims, one can easily determine a loss, while with liability claims, negligence is often debated.

"It's much more concrete in property," said Stephen Pratt, vp-carrier relations, quality and techni-

cal claims for Crawford & Co. in Atlanta.

"I don't care if it's a car or a house or something else, I can go out and price a piece of lumber, I can price the labor and I can move that case very quickly. For the most part, what you run into from a liability perspective is that emotion is much more involved," Mr. Pratt said. "Somebody feels they've been wronged because there's negligence involved and emotions often step in and you're not as objective as you are with a piece of lumber."

Indeed, "in the liability world, we're always in an adversarial situation; it's always a third-party situation, where someone is coming back to take something away from our clients," said Mark A. Kania, vp and liability practice leader for Sedgwick Claims Management Services Inc. in Memphis, Tenn.

So, "when you get a liability claim, the first thing you need to think about is this is an adversarial relationship, and, at the end of the day, it might wind up in court and you have to prepare for that," Mr. Kania said.

And as Tony Glenn, a New York-based vp of general casualty and environmental claims for Liberty International Underwriters, pointed out, "Given a highly technical product, a severely injured plaintiff and a very combative plaintiffs lawyer, a lawsuit can take on a life of its own."

Liability claims experts say that much of their jobs revolve around litigation management. Claims investigations must be conducted to determine fault and ensure that the insureds pay only what they are obligated to pay. As such, a high level of skills is a must, these claims experts say.

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Liability: Complex negligence claims often call for broad skills, outside expertise

Continued from page 20

instead of "Crime Scene Investigation," it's "Claim Scene Investigation," Mr. Kania said. "Our claims examiners have to have a huge spectrum of skills to be able to do this. Literally, you have to be able to take a look at the facts of the case and determine who's at fault and who's not at fault and what steps need to be taken to investigate the claim in order to come to a good conclusion."

A liability claims examiner, for instance, needs to know how to read and interpret a medical report, Mr. Kania said. "You also have to have a very good knowledge of the legal system in the state where the claim was made and you need to know what the law is in regard to the particular incident," he said.

And then all that information has to be looked at with the parameters of the liability policy taken into account to determine whether to settle or defend the case, Mr. Kania said.

"I look at our job to mitigate the damages," said Jim Thayer, vp and liability manager within Liberty Mutual's general liability claims operations in Boston. "We want to make sure we pay a fair amount to the claimant and make sure we pay what is owed from the insured's standpoint."

To do that, Liberty's claims professionals review medical records to determine whether the injured party's treatment was necessary and related to the particular incident, Mr. Thayer said. Liberty also looks at how long the injured party was off work and whether the absence was due to the injury, he said.

Often, claims professionals have to call on outside experts. And, depending on the case, these experts might include medical doctors, tax experts, vocational rehabilitation

experts and product and design engineers. Other experts who may be called on are economists, who make determinations about the future income streams that have been lost; and reconstructionists, who recreate the incidents in question, claims professionals say.

And while most lawsuits result in a negotiated settlement, policyholders are not afraid to fight a

good fight in court, they note.

By and large, clients are very protective of their reputations, and this is especially true with products liability clients, because "that is absolutely, positively, the reputation of the company's product, service and good name," said Annette L. Sanchez, executive vp and director of national practices and professional excellence at Sedgwick CMS.

Accounting firms also are taking a tough stand when it comes to certain professional liability claims, noted Chris Piety, director of claims for Redwood City, Calif.-based CAMICO Mutual Insurance Co. As a result of the accounting scandals over the last five years, "we've made it a point to try a few more cases than other carriers," especially those where a more sophisticated

claimant, such as a bank, shares some of the responsibility, he said.

"These types of claimants...have been trying to take advantage of the current climate, thinking they can push a claim against an accountant because of the scandals," Mr. Piety said. "So we've been trying those cases that we have to in order to say, 'You have to consider your fair share of the fault here.'"



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Claims audit tells if TPA is doing a good job

By RUPAL PAREKH

Employers are showing renewed interest in claims audits as a tool to improve efficiency and prevent unnecessary costs related to group health care administration,

experts say.

Particularly for companies that self-fund their medical plans—and that place fiduciary responsibility in the hands of third-party claims administrators—an independent audit offers an unbiased view on the ac-

curacy of the claims payment process and verifies a TPA's self-reported results, they say.

While claims audits are not new, a mixture of rising health costs and more emphasis on compliance are increasing their popularity, the experts note.

"It used to be that employers only did audits if there was something majorly wrong...if their claims costs were spiking or employees were complaining," said Susan Johnson, senior consultant and leader of the administration performance review group at Watson Wyatt Worldwide in Chicago. In recent years, though, the number of employers engaging in regular audits of their health plan TPAs "has increased exponentially," Ms. Johnson said. "I had one vendor tell me they went from 70 audits to 200 within a year."

Tom Will, practice leader for the Somerset, N.J.-based medical claims audit practice of Aon Consulting, noted that while "there has always been a core group of employers" interested in conducting audits, "we're seeing some firms that maybe in the past have not thought about but are now thinking about it."

A joint survey of employers conducted by the National Business Group on Health and Watson Wyatt released last week showed that 60% either had health care claims audit programs in place in 2005 or were planning to implement them in 2006 (see chart).

One of the reasons why more employers are showing increased interest in audits is that "cost pressures, which have always been on health care, are really coming to a head now," said Mark A. Rucci, senior vp and national practice leader for the TPA performance evaluation

practice at Princeton, N.J.-based Apex Management Group, a unit of Gallagher Benefits Services Inc.

"Before going out to ask the employees to contribute more in terms of higher premiums or increasing contributions or cutting benefits, an area where employers can look to make sure that their house is in

Sarbanes-Oxley Act—are concerned about obtaining accurate financial information from vendors, said Dan Priga, principal in Pittsburgh for Mercer Health & Benefits L.L.C. and national practice leader of Mercer's performance management specialty group.

The audit process

A typical claims audit usually takes place over a one-week period during an onsite visit to a TPA's offices.

Audit consultants take a sample of around 150-200 different types of claims, going from a zero-paid claim to the highest-paid claim in a system. Each claim is then checked for financial and payment accuracy, proper categorization and turnaround time. In addition, a consultant will examine the claims system being audited to ensure that all employees listed are eligible to receive benefits.

Next, the consultant will meet with the employer and the TPA to discuss its findings, following which a status report with recommended improvements is submitted to the employer.

The entire process from the time the project is undertaken to the issuing of the recommendation report takes anywhere between 12 and 16 weeks, audit consultants say.

According to Helen Darling, president of the National Business Group on Health, the two key things that should be checked in an audit are the eligibility of not only the workers themselves but also of their dependents. "It's amazing how many people forget to let the benefits officer know that they were divorced or that they have children that have aged out of the plan," Ms. Darling said.

In the interim, employers could be "paying for somebody who hasn't been a dependent for years, and that could cost up to millions of dollars," Ms. Darling said.

Payments to ineligible members are one of the most common errors found during claims audits, experts say, as employers are often late in informing their TPAs when employees or their dependents become ineligible for coverage.

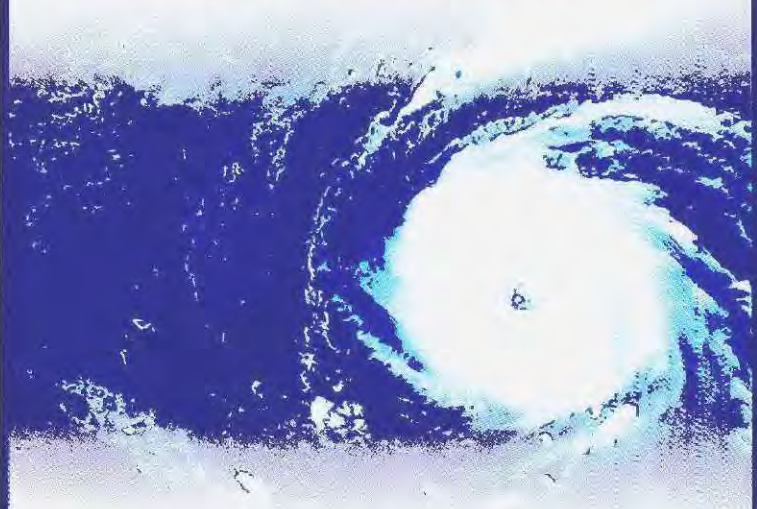
One example of such a problem involves so-called "retroactive terminations," which occur when workers have been fired but that information has not been communicated to the TPA in a timely fashion.

"Since the TPA believes the person is still eligible, often claims show up and they pay them but later find out that those claims should not have been paid," said Apex's Mr. Rucci. "It is incumbent upon the employer to watch for those things or to make sure that their TPA is (watching). If an employer assumes that a TPA is handling that kind of an issue, they are likely to be wrong," he said.

Other common problems uncovered during claims audits are the

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Continued on next page

Continued from page 22

improper assignment of provider discounts and the application of incorrect fees to in-network doctors, experts say.

And although employers' moves to automated claims processes generally have helped prevent errors, the increased automation has contributed to problems in some cases. "With automation, you've got a much higher consistency rate, whether that's good or bad," said Watson Wyatt's Ms. Johnson. With the old-fashioned claims process, a mistake might happen only once, but if a mistake is made at the programming stage, that error will occur in all the claims processed.

There are no hard and fast rules as to the frequency with which claims audits should be conducted; it depends upon "your comfort level with the administrator" and "how hands on you want to be," said Aon's Mr. Will. Most experts agree that, provided previous audits have been satisfactory and no sig-

"With automation, you've got a much higher consistency rate, whether that's good or bad."

Susan Johnson
Watson Wyatt Worldwide

nificant plan design changes have been made, once every three years is sufficient, he said.

If, though, "an audit has less-than-positive results, then the employer should certainly be engaging their health plan in discussions about readits," either full-blown audits or those that focuses more on problem areas, recommended Mercer's Mr. Priga.

Additionally, large multinational corporations with high staff turnover should conduct audits more frequently, said Ms. Darling, because it is more difficult in those circumstances to keep track of who should be covered by the plans.

Other factors that might trigger more-frequent audits are upgrades or changes to a TPA's technology, major changes in staffing or the location of a claims handling office, significant health plan design changes or the development of complaints or problems, experts say.

The cost of hiring an outside consultant to conduct a claims audit ranges from \$10,000 to \$65,000 for a standard audit and operations review. "It's not overly significant when viewed within the context of claims spent," Aon's Mr. Will said.

Still, the costs can be tough to justify for some employers.

James E. Crockett, manager of risk and benefits for Denver Water, last year sat down with staff to "discuss the merits" of conducting an independent claims audit of their health care claims administrator, CIGNA Corp. But in the end, they determined that "the internal audit practices used by CIGNA are sufficient...and the additional cost of doing the audit would not have justified us having it done."

"The audit process doesn't make for a good relationship with your (service) provider either," Mr. Crockett acknowledged.

"When you're on the receiving end of an audit, it's not the most pleasant thing in the world," agreed

Aon's Mr. Will, but, "in the vast majority of cases, the working relationship is very constructive."

"It's not adversarial at all," a spokeswoman from Wausau, Wis.-based Wausau Benefits Inc. said of the outside claims auditing process. "Obviously, they're never fun to do because they are a distraction, but we don't try to discourage our clients from doing them," the spokeswoman said.

And claims auditors aren't necessarily always the bearers of bad news. "There are audits where we identify that things are going well," Mr. Will said. "That gives you the peace of mind that you've performed your due diligence and the assurance that you are working with an effective partner."



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Between the Lines

Compiled by Joanne Wojcik

Office betting an odds-on favorite

As March Madness spreads through the nation's workplaces this year, employee assistance experts are cautioning employers about the risk of some fanatical fans becoming problem gamblers.

"A recent review of our Problem Gambling Help Line indicated a 35% increase in calls related to sports betting around the time of the NCAA tournament," said Marie Apke of Bensinger DuPont & Associates Inc., a Chicago-based EAP and operator of the 1-800-Gambler hotline. "Gamblers get kinetic and frenetic during the tournament."

March Madness and other types of office pools potentially can lead to gambling addiction, she warned.

"While one bet a year doesn't mean a person has a problem, seemingly innocent office pools are often catalysts for some people to become involved in sports betting because they get a taste of the world of gambling," Ms. Apke warned.

There's also the issue of lost productivity.

According to the Office Betting Pool Survey by media technology company The Vault Inc., 67% of employees say they have participated in an office betting pool, up from 61% last year.

Outplacement consultants Challenger Gray & Christmas Inc. estimate that employers could lose as much as \$3.8 billion due to lost productivity during the two-week tournament.

Policy ensures future of Wallace & Gromit

Wallace may have survived the 24-carrot gold bullet that ended the curse of Were-Rabbit, but the claymation character apparently was no match for the faulty wiring that sparked a fire in the Bristol, England-based warehouse where it was stored.

Fortunately, Norwich Union quickly provided the cash to rebuild Wallace and other components of Aardman Animations' Oscar-winning sets, props and models from "Wallace & Gromit and the Curse of Were-Rabbit" and other films, including "Chicken Run," that were destroyed in last October's blaze.

The work involved in making a complex prop like the elaborate pie machine used in "Chicken Run" is time-consuming and costly. So having coverage that ensured Aardman could resume operations as quickly as possible was imperative, according to Kieran Argo, head of exhibitions at Aardman, in a press release issued last week announcing the claim had been settled.

"We were devastated when the fire occurred, and we had discovered that our precious exhibition collection had been lost. Norwich Union's swift settlement enabled us to begin to recreate the assets we had lost to ensure a minimal impact," he said.

Lapsed comp policy closes Neverland

The nearly 70 employees of Michael Jackson's famed Neverland Ranch had to beat it recently when the California Department of Industrial Relations discovered that the pop star had been really bad this time.

The ranch's workers compensation policy from the State Compensation Insurance Fund expired on Jan. 10, 2006, according to Dean Fryer, a spokesman for the DIR in San Francisco. He said although it had been known that there had been ongoing problems with wages at Neverland, officials were surprised the ranch would allow its workers comp coverage—a requirement for doing business in California—to lapse.

But the park's many rides should be up and running again soon, said Mr. Fryer.

"We're working with the representative of Michael Jackson to ensure they secure workers compensation coverage, and they're being very cooperative," he told *Business Insurance*.

Tips and feedback from readers are welcome. Please send information to jwojcik@businessinsurance.com.

COMINGS & GOINGS - INDUSTRY



Mr. Mannebach



Mr. Pokora



Mr. Meenaghan



Mr. Gibson



Mr. Gormley

Agents/Brokers

Atlanta-based Beecher Carlson Holdings Inc. has named **Patrick Stumbras** managing director of its national energy practice. Mr. Stumbras, who will be based in Boston, was an account manager in the energy and marine division of McGriff, Seibels & Williams Inc.

Thilman Filippini L.L.C. of Chicago has named **John Mannebach** and **Michael Pokora** managing directors. Both previously were vps.

Peter C. Adams has been selected to head the sales and marketing of all insurance products at Adams & Sons brokerage in Auburn, N.Y. Previously, he was a middle-market executive underwriter for property and casualty lines at Hartford Insurance Co.

Michael A. Meenaghan has joined National Penn Insurance Agency Inc. as president. Previously, he was a senior vp with CBIZ Benefits & Insurance Services Inc.

Meadowbrook Insurance Agency has named **Herbert Gibson** director of its Southfield, Mich.-based business unit. He previously was a financial adviser for Prudential Financial Inc.

Managed care:

Dr. Robert Crocker has been named chief medical officer of San

Diego-based American Specialty Health Inc. Previously, he was chief of staff at River Oaks Hospital in Jackson, Miss.

San Francisco-based Blue Shield of California has appointed **Edward Cymerys** senior vp and chief actuary. Previously, he was senior vp of pricing and underwriting at PacifiCare Health Systems.

New York-based Aveta Inc. has named **Daniel Freier** and **Randall Herman** senior vps, actuary. Both previously were consultants to Aveta and were co-founders and principals of Pine Grove Advisors and Pine Grove Management.

Medco Health Solutions Inc., based in Franklin Lakes, N.J., has made several senior level appointments:

• **Kenneth Klepper**, formerly executive vp and COO, has been named president. He will remain COO.

• **Timothy Wentworth**, formerly president of Medco's national accounts group, is the new president and chief executive officer of Accredo Health Group Inc., a unit of Medco. He replaces former chairman and CEO **David Stevens**, who will remain chairman and who has been nominated to the Medco board of directors.

• **Bryan Birch**, former president of Systemed Inc., another Medco unit, is now president of the new employer accounts group.

Insurers:

Matthew Winter has been named president and CEO of AIG American General Life Cos., succeeding **Rodney O. Martin Jr.** Before joining AIG, he was executive vp and head of the individual insurance group at MassMutual Financial Group.

Lighthouse Underwriters, a specialty program underwriter in Annandale, Va., has promoted **Sean Gormley** to senior vp. Previously, he was vp and COO.

Other providers:

Robert F. Wolf has joined Navigant Consulting Inc. as director in the insurance and claims services practice in Chicago. Previously, he was a principal with Mercer Oliver Wyman.

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers. Please send news of recently promoted, hired or appointed senior-level executives with photos to: Joe Walker, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; jwalker@businessinsurance.com. Photos should be sent to: Kathy Barnes, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; kbarnes@businessinsurance.com.



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Barbados to institute workplace safety act

Legislation mandates standardized precautions, detailed recordkeeping

By GLORIA GONZALEZ

BRIDGETOWN, Barbados—Barbados employers will soon face new liability arising from legislation that creates a mandatory standard for workplace safety.

The legislation will require Barbados employers to take specific steps to ensure safe working environments, which will create additional costs for employers and is expected to have an indirect impact on their insurance programs. Employers, though, generally view the legislation positively because it fills a major void in the country's workplace safety regulations and provides a minimum standard for safety initiatives for all employers.

The Health & Safety at Work Act, which was passed by Parliament last year and is awaiting the governor general's signature, outlines a series of duties related to workplace safety for both employers and employees in Barbados and specifies penalties—fines and prison sentences—for any failures to comply with its provisions.

The HSWA is needed to create a uniform standard of best practices for workplace safety and to ensure that all companies with operations in Barbados conform to this standard, observers say.

"Generally in Barbados, the safety culture is one of reaction," said Brian Reece, environmental, health and safety officer for Barbados Light & Power Co. Ltd. in St. Michael, Barbados.



Previously, workplace safety was governed by the Factories Act, the scope of which was limited because it applied only to manufacturing facilities.

"From any standpoint, it was outdated, even from the point of view of employers," said Harry Husbands, executive director of the St. Michael-based Barbados Employers Confederation, which has been educating its members on the provisions of the act.

Under the HSWA, employers will be required to take reasonable precautions to ensure safety, many of which are specifically spelled out in the act. For example, the act requires an employer to take all practical steps to keep the noise level in the workplace below a level likely to injure employees. If the noise level cannot be reduced, the employer must provide employees with adequate protection to minimize its effect.

The act also mandates the creation of a health and safety committee for each business with 25 or more employees. Employee-elected representatives must make up at least half of the committee, which will be required to have quarterly meetings and will have the power to implement health and safety controls.

Despite a long list of new responsibilities, employers are expressing confidence in their ability to comply with the legislation, namely because extensive discussions on its various provisions were held among government officials, employers and union representatives prior to its passage.

"None of the stipulations of the act will be terribly burdensome," Mr. Reece predicted.

See BARBADOS / page 27

Updates

Investments boost Munich Re profits

Munich Reinsurance Co. posted a profit of €2.74 billion (\$3.25 billion) for 2005, up 45.4% from a restated profit for 2004, but its American Re Corp. unit posted a \$1.56 billion net loss, largely because of a \$1.4 billion reserve boost in the second quarter of 2005. Munich Re said that its profit for 2005 was boosted by investment income of €10.82 billion (\$12.81 billion), up 34.5% from the previous year.

Allianz sees net income increases

Allianz A.G. posted net income of €4.38 billion (\$5.19 billion) for 2005, up 30.7% over 2004. Munich, Germany-based Allianz posted net income of €3.55 billion (\$4.20 billion) for property/casualty business, up 2.4% over the comparable period last year. For property/casualty insurance, the company's combined ratio was 92.3% in 2005, compared with 92.9% a year previously, Allianz said. The insurer said that natural catastrophes in 2005 cost it €1.1 billion (\$1.30 billion).

Cat losses hit Converium's income

Converium Holding Ltd. reported net income of \$68.7 million for 2005, compared with a restated loss of \$582.5 million for 2004. The Zug, Switzerland-based reinsurer recently restated several years of results because certain finite reinsurance contracts bought and underwritten by the company had not properly been accounted for. Converium said its profits for 2005 were affected by combined pretax losses of \$164.8 million from European windstorm Erwin, Continental European flooding and a series of hurricanes last year. Converium's gross written premiums fell by 49.9%, to \$1.99 billion.

Hiscox profits fall; plans U.S. unit

Hiscox P.L.C. reported a pretax profit of £70.2 million (\$120.7 million) in 2005, down from £89.5 million (\$171.5 million) a year previously. Hiscox, which operates a multiline syndicate at Lloyd's of London, a U.K. insurance company and a Bermuda-based reinsurer, among other things, said profits were affected by a £165 million (\$283.6 million) net loss from the series of hurricanes last year. Meanwhile, Hiscox has opened a U.S.-based underwriting operation offering coverage for small and midsize U.S. professional services businesses outside the Fortune 1000.

U.K. rejects call to repay retirees for collapsed pensions

By CAROLYN ALDRED

LONDON—The U.K. government refused last week to compensate members of hundreds of insolvent pension plans that are not covered by a backstop for pension plans that was introduced in 2004.

Retirees should seek compensation from the companies that promised the pension benefits or

400 final-salary pension plans are thought to have lost benefits under defunct plans between 1997 and 2004. The plans collapsed after the government introduced minimum funding requirements for pensions but before the 2004 introduction of legislation that was intended to offer financial compensation to retirees in insolvent plans.

According to the 254-page report, which was published March 15, government leaflets issued about the minimum funding requirement suggested a higher level of pension security than actually was provided. Ms. Abraham also concludes that decisions taken by the Department of Work and Pensions, the government department that oversees occupational pensions, to extend periods for employers to make up pension plan shortfalls, weakened the minimum funding policy and were "taken with maladministration."

"Official information—about the security that members of final salary occupational pensions schemes could expect from the (minimum funding requirement)...was sometimes inaccurate, often incomplete, largely inconsistent and therefore potentially misleading, and that this constituted maladministration," she said in the report.

Ms. Abraham recommended that "the government should consider whether it should make arrangements for the restoration of the core pension and noncore pension benefits promised to all those" who were members of final-salary plans that

Aon found negligent in cover dispute with BP

Not all insurers told of added risks

By SARAH VEYSEY

LONDON—Aon Corp. plans to appeal a U.K. Commercial Court ruling that units of the brokerage had a duty to oil company BP P.L.C. to inform all participating insurers—rather than just the coverage leaders—when risks were added to an open-cover insurance policy.

Mr. Justice Coleman's March 13 ruling in *BP P.L.C. vs. Aon Ltd. and Aon Risk Services of Texas Inc.* stemmed from a long-running and complex dispute over a policy placed by Aon in 1998 to cover Amoco Corp., which later merged with BP, for certain construction risks.

Under the terms of the policy, which expired in June 2000, a group of insurers provided the oil company with coverage for eligible construction risks; because of the open-cover nature of the policy, BP could add risks to the coverage by informing its broker, subject to agreement by the underwriters. The policy was negotiated between Amoco and units of Aon in the United States, notably in Texas and Connecticut, and also Aon Ltd., which acted as a wholesale sub-broker.

The cover was led by New York-based American International Group Inc. and Zurich-based Swiss Reinsurance Co., and the following market included several London market underwriters and Lloyd's of London syndicates as well as other U.S. and European insurers.

A service agreement negotiated between Amoco and Aon Risk Services of Texas when the policy was placed outlined the services that Aon would provide to its client as

well as its fee structure. The agreement included a jurisdiction clause that stated that the contract should be governed by the law of the state of Illinois, where Amoco was based.

When BP and Amoco merged in December 1998, BP's risk management department in London and Amoco's risk management department in Chicago decided that certain BP projects should be added to the scope of the open-cover policy, provided the underwriters agreed, but BP expressed a wish that Aon Ltd. in London—with which it already had a working relationship—approach the underwriters to obtain their consent.

As part of BP's efforts to take advantage of the policy amid a hardening market, between May and June 29, 2000, the Aon units made 22 declarations to the lead underwriters of the policy. While the underwriters rejected some of these, a settlement agreement was reached among BP, AIG and Swiss Re whereby some were accepted while others were withdrawn. In addition, some were subject to higher premiums and deductibles.

While some of the following market agreed to this settlement deal, others representing about 42% of the coverage—including ERC Frankona Reinsurance Ltd.—objected. Legal proceedings ensued, and the U.K. High Court eventually found that the majority of the defendants were not on the risk because Aon Ltd. had not informed them before the expiration of the policy and had mistakenly assumed that it needed to make declarations only to the lead underwriters.

See AON / page 27



An estimated 85,000 U.K. retirees are thought to have lost benefits.

trustees for the defunct plans, the government said.

The government made its stand in face of a damning report by Parliamentary and Health Service Ombudsman Ann Abraham, which accused the Department of Work and Pensions of "maladministration" in its communication and application of its policy to strengthen the security of occupational pension plans and called on the government to compensate retirees that have lost pension benefits.

An estimated 85,000 retirees in

See PENSIONS / page 27

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UNITED STATES BANKRUPTCY COURT
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OFFICIAL RECEIVER OF
ATERFORSÄKRING AB LUAP,
DEBTOR IN A FOREIGN PROCEEDING
CASE NO. 03-10945 (PCB)

NOTICE IS HEREBY GIVEN THAT ON MARCH 10, 2006, THE BANKRUPTCY COURT ENTERED AN ORDER (THE "ORDER") CONTINUING THE PRELIMINARY INJUNCTION ORDER PURSUANT TO 11 U.S.C. §304 ORIGINALLY ENTERED IN THIS CASE ON FEBRUARY 19, 2003. THE ORDER SHALL REMAIN IN EFFECT PENDING A HEARING SCHEDULED TO BE HELD ON SEPTEMBER 12, 2006 AT 11:00 A.M. (THE "RETURN DATE") BEFORE THE HONORABLE PRUDENCE CARTER BEATTY, UNITED STATES BANKRUPTCY JUDGE, IN THE UNITED STATES BANKRUPTCY COURT LOCATED AT ONE BOWLING GREEN, NEW YORK, NEW YORK. ALL PAPERS SUBMITTED FOR THE PURPOSE OF OPPOSING THE CONTINUATION OF THE ORDER AFTER THE RETURN DATE SHALL BE FILED WITH THE COURT, WITH A COPY TO THE CHAMBERS OF THE HONORABLE PRUDENCE CARTER BEATTY AND SERVED ON COUNSEL FOR THE PETITIONER LISTED BELOW. SO AS TO BE RECEIVED AT LEAST FOURTEEN (14) DAYS PRIOR TO THE RETURN DATE. ANY PERSON WISHING TO OBTAIN A COPY OF THE ORDER SHOULD CONTACT COUNSEL TO THE PETITIONER.

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UNITED STATES BANKRUPTCY COURT
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AS ADMINISTRATOR OF
FOLKSAM INTERNATIONAL INSURANCE
COMPANY (UK) LIMITED,
DEBTOR IN A FOREIGN PROCEEDING
CASE NO. 02-14070 (PCB)

NOTICE IS HEREBY GIVEN THAT ON MARCH 10, 2006, THE BANKRUPTCY COURT ENTERED AN ORDER (THE "ORDER") CONTINUING THE PRELIMINARY INJUNCTION ORDER PURSUANT TO 11 U.S.C. §304 ORIGINALLY ENTERED IN THIS CASE ON SEPTEMBER 9, 2002. THE ORDER SHALL REMAIN IN EFFECT PENDING A HEARING SCHEDULED TO BE HELD ON SEPTEMBER 12, 2006 AT 11:00 A.M. (THE "RETURN DATE") BEFORE THE HONORABLE PRUDENCE CARTER BEATTY, UNITED STATES BANKRUPTCY JUDGE, IN THE UNITED STATES BANKRUPTCY COURT LOCATED AT ONE BOWLING GREEN, NEW YORK, NEW YORK. ALL PAPERS SUBMITTED FOR THE PURPOSE OF OPPOSING THE CONTINUATION OF THE ORDER AFTER THE RETURN DATE SHALL BE FILED WITH THE COURT, WITH A COPY TO THE CHAMBERS OF THE HONORABLE PRUDENCE CARTER BEATTY AND SERVED ON COUNSEL FOR THE PETITIONER LISTED BELOW. SO AS TO BE RECEIVED AT LEAST FOURTEEN (14) DAYS PRIOR TO THE RETURN DATE. ANY PERSON WISHING TO OBTAIN A COPY OF THE ORDER SHOULD CONTACT COUNSEL TO THE PETITIONER.

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REQUEST FOR PROPOSALS

The Medical Malpractice Joint Underwriting Association of Rhode Island

Request for Proposals
("RFP")—Serving Carrier

The Medical Malpractice Joint Underwriting Association of Rhode Island ("JUA") was established by the laws and regulations of Rhode Island for the purpose of providing medical malpractice insurance for licensed physicians, hospitals and other licensed health care providers.

The JUA is seeking proposals to secure an entity to act as a Servicing Carrier, Central Processing Agent, and Manager for the JUA, for a three (3) year term, commencing on January 1, 2007, in return for mutually agreed upon compensation.

To secure a copy of the RFP, please send an e-mail message to David P. Whitman, Esq., Counsel to the JUA, at dpw@hansoncurran.com or a written request may be sent to David P. Whitman, Esq., Hanson Curran LLP, 146 Westminster Street, Providence, RI 02903.

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CHANCERY DIVISION COMPANIES COURT
IN THE MATTER OF LION CITY RUN-OFF PRIVATE LIMITED
and
IN THE MATTER OF THE COMPANIES ACT 1985 (ENGLAND AND WALES)

IN THE HIGH COURT OF THE REPUBLIC OF SINGAPORE No. OS542 of 2005
IN THE MATTER OF LION CITY RUN OFF PRIVATE LIMITED
and
IN THE MATTER OF THE COMPANIES ACT, CHAPTER 50 OF SINGAPORE

NOTICE IS HEREBY GIVEN that as directed by an order of the High Court of Justice of England and Wales (the "English Court") dated 12 January 2006 and an order of the High Court of the Republic of Singapore (the "Singapore Court") dated 23 January 2006, both made in the above matter, a Creditors' Meeting was held at the office of KPMG LLP UK, 1-2 Dorset Rise, London EC4Y 8EN, United Kingdom at 9.30am Greenwich Mean Time (5.30pm Singapore time) on 23 February 2006 with a telephone link to the offices of Norton Rose in Singapore at 5 Shenton Way, #33-08, UIC Building, Singapore 068808 for the purposes of listening but not participating. At that Creditors' Meeting, the proposed Scheme of Arrangement dated 3 June 2005 as supplemented by the Supplemental Scheme Document dated 27 January 2006 (together, the "Scheme") was approved by the Scheme Creditors (as defined in the Scheme).

AND NOTICE IS FURTHER GIVEN that a petition was on the 8th day of March 2006 presented to the English Court for the sanctioning of the Scheme (the "Petition"). The Petition will be heard before Mr Justice David Richards in the Companies Court at the Royal Courts of Justice, Strand, London, WCA 2LL on Thursday 23rd March 2006.

Dated this 9th day of March 2006
Norton Rose, Kempson House, Camomile Street, London EC3A 7AN, United Kingdom
Tel: 020 7283 6000, Fax: 020 7283 6500, Ref: RSB/AA83325, Solicitors for the Company

Pender Mutual Insurance Company Limited (the "Company")

Notice of meeting ordered by the High Court of Justice of England and Wales pursuant to section 425 of the Companies Act 1985 and by the High Court of Justice of the Isle of Man pursuant to section 152 of the Companies Acts 1931-2004

NOTICE IS HEREBY GIVEN THAT on application by the Company, orders were made by the High Court of Justice of England and Wales on 8 March 2006 and by the High Court of Justice of the Isle of Man on 9 March 2006 that a single meeting of all the Scheme Creditors of the Company be convened at the Shangri-La Hotel, 22 Orange Grove Road, Singapore 258350, on 19 May 2006 at 10 am local time (the "Meeting") for the purpose of considering and, if thought fit, agreeing (with or without modification) to schemes of arrangement proposed to be made between the Company and its Scheme Creditors in accordance with section 425 of the Companies Act 1985 of England and Wales and section 152 of the Companies Acts 1931-2004 of the Isle of Man (together the "Schemes of Arrangement").

Scheme Creditors will shortly be receiving (if they have not already received) a copy of the Schemes of Arrangement and an explanatory statement together with a voting form and form of proxy for use at the Meeting. Scheme Creditors may vote in person at the Meeting or may appoint another person, whether a Scheme Creditor or not, as proxy to attend and vote in their place. Scheme Creditors are requested to submit any voting form and form of proxy to Paul Dougherty at Atlantic House, 4-8 Circular Road, Douglas, Isle of Man, IM1 1AG or by facsimile transmission to facsimile number +44 (0) 1624 610 414 or by e-mail to soa@pender-mutual.com by 5pm British Summer Time on 17 May 2006, but if the forms are not so returned, the chairman has discretion to accept them if handed to him at the Meeting.

The Courts have directed that Charles Fargher be chairman of the Meeting, and Angus Alexander be alternative chairman of the Meeting, and that the chairman shall report the results of the Meeting to the Courts.

The Schemes of Arrangement will not come into force unless they are approved by a majority in number of those Scheme Creditors present and voting at the Meeting, representing at least 75% of the value of all claims against the Company, and then subsequently sanctioned by orders of the High Court of Justice of England and Wales at a hearing, which is expected to take place on 25 May 2006, and the High Court of Justice of the Isle of Man at a hearing, which is expected to take place on 26 May 2006, an office copy of the order sanctioning the scheme of arrangement proposed under section 425 of the Companies Act 1985 of England and Wales and an office copy of the order sanctioning the scheme of arrangement proposed under section 152 of the Companies Acts 1931-2004 of the Isle of Man is delivered for registration to the Registrar of Companies of England and Wales and an office copy of the order sanctioning the scheme of arrangement proposed under section 152 of the Companies Acts 1931-2004 of the Isle of Man is delivered for registration to the Isle of Man Companies Registry of the Financial Supervision Commission.

Further copies of the scheme documents and information may be obtained from the scheme website at <http://www.freshfields.com/soa-pender-mutual> or by e-mailing soa@pender-mutual.com.

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Barbados: Employers prepare for safety rules

Continued from page 25

Barbados employers are already taking steps to comply with the legislation. C.O. Williams, a St. Michael-based construction company, created a health and safety committee and hired Samantha Nurse-Butler to oversee its health and safety initiatives.

"Our company is now getting prepared," said Ms. Nurse-Butler, group manager of C.O. Williams' health and safety division.

Barbados Light & Power's Mr. Reece said his company is also making changes to comply with the act such as revising its recordkeeping practices. The act requires employers to keep detailed records, maintaining such documents as copies of all accident reports and certificates of inspection for equipment for at least six years.

Barbados Light & Power is also instituting the mandatory scrutiny of various aspects of employees' health when appropriate, such as monitoring the hearing of those employees who work with loud machinery. As a result of these efforts, the company could be in full com-

pliance within six months to a year, Mr. Reece predicted.

While most companies are not yet in compliance, larger international companies tend to be further along in their efforts because some already have in place internal safety policies that apply to all their business units regardless of where they are located.

"I would say the majority are unprepared," said Ms. Nurse-Butler, who is the former industrial relations officer for the BEC. "Of course, it's not going to happen overnight for many companies, but they are getting ready."

Employers likely will face additional costs through the purchase of safety equipment needed to comply with the act; most such items will have to be imported to Barbados.

But these expenses are minimal compared with the costs related to workplace accidents such as higher insurance premiums and lost productivity, stressed Gregory Rose, director of Bridgetown-based Lynch Insurance Brokers Ltd., a provider of risk consulting services to Barba-

dos employers. The payoff for employers for investing in safety initiatives is fewer workplace injuries, decreases in lost work time and reduced insurance costs, Mr. Rose said.

The act is generally expected to have an indirect effect on employers' insurance programs. For example, insurers may become more diligent in reviewing policyholders' compliance activities and penalizing noncompliant companies through higher premiums, Mr. Rose suggested.

Insurers will have to look at the public liability policies they write to ensure that appropriate risk assessments are carried out, which may have an effect on policies and liabilities, BEC's Mr. Husbands said.

Future risk assessments may uncover new risks that will require employers to pay more for insurance, Mr. Reece acknowledged, but he said he believes his company's coverage will be relatively unaffected. "We were well covered before the act, and I think we will continue to be," he said.

Pensions: Government rejects compensation call

Continued from page 25

began winding up from April 6, 1997, to March 31, 2004, with insufficient assets. This should be done "by whichever means is most appropriate, including, if necessary, by payment from public funds, to replace the full amount lost by those individuals," Ms. Abraham states.

The position of parliamentary ombudsman was created in 1967 to investigate complaints about government departments and other public organizations.

The government denied that it had a responsibility to make good the pension benefits.

"For the report to assert that the taxpayer should make good all such losses—however they arose—is a huge and unsustainable leap of logic," said Minister for Pensions Reform Stephen Timms in a statement, adding that "responsibility must fall on those companies whose schemes were or are being wound up and to the trustees who,

with the benefit of professional advice, were responsible for protecting members' interests."

The government said, though, that it would review the Financial Assistance Scheme, which was established in 2004 as £400 million fund to offer assistance to retirees in insolvent pension plans. Ms. Abraham stated in the report that the Financial Assistance Scheme provided inadequate compensation.

According to Roger Turner, Leeds, England-based executive officer of the Occupational Pensioners' Alliance, a group representing employee members of occupational pension schemes, the establishment of the Financial Assistance Scheme was "a knee-jerk reaction tailored to be as cheap as possible. Very few people have got any money and something has got to be done."

Other observers say the government may still offer some compensation to the retirees.

"The government is unlikely to

offer full compensation but may, as a compromise, offer similar compensation to that provided by the Pension Protection Fund," said Tim Keogh, London-based worldwide partner for Mercer Human Resource Consulting Ltd.

The PPF became operational in April 2005. It is funded by an annual levy on all occupational defined benefit pension schemes.

Though employers would oppose the use of the PPF to compensate retirees in plans that became insolvent prior to the PPF's inception, he said.

Although the ombudsman's report does not have a direct impact on current pension plans, it will focus employers' and employees' minds on future compensation provisions, the solvency of their own plans and the importance of accurate communication, said Stephen Yeo, a senior consultant with the London-based pension consulting company Watson Wyatt Ltd.

Aon: Court finds broker negligent in BP case

Continued from page 25

In subsequent litigation, BP, some of its subsidiaries and other interested parties sued Aon Ltd., alleging that the brokerage had been negligent in not making declarations to all of the underwriters. BP sought damages equal to the sum it would have recovered from the so-called Frankona defendants had Aon made the relevant declarations to them—about \$80 million—and the costs of the Frankona action.

Aon Ltd., however, denied it owed BP a duty of care with regard to service, and pointed to a clause in the service agreement between Amoco and Aon Risk Services of

Texas, which stated that Aon Texas would hold the oil company and its affiliates "harmless against third-party claims on a no-fault basis" and indemnify BP against loss.

Mr. Justice Coleman ruled that, notwithstanding the existence of the service agreement between BP and Aon Texas, Aon Ltd. owed a duty of care to BP even though it was only a sub broker for the insurance contract.

Additionally, the judge ruled that the service agreement had not been intended to protect Aon Ltd. against negligence claims and that the existence of the agreement—which the judge examined under

the principles of both Illinois law and English law—did not absolve Aon Ltd. of its duty of care to BP.

The judge also ruled, among other things, that Aon Ltd. had undertaken to provide broker services to BP—and not just the services of a sub-broker—and thus had been negligent in not making declarations to all underwriters on the policy.

A further hearing will determine damages.

BP P.L.C. vs. Aon Ltd. and Aon Risk Services of Texas Inc., [2006], EWHC 424 (Comm); Case #2003.

NAIC: Reinsurance collateral

Continued from page 4

ing of the charge to say that some change must be done." Mr. Koziol said that while PCI is willing to look at all alternatives, "until we see something that provides the same level of security, we support the current collateral requirement."

"PCI also would be concerned if the full NAIC had multiple alternatives to choose among" in its winter voting session on the issue, he said.

Frank Nutter, president of the Washington-based Reinsurance Assn. of America said at the meeting, though, that he does not read the charge as being predisposed toward change. Yet Mr. Nutter added, "It's a wakeup call to U.S. insurers: The NAIC has called for proposals to lower security from unauthorized reinsurers." The RAA represents only authorized reinsurers.

Later during the meeting, though, Mr. Iuppa clarified that "there is no predetermined result" of the task force's work and that the group could decide that the current system "is perfect."

Mr. Iuppa's clarification "is very important for us and consumers," Mr. Snyder said. It "allows us to honestly explore if there are alternatives that are equally protective of solvency concerns as the present system."

Despite Mr. Iuppa's clarification, reinsurance task force chair Julie Bowler of Massachusetts said in an interview that it is highly improbable that the task force will endorse the existing system.

After the meeting, Dave Matcham, chief executive of the London-based International Underwriting Assn., said in an e-mail that he "welcomes the developments" and sees adoption of the white paper and the specific charge for the reinsurance task force as "undoubtedly positive."

"We remain optimistic that necessary changes will be implemented," Mr. Matcham said.

Joseph P. Gunset, general counsel of Lloyd's America Inc., the New York-based U.S. subsidiary of Lloyd's of London, said in an e-mail

that, "Lloyd's is optimistic about the potential for change in the legal requirements which govern the credit that may be taken by U.S. companies which cede reinsurance to alien reinsurers, such as underwriters at Lloyd's."

Hurricanes and terrorist attacks have made U.S. regulators more aware of the role that alien reinsurance plays in the U.S. market, Mr. Gunset said. "In particular, more regulators agree that the credit for reinsurance rules—which make no differentiation between an established reinsurer such as Lloyd's and a new untested company—need updating and do not work well in a modern, transparent regulatory environment," he said.

Lloyd's "takes comfort" that the wording of the joint resolution sent to the reinsurance task force "is a signal for change," Mr. Gunset said.

Members of the New York-based Risk & Insurance Management Society Inc. "are looking for the best reinsurance product at the best price," said Terry Fleming, a member of RIMS' external affairs committee and its board of directors. If the NAIC approves relaxing collateral requirements, it should expand the market by increasing the availability of reinsurance and could potentially reduce its cost, said Mr. Fleming, the Rockville, Md.-based director of risk management for Montgomery County, Md.

RIMS is expected to take a formal position sometime this year on the NAIC's review of the U.S. reinsurance system, he said.

In other action at the NAIC meeting, regulators decided to host a public meeting in New York to gather information to try and craft a long-term solution for terrorism insurance coverage for acts of terrorism once the Terrorism Risk Insurance Act expires Dec. 31, 2007.

Last week, the NAIC released details of the hearing, which will be held on Wednesday, March 29, at the Westin New York at Times Square. Persons wishing to testify should contact Eric Nordman at enordman@naic.org by March 23.

Letters

Continued from page 8

million), not €3 million (\$3.6 million) as stated in your article.

The Irish financial regulator is taking both the reinsurance directive and the International Assn. of Insurance Supervisors' standards for reinsurance regulation as the basis for the new regime in Ireland. In 2002, the IAIS stated in its paper on principles on minimum requirements for the supervision of reinsurance that, "where captives only insure the risks of their owners and are part of the same organization, they may not pose the same risk to the financial system, and separate regulations may be established recognizing this reduced risk."

Thus the financial regulator in Ireland is ensuring that it implements the globally accepted standards, as per the IAIS, and the European requirements, as per the rein-

surance directive, without putting unnecessary strain on the operation of captives within the country. As an organization, the Dublin International Insurance & Management Assn. Ltd. looks forward to the continuous success of Dublin as an international captive center, supported by sound and appropriate regulation.

Sarah Goddard

Dublin International Insurance & Management Assn. Ltd.
Dublin, Ireland

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Survey records satisfaction with fronting setups

By MICHAEL BRADFORD

ORLANDO, Fla.—Fronting services may be considered a necessary evil to some captive owners, but a recent survey shows that most are happy with their arrangements.

Around 100 members of the Captive Insurance Companies Assn. responded to the group's annual fronting services and reinsurance survey earlier this year. Their an-

swers, presented at CICA's 34th annual international conference in Orlando earlier this month, found that many captive owners are not shelling out burdensome amounts of money for their fronting services or facing huge reinsurance price hikes.

Nearly 80% of the respondents spent less than 10% of their premium costs on fronting, the survey showed. Forty-two percent spent

5% or less.

In a separate question that asked respondents to compare the cost of fronting fees to their annual premiums, the largest group of respondents said the amount was less than 5%.

"That belies some of the complaints you hear from time to time," said Michael R. Mead, president of M.R. Mead & Co. in Chicago, who presented the survey findings at the conference.

When asked about the value of their fronting relationship for the price they pay, captive owners indicated things are "pretty peaceful" on the fronting scene, said Mr. Mead. "Most people feel that the price and the value received are reasonable or moderate," he said.

"It's pretty quiet on the fronting scene this year," he said, with most respondents reporting their fronting costs rose less than 5% at the most recent renewal. "It sounds like everybody is getting along and playing nicely in the sandbox."

While workers compensation made up the biggest number of fronted programs, "that has come down dramatically from the past year," said Mr. Mead. "I'm not exactly sure why that is," he said, speculating that it could indicate a change in the mix of respondents.

The survey is "not something that is hugely scientific," Mr. Mead said. "It depends entirely on the

voluntary responses of the people who participate."

Mr. Mead pointed out that single-parent captives continue to make up the bulk of respondents, with 52.7% this year, but that percentage is not as large as in years past. The next largest groups of respondents were risk retention groups, with 16% of the respondents, and association captives, with 11%.

The main reason for using a fronting company was to have the captive's coverage pass through an admitted company, the survey showed. Regulatory compliance was the next most popular reason for using a front.

In addition, 73% of the respondents said their fronting companies provided reinsurance for their captives.

Interestingly, Mr. Mead pointed out, a small percentage of respondents—less than 5%—said no collateral was required by their fronting companies. "How are they doing this with no collateral?" he asked. The results did not provide an answer to that question.

"Collateral, obviously, is an important issue" when choosing a fronting company, said Richard Turner, managing director of sales with Liberty Mutual Alternative Markets in Conshohocken, Pa. "Most of the carriers that I know are pretty much compelled to try

to follow the same criteria," he said. Mr. Turner analyzed the survey results and spoke at the CICA session.

While expected losses will play a role in the amount of collateral sought by fronting companies, regulatory requirements have to be considered, said Mr. Turner. And the maturity and financial strength of the captive and whether parental guarantees are in place are among other influences that determine the collateral requirement, he said.

In an answer to a new question in the survey, 47% of respondents said they spend more than \$1 million on reinsurance for their captives. As to the value they perceive for the price of reinsurance, captives appeared content, most answering that the price was "reasonable" or "moderate."

"Again, it looks like a peaceable kingdom," said Mr. Mead.

"We've seen reinsurance costs, in some cases, go up" for captives, said Mr. Turner. Those costs appear to be "leveling out," though, in the "more traditional lines of coverage," he said.

Additionally, Magali Welch, principal with Johnson Lambert & Co. in Burlington, Vt., also participated in the session. She worked with CICA in preparing the survey questions and compiled the results.

CICA members can access the survey at www.cicaworld.com.

Rosenbaum honored at CICA annual conference

ORLANDO, Fla.—The Captive Insurance Companies Assn. drew around 400 attendees to its 34th annual international conference last week in Orlando, Fla.

The theme of the conference, held at the Hyatt Regency Grand Cypress, was "Facing the Challenge: Managing Captives in an Era of Change and Increased Oversight."

The conference featured two full days of educational sessions on a number of captive-related topics, including tax issues, health care captives, risk retention group basics, domicile

choice and others.

At the conference, CICA presented its first Distinguished Service Award to D. Hugh Rosenbaum, a London-based retired principal of Towers Perrin and a noted expert on captive matters. Mr. Rosenbaum said in accepting the award that he has "sought to improve the breed, and I think that's what all of us should be doing all the time."

CICA will hold next year's annual international conference in Tucson, Ariz., March 11-13.

More information on CICA is available at www.cicaworld.com or by calling 952-928-4655.

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Captives: Meeting medical needs

Continued from page 4

years ago, physicians weren't organized in a fashion that they had access to capital or infrastructure or all the necessary things to support a captive program," she said.

Through it all, captive owners have formed their companies as a way not so much to save money but to have insurance programs they could count on, Ms. Goodell said.

That was the case at Northwestern Memorial Hospital, the primary teaching hospital for Northwestern University in Chicago, according to Todd Burgener, director of insurance at the hospital and a panelist at the CICA meeting.

The captive was set up to consolidate the malpractice coverage needs of the hospital's doctors and faculty members, who number more than 1,500, Mr. Burgener said. The hospital has more than 6,000 employees and delivers around 10,000 children per year. It treats around 54,000 emergency room patients and performs about 30,000 surgical procedures annually.

Initially, the captive did not provide coverage for faculty members at the teaching hospital. But starting in 2004, those employees were offered coverage through the insurers, Mr. Burgener said.

Physicians not employed by the hospital have not been allowed to buy coverage from the captive, he said, "but we're looking at ways to pull them in and get them integrated."

The provision of malpractice coverage to independent physicians is the reason many health care captives are formed, according to Ms. Goodell.

It's one of the "key drivers" of captive formations, she said. That "ability to provide coverage for independent medical staff" was part of the motivation for Harvard in forming its captive 30 years ago, Ms. Goodell added. "While we've had changes in models, changes in domiciles and changes in structures, clearly, the underlying drivers have remained constant over the decades."

Jay Waters, vp-insurance at University Hospitals Health System, a Cleveland-based affiliate of Case Western Reserve University, said that the medical facility formed its Cayman health care captive in 2002. The motivation, he said, was to provide its units with "better risk management services, more aggressive claims handling" and other services that included a better coordinated defense for hospitals facing claims.

University Hospitals created a single-parent captive that was later reorganized as a segregated cell company.

Mr. Waters warned prospective captive owners that putting a health care captive together is not an easy task. "In order to do it right, it takes a lot of man-hours," he said. "Not that it's rocket science, but it is a lot of work. But it can be very rewarding at the same time."

OSHA: Senate confirms agency's new administrator

Continued from page 4

spire compliance through assistance and support rather than merely enforcement," said Mr. Freedman.

"I think he'll follow Mr. Henshaw's lead in working with all groups in trying to improve safety and health through compliance assistance, trying to stop injuries before they take place not just trying to punish employers when an accident or injury takes place," suggested Chris Tampio, director of employment policy for the National Assn. of Manufacturers in Washington.

"He knows the OSHA regs from his experience at the OSHA Review Commission," said Mr. Tampio. He added that NAM "had pushed the Senate—both Republicans and Democrats—to confirm a permanent head of OSHA. "They need to speed up the confirmation process," said Mr. Tampio.

The timing of Mr. Foulke's confirmation could make his job more difficult than it might otherwise have been, according to one observer.

"I think he's in a tough position," said Dave Heidorn, manager-government affairs and policy for the American Assn. of Safety Engineers

in Des Plaines, Ill. "It's really come so late in the second administration. I think the direction to take and the direction I think he will take is to pretty much carry on what John Henshaw did. I admire him for wanting to take the position and provide some competent leadership," he said.

An insurance industry workplace safety expert said that Mr. Foulke's work as an attorney representing employers could cause concern among some observers.

"I think for him to do a good job he is going to have to rise above what one would perceive him from his background," said Keith Lessner, vp-loss control for the Property Casualty Insurers Assn. of America in Des Plaines, Ill.

"From the perspective of the insurance industry, we would like to see someone who can balance the needs of labor and management, and I think in a public policy area there's a lot that can be achieved by finding those areas of common ground. And we have no reason to suspect that he won't work in that area, but if you look at his background, there is going to be more of a concern that he will be more of an employer advocate than to find the middle ground," said Mr. Lessner.

Ruling: 401(k) transfer option broke tax rules

Continued from page 4
be taken away.

The IRS regulations also stipulate that the separate employee account feature of a defined contribution plan, like a 401(k) plan, is a protected feature and must be preserved.

Funds can be transferred between defined contribution and defined benefit plans without violating Section 411(d)(6) if the funds are available for distribution to employees.

For example, an employee who retires and wants to transfer a 401(k) account balance to his or her

employer's defined benefit plan could do so without violating the IRS regulation, because the employee would have a right to take the entire 401(k) account balance.

But in a situation where an employee continues to work for the same employer, full distributions of 401(k) account balances are not allowed.

Given the IRS requirements for protection of separate defined contribution plan account balances for each employee, benefit experts at the time the arrangement was

unveiled said they would not be surprised if the IRS national office later reviewed the transaction. That is because while cash balance plans have hypothetical account balances, there is in fact only one plan, which lacks the actual individual account feature of 401(k) plans, experts said.

Additionally, while in defined contribution plans, like a 401(k) plan, investment earnings must be distributed to employees' accounts, in a cash balance plan, investment earnings belong to the plan.

Pregnancy: Stance reversed on pre-'79 leave credit

Continued from page 3

the plaintiff, who had received less credit for her 1972 pregnancy-related leave than others on disability, be credited with additional leave in order to qualify for early retirement. That was the basis for the district court's earlier ruling in favor of the plaintiff, it says.

The appellate decision says, though, that "of course, *Pallas* was decided before the Supreme Court's decision in *Landgraf*, and neither the parties nor the court had the benefit of that clarification of retroactive law."

In her dissenting opinion,

though, Judge Pamela Ann Rymer said, "I do not believe that the reasoning or theory of *Pallas* is so irreconcilable with the reasoning or theory of *Landgraf* as to give this panel license to overrule it."

Pallas "was premised on a discrete act—the decision to deny a retirement benefit—that gave rise to a current violation of the PDA," said Judge Rymer.

Commenting on the decision, plaintiff attorney M. Suzanne Murphy, of Weinberg, Roger & Rosenfeld in Oakland, Calif., said she plans to ask for a rehearing of the case before the full court.

The *Pallas* decision "is good law and should have been binding on this panel," said Ms. Murphy. The majority panel was "far too willing to disregard it and find that it had been undermined."

An AT&T attorney could not be reached.

Noreen Hulteen; Eleanor Collet; Linda Porter; Elizabeth Snyder; Communications Workers of America, plaintiff-appellees, vs. AT&T Corp., defendant-appellant; No. 04-16087, 9th U.S. Circuit Court of Appeals, No. CV-01-01122-MJJ.



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MMC: Broker blasts state of Florida lawsuit on bid rigging, steering

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"My goal is to ensure that Floridians are refunded for the millions of dollars in fees or commissions they were improperly charged," Mr. Gallagher said in his own statement. He noted that MMC and its affiliates brokered approximately 15,000 insurance contracts in Florida from 1998 through 2004.

The suit is the culmination of an 18-month investigation by the attorney general's antitrust division and the Department of Financial Services' Office of Insurance Regulation.

It comes, however, as MMC continues to move forward following its January 2005 settlement with Mr. Spitzer and New York Superintendent of Insurance Howard Mills, in which it agreed to change its business practices and to establish an \$850 million fund to reimburse affected clients nationwide.

So far, 34 state regulators, including California Insurance Commissioner John Garamendi last week, have endorsed MMC's settlement with Mr. Spitzer and have agreed

not to sue the brokerage over the allegations. In addition, roughly half of the 140,000 eligible policyholder clients have opted to participate in MMC's \$850 million settlement last year and signed a waiver releasing MMC from future claims.

"This complaint never should have been filed. It distorts the facts, disregards the events of the past 18 months and ignores releases signed by the state of Florida itself," MMC attorney Barry Richard, a partner in the law firm of Greenberg Traurig L.L.P. in Tallahassee, Fla., said in a statement. Mr. Richard described the allegations in the latest suit as having been "cut and pasted" from Mr. Spitzer's 2004 suit.

Marsh's Florida clients, many of which are referenced in the complaint, "overwhelmingly accepted" MMC's settlement and have begun to receive more than \$21 million in distributions, Mr. Richard said. "Indeed, in connection with this settlement process, the state of Florida itself has executed legally binding documents releasing all claims against Marsh," he said.

A spokeswoman for Attorney General Crist's office acknowledged that the Florida Department of Management Services did participate in MMC's settlement fund but

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**Barry Richard
Greenberg Traurig L.L.P.**

said that the settlement was based strictly on its interaction as a Marsh client and is "a completely separate and different issue" than the state's authority to seek civil penalties and losses to which it believes Florida claimants are entitled.

"We believe the Spitzer suit, because of its limited time frame that it covered and the limited areas of recovery, left as much as one-half of what could have been illegally gained from Florida entities on the table," a spokesman for the Florida Department of Financial Services said. "Therefore, we're going after what we believe could be as much as \$25 million."

Florida's RICO Act provides for the restitution of up to three times the amount lost due to unlawful conduct, as well as injunctive relief and revocation of the authority to conduct business in the state, according to the state.

Attorneys familiar with MMC's settlement say what is at issue is whether Florida, in signing Marsh's release, waived its rights to bring suit on behalf of injured Marsh clients in its capacity as a regulatory and law enforcement entity.

"If the state of Florida did, in fact, execute the releases and receive consideration, it will be interesting to see whether Florida has waived the state's rights to further pursue

Marsh," said James Wagner, a partner with Howrey L.L.P. in Washington. "In any event, I think it will be very difficult for Marsh to sustain an argument that this suit cannot be maintained on behalf of Florida corporate residents that did not execute any releases in conjunction with the Spitzer settlement."

"Had the state never been a customer of Marsh, could the state bring the present action? If that's true, unless the settlement agreement that the state signed unmistakably waives their sovereign claims, this action goes forward," said Marc Mayerson, a partner with Spriggs & Hollingsworth in Washington.

"Even if the state of Florida released all of its commercial claims against Marsh...would that remove its executive power to enforce its laws? That's an interesting question," said Elaine Metlin, an attorney in the Washington office of Dickstein Shapiro Morin & Oshinsky. "What is clear is the scope of Marsh's release is going to be litigated." Ms. Metlin said.

Massachusetts: Bill would tax employers that don't offer health care coverage

Continued from page 1

employers with 10 or fewer employees would have been exempt.

That tax, though, would have been offset by employers' health insurance costs. Offsetting costs would have included an employer's premium contributions, as well as contributions to health savings accounts for companies with HSA-linked high-deductible plans.

By contrast, Sen. Travaglini's proposal, which the Senate passed last year, would have required employers with more than 50 employees to reimburse the state if their employees used a state health care program for the uninsured.

Amid the deadlock, the legislators forged a compromise, leaving it to a conference committee, which has been meeting for the past couple of weeks to hash out the details.

Many key details have yet to be released. For example, it is unknown what portion of a group health premium an employer would have to pay for it to consider offering a health insurance plan and thus be exempt from the tax.

Similarly, details haven't been disclosed on how much cost sharing an employer could impose and still be exempt from the tax.

It also isn't known if an employer would be exempt if it offers coverage only to full-time employees and not to part-time, temporary or seasonal employees.

"The devil truly is in the details. A lot still has to be worked out," said Cameron Congdon, a principal with Towers Perrin in Boston.

Still, the \$295 per employee tax has not triggered the intense opposition from the business commu-

ty that the payroll tax did, he notes. "There has been much less noise."

The reason for the reduced oppo-

The \$295 per employee tax has not triggered the intense opposition that the payroll tax did. "There has been much less noise."

**Cameron Congdon
Towers Perrin**

sition is clear—the financial impact would be much less than the earlier proposed 5% to 7% payroll tax.

Still, some employer groups are waiting for the complete proposal

before staking out a position. "We are waiting until we see a final bill," said a spokesman for the Associated Industries of Massachusetts, a 7,600-member business lobbying group in Boston.

Others, though, worry the proposal could tarnish the state's reputation in the business community.

Some employers might say, "Massachusetts is that state where there is that head tax," said Bill Vernon, state director for the National Federation of Independent Business in Boston.

If the proposal is enacted, it would be the first of its kind, though, at least two states—New York and Massachusetts—impose surcharges on hospital bills to help fund coverage for the uninsured, and a third state—Maine—imposes a small surcharge on health insur-

ance premiums to subsidize coverage for the uninsured.

Additionally, Maryland passed legislation—now being challenged in federal court—that requires employers to pay into a pool that provides coverage for the low-income uninsured if their own health insurance costs fall below a certain percentage of payroll. But the way the statute was drafted it only applies to Wal-Mart Stores Inc., the huge Bentonville, Ark.-based retailer.

In the 1980s, Massachusetts enacted legislation that would have imposed a \$1,680 per employee tax on employers to fund coverage for the uninsured. But employers would have been able to offset that tax by the amount they spent on health insurance. That law, though, never went into effect and ultimately was repealed.

Wal-Mart dismisses AFL-CIO Medicaid report

By JERRY GEISEL

Wal-Mart Stores Inc. is dismissing as misleading and flawed an AFL-CIO report that says the retailing giant has more employees and dependents enrolled in Medicaid in at least 19 states than does any other employer.

Noting that Medicaid, the public health insurance program that provides coverage to low-income individuals, represents one of the fastest-growing expenses for states, the labor union organization report says a "clear component" of rising costs "is a decision by employers—including some that are highly profitable—to shift onto taxpayers the costs of insuring their workers."

The AFL-CIO report is based on a variety of sources, including studies by other organizations.

According to the report, "Wal-Mart's refusal to pay decent wages and provide affordable

health insurance to its workers puts it atop the list in at least 19 of the 23 states surveyed here. This abuse of poverty health care programs means Wal-Mart is directly contributing to the nation's Medicaid crisis."

The report says, for example, that in Maine about 10% of Wal-Mart employees get health insurance through Medicaid and other public assistance programs, while in New Jersey, Wal-Mart had more employees and dependents enrolled in Medicaid than any other employer, even though Wal-Mart is only the 8th-largest employer in the state.

A spokeswoman for Bentonville, Ark.-based Wal-Mart questioned the report's methodology. For example, in some cases, the AFL-CIO's report cited data from 2005 and 2004 and in one state, Georgia, the data cited goes back to 2002.

Additionally, the Wal-Mart spokeswoman said the retailer has helped hundreds of thou-

sands people gain access to group health insurance.

"Thirty percent of our associates had no coverage before coming to Wal-Mart....We have helped more than 260,000 people leave the ranks of the uninsured," the spokeswoman said.

The AFL-CIO has been lobbying states to approve legislation that would require large employers to spend at least a certain percentage of their payroll on health care insurance plans or to pay an assessment that could be used to subsidize public health care programs, such as Medicaid.

Maryland is the only state to have passed such legislation, written in such a way as to only apply to Wal-Mart. That measure now is being challenged in court by a retail trade association, which says the measure is pre-empted by the Employee Retirement Income Security Act.

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Chrysler: Salary-based health care contributions

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ability to pay," Mr. LaSorda said.

The concept of salary-based contributions has existed for many years, but more employers are making requests for modeling salary-based contributions than ever before, said Jay Savan, health and welfare group leader for Towers Perrin in St. Louis. In 2005, 10.3% of employers had salary-based contributions for single coverage, while 10.9% had them for family coverage, according to a Towers Perrin survey.

"It's not a completely new concept, but it's something that has picked up steam in the last 24 months," he said.

According to Mercer Human Resource Consulting, 5% of all employers and 8% of large employers had salary-based contribution structures in 2005.

The goal for most employers that implement salary-based contribution structures is to make their compensation package more equitable for employees and make health care premiums more affordable for low-wage earners, consultants say. "Generally speaking, companies are not using this as a cost-savings mechanism," Mr. Savan said.

Salary-based contribution structures do have some inherent challenges, consultants say. Most such structures are based on fixed salary levels, so employees making just above these levels are forced to pay higher health care premiums, decreasing their compensation levels. In order to compensate, companies

promoting employees, for example, may give them higher raises than they normally would have received. "That creates some complexity over the whole compensation process," said Dale Yamamoto, health care actuary for Hewitt Associates Inc. based in Lincolnshire, Ill.

The best approach to salary-based employee contributions, Mr. Savan suggested, is to require that all employees pay the same percentage of their salaries toward health care premiums rather than base it on fixed salary levels. This prevents the problem of employees having to pay substantially higher premiums simply because their salary is above a pre-determined threshold while also addressing the affordability of the contributions themselves, he said.

But most employers that have salary-based contribution levels choose to take the band approach rather than a fixed-percentage approach for all employees because the fixed-percentage approach is administratively cumbersome, meaning that all employees make different contributions toward their health insurance premiums.

Meanwhile, Chrysler's move to introduce an HRA for certain retirees is part of an emerging trend, consultants say. Employers such as Chrysler are concluding that Medicare-eligible retirees have other options for health care coverage, so they create these accounts to enable retirees to make their own decisions on what health care plans to buy, Mr. Yamamoto said. "I

think we might see more of what Chrysler's doing," he said.

In 2007, Chrysler will credit each eligible retiree's account with \$1,750 and an additional \$1,750 for each retiree's spouse or domestic partner. In 2008, the amount credited will increase by 3%. Retirees will be able to use the HRA balances to pay for eligible health care expenses such as Medicare Part B premiums—currently about \$1,050 per person—and Part D premiums, which vary depending on the plan.

Account funds for deceased retirees with no surviving spouses or partners revert back to the company, the spokesman said.

Post-65 retirees currently contribute, on average, about \$3,700, for family and individual coverage toward their health care premiums. A company spokesman attributed the high average to substantial fluctuations in health care costs for individual retirees.

Chrysler should consider offering an HRA to active employees to allow them to accumulate funds for retirement over time, Mr. Savan suggested. The company does not offer HRAs to its active employees but does offer health savings accounts, the spokesman said.

But, for the most part, Chrysler's plan is consistent with what Towers Perrin has done with other employers and its announcement will likely encourage more companies to take this approach, Mr. Savan said. "I think it's definitely a harbinger of things to come," he said.

Late News

Continued from page 1

The company said last month it would contribute \$575 million to the settlement; the D&O insurance proceeds would not reduce the amount Nortel has agreed to pay.

Reinsurers see rise in combined ratio

U.S. reinsurers reported a 129.4% aggregate combined ratio for 2005, compared with the 106.2% ratio posted by a similar group of reinsurers in 2004, according to a survey of 26 reinsurers by the Reinsurance Assn. of America. The 129.4% ratio reflects a 102.9% loss ratio and a 26.5% expense ratio. The reinsurers wrote \$25.3 billion in net premiums in 2005, a 10.9% decrease from the total reported for 2004.

401(k) reform bill introduced in Senate

Under a bill proposed last week by Sen. Max Baucus, D-Mont., the 10% penalty tax that now generally applies on 401(k) plan distributions taken before age 59 1/2 would be waived for distributions used to make a down payment on a first home or to pay higher education expenses for plan participants, their spouses, children or grandchildren. Additionally, the penalty tax would not apply for distributions taken to pay for health insurance premiums by employees who lose their jobs. The measure also would pre-empt state laws that could interfere with automatic enrollment.

Kansas passes comp reforms

Kansas legislators last week sent a workers compensation bill to Gov. Kathleen Sebelius that, among other things, would reduce benefits for injuries stemming in part from pre-existing health conditions. S.B. 461 would also allow a company to reduce disability payments if a worker is laid off or quits their job. A spokeswoman for the governor said she has not decided whether she will sign the bill.

Charges dampen AIG's income

American International Group Inc. posted a profit of \$10.48 billion for 2005, up 6.5% over 2004, though its fourth-quarter net income fell 72% to \$444 million, due in part to the \$1.15 billion aftertax charge taken to fund a settlement the insurer

reached with officials last month. Net written premiums for AIG's general insurance operations grew 3.1% to \$41.87 billion for the year. The insurer posted a combined ratio of 105%, compared with 100% in the prior-year period. AIG's results also include a \$1.19 billion aftertax charge related to an increase of nearly \$1.82 billion to net reserves, as well as aftertax catastrophe losses of \$2.11 billion related to mostly to the 2005 hurricanes.

Pennsylvania OKs tort reform bill

The Pennsylvania Legislature has passed a bill that would ensure civil defendants pay only damages they are found to be directly responsible for in most lawsuits. Under S.B. 435, a defendant found negligent or strictly liable for an injury would be responsible only for his or her share of the total damages awarded to compensate the plaintiff, in most circumstances. Joint and several liability, though, would still apply in certain situations, such as when the defendant is found at least 60% liable.

CDHP use growing, NBGH survey finds

Twenty-nine percent of employers now offer high-deductible health plans with a health savings account or a health reimbursement arrangement, and an additional 33% plan to do so in 2007, according to Watson Wyatt Worldwide and the National Business Group on Health, which surveyed 585 midsize and large companies for its annual survey. By comparison, only 13% offered a CDHP in 2005, and only 7% did so in 2004. But while 80% of the respondents found consumer-driven health plans to be at least somewhat effective at increasing employee involvement in health care decision-making, only 59% said they find such plans to be somewhat effective at controlling health care cost increases.

Briefly noted

The Mississippi Legislature has passed a bill that would eliminate the annual \$500 registration fee now paid by risk retention groups that are licensed outside Mississippi.... Startup reinsurer Lancashire Insurance Co.'s A- financial strength rating has been placed under review with negative implications by A.M. Best Co. Inc. Best said the move comes after Bermuda-based Lancashire announced the unexpected departure of vp and underwriter Alex Richards.

BI Stock Index [3/13 - 3/17]

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Percentage change of
BI Stock Index vs. key indicators

BI Stock Index

3008.29



1.85

Dow Jones

11279.65



1.84

S&P 500

1307.25



2.00

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

Largest gains

AEGON N.V.	9.92%
SCOR S.A.	9.28%
IPC Holdings Ltd.	7.93%
Tower Group Inc.	7.61%
CNA Financial Corp.	6.99%

Largest losses

Fairfax Financial	-5.70%
Gainsco Inc.	-5.25%
UNICO American Corp.	-2.06%
Brown & Brown	-1.99%
Sierra Health Services	-1.87%

Weekly change by market segment

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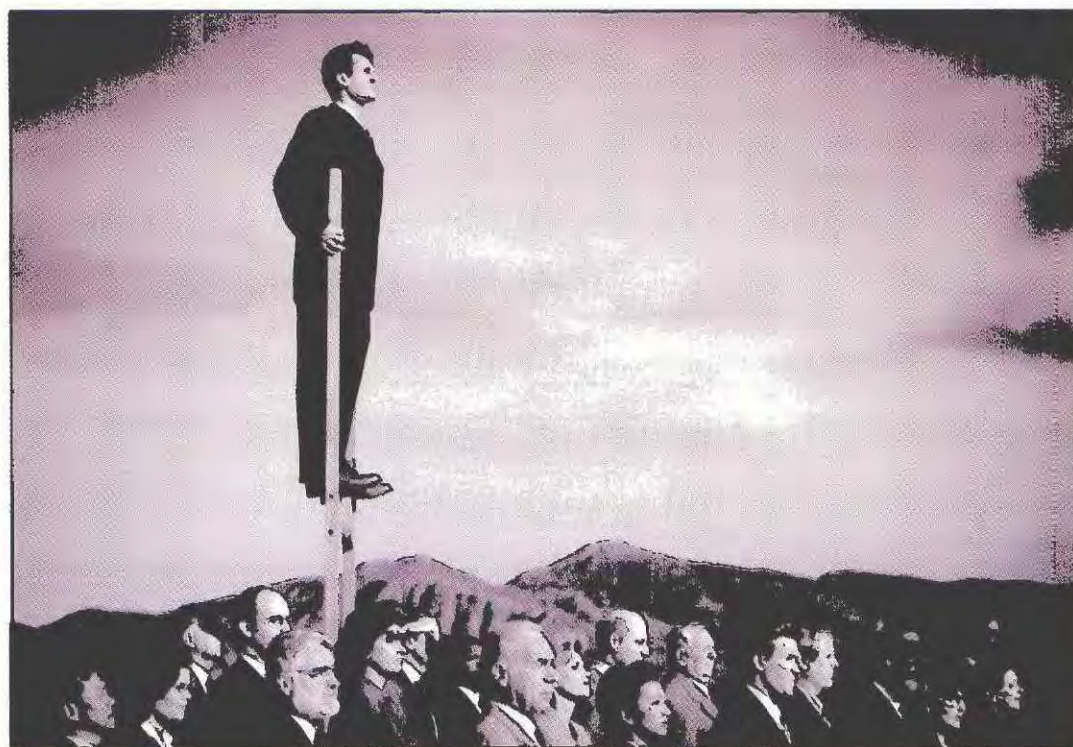
At BusinessInsurance.com

New Online Poll: Do you believe state regulation of the insurance industry is: a) excellent; b) good; c) fair; d) poor?

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