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INSURERS FIGHT FEDERAL-MOGUL OVER ASBESTOS FUND MEASURE IN CHAPTER 11 PLAN / PAGE 3

In Brief

Hurricane forecast sees fewer storms

Hurricane forecasters at Colorado State University have downgraded predictions for this year, saying they expect four named storms in the Atlantic the rest of the season. The forecasters earlier had predicted five named storms for the period, though October and November still are expected to see above-average activity. Two of the four named storms predicted for the rest of the season are expected to become hurricanes. In April, CSU forecasters said they expected 17 named storms for the season. As of Oct. 1, there had been 13, including four hurricanes. La Niña conditions are expected to extend this year's hurricane season.

High court declines birth control case

The U.S. Supreme Court has declined to hear an appeal filed by social service organizations operated by the Roman Catholic Church and other religious groups that sought an exemption from a New York law requiring them to provide birth control coverage to their employees. Catholic Charities and nine other church-affiliated groups filed suit in 2005, arguing they should be exempt from the Women's Health and Wellness Act of 2002, which expanded women's health care coverage to include contraception, among other things. The law provides exceptions for churches, seminaries and other institutions with mainly religious missions that serve primarily followers of

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Sen. Chuck Grassley, R-Iowa, center, speaks about the State Children's Health Insurance Program. He is flanked by Sen. Max Baucus D-Mont., left, and Sen. Jay Rockefeller D-W.Va. President Bush vetoed its reauthorization last week.

More burdens seen for benefits plans

SCHIP still worries sponsors despite veto

By **GLORIA GONZALEZ**

WASHINGTON—Health plan sponsors would face significant administrative challenges if a bill that would expand the government health insurance program for children becomes law despite having been vetoed last week.

Of particular concern for employers are provisions of the bill that would increase notification and disclosure requirements and extend the Family and Medical Leave Act for employees with family members injured during military service.

The Children's Health Insurance Program Reauthorization Act of 2007 was passed by Congress in late September in an attempt to allow millions of uninsured children to enroll in the government health care program. President Bush vetoed the bill last week, citing concerns about income eligibility levels for the program used by various states and the possibility of moving millions of children with private health insurance into the government health care system. Democratic congressional leaders have vowed to attempt to override the veto.

There are enough votes in the Senate to override the veto, as the measure passed the Senate by a 67-29 vote. The House of Representatives is at least 20 votes short for a veto override, but the Democratic leadership has launched an intensive lobbying effort to persuade

See **SCHIP** page 66

SCHIP PROVISIONS

A bill to reauthorize the State Children's Health Insurance Program has key provisions that would affect employee benefit plans, which include:

- Allowing states to provide premium subsidies for qualified employer-sponsored coverage to low-income employees with children eligible for both the government program and employee benefit plans.
- Requiring employers to notify employees about their ability to enroll in state health care programs and provide information on premium assistance to employees living in states that offer such assistance.
- Creating special enrollment periods for employees or dependents who lose eligibility for the government program or become eligible for premium assistance to join their company health plans.
- Requiring plan sponsors to disclose information about their benefit plans to states upon request.
- Amending the Family and Medical Leave Act to provide for extended leave of up to 26 weeks in a one-year period for an employee to care for an injured member of the armed services.
- Banning employers from denying family members caring for injured service members promotions, employment or benefits for a one-year period.

Employers fear fallout from 'no-match' rules

Illegal immigration crackdown may spark suits

By **DAVE LENCKUS**

SAN FRANCISCO—Employers fear that they will face greater employment discrimination risks if a federal judge this week upholds expanded employment authorization regulations that are part of the Bush administration's effort against illegal immigration.

Employers, labor unions and civil liberties groups hope that U.S. District Judge Charles Breyer in San Francisco will render the issue moot later this week, when the judge is expected to decide whether the U.S. Department of Homeland Security can implement its new regulations, "Safe-Harbor Procedures for Employers Who Receive a No-Match Letter."

The AFL-CIO and other San Francisco-area labor and employer groups filed a lawsuit challenging the regulations on Aug. 28 in federal court in San Francisco. The suit names as defendants DHS, the U.S.

Immigration and Customs Enforcement agency and the U.S. Social Security Administration

Judge Breyer issued a temporary restraining order against the regulations on Aug. 31. On Oct. 1, the judge indicated he needed 10 more days to rule in the case.

The labor and employer groups assert—among other things—that the regulations would impose unreasonable procedures and deadlines for reconciling discrepancies in employees' Social Security information to avoid facing possible government sanctions for employing unauthorized workers.

Under the rules, employers would have to take prescribed steps after receiving so-called "no-match" letters from Social Security. The letters identify employees whose information on file with the agency does not match their information on their W-2 Forms.

See **NO-MATCH** page 6

N.Y. plans to mandate natural cat reserves

Insurers voice concerns over tax implications

By **MARK A. HOFMANN**

NEW YORK—Insurers remain concerned about the tax implications of a proposal that would require companies underwriting property policies of all kinds in New York state to create catastrophe reserve funds to help pay claims caused by hurricanes and other natural disasters.

Under the proposal announced by the state insurance superintendent last week, the reserve requirement—which would be the first of its kind adopted by any U.S. state—would cover losses related to natural catastrophes such as hurricanes, wind storms, hail, earthquakes, winter storms or tsunamis, according to the department. The regulation would require companies to

reserve the amount they now charge policyholders for catastrophe protection, less any taxes paid and the cost of reinsurance.

"There are many proposals to have government take over or subsidize hurricane insurance, as it does with flood insurance," New York Insurance Superintendent Eric Dinallo said in a statement. "I believe it is better to find a private-sector solution. That's why we are proposing a new state regulation requiring insurance companies to set aside the portion of the premium they now collect for catastrophe protection. This reserve fund will help pay the claims if and when hurricanes and other disasters do

See **RESERVES** page 66

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CONFERENCE EXTRA

National Consumer Driven Healthcare Summit

Business Insurance offers additional coverage from second National Consumer Driven Healthcare Summit, held last month in Washington. Go to www.BusinessInsurance.com/conferenceextra.

RIMS survey says rates likely to continue decline

Only property rates increase in third quarter

By KRISTIN GUNDERSON HUNT

Most commercial insurance premiums continued to drop in the third quarter of 2007, with only property coverage seeing a slight uptick, according to a survey of risk managers released last week.

And barring a major catastrophe, the softening is expected to continue.

"If there is no major catastrophe, I think the soft market is going to continue to go down well into 2008 and maybe beyond," said David Bradford, editor-in-chief of Advisen Ltd., the New York-based insurance industry analyst that produced the survey.

The RIMS Benchmark Survey is based on risk managers' premium renewal rates, which are submitted to the New York-based Risk & Insurance Management Society Inc.

Advisen then compares the renewal premiums with the previous year's rates and reports the differences. Approximately 1,200 risk managers report their renewal information during the course of a year.

Many of the same trends played out in the third quarter as in recent quarters, according to the RIMS survey. Average renewal premiums for property coverage were the only premiums to increase, rising 2.1%. According to Mr. Bradford, property premiums are still reflecting the fallout from the 2005 hurricanes, which drove prices up drastically.

Although premiums for hurricane risks are stabilizing, surging premiums for earthquake risks along the West Coast in California, Alaska and Oregon are affecting the nationwide average, Mr. Bradford

See RIMS page 67

Kanjorski to continue insurance hearings

By MARK A. HOFMANN

WASHINGTON—The head of the House panel charged with insurance matters intends to continue a series of hearings on insurance regulatory matters throughout the current Congress.

Rep. Paul Kanjorski, D-Pa.—the chairman of the House Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises—revealed his plans Wednesday as the first of the hearings began. "Let me be clear: I have no battle plan, no ax to grind, and am open to considering all points of view," he said.

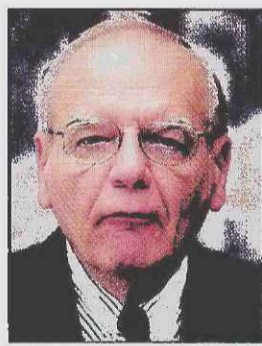
Rep. Kanjorski also made clear that the process would not be completed quickly.

"Before moving to finalize any legislation, I would additionally envision that we will create bipartisan, member-driven task forces to study targeted issues related to insurance regulatory reform and put together recommendations for a bill," he said. "These task forces should help us to reach a consensus."

Wednesday's witnesses—all of whom represented the private insurance industry except Walter Bell, the Alabama insurance commissioner who serves as president of the National Assn. of Insurance

Commissioners—demonstrated that there is no consensus on whether insurers and producers should be permitted to choose to be regulated by a new federal insurance regulator rather than state authorities.

Representatives of the Council of Insurance Agents & Brokers, the American Insurance Assn. and the American Council of Life Insurers all repeated their organizations' calls for the optional federal charter. Witnesses who appeared on behalf of the National Assn. of Mutual Insurance Cos. and the Independent Insurance Agents & Brokers of America reiterated their opposition to the OFC, while holding that state insurance regulation is falling short in some areas.



CNP

'Let me be clear: I have no battle plan, no ax to grind, and am open to considering all points of view.'

Rep. Paul Kanjorski
D-Pa.

Mr. Bell defended state regulation, holding that individual state insurance markets "dwarf" those of many sovereign nations.

The panel's ranking minority member—Rep. Deborah Pryce, R-Ohio—said that where "progress has occurred" in state insurance regulation, it has "largely" been due to federal pressure. Rep. Pryce also said she intends to introduce bipartisan legislation later this year that would allow risk retention groups to underwrite property as well as liability risks for their members.

Two insurers object to Federal-Mogul plan

Bankruptcy court hears closing arguments

By DOUGLAS McLEOD

PITTSBURGH—Asbestos defendant Federal-Mogul Corp. is hoping to overcome several final hurdles to its Chapter 11 reorganization plan following closing arguments on the plan's confirmation in a federal bankruptcy court last week.

Two of Southfield, Mich.-based Federal-Mogul's liability insurers—Travelers Indemnity Co. and Employers Insurance Co. of Wausau—are objecting to one of two versions of the plan, arguing that it impairs their policy rights and fails to comply with bankruptcy rules.

Both insurers told a U.S. bankruptcy judge last week that they will appeal if the plan is confirmed over their objections.

Separately, Hartford Financial Services Group Inc. has refused to join five other insurers in a settlement involving PepsiAmericas Inc., a former owner of a Federal-Mogul manufacturing unit. Minneapolis-based PepsiAmericas had objected to both versions of the plan but agreed to drop its objections with the consent of its insurers. Hartford's refusal has cast doubt on the Pepsi-Cola bottler's participation. A PepsiAmericas spokeswoman declined to comment.

Federal-Mogul is pushing for confirmation of either version of its plan so that it can exit Chapter 11 before year end, when favorable terms on a \$3.5 billion exit financing package are set to expire and would have to be renegotiated.

Lawyers involved in the case said they are uncertain how quickly U.S. Bankruptcy Judge Judith K. Fitzgerald will rule on the plan. Another hearing is scheduled for this week.

Auto parts maker Federal-Mogul filed for Chapter 11 protection in 2001, deluged with asbestos injury claims related to brake pads, gaskets and other products it manufactured.

After several years of negotiations and settlements with insurers and other parties, the company filed a fourth amended reorganization plan earlier this year. The plan would create a series of trust funds to handle seven separate "streams" of asbestos claims arising from different Federal-Mogul operations, including its Felt Products Manufacturing Co. unit, its Vellumoid gasket division and businesses it acquired from Pneumo Abex Corp.

The trust funds would receive a majority stake in the reorganized Federal-Mogul's common stock along with proceeds of insurance recoveries.

Travelers and Wausau have objected to the plan's treatment of Felt Products and Vellumoid claims. The insurers argue that the

FEDERAL-MOGUL SAGA

Major events in the history of Federal-Mogul Corp.

- Oct. 1, 2001: Federal-Mogul and subsidiaries in the United States and United Kingdom file for bankruptcy reorganization after being deluged with asbestos injury claims.
- Nov. 17, 2006: A British court discharges the U.K. subsidiaries from court administration.
- Feb. 2, 2007: After years of negotiations and settlements with insurers and others, Federal-Mogul wins court approval to present a fourth amended reorganization plan to creditors. All classes of creditors, including representatives of current and future asbestos claimants, vote in favor of the plan.
- June 18, 2007: Hearings to confirm the plan begin before a U.S. Bankruptcy Court Judge Judith K. Fitzgerald in Pittsburgh.
- Oct. 1-2, 2007: Judge Fitzgerald hears closing arguments on confirmation of the plan, which Federal-Mogul seeks to put into effect before year-end. Two insurers—Travelers Indemnity Co. and Employers Insurance Co. of Wausau—object to the plan's treatment of certain claims.

plan violates bankruptcy rules because a trust subfund intended to cover the claims would be funded only with insurance proceeds, not with stock or other contributions from Federal-Mogul. A trust fund for the claims isn't even necessary, insurers add, because they amount to a small fraction of Federal-Mogul's overall liabilities and have large policy limits available to cover them.

PepsiAmericas' objections, meanwhile, relate to Pneumo Abex, a predecessor of which the bottling company owned in the 1970s and 1980s.

Two versions of Federal-Mogul's plan differ mainly in how they treat Pneumo Abex claims. The "A" version of the plan would channel all of these claims into a trust and bar further claims against Federal-Mogul and a previous owner of the business, Cooper Industries Inc. The "B" version would protect only Federal-Mogul.

PepsiAmericas had objected to both versions on the grounds that they would tap PepsiAmericas policies during the period it owned Pneumo Abex to fund Pneumo Abex claims.

While PepsiAmericas later agreed to drop its objections with insurers' agreement, it was unclear late last week whether the bottler would maintain that stance.

Risk retention groups criticize overzealous states

Some back penalties for violating the Liability Risk Retention Act while others favor creating a federal regulator

By **MARK A. HOFMANN**

WASHINGTON—The Liability Risk Retention Act should be amended to punish states that ignore it by subjecting risk retention groups to abusive and illegal regulation, according to some state regulators.

Under federal law, risk retention groups that meet the licensing requirements of one state do not have to meet the licensing requirements or other regulations of other states in which they operate. But as several participants noted during a panel discussion of regulatory issues at the National Risk Retention Assn.'s annual meeting late last month in Washington, some states attempt to get around the law.

To deal with those states, the risk retention statute should be amended to allow punitive damages to be levied against states that break the law, said Dana Sheppard, associate commissioner in the District of Columbia's Department of Insurance, Securities and Banking. Congress should "give the act teeth" that he said "would give those states pause" before ignoring the law.

"Probably the best solution would be to sue those states, but very few risk retention groups have that kind of money," said Jeffrey Kehler, program manager for the South Carolina Department of Insurance's alternative risk transfer services area. Like Mr. Sheppard,

Mr. Kehler said, "Now would be a great time to put some teeth into the act."

"Throw them in jail," said Rod Morris, Arizona administrator of captive insurance, to the audience's laughter.

William White, administrator of the Delaware Department of Insurance's captive insurance program; Craig Watanabe, Hawaii's captive insurance administrator; and Gary Cooper, deputy commissioner of captive programs in Nevada's Division of Insurance, advocated getting the National Assn. of Insurance Commissioners involved in the issue. One idea was to tie NAIC accreditation to states' willingness to abide by national risk retention

group rules. Another would be to have the NAIC serve as arbitrator in disputes between RRGs and the states. But Mr. Morris said he was not sure that the NAIC would have the authority to enforce decisions made through arbitration in such disputes.

States need to be educated that "these things aren't going away," said Mr. Cooper.

"I agree it's an educational process," said Peter Raymonc, director of examinations for the Vermont Captive Insurance Division.

But regulators on the panel said that some states simply do not like risk retention groups and captive insurers. The majority of states that don't have captives are unhappy

with their limited authority to regulate them. They believe "risk retention groups should be regulated like traditional companies." Mr. Cooper said that some states "don't like the concept" of risk retention groups, adding that only a few states fell into that category.

There's a camp within insurance regulators that does not like "limited regulation—they believe in unbridled regulation," said Mr. Kehler, who cited Florida as an example of that approach. In fact, both Florida and California came up repeatedly as examples of states that subject RRGs to regulation beyond that provided by federal

See **RRGs** page 67

WellPoint separates commercial, consumer

Revamp extends to the executive ranks

By **GLORIA GONZALEZ**

INDIANAPOLIS—WellPoint Inc.'s decision to realign its business operations and make numerous executive-level changes is not a cause for concern for employers, analysts say.

The Indianapolis-based health insurer last week announced a reorganization of the company to create two separate units focused on the commercial and consumer health insurance sectors and the creation of a new health solutions division focused on optimizing the quality of health care and the cost of care management, effective Oct. 15.

The commercial business unit will include small and large local group customers, national accounts, UniCare and the specialty products division. A separate consumer business unit will include the senior and state-sponsored—namely state Medicaid programs—division and the individuals-under-65 segment.

"It's nothing revolutionary," Stephen Zaharuk, vp and senior analyst for Moody's Investors Service Inc. in New York, said of the company's decision to create the two separate business units.

In making the changes, Angela Braly, president and chief executive officer of WellPoint, is "putting her stamp on the company" after tak-

ing the leadership reins from Larry Glasscock on June 1, said Bradley Ellis, director at Fitch Ratings in Chicago.

The separation of the company's business operations into two distinct units could position WellPoint to take advantage of growth opportunities in the government segment

by refining its focus on that business, said Joseph Marinucci, credit analyst with New York-based Standard & Poor's Corp.

Several WellPoint executives, including John S. Watts Jr., president and CEO of the combined commercial and consumer unit, will resign from the company in the next 15 months, the company also announced.

Each new segment will have a new president and CEO leading the division, all of whom were hired internally, which is a good sign because "they are people who know the organization," said Sally Rosen, a senior financial analyst with Oldwick, N.J.-based A.M. Best Co. Inc.

The changes will not affect the day-to-day operations of the company that have the most impact on buyers, such as pricing and claims processing, analysts say.

"I don't see it as a drastic change," Mr. Zaharuk said. "I don't think anyone should be nervous about it."



Angela Braly took over as president and CEO of WellPoint Inc. in June.

Errors and Omissions

A story in the Oct. 1 edition, "Capacity not Available for Megacatastrophes," contained an out-of-date title for Kristian Moor of American International Group Inc. Mr. Moor is AIG's executive vp, domestic general insurance.

Unusual tactics back captive success

Energy company expands covered benefits; automaker builds its brand

By **JERRY GEISEL**

SOUTHAMPTON, Bermuda—A captive that pioneered funding employee benefit risks is taking on more of them.

Seven years ago, Columbia Energy Group broke new ground when the Labor Department approved its proposal to fund long-term disability risks through the Vermont branch of its Bermuda-domiciled insurance subsidiary, Columbia Insurance Group Ltd.

Columbia Energy, then of Herndon, Va., was not the first U.S.

employer to fund benefits through a captive. But Labor Department rules—chiefly one that required 50% of a captive's business to be third-party risks—were a near-impermeable barrier to funding

MORE BERMUDA COVERAGE: The island remains captive sponsors' "domicile of choice," but Vermont is a strong competitor. This story is online at www.businessinsurance.com/conferenceextra.



benefits through a captive since few employers would want to take on so much third-party business.

While the Labor Department never abandoned its 50% test, it gave employers an alternative way of winning departmental approval to fund benefits through their captives when it approved Columbia Energy's application.

To gain approval, an employer has to use a highly-rated insurer to write the policies, increase benefits for plan participants and use an

See **BENEFITS** page 63

Consumer-driven health care debated

Employer, insurer adoption rates of CDHPs fall short of expectations

By **JOANNE WOJCIK**

WASHINGTON—Is consumer-driven health care just getting started or is it already on its way out? The answer depends on whom you ask.

Both perspectives were presented last month at the National Consumer Driven Healthcare Summit in Washington, ruffling more than a few feathers.

Unlike many health insurance industry events that generally "preach to the choir," the summit featured presentations from two Washington-based groups that have been highly critical of the consumer-driven health movement: the New York-based Commonwealth Fund and the Yonkers, N.Y.-based Consumers Union.

Sara Collins, assistant vp at the Commonwealth Fund, presented findings of the 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, which found that enrollment in CDHPs has been virtually static since 2005.

Jim Guest, president and chief executive officer of the Consumers Union, offered his impressions of the study.

"Consumers did not drive HSAs," Mr. Guest insisted. "They may be good for the wealthy and the healthy," but HSAs are mostly driven by "employers trying to save money and insurers trying to increase profits," Mr. Guest said.

James Robinson, newly named editor-in-chief of Bethesda, Md.-based health care industry journal Health Affairs and a former economics professor from the University of California-Berkeley, said the death knell is already sounding for the health plan model just six years

after it was introduced.

"The vision of self-directed care has faded" and is being replaced with population-based health management approaches, he said during another panel discussion held during the three-day summit.

In addition, employers and insurers are not adopting consumer-driven plans at the rate that had been expected, and the individual market is not developing to allow employers to get out of the health care business, Mr. Robinson said.

Contrary to the original objective of consumer-driven health care—that plan members be given the freedom to choose providers—most CDHP members are choosing providers that are linked to managed care networks, "demonstrating that they value the role of the health plans in negotiating unit prices and providing utilization management," Mr. Robinson said.

In fact, many early CDHP companies have "been swallowed up by

See **CDHP** page 65

MORE NCDHS COVERAGE: Walk-in clinics with a customer focus and "information therapy" programs bring surprising cost drops. These stories are online at www.businessinsurance.com/conferenceextra.





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No-match: Employers fear rules may add to liabilities

CONTINUED FROM PAGE 5

As in the past, a no-match letter does not authorize an employer to terminate those workers.

But unlike before, employers and employees would have to reconcile the discrepancy within 93 days. Problems can be corrected within 90 days by employers or employees detailing how the no-match occurred, such as through a clerical error or because an employee changed names after marrying.

If the no-match cannot be rectified within 90 days, employees would have three more days to verify that they are authorized to work. They would have to do that by completing the federal I-9 employment verification form and presenting documents—except those containing the questioned Social Security number and lacking a photo—that all prospective authorized workers are required to produce before an employer is permitted to hire them.

Despite a contrary assertion in the AFL-CIO lawsuit, the DHS regulations do not state that employers must terminate employees who fail to resolve the problem. Employers that retain those employees, however, would risk exposing themselves to civil and criminal prosecution for having "constructive knowledge"—or a substantial amount of circumstantial evidence—that they were employing unauthorized workers.

Among the problems with the regulations is that the Social Security database is fraught with errors, the AFL-CIO says in its lawsuit. For example, a December 2006 report by Social Security's Inspector General points out that an agency file containing information on all new and replacement Social Security cards contains more than 17.7 million records with information discrepancies and that almost 12.7 million of those records pertain to native-born U.S. citizens.

If Judge Breyer upholds the new regulations, Social Security is ready to send no-match letters to 140,000 employers with at least 10 employees for whom discrepancies have been identified, according to an agency spokeswoman. She could not say how many employees would be affected at those companies, but she noted that the agency also is ready to send no-match letters to 8.6 million individuals.

Given the number of Social Security errors and the limited time to resolve them, employer attorneys and officials for employer groups say some authorized workers of particular national origins likely will be terminated mistakenly.

In its information insert, Immigration and Customs Enforcement assures employers that the U.S. government would not prosecute them for mistakenly terminating authorized employees if the new rules were followed and applied consistently in all cases.

The problem with that assurance is that the U.S. Department of Justice and the U.S. Equal Employment

Opportunity Commission have not publicly stated whether the government would honor it, said Heath Weems, director of education and workforce policy at Washington-based National Assn. of Manufacturers. Mr. Weems said Immigration and Customs Enforcement is not authorized to unilaterally issue that guarantee.

The Justice Department did not respond to requests about the guarantee.

Even if the government does not prosecute an employer, nothing in the new regulations would prevent mistakenly terminated workers from filing suit, Mr. Weems said.

Employer attorney Gerald L. Maatman, a partner at Seyfarth Shaw L.L.P., agrees.

But while the Safe Harbor regulations create "many hoops to jump through," they also establish "a pretty darn good defense" for employers that comply with them, Mr. Maatman said.

The key for employers would be handling all no-match cases "exactly the same way," regardless of an

While the Safe Harbor regulations create 'many hoops to jump through,' they also establish 'a pretty darn good defense' for employers that comply.

Gerald L. Maatman,
Seyfarth Shaw L.L.P.

employee's national origin, said employer attorney Clare Draper, a partner at Alston & Bird L.L.P. of Atlanta.

But the appropriate response if a no-match issue cannot be resolved within 93 days is a troubling issue for employers, because the DHS regulations do not provide clear directions, said Shawn McBurney, senior vp of governmental affairs for the Washington-based American Hotel & Lodging Assn.

That lack of guidance suggests that DHS expects its rules would be "self-enforcing" by scaring away unauthorized workers, he said.

An Immigration and Customs Enforcement spokeswoman scoffed at the prospect that employers would face any discrimination claims from terminated workers.

She noted that authorized workers who are identified in Social Security no-match letters and cannot rectify the problem in time still would be allowed to produce a few of about 30 different documents that would demonstrate they may work legally in the country. Their inability to produce any of those documents strongly suggests they are unauthorized workers, she said.

AFL-CIO, et al. vs. Chertoff, et al., U.S. District Court for the Northern District of California, No. 07-CV-4472 CRB.

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Business Insurance OPINIONS

UAW health care deal good for all involved

THE UNITED AUTO WORKERS union's new contract with General Motors Corp. finally recognizes a problematic burden that many employers face.

In our view, the most significant part of the agreement involves retiree health care benefits. Under the agreement, which awaits ratification by UAW members, GM is to contribute roughly \$30 billion to a special trust—a voluntary employees' beneficiary association—that the UAW, or its appointees, will control.

In return, GM no longer will provide retiree health care coverage and no longer will be responsible for accumulated obligations now estimated at more than \$50 billion.

Why would UAW leaders, whose prior efforts have focused with great success on winning gold-plated health benefits for members, agree to allow GM to contribute far less—and then no longer provide any coverage—than the current value of retiree health care benefits?

The answer is simple: The UAW recognizes that the retiree health care burden is a crushing cost for GM. If GM has to continue to spend billions each year on retiree health, it isn't going to have the money it needs to develop better products and compete more effectively with its more cost-efficient rivals. That means fewer jobs for UAW members.

And, in a worst case scenario, if retiree health care costs along with other problems result in GM, which has lost about \$12 billion over the past two years, filing for bankruptcy, all retiree health care benefits could be lost. That would be a catastrophe for several hundred thousand GM retirees and dependents.

In short, the UAW recognizes, if somewhat belatedly, real world economics. If the agreement improves GM's fiscal health, that will be a real victory not just for GM but for UAW members as well.

The UAW recognizes that retiree health care is a crushing cost for General Motors.

Regulatory reform saga may be worth the wait

REP. PAUL KANJORSKI'S announcement that he intends to conduct a thorough examination of insurance regulatory issues—with an emphasis on thorough—comes as little surprise.

The chair of the House Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises is not known for his rashness. But although proponents of comprehensive insurance regulatory reform—and we count ourselves among them—would prefer action sooner rather than later, the Kanjorski approach certainly has merit.

Rep. Kanjorski, D-Pa., has noted that nearly everyone involved in the regulatory debate acknowledges serious shortcomings in the current state system. The major point of contention is whether those shortcomings are serious enough to warrant developing a system of federal regulation for those who prefer one regulator to more than 50.

Rep. Kanjorski emphasizes that he is not launching his examination with any preordained result or with any ax to grind. But by examining all aspects of regulation, Rep. Kanjorski may well put to rest any residual notions that the existing system can be reformed to the extent it must to meet the demands of a 21st century global insurance marketplace.

We realize that Rep. Kanjorski's approach means there's a long road ahead for reformers. But if that road ends with the establishment of a system of optional federal chartering for insurers and producers alike—the trek will have been well worth the effort.



BI beats list

In an effort to ensure continuing timely coverage of risk management, insurance and benefit-related news, *Business Insurance* has formalized a list of its reporters' assigned beats. This list is not intended to be exclusive but rather to represent core subject areas of importance to BI readers. BI welcomes ideas and tips from readers on these and other areas. Following is a list of the beats and the principal reporters for each:

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Benefits-retirement savings/pensions: Jerry Geisel.	Industry Focus: Rodd Zolkos, Meg Fletcher.	Risk management profession: Dave Lenckus.
Canada-risk management and benefits: Gloria Gonzalez.	Insurance coverage litigation: Douglas McLeod.	Runoffs/receiverships: Douglas McLeod.
Employment practices: Judy Greenwald.	Insurance fraud: Douglas McLeod.	Safety/ergonomics: Meg Fletcher.
Environmental risk management: Sally Roberts.	Latin American markets: Roberto Cenicerros.	Surplus lines/wholesalers: Roberto Cenicerros.
Federal regulation/legislation-benefits: Jerry Geisel.	Property/casualty industry operations: Judy Greenwald.	Tort reform: Mark A. Hofmann.
	Professional liability: Dave Lenckus.	Work/life benefits and EAPs: Sally Roberts.
	Property loss control/cat risks: Mark A. Hofmann.	Workers compensation: Roberto Cenicerros.

Online Poll at www.businessinsurance.com

Should Congress seek to equalize the tax burden of U.S.-owned and Bermuda-owned insurers and reinsurers?



NEXT WEEK'S POLL: How many more unions will take on responsibility for managing their members' retiree health care arrangements?

BI Online Poll tool sponsored by Wausau Insurance Cos.

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- 40 years of new terminology
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BI has witnessed 40 years of an industry's evolution



In the 40 years since *Business Insurance* began publishing, we've devoted a lot of time and ink to chronicling change. How many issues have we produced since our first one in 1967? Give or take a few, I estimate that *BI* has published 1,737 regular issues as a biweekly from '67 to

'81 and as a weekly magazine since then. Two of the hallmarks of *BI* are the talent and longevity of our staff. I have been privileged to work at *BI* for the past 15 years, though many of my colleagues have been here even longer. One of them, our Editor-at-Large Jerry Geisel, has been with the magazine for more than 30 years.

I could not be more proud of our staff, who strive daily to help our readers understand the complex issues facing risk managers and benefit managers, and the legacy of my predecessor editors, who all helped to make *BI* a must-read.

Anniversary issues such as this one are an opportunity for self-congratulation, but we thought it would be more important—and more

interesting—to reflect the industry we cover. As a result, this edition looks at the major developments in commercial insurance, risk management and benefits since 1967. We traced the evolution of major lines of coverage, such as directors and officers liability insurance, as well as health care benefits.

Because insurance is a people business, we've profiled several iconic leaders whose vision shaped the industry over the last four decades.

This issue also contains columns by several astute observers of the industry. Regular columnists John J. Hampton and Myron Picoult are joined by Gordon Stewart, past president of the Insurance Information Institute, who will be writing a periodic column on the intersection of insurance and social policy. Paul Winston, our editorial director and associate publisher—who has been at *BI* nearly 25 years himself—and Jerry Geisel offer their perspectives on the past 40 years, too.

Online, readers will find additional features, including a slide show of editorial cartoons by Roger Schillerstrom, who has been sketching for us since the mid-1980s.

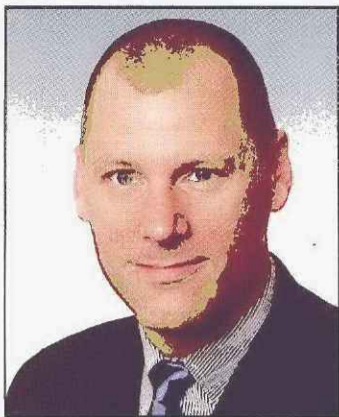
We don't know what the next 40 years will bring, but *BI* will be there to cover those events.

Regis J. Corica

PEOPLE/EVENTS/ISSUES



Getting ready to cover the next 40 years of changes



By **PAUL WINSTON**

On the 40th anniversary of *Business Insurance*, I have an opportunity to reflect on the changes affecting our readers over the previous four decades and consider what the future might hold.

The biggest change can be found in our title. *Business Insurance* was an apt description of the market we served in 1967: The buyer of commercial insurance, including both property/casualty and life/health coverages.

Not long after our launch, however, the risk manager arrived on the scene, exploring ways not only to buy insurance more cheaply but also to analyze and control the risks that insurance covered.

While the original motivation of this professional manager often was simply to better understand insured exposures, today, with the growing focus on enterprise risk management, the goal also is to analyze, control and communicate risks that cannot yet be transferred. Risk managers today also have

greater attention from the board, due to new corporate governance regulations on the public disclosure of risk as well as the ever-present threat of liability and litigation.

Another change for risk managers is that insurance today is not automatically the ultimate solution to finance or transfer risks, first with the advent of captive programs and later with other financial tools, such as securitization.

On the benefits side, we have seen a similar development of a professional manager of these

programs from the humble origins of a business insurance buyer.

With the health care cost inflation witnessed over 40 years, the value of benefit managers' efforts to control those costs has also grown in importance. Benefit managers have striven to combat inflation through analysis of health care cost drivers; creative and varied plan designs; and introduction of programs to manage costs on the front end, such as preventive wellness care, and on the back end, through case management of high-cost procedures.

For benefit managers, the effort to gain in prestige and be recognized for their efforts has been a challenge because the key metric of success is the cost of health care that, despite their best efforts, remains largely beyond their control. Consider that it is the plan participant's health and behavior that has the greatest impact on health care costs; less so the benefit manager's programs and plan designs. Similarly, the effectiveness of the medical system has traditionally been a take-it-or-leave-it arrangement, beyond the influence of the employer. Both elements must be addressed in order for the benefit manager to gain a grasp of health care inflation.

What about the future?

For risk managers, a glimpse can be seen in current developments: major losses from unmanaged supply chains, reputational risks caused by outsourcing operations to countries with poor regulation, global infrastructure facilitating the spread of pandemics, ideological conflicts giving rise to security and terrorism exposures, inefficient markets and regulatory models, volatility in the supply of natural resources, abandonment of traditional insurance structures and players, and more severe catastrophe losses caused by the higher property values and lives at risk. The key for risk managers will be helping to view the big picture of risks—not try to identify every possible risk and adverse outcome.

On the benefits side: more aggressive wellness programs, including smoking cessation and fitness; more direct employer involvement in delivering basic care, including onsite nursing care; more advanced benefit financing models in the private sector; development of a benefits manager organization to advance the profession and provide much-needed advocacy; and growing political pressure to make government the primary payer for basic medical care, with employers providing additional care and options as a benefit. For benefit managers, the big change will be the need to influence health care at a fundamental level—both in the well-being of employees participating in their plans and in shaping the health care system itself that cares for them.

Business Insurance looks forward to covering these developments for the next 40 years.

Paul Winston is associate publisher and editorial director of Business Insurance, which he joined in 1985.

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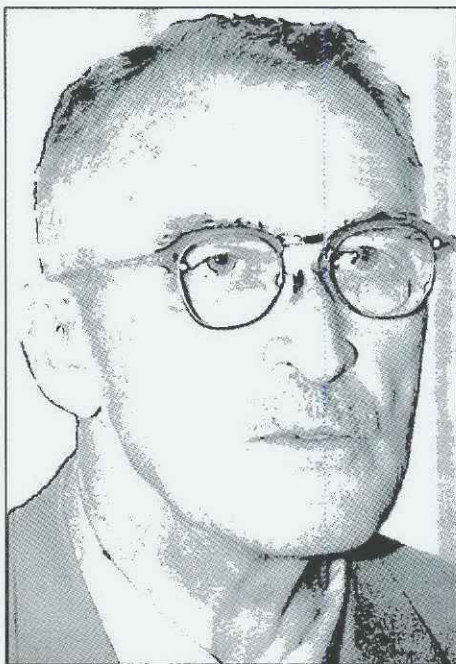
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Risk pioneer advanced profession

Douglas Barlow, who created first risk management program, was a mentor to many

By **DAVE LENCKUS**

Douglas Barlow



Circa 1970



1992

Douglas Barlow stood erect—regally, some say—and spoke professorially.

It seemed fitting for the man considered the father of risk management, according to those who knew Mr. Barlow.

It also seemed remarkable, according to one observer who was influenced by him, because of the illness that the Canadian had to overcome as a young man.

Ironically, it was his battle with tuberculosis that led the bespectacled Mr. Barlow, who sported a David Niven-style moustache and spoke with a light British accent, to the risk management profession.

But Mr. Barlow took the lead from there. He exhorted that all management is risk management and was named the first risk manager in 1963. He stressed the importance of understanding the full cost of risk, not just the insurance expense piece. He advanced new ideas about risk until he died. He willingly gave advice when sought out by younger risk managers. And he truly enjoyed mentoring.

Despite his distinguished demeanor, the highly educated Mr. Barlow was a kid at heart, said Shirley Brennick, who was his life partner his last 26 years and who emphasized their 40-year age difference.

It was that attitude that energized him until his death in 1998 at age 91 to continue investigating new ideas—in risk management and other areas of personal interest, such as technology, she said.

Indeed, “he was editing his last article in his hospital bed” two weeks before he died at home of pneumonia and congestive heart failure, Ms. Brennick recalled.

Mr. Barlow, who was born in 1907, had no aspirations as a young man to build a career in insurance. He earned a bachelor’s degree in math and a master’s degree in astrophysics in the 1920s. Then he headed to the University of Oxford in England where, as a Rhodes Scholar, he earned two law degrees. Upon his return to Canada, he earned another civil law degree that familiarized him with the Napoleonic Code.

But with his education concluding at the height of the Great Depression, he had difficulty finding work in the field of law. He eventually took a position as general counsel with an insurance broker in Quebec City.

Mr. Barlow also became a professor of insurance at Laval University in Quebec and briefly opened his own law office.

But after he contracted tuberculosis—the second time he had fallen ill with the disease—he had to abandon his law career for something less taxing on his system, Ms. Brennick said.

Given his insurance background, Mr. Barlow in 1959 landed a position as insurance manager for Toronto-based agricultural equipment manufacturer Massey-Ferguson Ltd., which eventually disappeared as a corporate entity but remains an equipment brand for AGCO Corp. of Duluth, Ga.

At Massey-Ferguson, he was credited with creating the first global insurance and risk management program that encompassed all of the company’s exposures worldwide. In 1965, he launched one of the earliest captive insurers to write the company’s primary property and liability coverages.

After years of exhorting that all management is risk management and that insurance procurement is just one aspect of

it, Mr. Barlow received the title of risk manager in 1963.

Marc Darby, a fellow Canadian whose risk management career was beginning as Mr. Barlow’s was ending and who occasionally sought advice from the Rhodes scholar, marveled at his mentor’s achievement.

“So many years back, risk management was not even known, but he was able to instill risk management within his organization,” said the former president of the Risk & Insurance Management Society Inc., who is retired.

Mr. Barlow’s profession would never be the same.

“It’s had an impact on organizations ever since,” said Nowell Seaman, manager-risk management and insurance services at the University of Saskatchewan in Saskatoon and the immediate past president of the Canadian Risk & Insurance Management Society Inc.

The recognition of the need for someone “to captain the function of risk” is understood today, but in the 1950s, 1960s and 1970s, “this wasn’t spoken of explicitly,” Mr. Seaman said.

Mr. Barlow championed his concept of risk management through his long involvement in RIMS, which was named the American Society of Insurance Management Inc. when it was created in 1950.

But Mr. Barlow did not stop at that, nor did he stop after retiring. In his final years at Massey-Ferguson, Mr. Barlow headed ASIM as its president. During his 1971-1972 term, he was appointed chairman of a committee charged with determining whether to rename the organization. In 1975, the committee chose the organization’s current name.

“This change represented more than a name change since it permitted members to emphasize that we were doing more than purchasing insurance (e.g. loss prevention, transfer, avoidance, etc.) even though effective negotiation of insurance was still an important task,” retired risk manager Lloyd Hackett said in a statement. Mr. Hackett was the risk manager for Toronto-based T. Eaton Co. Ltd., once Canada’s largest department store chain before folding in 1999.

“I think he really raised the professionalism of the organization,” said Susan Meltzer, a protégé of Mr. Barlow and the 1999-2000 president of RIMS.

He “tried to lead or push RIMS to lead the way” on many issues of importance for risk managers, including the organization’s image, its role in aiding members with their education and encouraging members to broaden their overall business knowledge, said Ms. Meltzer, assistant vp of risk management for Aviva Canada Inc. of Scarborough, Ontario.

Mr. Barlow also is widely credited for devising the concept that an organization’s total cost of risk extends far beyond the insurance premiums it has paid and includes factors such as its investment in loss prevention, unreimbursed loss expenses and administration expenses.

“This is really the concept that started getting people to think that they need to control risk,” Ms. Meltzer said.

While Mr. Barlow was a pioneer in adopting and strongly advocating the concept, he was troubled when credited with developing it, Ms. Meltzer and Mr. Hackett noted. The concept was developed in the late 1950s by the late H. Wayne Snider, a

professor at Temple University. Mr. Barlow began implementing the risk management concept at Massey-Ferguson in the early 1960s.

The distinction between the concept’s creation and its introduction to the risk management community is lost on many observers, however.

“Any professor in any university can think of any concept, but somebody has to implement that concept somewhere” and then “sell the concept to his peers,” Mr. Darby said. “Doug is the soul of this concept.”

But he never thought it was something that risk managers should use to benchmark their organizations against others, because every organization’s risk is unique, Ms. Meltzer said.

Mr. Barlow also is remembered for his mentoring of and influence on young risk management professionals.

“Everything that was new was of interest to him,” Ms. Brennick said. “That’s why he so enjoyed the company of younger people,” ranging from the neighborhood youth he taught to handle power tools effectively and safely, to the college students he encouraged to pursue careers in risk management, to risk managers who asked for his advice.

“He was the early version of the Spencer Foundation,” the RIMS educational support program for college students, said Walter S. Tomenson, a managing principal and the senior client adviser at New York-based Integro Insurance Brokers Ltd.

When Mr. Tomenson was in college, his father—a principal of a Canadian insurance brokerage for which Mr. Barlow later became corporate secretary—arranged for Mr. Barlow to review the younger Mr. Tomenson’s thesis comparing insurance regulation in Canada and the United States.

Mr. Barlow “was really supportive and encouraged me to continue my writings,” Mr. Tomenson said.

Ms. Meltzer said Mr. Barlow mentored her for years. She met him a month after she began her risk management career in 1983, but their relationship “stepped up” tremendously when she joined the RIMS Executive Committee in 1994, she recalled.

“I would get these amazing phone calls from him. He’d say, ‘Here’s a concept, but I don’t want to think about it anymore.’ That was his way of mentoring me,” she said, adding that he sometimes would deliver his ideas in a handwritten note. In the mid-1990s, he was theorizing about what is now known as enterprise risk management, she recalled.

Others fondly remembered how Mr. Barlow gladly and robustly shared his thoughts on risk management one-on-one with risk managers who sought his advice.

“My feeling was that he was pleased that I called him,” recalled Mr. Darby, a member of the *Business Insurance* Risk Management Honor Roll in 1992. “Needless to say, he was a good consultant of mine,” said Mr. Darby, who retired from Montreal-based Bombardier Inc. in 1998.

Mr. Barlow also held court for groups of risk managers in hotel suites during RIMS conferences and at his own residence near Toronto when he was involved in industry groups.

“Douglas liked nothing better than to find somebody who was willing to listen to his theories about risk management,” Ms. Meltzer said.



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Risk management's role in property loss control matures

Managers take advantage of advances in computer technology, catastrophe modeling

By **MARK A. HOFMANN**

Property loss control has evolved with the risk management profession itself.

Forty years ago, fire was the peril that received the most focus, and that focus tended to come in the form of one particular type of sprinkler system used almost exclusively for manufacturing facilities, experts say. Computer catastrophe modeling didn't exist, because the ubiqui-

tous electronic data processing systems and networks of today didn't exist. And terrorism simply wasn't part of the picture.

But as risk management has matured, so has loss control and risk managers' role in loss control, said Steven Sachs, senior vp in Hilb Rogal & Hobbs Co.'s Columbia, Md., office.

Mr. Sachs said that when he entered risk management nearly 40 years ago, "risk management was

somewhat in its infancy—risk managers were thought of as insurance buyers." Building codes didn't even require sprinklers for shopping centers, said Mr. Sachs, who spent much of his career as risk manager for the Rouse Co., a shopping center owner and manager that has since been acquired by Chicago-based General Growth Properties Inc.

"Now, it's a different world," with risk managers being involved in the design of the structures it is their

responsibility to protect, he said.

"The key thing is risk managers getting involved on the front end," Mr. Sachs said. "It's a lot less expensive to look at those things before you put the first shovel in the ground" than to try to build in loss control after a structure is ready for occupancy.

In addition, loss control has gone beyond simply protecting a piece of property.

"It's not only objects any more,

it's whole processes and systems," said Mike Petruzzello, executive vp and chief underwriting officer for Hartford Steam Boiler Inspection & Insurance Co., a Hartford, Conn.-based unit of American International Group Inc. "We talk about systems today more than specific objects."

One of the biggest changes over the past decade or so is that risk managers are demanding ownership of their loss data, whereas they had once left that under control of their underwriters, said John Durante, president of Risk Logic Inc. in Woodcliff Lake, N.J. As a result, they've turned to third-party vendors to help them make the best use of the data.

The expansion of computer technology has been a critical component of loss control, said Bob Esenberg, former risk manager for the city of Virginia Beach, Va., and now the Virginia Beach-based president of States Self-Insurers Risk Retention Group Inc. in Minneapolis. In the 1970s, all loss control information had to be updated using key-punch computer cards, and catastrophe modeling "was unheard of," he said. Now, both risk managers and insurers are using cat modeling "very extensively," he said.

"A lot of loss control techniques now are available at the press of a finger," Mr. Esenberg said. "Before, it took a lot of energy and effort to learn a lot of things about loss control."

"The biggest changes are the influence of science and technology in loss control," said Terry Fleming, director-division of risk management for Montgomery County, Md. in Rockville. This includes better sprinkler systems, better compartmentability in buildings and better building materials, he said.

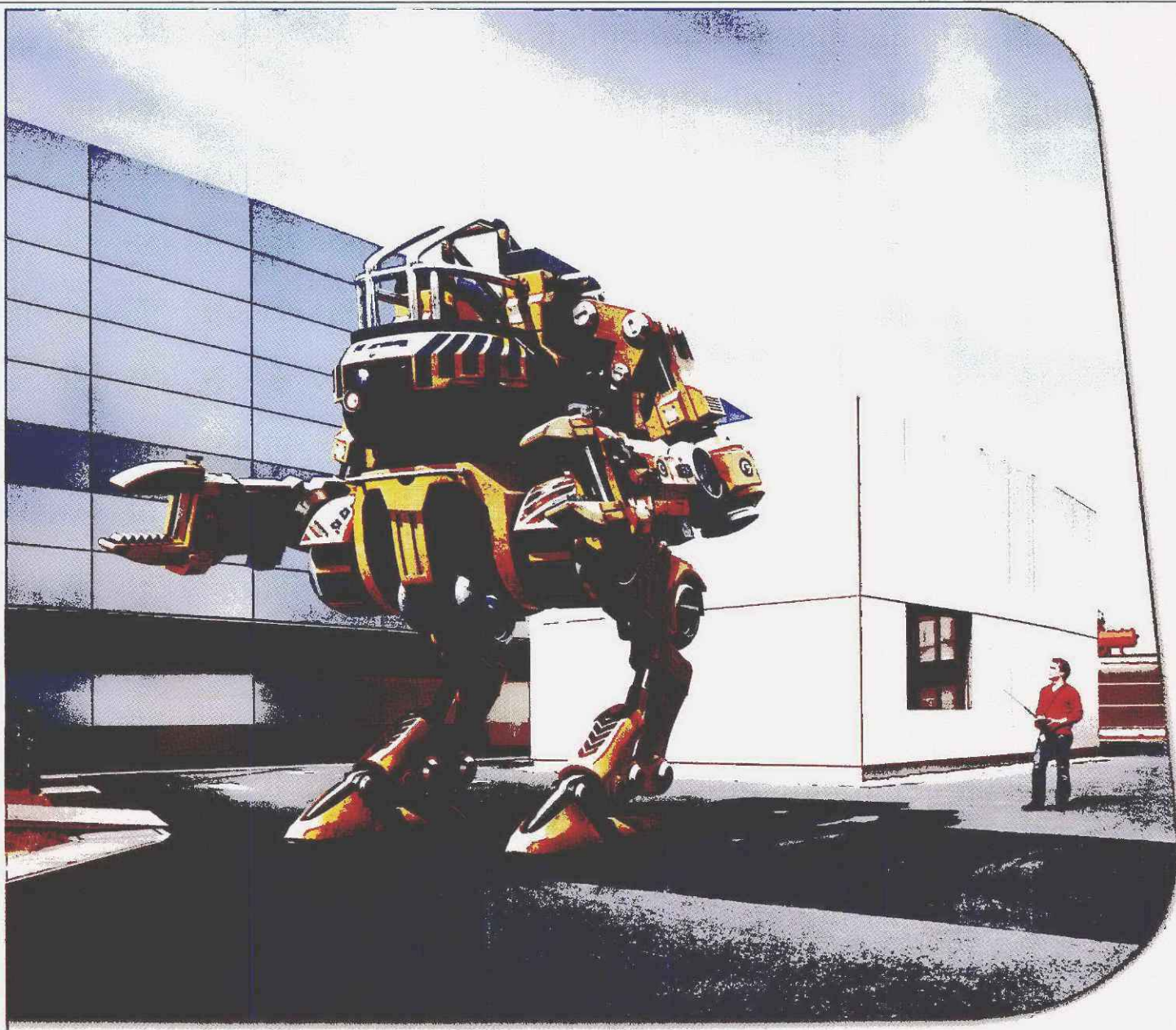
Another major change has been "engineering loss control at the developmental" stages of a project, he said. "For example, having your loss control engineer work with the architect" and integrate loss control options in the actual plans versus jury-rigging something after the building's already been built is the preferable approach, he said.

Fire control

Given the long emphasis on fire peril, perhaps it's not surprising that improvements in sprinkler systems have been a hallmark of the past 40 years.

"The single most impressive innovation as it relates to fire has been the advent of the suppression mode sprinkler," said Tom Lawson, senior vp-engineering and research for Johnston, R.I.-based Factory Mutual Insurance Co., which does business as FM Global. Standard sprinklers were control mode sprinklers, which controlled the fire until someone arrived to put it out, he said. The fire could grow and produce a lot of smoke.

As products became more susceptible to smoke and water damage, the desire was to suppress the fire,



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CONTINUED FROM PREVIOUS PAGE

"not just control it," he said. The new sprinklers resulted in smaller areas affected by fire, less smoke and less damage, he said.

"Sprinkler technology has evolved significantly," said Joe Stavish, North American property risk control practice leader with Willis Group Holdings Ltd. in New York. "Where we had a single standard spray sprinkler head, we now have extra large orifice heads and early suppression, fast-response sprinkler heads."

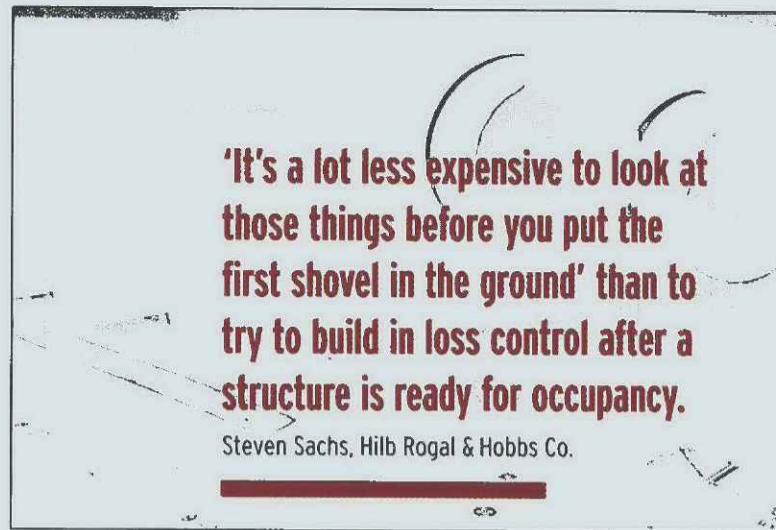
The use of sprinkler systems also has spread into light-hazard exposures such as offices and nursing homes from more traditional manufacturing facilities, he said.

Corporations became more deeply involved in loss control efforts. For example, Bethesda, Md.-based Marriott International Inc. carried out two initiatives in the early 1980s using controlled fires to prove the efficacy of plastic piping in hotel room sprinkler systems. Before the successful Marriott tests, sprinklers relied on iron piping, which was more difficult to install than plastic and which took rooms out of service for days during a retrofit.

Disaster mitigation

With the advent of computer models for both earthquake and windstorm exposure, it is possible to predict the probable maximum loss associated with a facility or multiple facilities in a single zone of influence, said Mr. Stavish.

Engineering has played a key role



in mitigating both perils as well, he said. Buildings now contain elements such as quake-actuated safety shutoff valves, which cut off natural gas automatically to prevent fire following a quake.

For windstorm, roof systems have been reinforced, with the insurance industry increasing its resistance requirements, he said. Roofs that have a wind resistance of 145 to 175 mph are replacing those with 90 mph resistance, said Mr. Stavish.

FM Global "spent a lot of time studying Hurricane Katrina," said Mr. Lawson. After looking into issues involving building material and wind speeds, "we determined there were some pretty basic fixes."

Most windstorm protection can be done for \$10,000 or less at a facility, said Mr. Lawson. This can involve simply nailing down the

flashing around the perimeter, adding more fasteners and improving roofing systems, he said.

Structures also are being made more resistant to terrorist attacks, said Mr. Stavish. Designs incorporate blast-resistant and projectile resistant glass, and there is a renewed emphasis on stair tower construction. Masonry reinforced concrete stairwells can act as "shelter in place" for employees, he said.

Electronic advances

Increasing electronic interconnectivity has also driven advances in loss control.

Electronic data processing as it now functions "didn't exist" 40 years ago, said Fletcher MacGregor, managing director-global natural hazards specialty practice and emergency management specialty prac-

tice for Marsh Inc. in Detroit. He noted that "we've gone through the whole Halon period (for protecting data processing systems against fire), which worked very effectively and was not deemed to be hazardous until the issues with ozone" arose and resulted in the Montreal Protocol of 1987, which banned the use of the fire-suppressing substance. Electronic data processing loss control issues are being addressed through housekeeping, extinguishment and a "pretty rigid set of protocols associated with backup" of data, he said.

Concern that computers would cease to function on Jan. 1, 2000—the so-called "Y2K" bug—also played a role in enhancing EDP-related loss control, he said. "In a lot of ways, the Y2K experience allowed the (information technology) community to lead the way on the business continuity aspects front. They had to go through a lot of soul-searching as we approached the turn of the century."

Global positioning satellite technology has proved valuable in earthquake and flood analysis, said Ken Travers, senior vp in the Wilmington, Del., office of Houston-based ABSG Consulting Inc. It is "being widely used and embedded in the software for cat modeling," he said, including soil information, which is critical for quake and flood analysis.

Applying computer modeling to determining blast and explosion risk has been used in terrorism impact analysis, said Mr. Travers. The models allow their users to test containment technologies, and ABSG has internally developed a model that

deals with the dispersion of gaseous agents, he said.

Modeling has its limits, though, said Bruce Conrad, Zurich property line of business director for risk engineering at Zurich North America in Schaumburg, Ill. There's a lot of potential with both fire and smoke modeling, "but we haven't gone to the brave new world" where we would base design criteria solely on modeling, he said. Test-based standards are still necessary, he said.

Global Risk Consultants Corp. and Miyamoto International recently created a new company called Global Risk Miyamoto to offer "site specific hurricane, windstorm and flood reviews using structural engineers," said Bill Ramonas, chairman and chief executive officer of Global Risk Consultants in Clark, N.J. He said that when firms began using computer modeling in the 1980s, the process was 80% engineering and 20% modeling. "Now it's probably 80% modeling, and you're lucky if it's 20% engineering," he said. Nonengineers use the tools and try to determine structure characteristics "without leaving their office." While that might work for an insurer with thousands of structures, "for a risk manager who's looking to protect the top 10 most valued properties, it's the misuse of a tool."

"It would be somewhat akin to trying to cut down a tree with a pair of scissors or cut a piece of paper with a chainsaw," he said. "So we're going back to basics, and we have site specific services—it's kind of back to the future."

As business has changed, so has coverage for business interruption losses

By MARK A. HOFMANN

As the economy has grown over the past 40 years, so has the reach of business interruption coverage.

What was once a matter of replacing income from a temporarily shut down domestic operation has grown into a complex enterprise as risk managers deal with issues related to globalization, bare bones inventories and supply chain questions.

Exposures that were not considered four decades ago—such as pandemics that may leave physical plants untouched but unusable—must now be taken into account in determining business interruption exposures.

One critical issue has been the development of business continuity planning.

Business continuity planning evolved with electronic data processing rooms, "where the (information technology) became such a critical part of the business," said Joe Stavish, North American property risk control practice leader for Willis Group Holdings Ltd. in New York. Disaster recovery plans evolved into business continuity management, and property insurers want to see evidence of continuity planning, he said.

"There's been a lot greater focus on not just basic loss control engineering, but more around business continuity planning," said Robert Howe, global property practice leader at Marsh Inc. in New York.

But business interruption insurance does not always fully cover market share that might be lost during a down period of time, he said. "Smart companies need to have

good business continuity plans."

"I think what's changed is the whole supply chain, with just-in-time manufacturing and increasing of outsourcing and third-party suppliers," leading to a supply chain that "is really getting stretched," said Tom Lawson, senior

vp-engineering and research for Johnston, R.I.-based Factory Mutual Insurance Co., which does business as FM Global.

"It's not that easy nowadays to replace that third-party supplier," he said.

He said risk managers need to have specialists such as forensic accountants—whose practice has come into its own over the past decade or so, according to Mr. Lawson—who can analyze financial exposure. That's married to property risk assessments to determine where the supply chain is the most exposed, he said.

Some changes have been more prosaic.

"The forms have changed a little bit," said Marsh's Mr. Howe. "If you look back 20 years ago, most of our large commercial clients were using a gross earnings form and that still carries forward today," he said.

In the late 1980s, there was a movement to get away from gross earning terminology, and the Insurance Services Office Inc. came out with business income forms, he said. "But essentially, they try to get you to the same place—which is restoring you to where



you were before a loss."

The more critical changes have come in the nature of the exposure, said Mr. Howe. The risk surrounding suppliers "has changed pretty dynamically" during the past 15 or so years, he said.

For example, a U.S.-based manufacturer might have made all of its own components just a few years ago, and now that same manufacturer may outsource manufacturing of those components, he said. Meanwhile, technology has made it possible to carry out more production in a "smaller footprint," said Mr. Howe.

As a result, all of the products might be manufactured at one site rather than five, and "that creates a magnification of the business interruption risk." With multiple plants, a shutdown of one simply meant switching operations to another, he said. With one plant, that cushion disappears.

The changes in exposure have led to changes in the period a business interruption policy will provide indemnification, experts say.

"One of the biggest things is extended period of indemnity," said Steven Sachs, senior vp in the Columbia, Md., office of Hilb Rogal & Hobbs Co. That covers the gap between when, say, a store reopens and when it resumes full business.

Before the terrorist attacks of Sept. 11,

"some people would get 365 days of EPOI," he said. The coverage, which had usually applied to only about 30 days 40 years ago, had been gradually expanded during soft market periods, he said. Although available EPOI capacity shrank after 9/11, "it's getting back up," he said.

"As the need has increased, so has the coverage," said Dan Loris, senior vp at Zurich North America in Schaumburg, Ill.

Along with the EPOI, business interruption coverage has responded to the economic changes of the past four decades in myriad ways, noted Mr. Loris. For example, coverage can be triggered when the policyholder cannot get products in or out of its facility. There is contingent business interruption extended to "anchor store coverage" that responds to the needs of small businesses that suffer loss when a mall's anchor store shuts down, leaving fewer shoppers to patronize other businesses, he said.

Historically, business interruption coverage has been triggered by actual physical loss, said Mr. Loris. But there is a form of infectious disease coverage that extends to health care and hospitality industries whose facilities could be shut down, but not physically damaged, by a disease outbreak.

All-premises service interruption has been expanded to include Internet, telephone and satellite problems, he said.

"Today, there's a much greater recognition that BI has potential to be a much larger component of loss than previously" was the case, said Mr. Loris. "The larger the loss, the larger the proportional component of the business income is to the total."



Insurer consolidation trend follows market's fortunes

By JUDY GREENWALD

Merger and acquisition activity in the commercial property/casualty insurance industry over the past 40 years has in some respects been a stepchild of the pricing cycle, many observers say.

As a hard market leaves insurers flush with capital, M&A activity has often been a good way to make use of that extra cash. But there have been other driving factors as well, including the desire for geographical and product diversity, economies of scale and increased market share. Negative factors, such as financial pressure and poor underwriting results, have also played a role in industry M&As.

Another more ephemeral trend has been building financial "supermarkets," which is best exemplified by Citicorp's 1998 acquisition of Travelers Group Inc. and renaming the combined operation Citigroup Inc.

Observers point out, however, that the insurance industry has lagged consolidation in many other industries and remains highly fragmented.

M&As that have occurred, though, have been largely beneficial to the industry in creating economies of scale, although observers disagree on its effect on risk managers, who generally have fewer choices among larger-scale operations (see related story).

M&A activity has to a large extent reflected the cycle, many observers say.

"Historically, we've tended to see consolidation pick up in the P/C business as top line progress gets more difficult to achieve, and that usually occurs in a soft market environment, obviously," said John Gwynn, managing director at Memphis, Tenn.-based Morgan Keegan & Co.

"It kind of goes in waves," said James B. Auden, senior director at Chicago-based Fitch Ratings, about M&A activity. "You had a period where conglomerates were more in vogue, and you had noninsurance entities buying insurance companies," he said. These have included Citigroup, ITT Corp., Xerox Corp. and General Electric Co.

"I think there are times when having broader capabilities seem to be in vogue, and there are times when being very, very focused seems to be in vogue," said Jay S. Benet, vice chairman and chief financial officer of St. Paul, Minn.-

based Travelers Cos. Inc. The key issue is how the acquired business can be leveraged in expenses, distribution and product creation, he said.

Travelers has had a part in both trends—Travelers Property Casualty Corp., which Citigroup spun off in 2002 and which merged with St. Paul Cos. Inc. in 2004.

A desire to add territory also has been an M&A factor, observers say.

"A lot of the M&A activity has been driven by foreign insurers trying to diversify geographically by getting into the U.S. market," said John Iten, director at New York-based Standard & Poor's Corp.

Examples include Royal & SunAlliance Group P.L.C.; Zurich Financial Services Group; and Munich, Germany-based Allianz S.E., which acquired Fireman's Fund Insurance Co. in 1991.

The weak dollar could lead to more of this, said Mark Charron, a principal and national actuarial and insurance solutions leader for Deloitte Consulting L.L.P. in Hartford, Conn. "Because of the currency differences right now, the value of the dollar vs. other world currencies clearly is at a low point here, which makes many of our domestic insurance companies more attractive."

Observers say the M&A activity has largely been driven by multiple trends rather than individual personalities.

"Within the P/C sector, there's no personality that jumps to mind that was really a driving force that has a long-term impact on the industry," said Mr. Iten.

Observers also note that the industry has lagged others on the M&A front, including the banking industry.

"The (insurance) industry structure is not that conducive to a lot of consolidation activity," said John L. Ward, chief executive officer of Cincinnati-based Cincinnati Partners L.L.C. "The ownership structure in many ways tends to be an impediment, with a number of big mutual companies in the industry."

Nor is this situation likely to change, observers say.

There will not be massive consolidation in the future, said Oren Linden, Watson Wyatt Worldwide's New York-based practice leader for U.S. Property & Casualty Actuarial Services. "I think you'll see the occasional large deal and a lot of little deals."

Fewer insurer insolvencies expected

Company management and regulation make positive changes

By JUDY GREENWALD

Some big-name companies, including Kemper Insurance Cos., Reliance Insurance Group and Home Insurance Group, among many others, have left the insurance industry scene over the past 40 years.

While there are reasons particular to each company, there are some common factors that explain their disappearance as active insurers, including inadequate loss reserves, poor underwriting, weak pricing, too-rapid growth, mismanagement, unreliable reinsurance and unforeseen liabilities, such as asbestos, observers say.

In many cases, it is a matter of "you underpriced your business, you

overextended your capital and your reserves were way short, and it took a long time to figure it out or own up to it," said James B. Auden, senior director at Fitch Investors Service in Chicago.

But many believe company management and regulation will mean fewer insolvencies in the future.

According to studies by Oldwick, N.J.-based A.M. Best Co. Inc. of the 1,013 financially impaired companies in the property/casualty industry between 1969 and 2006, 53.3% were caused by a combination of deficient loss reserves, inadequate pricing and rapid growth. Best designates an insurer as financially impaired following the first official

regulatory action taken by an insurance department.

The Best survey indicates the primary cause of a company's insolvency, said John Williams, a Best senior business analyst, but "there are often multiple causes that will take a company under." A common pattern is for an already financially weakened company to be "hit by some shock to the system," such as a hurricane, and then fall into insolvency.

While some large companies have failed, Mr. Williams said most tend to be smaller, relatively young companies that "lack the experience, the history of going through hard and

See **INSOLVENCY** page 20

M&As benefit insurers, not buyers

Acquiring companies grow, but buyers often see neutral effect

By JUDY GREENWALD

Have mergers and acquisitions been good or bad for insurers and risk managers?

Observers agree that, despite some failures, M&As generally have been beneficial for insurers and reinsurers, creating bigger, stronger entities.

But observers disagree on how consolidation has affected risk managers, who have been left with fewer choices but often stronger providers.

M&A is good for the industry, "but I don't think there's been enough of it to make a whole heck of a difference in terms of moderating the underwriting cycle," said John Iten, director at New York-based Standard & Poor's Corp.

Insurance is "still a very unconcentrated industry relative to other industries, including banking," Mr. Iten said.

"There have been some benefits" to individual insurers, said Mr. Iten. In the 2004 St. Paul Cos. Inc. and Travelers Property Casualty Corp. deal, for instance, "Clearly there were synergies there in terms of reducing expenses," he said.

"I think that was probably the driver" in the 1995 merger of Continental Corp. and CNA Financial Corp. as well, although "what made that one less than ideal was the emergence of asbestos and other issues" that made it a "fairly expensive acquisition for CNA," said Mr. Iten.

"I think you have to look at individual transactions," said Jay S. Benet, vice chairman and chief financial officer of St. Paul, Minn.-based Travelers Cos. Inc. "In any merger, it's the ability to execute that really separates successful ones from unsuccessful ones."

The St. Paul-Travelers merger, for instance, involved the efforts of thousands of people to make sure there was no disruption in the marketplace and that the fundamentals

of the business, such as getting premium notices out and paying losses, went smoothly.

"It's a tough process to go through. You learn a lot," Mr. Benet said.

"In some ways, when you have the bigger companies, you end up having better management in terms of risk management or expense efficiency," said Cliff Gallant, an analyst with Keefe, Bruyette & Woods Inc. in New York.

"When General Re, for example, came under Berkshire, there were a lot of charges that had to be taken, but they certainly have proved their underwriting ability and improved their risk discipline," Mr. Gallant said. There were also charges that came out of the Travelers and St. Paul merger, such as the merged entity's \$1.01 billion addition to asbestos and environmental liability reserves in 2005 that affected fourth-quarter 2004 earnings. However, "the combined entity is probably healthier than the two independent companies were," he said.

John L. Ward, chief executive officer of Cincinnati-based Cincinnati Partners L.L.C., said recent mergers have been different from those in the past in which companies may have merged from a position of weakness.

"I do see a bit of a change in perspective on that front," Mr. Ward said. "Several of the fairly good-sized transactions announced in the last couple of years have been among two very strong companies," where both felt the deal could move their business plan forward. This includes Liberty Mutual Group Inc.'s \$2.7 billion acquisition of Fairfield, Ohio-based Ohio Casualty Corp., which was completed in August.

"I think it's a positive shift in that it's a sign that companies are taking charge of their future, and not looking to M&A activity as the way out of a problem or set of problems," said Mr. Ward.

Meanwhile, many observers say the M&A activity has had a neutral impact on risk managers.

"I don't think there's been an appreciable effect from a buyer's perspective just because there are so many competitive alternatives," said Mark Lane, an analyst with William Blair & Co. in Chicago. "There may be an acquisition from time to time that creates dislocation in certain product categories, but all in all, it's a pretty competitive market."

James D. Hinton, vp-risk and insurance at Nashville, Tenn.-based HCA Inc., said while there have been some consolidations, new companies, including those in Bermuda, have also joined the field.

"We've got a big property program with a lot of windstorm activity, and we have almost 40 insurers on it. I don't know how many you need," Mr. Hinton said.

Mr. Benet said M&A activity can be beneficial to the insurance buyer.

"I think to the extent that insurance companies are able to use their larger databases to fine-tune what products they should be offering, and have a better understanding of what the underlying dynamics are that are driving the cost of the product, that could certainly be translated into better products to whoever's purchasing them, whether it's an individual or a business," Mr. Hinton said.

But Ellen Vinck, vp of risk management, benefits and safety for BAE Systems Ship Repair Inc. in San Diego, said, "I think possibly in the larger picture many people might perceive it as being neutral. Personally, I think whenever the field of choices shrinks, that's not necessarily positive. It's always nice to have a lot of different choices as far as who's there," she said.

"I certainly wouldn't look at it as a box of Crayolas anymore. My 64-choice Crayola box is now down to the primary colors," Ms. Vinck said.



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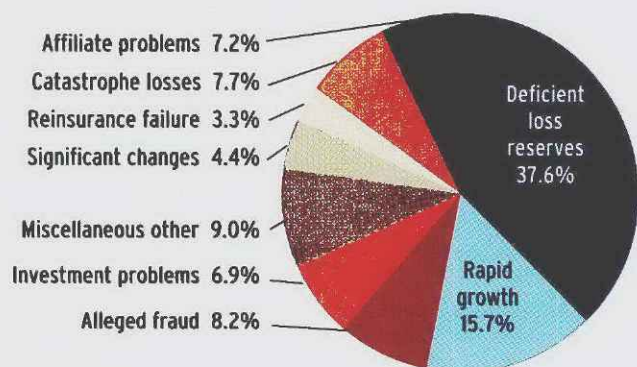


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WHY DO PROPERTY/CASUALTY INSURERS FAIL?

Reasons for impairments from 1969-2006



Source: A.M. Best Co. Inc.

Insolvency: Rating agencies ease concerns

CONTINUED FROM PAGE 18

soft markets."

In soft markets, "you've got price drops, while loss costs are going the other way," said Mark Charron, a principal and national actuarial and insurance solutions leader for Deloitte Consulting L.L.P. in Hartford, Conn. "There's been a number of companies that have gotten caught in that upside-down situation."

Furthermore, "It's one thing to see those loss costs increasing, and it's one thing to watch prices come

down, but recognizing that quickly enough to turn it around so you, in fact, can recover is actually absolutely critical," Mr. Charron said.

There is a tendency in a cyclical market "to be overly optimistic, and even when everyone knows that rates are too low, there's always this kind of thinking (that) you can write yourself out of the problem by generating more premium," said Jonathan Bank, an attorney with Lord Bissell & Brook L.L.P. in Los Angeles.

Unreliable reinsurance has been a factor in insurer failures as well, said

Mr. Charron. Insurers "always need to be diligent and attentive to what reinsurance is really being put in place and its stability."

Societal changes have also played a role, "particularly in terms of where the law has gone in assessing liability in the states," said Mr. Bank. "I think the insurers have largely been in the wrong place at the wrong time in terms of being the party with deep pockets who suddenly finds itself liable for so many things that other countries have not put on the shoulder—or on the back, really—of insurance companies."

"It would be pretty simple to say there was significant underreserving, (but) it was pretty hard to predict" the way claims would develop, said Mr. Bank. "No one got asbestos right," he said.

There are likely to be fewer insolvencies in the future, though, say some observers.

"As the influence of the rating agencies has increased over the years, solvency concerns have diminished somewhat," said John L. Ward, chief executive officer of Cincinnati-based Cincinnati Partners L.L.C. State regulators have also directed "substantial resources toward solvency issues," he said.

In addition, the evolution of risk-based capital "has played an important role both from a rating agency and a regulatory perspective in terms of measuring the financial strength of a company" and in helping to prevent insolvencies, Mr. Ward said.

"When I came into the business, you had individuals who could get away with murder in terms of underwriting," because there was little oversight, said John Wicher, principal at John Wicher & Associates in San Francisco.

"A very positive change has been the adoption of a disciplined, modern approach, where you have safeguards in place" so underwriters no longer have the "unfettered ability to write business," he said.

Those organizations still in the managing general agency business have "really proven themselves," said Mr. Wicher. "You don't see any longer an MGA bringing down a company because they were given the pen."

In recent years, the insurance industry has had an influx of former banking executives and management consultants, said Chris McShea, a principal with Ernst & Young L.L.P.'s insurance advisory practice in Chicago.

Such executives will monitor their firms in a different way than prior generations of management "and probably in a manner that would be more likely to generate a sale of the company than to compete hard until it's too late for a sale," Mr. McShea said.

"There will always be companies that get in over their heads, but I don't see it as a near-term issue, just because the profitability of the business has been so good and the market has made a lot of companies look very smart," said Mark Lane, an analyst with William Blair & Co. in Chicago. "That'll change, but it'll take a couple of years."

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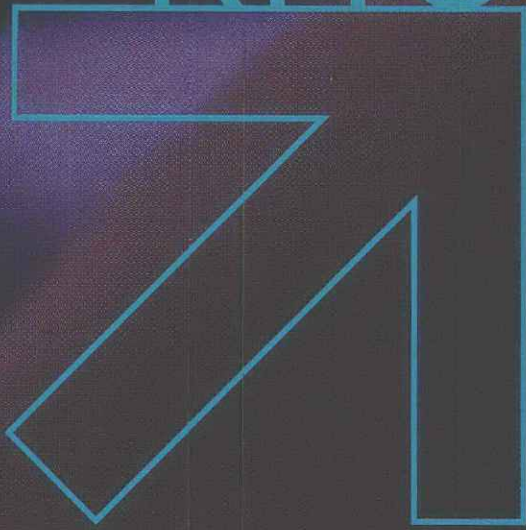
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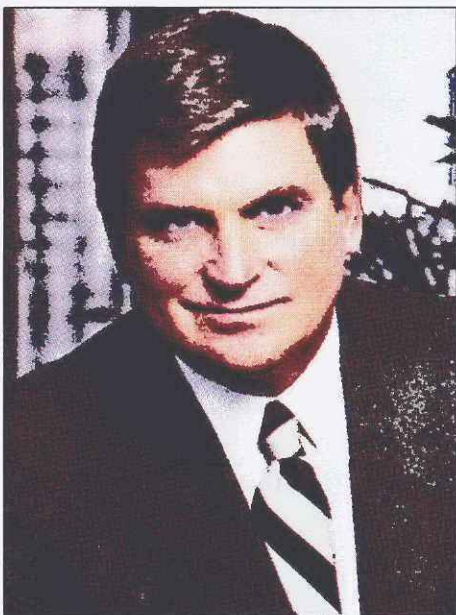


Building on a vision of a broker

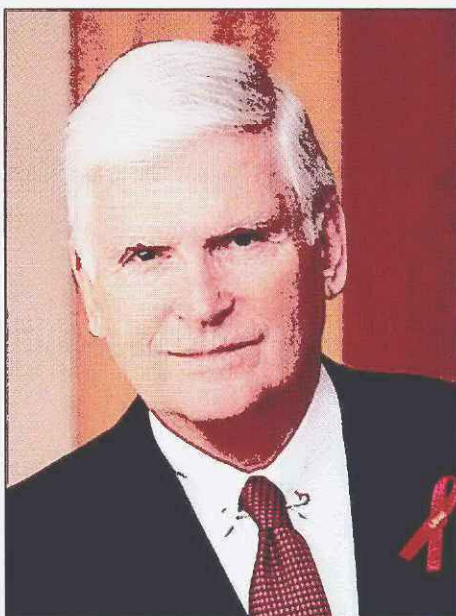
Founder's belief in value of intermediaries shapes development of industry giant

Patrick G. Ryan

By REGIS COCCIA



Circa 1970s



2005

When people speak of Aon Corp. founder Patrick G. Ryan, a word many use is "vision."

Aon's remarkable growth from a tiny managing general agency in 1964 into a global professional services company reflects Mr. Ryan's view that advisers would be more valued over time.

In the early years, however, not everyone shared that vision, he admits.

"Over the years, the general belief, from the mid-'70s on through the '80s and all the way up to the end of the '90s, was that brokers were in secular decline, it was a commodity product, it would be disintermediated. It was seen as a business that didn't have that great a future," Mr. Ryan said.

In 2000, the Risk & Insurance Management Society Inc. surveyed its members on whether they would use a broker more or less in the future, and "a dramatic number of responses" indicated risk managers would rely on brokers less or significantly less, Mr. Ryan said.

"History has proven that the broker, i.e. the adviser, the advocate, is much more important in buyers' minds," he said. Today, "the issue is 'I want more creativity, I want more from you, in helping me think through how to manage these risks.'"

At a time when investment banks and even some insurance company executives were predicting brokers' demise, Mr. Ryan stuck to his belief that brokers would play an ever-greater role. That belief led Aon to acquire other firms and build a footprint that today spans more than 120 countries. In *BI*'s annual ranking, Aon has been the world's second-largest broker by revenue in every year since 1996.

As executive chairman, a role he has held at Aon since 1990, Mr. Ryan meets with clients and is one of Chicago's most visible businessmen. Mayor Richard M. Daley tapped him to head the city's committee for the 2016 Olympic Games,

and Mr. Ryan has been honored many times for his leadership and integrity in business.

Aon is the name under which the holding company has traded since 1987, though its history of acquiring brokerage operations dates to 1977. A turning point came in 1982, when the Ryan Insurance Group merged with Combined International Corp. That enabled Mr. Ryan to begin the series of deals that brought his vision of building a global firm into focus.

"We had a dream and no money, or very little money. When given the opportunity to take over Combined...that gave us access to capital and so within a month, we bought Rollins Burdick Hunter, which was the seventh-largest broker," he said. "That was clearly a defining moment in the ability to execute the vision. We were basically a U.S. business up to 1991, when we were ready and had the opportunity to purchase Hudig-Langeveldt, which gave us position in Europe and Asia."

In 1992, the company acquired Frank B. Hall & Co. Inc. and became known as Rollins Hudig Hall Group. It adopted the name Aon Group in 1995 as it continued to make other large acquisitions, and its largest was the \$1.2 billion purchase of Alexander & Alexander Services in 1997.

Things have not all been smooth sailing for Aon, however. When then-New York Attorney General Eliot Spitzer launched investigations of industry practices, including suing Marsh for fraud, Aon was drawn into probes of bid rigging and steering business. No Aon employees were found guilty or pleaded guilty to wrongdoing, however, and Aon agreed to a \$190 million settlement in early 2005. Mr. Ryan says he is enormously proud that Aon's people and its culture of integrity "withstood a lot of scrutiny from internal and external forces."

One person who has a strong perspective on Aon's growth under Mr.

Ryan is the man who succeeded him as president and CEO, Greg Case. Before joining Aon in 2005, Mr. Case led the global insurance and financial services practice at McKinsey & Co. in Chicago.

"I observed the industry for the better part of 20 years. I watched with tremendous admiration what Pat Ryan was building. It looked like he had a vision that very few could've come up with and fewer still could've executed," said Mr. Case. "He was building a global professional services firm, the likes of which had never been seen before. It's a strong commentary on the capabilities of the man, and that's what I saw on the outside."

"Having spent time inside Aon, I am stunned at the capabilities that Pat Ryan was able to pull together. I've had the fortune to be inside many professional services firms, and I believe this man—through force of will and insight and vision—was able to pull together one of the finest professional services businesses in our space," Mr. Case said.

Tim Cunningham, a principal at OPTIS Partners L.L.C. in Chicago, said Aon's emergence as a global brokerage and largest competitor of Marsh & McLennan Cos. Inc. has helped give insurance buyers options.

"Aon clearly is reflective of Pat Ryan. He built a formidable competitor to Marsh, which historically was the 800-pound gorilla," Mr. Cunningham said. "When Pat began building Aon, there was a significant gap between Marsh and Aon in revenue. From the buyer standpoint, Aon gave buyers another broker of choice."

Mr. Ryan's involvement in the deals that built Aon is a testament to his skill as a salesman, he said. "He makes things happen."

"He continues to be the ultimate client guy. Pat continues to be the ultimate closer," said Mr. Case. "I consider it a pure joy to be able to work alongside a man with his passion."

RISK & BENEFITS REDEFINED

Industry terms no one used 40 years ago

401(K) PLANS Before the 1978 amendment to the tax code that gave these plans their name, 401(k) was just a meaningless jumble of characters, but now the plan is the primary retirement savings vehicle for millions of employees.

AUTOMATIC 401(K) PLAN ENROLLMENT With the decline of defined benefit pension plans, employers are looking for ways to increase the likelihood that employees have enough savings for retirement. One way, whose popularity has soared since Congress in 2006 gave its seal of approval, is to automatically enroll employees—unless they specifically object—in 401(k) plans, with a stipulated and typically increas-

ing percentage of employee salary contributed to the plan and funneled to an investment option offered by the plan.

BID RIGGING Former New York Attorney General Eliot Spitzer's 2004 investigation into the insurance industry revealed several now-infamous industry terms, but perhaps this is the one that is most readily identified with the saga.


CASH BALANCE PENSION PLANS The plans, the first of which was launched in 1985, get their names from their basic design in which benefits are, like a 401(k) plan, expressed as a cash lump sum. The benefit formulas are easy to understand, with participants receiving credits equal to a percentage of salary. Accounts balances are credited with interest, such as the

prevailing rate on the one-year U.S. Treasury bill, plus one percentage point.

CATASTROPHE BONDS While insurers and reinsurers have been reinsuring or retroceding their risks for many years, it wasn't until the 1990s that they found ways of doing so that directly accessed the capital markets.

CATASTROPHE MODELING Before the late 1980s, insurers and reinsurers relied on traditional underwriting methods to analyze their exposure to natural catastrophe risks. The introduction of computer-based probabilistic models revolutionized the underwriting process.

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Market took off after directors, officers found personally liable

Two court rulings in 1968 brought risk to attention of executives; 1976 ruling opened the spigots of securities class actions

By DAVE LENCKUS

Insurers first offered directors and officers liability insurance 70 years ago, but the coverage did not draw insurance buyers on a large scale until the late 1960s, when courts began handing investors victories in securities litigation.

The first D&O policy, written by Lloyd's of London underwriters, appeared in the United States in the mid- to late 1930s after the enactment of the first federal securities laws, according to market experts.

"For the first time, you, as a director or officer, faced exposure" over investors' losses, said policyholder attorney William Passannante, a partner with Anderson Kill & Olick P.C. of New York.

Federated Department Stores Inc., now known as Macy's Inc., is widely considered the first buyer of the coverage.

Market experts disagree over whether the earliest Lloyd's policies consisted of what came to be the coverage's traditional A and B sides. Side A covers executives directly when corporate indemnification is precluded; Side B reimburses the corporate entity after it has indemnified its executives.

But Carol A.N. Zacharias, senior vp and underwriting counsel for ACE USA in New York, maintains that the Lloyd's policy contained both sides. There was little demand for the coverage, however, because organizations were not yet allowed to indemnify their executives, and most executives did not perceive that they faced a great risk, she said.

That perception changed in 1968, when the 2nd U.S. Circuit Court of Appeals ruled in *Escott vs. BarChris Construction Corp.* that the defendant company's directors and officers were personally liable to investors who relied on misleading financial figures developed by an outside accounting firm. The court ruled that the executives failed to exercise due diligence by not substantiating the figures.

"This jolted Ds and Os," said insurer attorney Dan A. Bailey, a partner with Bailey Cavalieri L.L.C. of Columbus, Ohio. "It led to a lot of companies buying this product."

Another ruling by the 2nd Circuit that year also startled executives, Mr. Passannante noted. In *SEC vs. Texas Gulf Sulphur Co.*, the court ruled that executives could be held liable for investors' losses even when the defendants did not personally profit from their actions.

While those cases got directors' and officers' attention, they did not drive up claim frequency significantly.

But the U.S. Supreme Court's 1976 ruling in *Ernst & Ernst vs. Hochfelder* did. In that case, the court ruled that plaintiffs did not have to prove they were intentionally deceived but only that corporate officials were reckless.

"That starts the spigot" of securities class action claims and fuels the growth of powerful plaintiff law firms, Mr. Bailey said.

Meanwhile, a 1972 Pennsylvania federal court case, *Bird vs. Penn Central Co.*, sent a warning to buyers that insurers would not tolerate misrepresentations in coverage applications.

The court confirmed that Lloyd's underwriters could rescind their policy covering the directors of Penn Central, which at that time was the biggest company in U.S. history to file for bankruptcy. Underwriters sought the rescission after investigations into the company's demise

unveiled that some top corporate officials were involved in an illegal scheme to profit from the company's employee pension plan investments.

At the time, D&O policies did not have severability provisions, so innocent as well as culpable executives could have lost their coverage. Lloyd's underwriters later settled the dispute for a small fraction of policy limits, according to insurer attorney Stu Ross, who represented Lloyd's. Mr. Ross is now a partner with Ross,

Dixon & Bell L.L.P. in Washington.

Insurer attorney Richard J. Bortnick, a partner with Cozen O'Connor P.C. in Philadelphia, says that the case highlighted the value of D&O insurance.

It also demonstrated an important concept in coverage litigation, Mr. Ross said: "Insurers have some rights, too."

Over the next decade, corporate America's merger and acquisition binge compounded claim problems

for buyers and insurers. Mergers that did not fare well led to state court lawsuits in which investors claimed that top management breached their fiduciary duties. In three decisions in 1985, the Delaware Supreme Court agreed.

"That was a huge wakeup call" for executives who had relied on the business judgment rule to protect them from such claims, Mr. Bailey

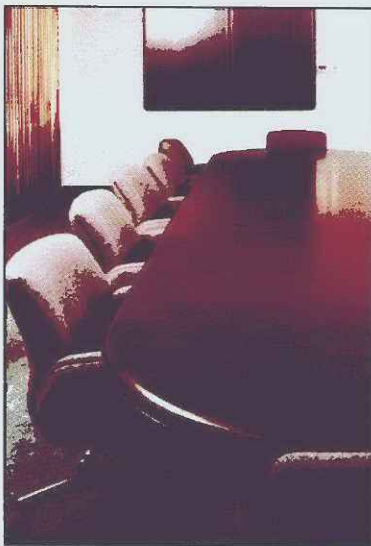
Continued on next page

THE TRUE STORY OF THE TORNADO THAT COULDN'T

And the race that couldn't be cancelled.

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CONTINUED FROM PREVIOUS PAGE

said. The rule guards executives from liability for poor business results if the executives had used sound reasoning in making their business decisions.

The resulting crush of losses exacerbated the already tightening insurance market. Many buyers could not find coverage after many D&O insurers exited the market, and buyers that did find coverage could not find enough. Plus, the cost of coverage shot up from five or six figures to seven figures, recalled broker Lou Ann Layton, a managing director and the national D&O practice leader for Marsh Inc. of New York.

Those market conditions drove buyers to set up their own Bermuda-based excess liability facilities, including what are now known as ACE Ltd. and XL Capital Ltd.

When the market began softening in the late 1980s, policy terms and conditions began broadening to extend defense costs to executives facing criminal charges.

That is an indication that policy enhancements have gone to insiders more than independent directors, noted Evan Rosenberg, a senior vp with Chubb Corp. unit Chubb Specialty Insurance of Warren, N.J.

At the same time, the Supreme Court knocked down a litigation barrier for class action plaintiffs. In its

1988 ruling in *Basic Inc. vs. Levinson*, the court ruled that every member of a class action does not have to prove they relied on misleading financial material, as long as the material was absorbed into the investor community and affected the defendant company's share price.

"The securities class action arena really starts taking off," Mr. Bailey said.

But buyers hoped to see a reduction of frivolous claims with the enactment of the Private Securities Litigation Reform Act of 1995. Claim frequency did drop below 1995 claim levels for two years but then went up sharply until 2005, largely because of an unstable stock market

and a rash of corporate fraud in the early part of this decade.

That wave of corporate scandal led to the Sarbanes-Oxley Act, the 2002 federal statute designed to improve corporate governance and hold corporate officials accountable for the accuracy of financial statements.

While securities class action claim frequency has fallen for a few years, loss severity is rising. And many market experts contend that the frequency figure is misleading, because it doesn't take into account a number of derivative action lawsuits.

The mid-1990s also marked the zenith of coverage allocation disputes between insurers and policyholders.

Insurers did not want to cover the portion of losses attributable to the actions of the uninsured organizations. That meant policyholders could expect only partial coverage of their losses, even though they contended that a corporation's and individuals' actions were inseparable and that settlements were not any larger because of a corporate entity's actions.

The issue "was an evolving train wreck," as alleged damages, and therefore the amount of coverage at stake, grew larger, said Steve Shappell, managing director of the legal and claims practice for Aon Corp. unit Aon Financial Services Group in Denver.

Three federal appellate courts returned pro-policyholder decisions in the dispute in 1995, prompting underwriters to modify D&O policy forms. Eventually, the market responded to policyholders' demands for full entity, or Side C coverage, rather than the alternative option of a preset allocation.

But that decision eventually hurt corporate executives sued over their organizations' bankruptcies. Because their policies now included entity coverage, the policies were corporate assets that bankruptcy courts froze along with all other corporate assets.

The spate of corporate corruption and financial problems and the resulting multibillion dollar class action settlements this decade has popularized stand-alone Side A coverage for securities claims, which Bermuda-based C.O.D.A.—later acquired by ACE—introduced in the 1980s. The separate tower of difference-in-conditions coverage comforts directors not only because of the additional limits it provides but also because it cannot be frozen or rescinded.

Market experts foresee other potentially significant developments for D&O insurers and policyholders over the next five to 10 years.

Aon's Mr. Shappell and Chubb's Mr. Rosenberg pointed to the brewing coverage allocation debate involving corporate investigations by the Securities and Exchange Commission. D&O policies do not cover costs related to those investigations, though they often are intertwined with covered claims.

Mr. Bailey questioned whether companies might have to defend against claims that their operations contributed to climate change, while also dealing with the Supreme Court's ruling that greenhouse gases are pollutants; D&O policies typically contain pollution exclusions.

On July 6, 2006, a powerful tornado tore through Atlanta, leveling everything in its path. When it reached the multimillion-dollar *Atlanta Motor Speedway*, entire sections of the track vanished.

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40 years of risk management highlights start with the birth of the profession

By John J. Hampton

As *Business Insurance* celebrates 40 years of publication, it is a time to reflect on key developments and turning points in risk and risk management since 1967. Here are some highlights:

1960s-1970s

■ **INSURANCE BUYERS MORPH INTO RISK MANAGERS.** From the late 1800s, organizations recognized the importance of insurance. Still, it was not until the 1960s that we learned the lesson of the Hartford Steam Boiler Inspection & Insurance Co. The title "inspection" comes before "insurance" on purpose. A company could not buy boiler insurance if it did not pay for regular inspections because when boilers are inspected and maintained, they rarely explode. Organizations got serious about risk management starting in the 1960s after Massey-Ferguson appointed Douglas Barlow as the first professional risk manager. In 1975, the American Society of Insurance Management changed its name to the Risk & Insurance Management Society.

■ **CAPTIVES CHALLENGE TRADITIONAL INSURERS.** Since the founding of the first captive in Bermuda in the 1960s, organizations have gained a more sophisticated understanding of insurable risk. A captive allows the retention of high-frequency, low-severity exposures such as vehicle accidents and employee injuries. Efficiencies are achieved when an organization controls the processing of claims using its own captive rather than dealing with an unrelated insurer. Captives can be a critical risk management tool when traditional insurance markets do not offer the capacity or coverages organizations need.

1980s

■ **EXPANSION OF LIABILITY CONCEPTS.** Legal liability arises in the normal course of business. By the 1980s, nothing was simple as the U.S. tort system exploded with new lawsuits. Contract law changes included implied warranties, express disclaimers and

strict liability. Punitive damages became a tool to compensate for pain and suffering. Courts awarded judgments for psychic injuries and even hypothetical damages. Class action and medical malpractice lawsuits grew exponentially.

■ **IGNORANCE OF LONG-TERM RISK VIEWS.** In 1986, Roger Smith was named CEO of the Year by *CEO Magazine*. Short-term achievements drove the honor. The magazine did not seem to notice General Motors' underfunded pension plan or the impact of expensive lifetime health care for a growing population of retirees. The consequences of such myopia by automakers would hit GM, Ford and Chrysler hard 20 years later.

1990s

■ **DEMISE OF THE LIKELIHOOD OF NUCLEAR DISASTER.** In the early 1990s, the breakup of the Soviet Union left the specter of a renegade nuclear incident but greatly reduced the prospect of global destruction. This is a pleasant reduction of risk in the 40-year period.

■ **HURRICANE ANDREW CHALLENGES THE ACTUARIES.** When Hurricane Andrew struck Florida in 1992, actuarial data was quite precise in forecasting damages. Past hurricanes allowed insurance rates to be set based on losing 10% to 20% of roofs. The problem was that much of the data was based on masonry walls and tile roofs. A 1980s development boom in Florida produced substandard construction. After Andrew, many subdivisions had lost every single roof. Insurers were reminded that actuarial data has to be examined carefully, assumptions must be tested and underwriting must be augmented by qualitative assessments. Andrew also ushered in the era of catastrophe modeling, a tool widely used today.

■ **CEO PERFORMANCE RISK.** As the 1980s ended, corporate boards wanted to ensure that CEOs were rewarded for improving the performance of common stock. Bonuses were tied to stock price. When the Dow went from 3,500 in the early

1990s to 11,000, the rising tide lifted all boats and CEO compensation. By the mid-1990s, mediocre performance was highly rewarded.

■ **INTERNET RISK.** A broad spectrum of new words arose in the late 1990s and around 2000 to identify new exposures as a result of electronic communications. They included hackers, spam, viruses, phishing, pharming, illegal downloading, industrial espionage, spyware and cyber terrorism.

2001-Present

■ **COMMERCIAL INSURANCE AND WAR RISK.** The terrorist attacks of 9/11 exposed the insurance industry to almost unimaginable catastrophic loss. Individuals and small groups could expose a nation to massive losses previously associated with wars. A dirty bomb in New York City, for example, could cause \$800 billion or more in insured losses. Insurance reserves are only about half that amount. The world has become a riskier place for those whose job it is to protect others from massive loss.

■ **OUTLAW ENVIRONMENTS.** Global sourcing and distribution cause an expansion of operations into areas of the world where corruption permeates governments and the legal and banking systems. Counterfeit products, violations of patents and copyrights, and theft of intellectual property are rampant. Many companies do not have effective risk mitigation strategies or remedies to fight back.

■ **ENVIRONMENTAL RISKS.** Temperatures and oceans may be rising, natural resources may be declining, pandemics may be approaching and governments may be unable to mobilize resources until after a crisis occurs. As Hurricane Katrina showed in 2005, the response to an environmental disruption may be too little too late.

It is hard to escape a conclusion that, with the exception of nuclear disaster, the world has become more risky. We will see what happens in the second 40 years of *Business Insurance*.



John J. Hampton is the KPMG Professor of Business and Dean of the School of Professional and Continuing Studies and Graduate Business Programs at St. Peter's College in New Jersey. He specializes in business ethics, legal liability and enterprise risk management. He is a former executive director of RIMS. To read Mr. Hampton's columns and interviews, visit www.BusinessInsurance.com/ERM.

RISK & BENEFITS REDEFINED

Industry terms no one used 40 years ago

CLAIMS-MADE FORM In an attempt to curb long-tail liability losses, the insurance market introduced this form in 1986 as an alternative to the traditional occurrence form, where insurers on the risk at the time of the original loss were liable for losses. Under claims-made forms, when the loss is discovered the insurer on the risk pays the claim.

COBRA CONTINUATION COVERAGE Enacted in 1986, the Consolidated Omnibus Budget Reconciliation Act gives employees who terminate employment the right to continue their employer-provided coverage for 18 months; dependents who lose coverage due to death, divorce or marital separation also can get

COBRA for up to 36 months. Employers can charge a premium of up to 102% of the group rate for COBRA coverage.

CONSUMER-DRIVEN HEALTH CARE From its origins less than a decade ago, consumerism in health care continues to be seen by many as the next step in making workers take more responsibility for their health care choices.

CORPORATE MEMBER OF LLOYD'S OF LONDON For most of its more than 300 years, Lloyd's has relied on individual members who pledged their entire wealth to support their underwriting. After disastrous losses shook the market in the 1980s and 1990s, Lloyd's in 1994 began allowing corporate members, which now make up most of its capacity.

CYBER LIABILITY The development of the Internet has changed the way businesses operate and the liabilities they face. Starting in the 1990s many businesses that previously did not have to concern themselves with issues such as copyright infringement and libel, found themselves exposed to the risks simply by establishing a Web site.

DOMESTIC CAPTIVE DOMICILES In the early 1970s, Colorado became the first U.S.-based captive domicile, but it wasn't until 1981 and the passage of Vermont's captive legislation that a domestic domicile was created that would truly rival offshore domiciles like Bermuda and the Cayman Islands.

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Consolidation among brokerages builds global capabilities

M&A has long driven intermediaries' growth, but 1980s marked acceleration of deals

By SALLY ROBERTS

Of the 16 brokers that appeared in *Business Insurance's* first broker profile issue in 1972, only one remains today: Marsh & McLennan Cos. Inc.

With \$151 million in commissions and fees, New York-based MMC was the largest among the 16 U.S.-based firms, which included names such as Johnson & Higgins, Alexander & Alexander Services Inc., Frank B. Hall & Co. Inc., Fred S. James & Co. Inc. and Corroon & Black Corp.

While MMC, with more than \$10.0 billion in 2006 brokerage revenues, continues to dominate the brokerage field, the market is now global in nature and other brokers have grown into major players, including Aon Corp., Willis Group Holdings Ltd., Arthur J. Gallagher & Co., Wells Fargo Insurance Services Inc. and Brown & Brown Inc.

Like other industries, consolidation has played and continues to play a key role in the insurance brokerage marketplace, which has seen a number of big-name firms disappear over the years and new firms emerge.

But it wasn't until the 1970s that consolidation gained much traction in the brokerage marketplace, observers say.

Very early in the 1970s, the brokerage industry was mainly a vast distribution network of small and regional privately held companies all over the United States, with MMC and A&A the lone publicly traded exceptions, said Russell Miller, who founded San Francisco-based insurance merger and acquisitions advisory firm Russell Miller Inc. in 1971.

"People woke up to the fact that the insurance brokerage business was one you could take public" and firms such as Fred S. James and Frank B. Hall took a spot on the public scene, Mr. Miller said.

Insurance brokerage stock values were high during that time and publicly held brokers began "merging like mad," using their stock to acquire other firms around the country, he said.

As clients were beginning to grow nationally and internationally, the thought became, "If I don't have an office in (a certain city), I'm going to lose that client because they will sign up with the local broker," Mr. Miller said.

Turning point in 1980s

In the early 1980s, firms like Corroon & Black, A&A and Frank B. Hall "were filling out their score cards" and "if you were a premium privately held broker in...one of the five major metropolitan markets around the country...often times...you became A&A's San Francisco office" as one example, said John Wicher, a principal with John Wicher & Associates Inc. in San Francisco.

"There were so many deals done" in the mid-1980s when the new publicly traded brokers sought to grow across the United States, he said. And privately held brokers were having a tough time with perpetuation and often "reached the conclusion that an internal sale was not practical," Mr. Wicher said. So they sold their firms to the public brokers making attractive offers.

It was also during this time that acquisitions became more global in nature. Marsh acquired London-

based C.T. Bowring & Co. Ltd. in 1980; A&A, after failing to secure a deal with London-based Sedgwick Group P.L.C., acquired London-based Alexander Howden Group Ltd. in 1982.

"There was a turning point at the beginning of the '80s when you started to see things like Marsh buy Bowring and A&A buy Howden. It started a momentum," said Michael D. O'Halloran, executive chairman of Aon Re Global in Chicago.

It was also at this point that brokerage consolidator Bernard H. Mizel came on the scene with a new and different strategy: aggregating smaller, regional agencies into a national brokerage platform.

"I had a vision of what I wanted to create, which was an organization that would be an alternative for very strong local and regional brokers to become part of something that would serve their need to grow and expand as well as their clients' needs



for various financial service products such as life insurance, employee benefits and property/casualty insurance, Mr. Mizel said.

In all, Mr. Mizel completed 371 acquisitions of middle-market brokers over 25 years as he built up

middle market firms such as Bache Insurance Services in the early 1980s, American Business Insurance Inc. in the mid-1980s and early 1990s, and USI Holdings Corp. in the mid-1990s.

See **CONSOLIDATION** page 30

Aetna, CIGNA divestitures reshaped P/C market

By SALLY ROBERTS

Insurers in the property/casualty market have come and gone over the years, but few market departures have had as much impact as those by Aetna Life & Casualty Co. and CIGNA Corp.

Their unique property/casualty division divestitures not only resulted in two major health care insurers, they also resulted in two major players in the property/casualty market—Travelers Corp. and ACE Ltd.

While each deal was unique, the reasons for selling their property/casualty operations in the 1990s were quite similar, observers say.

Both Aetna and CIGNA had difficulties building profitable property/casualty operations and both decided to shed noncore businesses and to focus solely on health care.

And for CIGNA specifically, the deal allowed it to jettison its long-tail asbestos and environmental liabilities that it had shifted to a separate runoff company as part of an extremely contentious reorganization.

Travelers paid \$4 billion in cash in 1996 for Aetna's P/C operations, while ACE paid \$3.5 billion in 1999 to acquire CIGNA's P/C operations, including its long-tail liabilities.

"It was pretty dramatic and interesting," said John Wicher, a principal with John Wicher & Associates Inc. in San Francisco. "You had two of the largest property/casualty players throwing in the towel."

"There have been larger trans-

actions in the industry over the last 40 years, but there have been none as market changing as the CIGNA and Aetna divestitures," said John L. Ward, chief executive officer at Cincinnati Partners L.L.C., an insurance industry advisory firm.

In addition to Aetna and CIGNA then becoming health care giants, CIGNA's P/C operations gave ACE, which at the time was a specialty insurer and reinsurer with operations based largely in Bermuda and London, a worldwide insurance franchise that included a significant presence in the U.S. market. And Aetna's operations gave Travelers needed scale and "set the stage for what would ultimately be a couple of years down the road the megatransaction between Travelers and Citigroup," Mr. Ward said.

While the deals made sense for all the players, they specifically allowed CIGNA and Aetna to take advantage of the opportunities occurring in the health insurance market.

"Aetna, like CIGNA, had developed a leading position in managed care where they had some control and...they recognized the favorable demographics and wonderful growth opportunities in the health care business," said Mark Puccia, a managing director of Standard & Poor's Corp. in New York. "It was a logical shift for them to leverage the business they had better control of and...saw wonderful profit potential."

"Aetna was a company that (had) tried to be all things to all

people," said Myron M. Picoult, an independent insurance consultant who spent 38 years as an insurance analyst. "Clearly there were service problems and inefficiencies." That, in addition to management's belief that "the health care business would probably afford them better returns going forward," ultimately led to the divestiture, he said.

Similarly, CIGNA "decided to make a bet on the health care business. They believed that was a better business to be in," Mr. Picoult said. "It seemed to be a much easier decision for (CIGNA) than for Aetna."

Indeed, in an effort to maintain its A- rating with A.M. Best Co. Inc. for its active operations, CIGNA shifted its long-tail asbestos and environmental liabilities in 1995 into a separately capitalized runoff company, Brandywine Holdings Corp.

The so-called "good book/bad book" reorganization was extremely contentious and resulted in years of bitter litigation that extended to July 2006 when ACE sold the runoff operations to a London investment firm.

Both the separation of the good book/bad book operations of CIGNA and the sale of its P/C operations were "excellent strategic moves" for CIGNA, Mr. Ward said, but "the divestiture was not in and of itself due to its asbestos and environmental exposures. It was one in a series of divestitures, several of which already occurred leading up to the transformation into a managed care health care-oriented business."

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Consolidation: Urge to go global began to pick up steam in 1980s

CONTINUED FROM PAGE 28

During the time USI and other aggregators—Poe & Brown Inc., Hilb, Rogal & Hamilton Co. and Acordia Inc., among them—were acquiring a number of smaller agencies around the country, consolidation among the nation's largest brokers went into overdrive.

A number of well-known and established firms disappeared over the years, including Fred S. James, which Sedgwick acquired in 1985; Corroon & Black, which merged with Willis Faber P.L.C. in 1990;

and Frank B. Hall, which Aon acquired in 1992. But that was nothing compared with the frenetic pace with which Marsh and Aon attacked the market.

Marsh and Aon were responsible for the disappearance of eight of the world's 20 largest brokers from *BI*'s 1995 rankings. From 1996 through 1998, Aon acquired such top-tier brokers as A&A, Bain Hogg Group P.L.C., Group le Blanc de Nicolay, Jauch & Huebener KGaA and the Minet Group. During the same period, Marsh acquired Cie. Europeenne de Courtage d'Assurances et de

'There's more competition, maybe not in pure numbers, but I see more competition today than I have ever before.'

Michael O'Halleran, Aon Global Re

Reassurances, J&H and Sedgwick.

"What started the momentum

was a growing recognition that clients were in need of global capabilities" and the need to improve the distribution of products and enhance service offerings for those clients, said Mr. O'Halleran, who at the time was president and chief operating officer of Aon Corp. and president of its brokerage operations. "We were in a very soft market back then and were all looking to grow."

In addition, "the supply and demand curve was out of synch," Mr. O'Halleran said. "The inefficiencies were everywhere and the idea was by bringing one plus one

together, you'd get at least two-and-a-half if not three in terms of a return" with a better, bigger company with global scale.

While concerns were raised that the mass consolidation at the top of the brokerage ranks resulted in just two megabrokers from which buyers could choose, observers say that fear never really came to fruition.

"There's more competition, maybe not in pure numbers, but I see more competition today than I have ever before," Mr. O'Halleran said. "If you look back at what we did over that period of time and subsequently...and say, 'Who won?' I think all day long the client won."

"I would contend that the consolidation at the top did not result in a shrinking of the marketplace" but rather resulted in "a broadening opportunity for buyers," said John L. Lumelleau, president and CEO of Kansas City, Mo.-based Lockton Cos., which joined *BI*'s top 10 list of the world's largest brokers for the first time this year.

"The dislocation of talent as a result of the consolidation had the most dramatic impact on the growth of other brokers and large agencies. I am, like so many other folks, an example of that," said Mr. Lumelleau, who joined A&A in 1976 and resigned in July 1997, six months after Aon completed its acquisition.

"It was not that the other firms are not fine firms. We thought there were other opportunities to make an impact in the marketplace and took advantage of them," Mr. Lumelleau said.

"The rumors of consolidation in the '90s causing a monopoly in the industry just didn't happen," said Ken Crerar, president of the Council of Insurance Agents & Brokers in Washington. "It's a highly competitive market today and provides a lot of choice for customers."

The fact of the matter is "consolidation is a natural byproduct of any industry as it ages," Mr. Crerar said.

Indeed, 10 years after mass consolidation shook up the brokerage market, it continues to occur, albeit not as dramatically.

While brokerages such as Arthur J. Gallagher & Co., Brown & Brown and Hilb Rogal & Hobbs Co. continue to acquire smaller agencies, larger deals such as Lockton's \$170 million acquisition of Alexander Forbes International Risk Services last year, continue to occur and change the brokerage market landscape.

More recently, though, banks and private equity firms have dominated the consolidation trends. Today, two of the world's largest brokers in *BI*'s rankings, Wells Fargo Insurance Services and BB&T Insurance Services, are owned by banks, as well as a number of brokers listed among *BI*'s rankings of the 100 largest brokers of U.S. business.

Private equity firms have taken an interest in the brokerage market as evidenced by the \$1.4 billion buyout last year of USI, the \$1.9 billion buyout of Hub International Ltd. and the \$1.1 billion buyout of Alliant Insurance Services Inc.

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1967 - 2007

40TH

FORTY YEARS OF BI

A timeline of key events in risk management





40 YEARS OF RISK MANAGEMENT EVENTS



The St. Paul Cos. offers the first electronic data processing policy to protect computer equipment that businesses are increasingly using.

Hurricane Camille, called the most violent storm in U.S. history, devastates the Gulf Coast, but insured losses do not rival those of Betsy four years earlier.



Lloyd's of London admits women to work in the underwriting room.



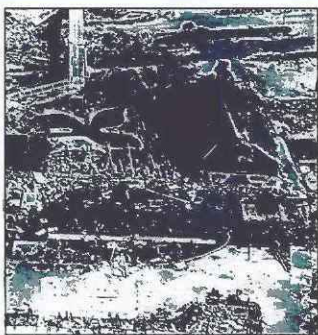
1967 1968 1969 1970 1973 1975

Crain Communications Inc. launches *Business Insurance*.

Delaware enacts law allowing corporations to buy directors and officers liability insurance and indemnify directors and officers for certain acts. The legislative approval led to widespread popularity of D&O coverage.

Lloyd's of London reports the first operating loss for the market in its 280-year history. Under Lloyd's three-year accounting, much of the loss came in the form of claims from Hurricane Betsy in 1965.

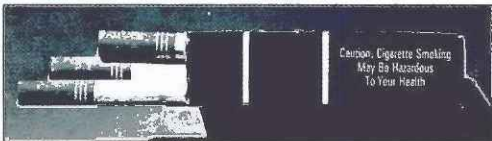
Capacity shortage prompts Lloyd's to seek investors outside the United Kingdom for the first time.



President Richard Nixon signs the Occupational Safety and Health Act, which created dozens of new workplace health and safety regulations and formed a federal agency to enforce them.

In *Borel vs. Fibreboard*, the 5th U.S. Circuit Court of Appeals rules an asbestos manufacturer has a duty to warn insulation workers of the hazards of asbestos. The case is the first to extend strict liability for the failure to warn end users of a product's possible hazards.

Five securities suits against Mattel Inc. are settled for \$30 million in what is the largest settlement to date.



A federal judge rules that federally mandated warnings on cigarette packages do not shield tobacco companies from lawsuits by smokers.



The California Insurance Department is permitted to liquidate Mission Insurance Co., one of the biggest insolvencies ever.

California voters approve Proposition 103, which mandates rollback of property/casualty rates and makes the state insurance commissioner's post an elected office.



1984 1986 1987 1988

At least 3,000 die following a poisonous gas leak from a Union Carbide plant in Bhopal, India, one of the worst-ever industrial accidents.



President Ronald Reagan signs an expansion of the Risk Retention Act, allowing RRGs to directly write all commercial liability risks except workers compensation.

A majority of states adopt ISO's revised claims-made general liability policy form. Insurers use the form for primary coverage mainly on the largest and most hazardous exposures.

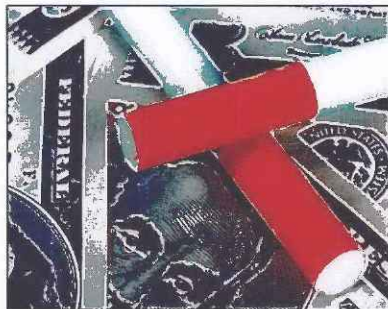
The Piper Alpha oil rig explodes in the North Sea, killing 166 and resulting in more than \$2 billion in insured losses. It remains one of the largest man-made disasters in history.



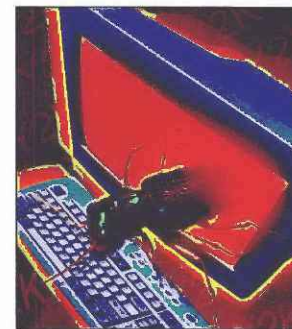
Pan Am Flight 103 explodes over Lockerbie, Scotland, killing all 269 aboard. The crash changes aviation and security procedures worldwide.

State attorneys general launch antitrust litigation against insurers, reinsurers and insurance trade groups, alleging they conspired to manipulate prices in the commercial liability insurance market. The case is settled in 1994.

Aon Group's \$1.23 billion acquisition of Alexander & Alexander Services makes Aon the world's largest retail brokerage as well as the world's largest reinsurance intermediary.



The crash of a Swiss MD-11 off the coast of Nova Scotia kills all 229 aboard and results in one of the largest-ever insured hull losses, more than \$125 million.



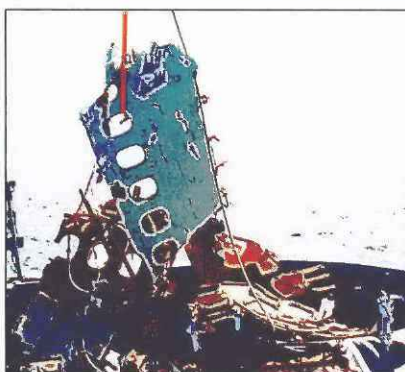
In the worst terrorist attack in history, four planes are hijacked and two are crashed into the World Trade Center. Nearly three thousand are killed and the WTC complex is destroyed, generating claims across many lines of coverage.

1995 1996 1997 1998 2000 2001

CIGNA Corp.'s plan to place its long-tail liabilities into a separately capitalized runoff unit draws criticism from policyholders and other insurers.

The tobacco industry agrees to pay more than \$360 billion to settle a class action lawsuit brought by a group of states. The settlement is later reduced to \$206 billion but does not shield cigarette makers from individual suits.

Marsh & McLennan Cos. buys Johnson & Higgins in a \$1.8 billion deal, reclaiming Marsh's spot as the world's largest broker.



The millennium computer bug, dubbed Y2K, fails to cause the widespread losses that many computer experts had forecast. The bug was rooted in internal clocks containing only two digits for the year, suggesting that the year 2000 would make computers assume the year had reverted to 1900.





40 YEARS OF RISK MANAGEMENT EVENTS

Two Boeing 747s collide on a runway in the Canary Islands, killing nearly 600 people and causing one of the biggest-ever insured aviation losses. ▶



President Jimmy Carter creates the Federal Emergency Management Agency to centralize federal disaster relief efforts. ▶



Congress passes the Risk Retention Act to allow risk retention groups to write product liability coverage for members across the country after meeting the licensing requirement in one state.

1977



Insured losses from Hurricane Hugo reach \$4 billion, making it the costliest storm to date.

A 7.1 magnitude earthquake jolts San Francisco, causing an estimated \$1 billion in damage.

Oil tanker Exxon Valdez runs aground in Alaska's Prince William Sound. Litigation leads to a multibillion-dollar punitive damages award. ▶

1978

▶ Howard T. Weber, director of insurance at Minnesota Mining & Manufacturing Co., is *BI's* first Risk Manager of the Year.

1979



▶ Congress passes the Superfund law in response to the Love Canal pollution scandal. The law permits the Environmental Protection Agency to clean up sites and seek recovery from potentially responsible parties.

In a case involving the drug DES, the Supreme Court rules that manufacturers can be held liable based on their market share.

1980

Hurricane Andrew hits south Florida, causing a record \$15.5 billion in insured losses. Later upgraded to category 5, it remains the second-worst hurricane loss ever. ▶

Los Angeles riots following the acquittal of police officers in the beating of motorist Rodney King verdict result in \$775 million in insured property damage. It sets the record for any single U.S. civil disorder. ▶

1981

A federal appeals court rules that a triple trigger exists for asbestos-related diseases, expanding policyholders' ability to tap multiple policies for long-tail claims.

1982

The Insurance Services Office Inc. issues a new comprehensive general liability form requiring risk to be written on a claims-made basis.

1989



The Persian Gulf War creates chaos for insurance buyers with war-risk policies, whose prices rise sharply.

1992



Lloyd's unveils a radical "reconstruction and renewal" plan of reforms that include corporate capital.

1993

▶ Northridge, Calif., earthquake causes an estimated \$12.5 billion in insured losses.

Hannover Re Group shifts \$85 million of catastrophe risk to the capital markets in one of the first-ever hazard risk securitizations.

A federal judge approves a \$4.75 billion global settlement by the makers of silicone breast implants.

1989

1991



An undersea earthquake off of Sumatra triggers a rare tsunami in the Indian Ocean. More than 200,000 are killed in the disaster.

New York Attorney General Eliot Spitzer sues Marsh & McLennan alleging fraud and bid rigging, triggering a wave of investigations into insurance industry practices. ▶



Major brokers pay more than \$1 billion to settle investigations by attorneys general in New York and other states. Several brokers agree to cease accepting contingent commissions.

Longtime American International Group Inc. Chairman Maurice R. Greenberg resigns following investigations by Eliot Spitzer, who also brings civil fraud charges against him. ▶



AIG pays \$1.64 billion to settle the Spitzer investigations.

Insurers and property owners get a reprieve in an unusually calm windstorm season in which no hurricanes make landfall in the United States.



2002

▶ Scandals at Enron, WorldCom and other companies lead Congress to pass the Sarbanes-Oxley Act, ushering in a new era of corporate governance and regulatory compliance.

The Terrorism Risk Insurance Act created a federal backstop that was designed to stabilize the market for terrorism insurance, but few purchase it.

2004

Four major hurricanes strike Florida, during an unusually active season in which hurricane forecasters ran out of names for storms. ▶



2005

Hurricane Katrina devastates the Gulf Coast and triggers massive flooding in New Orleans, creating the largest-ever insured catastrophe. Losses are estimated at more than \$30 billion. ▶



2006

Crain Communications launches *Business Insurance Europe*. ▶



2007

▶ Insurers settle a six-year coverage dispute over the destruction of the World Trade Center, closing a contentious chapter after the Sept. 11, 2001, terrorist attacks.

Private equity firms take ownership stakes in several large brokers.

200,000 REASONS

A SPRINKLER HEAD DOES NOT

DOUBLE AS A COAT RACK.

WAUSAU PACKAGE AT WORK. Recently, we received some interesting property claims. Hotel guests, trying to expand their closet space, enlisted the help of sidewall sprinkler heads, using them as makeshift coat racks. The weight of the clothing damaged the fusible element of the sprinklers, setting them off and causing more than \$200,000 in water damage. When our loss



prevention experts located the source of the problem, they quickly advised clients to place a warning sign next to sidewall

sprinklers to prevent similar damage. Simple, but effective. That kind of industry knowledge and attention to detail can be found throughout Wausau, in any of our areas of expertise – from hospitality to construction. And with Wausau Package, you can leverage that expertise to get comprehensive coverage tailored to the specific needs of your business. It's all part of Wausau TotalValueSM and our commitment **PRICE ≠ COST.** to lowering your total cost of risk. A commitment backed by the financial strength of Liberty Mutual. To learn more, contact your Wausau Signature Agency representative or your appointed Wausau producer.



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Washington heavyweights have shaped insurance industry

REP. JOHN D. DINGELL, D-Mich., has never been afraid to rock the boat. And that's just what he did as chairman of the Energy and Commerce Committee in 1990 when he released a report "Failed Promises." That report—and its 1994 follow-up, "Wishful Thinking"—gave state insurance regulators heartburn as they read of the shortcomings of



Sen. Dingell

state-based insurance regulation in dealing with interstate problems such as fraud.

After the first report appeared, Rep. Dingell introduced a measure to provide federal insurance solvency regulation, but the bill failed to pass. Nevertheless, Rep. Dingell's actions helped stir support for a federal role in insurance regulation, support that now manifests itself throughout much of the insurance industry as support for an optional federal charter for insurers.

Rep. Dingell—now the longest-serving member of Congress and once again chairman of the Energy and Commerce Committee courtesy of the Democratic congressional victories of 2006—has not shied away from health insurance issues either. The longtime proponent of what he in a 1997 *Business Insurance* interview called an "intelligent single-payer" health insurance system seems likely to be a major player in any future health care debates.

Senate Banking, Housing and Urban Affairs Chairman **CHRISTOPHER J. DODD**, D-Conn., has been a crucial player in efforts to create and maintain a federal government terrorism insurance backstop ever since the idea first emerged in the aftermath of the Sept. 11, 2001, attacks on the World Trade Center and elsewhere.

As an original co-sponsor of the Terrorism Risk Insurance Act of 2002, the veteran lawmaker helped shepherd both TRIA and the 2005 successor bill that extended the program through the end of 2007

through the committee and the Senate floor. Only days after the 2006 Democratic congressional victories made him the likely Banking Committee chairman, Sen. Dodd said that extending the program—perhaps permanently—would be high on the panel's agenda.

The committee has yet to move on the issue, but the senator has given no indication that he's lost his enthusiasm for the program, despite the demands of his presidential campaign.

Sen. Dodd won plaudits for his work on another risk management

issue in 1999, when he joined Sen. Bob Bennett, R-Utah, in promoting legislation that gave businesses protection from liability arising from the much-feared "Y2K" computer glitch. The glitch, fortunately, turned out to be of little consequence.

Former **REP. JAMES FLORIO**, D-N.J., left a mixed legacy on risk management issues.

On one hand, he was one of the chief proponents of the Liability Risk Retention Act of 1986, which expanded the 1981 Product Liability Risk Retention Act to allow risk retention groups to write all types of commercial liability coverage except workers compensation. Risk retention groups write product liability coverage for member policyholders in any state after meeting the licensing requirements of one state.

On the other hand, he also was the author of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, which created the so-called Superfund to pay for the cleanup of the

nation's most polluted sites and subjected corporations to liability for acts that were legal when they occurred. Repeated efforts to reform Superfund's liability system failed during the early 1990s.

By that time, though, Rep. Florio had left Congress to become governor of New Jersey. He served one term before being defeated by Christine Whitman. Ironically, President George W. Bush named Gov. Whitman head of the Environmental Protection Agency in 2001, which administers Superfund.

Former **SEN. PHIL GRAMM**, R-Texas, prefers the free market to government regulation when it comes to economic matters.

So perhaps it should come as no surprise that the one-time economics professor emerged as one of the prime movers in the deregulation of the financial services industry.

With former Reps. Jim Leach, R-Iowa, and Tom Bliley, R-Va., Sen. Gramm drafted the Gramm-Leach-Bliley Financial Services Modernization Act that became law in 1999.

The law repealed the Glass-Steagall Act, a Depression-era measure that had prohibited banks from offering insurance and investment services.

Under the 1999 law, the same financial services company can be involved in commercial banking, insurance and investment products. The measure did not, however, lead to wholesale changes in the

commercial insurance industry. Banks generally preferred to pursue personal lines opportunities, although some did get involved in the commercial insurance brokerage business. Sen. Gramm retired from the Senate in 2002.

SEN. CHARLES GRASSLEY, R-Iowa, played key roles in both risk management and pension issues.

In 2005, he introduced the Class Action Fairness Act, which became the most ambitious piece of federal tort reform legislation to become law. Among other things, CAFA aimed to reduce the impact of forum shopping by allowing either party in certain class actions that involve plaintiffs and defendants from different states to have the case moved to federal court from state court. Backers of the bill—which numbered

virtually all of the business community—had long argued that defendants and plaintiffs in such cases could be more likely to receive impartial justice in a court not subject to local prejudice.

On pension reform, Sen. Grassley was the lead in winning passage of legislation that requires employers that match employees' 401(k) contributions with company stock to allow employees to divest those contributions after three years. The measure came in reaction to the collapse of Enron Corp. in 2001.

As chairman of the Senate Commerce, Science and Transportation Committee from 1987 to 1995, former **SEN. ERNEST HOLLINGS**, D-S.C., wielded considerable power, which he never failed to use to block tort reform initiatives.

The senator, better known as "Fritz" Hollings, was particularly opposed to efforts to create a uniform federal product liability code, efforts spearheaded on his committee by Sen. Robert Kasten, R-Wis.

But Sen. Hollings' interest in risk management and insurance issues went beyond foiling product liability reform. He opposed efforts to give businesses some liability protection for problems

emerging from the so-called Y2K computer glitch that caused considerable concern in the late 1990s.

And as a member of the senatorial minority, Sen. Hollings sought to subject multistate insurers to regulation from a powerful new federal Insurance Commission that would have had the power to set rates, issue licenses and investigate market conduct. Nothing came of that

effort, and Sen. Hollings retired from the Senate in 2004.

Former **SEN. ROBERT KASTEN**, R-Wis., was a man on a mission—to reform the nation's patchwork of product liability statutes.

First elected to the Senate in 1980, the Badger State lawmaker repeatedly introduced federal product liability reform legislation as a member of the Senate Commerce, Science and Transportation Committee. And Sen. Kasten repeatedly ran into a legislative roadblock in the form of

Chairman Ernest Hollings, D-S.C. Although President George H.W. Bush's administration was outspoken in its support of tort reform, including product liability reform, and although the details of successive product liability reform bills differed, not even the best efforts of Sen. Kasten could get a bill through committee. In 1992, he was defeated in this effort to win a third term in the Senate, and retired to private life.

As the first chairman of the House Financial Services Committee, former **REP. MICHAEL OXLEY**, R-Ohio, increasingly brought insurance issues under the jurisdiction of what had previously been called the House Banking Committee.

Of course, his name is most closely associated—along with that of former Sen. Paul Sarbanes, D-Md.—with the Sarbanes-Oxley Act of 2002, a law that created new financial reporting standards for U.S. businesses. But Rep. Oxley's influence extended far beyond that landmark piece of legislation.

In addition to promoting the federal terrorism insurance backstop, Rep.

Oxley used his position to draw attention to what he considered shortcomings of the state-based insurance regulatory system.

In 2004, he and colleague Rep. Richard Baker, R-La., circulated a draft State Modernization and Regulatory Transparency Act. The draft, which represented the most comprehensive proposal to modernize insurance regulation in 60 years, called for pre-empting state rating laws for commercial and personal lines coverages, and creating a seven-member federal body that would seek to resolve conflicts among state laws.

But the so-called SMART bill never progressed before Rep. Oxley retired from Congress in 2006 and his successor as committee chairman—Rep. Barney Frank, D-Mass.—has focused on other issues.

No one ever accused former **SEN. PAUL SARBANES**, D-Md., of being the flashiest member of the world's greatest deliberative body during his three decades there. In fact, Sen. Sarbanes often seemed to go out of his way to avoid attention.

But as chairman of the Senate Banking Committee and primary author of the Sarbanes-Oxley Act of 2002, the scholarly lawmaker—who did not seek re-election in 2006—had an impact about which most colleagues could only dream. The act responded to a series of financial and accounting scandals that rocked the

economy early in the decade. The discovery of financial chicanery at company after company led to enactment of the Sarbanes-Oxley Act. The act required corporations to meet enhanced reporting and auditing standards. By doing so, it also opened corporate directors and officers to new liability exposures.

Sarbanes-Oxley didn't immediately restore probity to the marketplace—by 2003, scandals wracked the mutual fund industry. Yet five years after its enactment, and despite efforts to scale back its reach, the Sarbanes-Oxley Act is credited with having enhanced corporate accountability, albeit at a cost.

Although certainly a conservative, **SEN. JOHN SUNUNU**, R-N.H., isn't afraid to tackle the notion that the states do it best when it comes to insurance regulation.

During the past two sessions of Congress, the senator has joined forces with Sen. Tim Johnson, D-S.D., in sponsoring legislation that would allow both property/casualty and life insurers and producers to be governed by new, optional federal charters rather than having to be regulated by the states, as is now the law under the McCarran-Ferguson Act. Similar legislation was recently introduced in the House.

Sen. Sununu and allies have presented the proposal as a matter of economic security that would allow insurers to better compete internationally.

But he also has made it clear that he's under no illusion that radically changing the nature of insurance regulation will be easy. Despite the growth of pro-optional federal charter sentiment in recent years, the property/casualty industry itself remains divided on the issue. The effort to enact optional federal charter legislation appears likely to be one that will engage Congress for some time to come.

—By Mark A. Hofmann

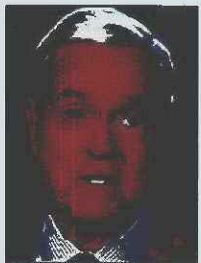
PHOTOS: ASSOCIATED PRESS, GETTY IMAGES



Sen. Dodd



Sen. Gramm



Sen. Hollings



Rep. Oxley



Sen. Sununu



Sen. Kasten



Sen. Grassley



Rep. Florio



Major Washington players in the employee benefits arena

If there were just one person considered the father of the Pension Protection Act, most Washington pension observers agree it would be **REP. JOHN BOEHNER**, R-Ohio.

As chairman of the U.S. House Education and the Workforce Committee, the Ohio Republican launched the reform drive in 2003 with hearings on pension plan



Sen. Boehner

underfunding and the threat it posed to the Pension Benefit Guaranty Corp. In 2005, Rep. Boehner spearheaded a bill to strengthen pension plan funding in the House of Representatives, where it picked up significant bipartisan support.

While a loyal Republican, he was not blindly loyal. The funding rules in his bill, for example, were less stringent than those proposed by the Bush administration—a difference that was deliberate.

"Make the rules too harsh and you drive employers out," Rep. Boehner warned in 2005.

After his elevation to House majority leader in 2006, he continued to play a pivotal role in the reform drive. Among other issues, he helped iron out differences in House and Senate bills concerning how cash balance plans should be protected from age discrimination suits. His long crusade was successful when conferees agreed on a final bill last year.

The result, said Rep. Boehner, who now is the House minority leader, is a law that will protect taxpayers who could have been on the hook for a multibillion dollar bailout of the PBGC had Congress not acted.

ROBERT J. DOLE is a study in contrasts. The one-time Senate majority leader and Senate Finance Committee chairman was undeniably brilliant. On the other hand, with that brilliance came a caustic wit.

Similarly, his role on employee benefit issues was a mixed one. One of his greatest legislative achievements came in 1983 when he led the revamp of the nation's biggest



Sen. Dole

retirement program—Social Security. That legislation raised payroll taxes, required nonprofit employers that had opted out to rejoin Social Security, and prospectively raised the age at which employees could retire and collect full Social Security benefits. It also assured solvency of the program for decades.

By contrast, Sen. Dole for years fought to curb the tax advantages of employee benefit plans.

He also came close in 1984 to winning passage of legislation that essentially would have gutted special trusts, known as voluntary employee

beneficiary associations, as a tax-effective way to fund employee benefit programs.

First elected to the Senate in 1968, he resigned in 1996 to focus on his unsuccessful presidential campaign.

For more than a decade, **SEN. PETE DOMENICI**, R-N.M., has been the driving force behind efforts to require employers to provide the same health care coverage in for mental disorders as they do for other medical conditions.

In 1996, Sen. Domenici worked closely with Sen. Paul Wellstone, D-Minn., who later died in a plane crash, to push for passage of legislation that



Sen. Domenici

forced employers to drop discriminatory annual and lifetime dollar limits for mental health care expenses in their plans. Since then, he has pushed to end common practices of employer health plans, such as limiting the number of annual covered visits to mental health professionals but not imposing a comparable limit for other medical providers.

Now, many believe, Sen. Domenici's long drive for parity has a good chance of succeeding during the current congressional session as there is broad, bipartisan support for the legislation, which passed the Senate last month.

JOHN ERLENBORN was a rare legislator whose accomplishments encompassed both employee benefit and risk management issues.

The Illinois Republican, who served 10 terms in the House before deciding not to seek re-election in 1984, was a key architect of what



Rep. Erlenborn

became the Employee Retirement Income Security Act of 1974. In the mid-'80s, he played the lead role in the passage of legislation to give states more authority to regulate self-funded multiple employer welfare arrangements and close loopholes in federal law that had allowed the proliferation of health insurance scams.

He also championed passage in 1984 of reforms of the federal Longshore and Harbor Workers' Compensation Act, which put new limits on benefits and increased penalties for fraud and abuse.

Still, Mr. Erlenborn had his disappointments. He pushed hard to extend ERISA to public pension plans, but his effort failed to generate much support in Congress.

He died Oct. 30, 2005, at age 78 of a neurological disease.

Several U.S. senators and representatives played pivotal roles

in the development and passage of the Employee Retirement Income Security Act, but **JACOB JAVITS** deserves much of the credit.

Moved by the impact on retirees when Studebaker Corp. collapsed in the early 1960s and failed to adequately fund its pension plan, Sen. Javits, R-N.Y., was the first to propose legislation to create a federal agency to guarantee a portion of employees' and retirees' benefits when underfunded plans were terminated.



Sen. Javits

Through sponsoring numerous hearings in which plan participants laid out how deficiencies in federal law led to their loss of expected benefits, the longtime New York senator helped build public support for enactment of a pension reform law and pressured Congress to enact those reforms.

Congress responded in 1974 by passing ERISA, which set pension funding, vesting and participation rules and established the Pension Benefit Guaranty Corp. to protect benefits. ERISA set the pace for a wave of pension laws that followed.

Sen. Javits left the Senate in 1981 after he lost a bid for a fifth term. He died in 1986 at the age of 86.

Once upon a time, employees changing jobs had good reason to worry about the impact on their health insurance coverage for pre-existing medical conditions.

Employers, fearful of huge medical bills, typically denied coverage for newly hired employees' pre-existing conditions. That made some employees reluctant to change jobs, even when they received better jobs.

But such worries have been history thanks to the efforts more than a decade ago of then-**SEN. NANCY KASSEBAUM**, R-Kan. As chairman of the Senate Labor and Human Resources Committee, she worked carefully with panel Democrats, especially Sen. Edward Kennedy, D-



Sen. Kassebaum

Mass., to win passage of health care portability legislation. Simply put, any pre-existing medical condition exclusions imposed by a new employer must be offset by the period of time an employee maintains continuous coverage. That simple change in law engineered by Sen. Kassebaum—her last major legislative initiative before retiring from Congress in 1996—ended so-called health insurance-driven job lock for employees.

DAN ROSTENKOWSKI, the one-time political titan, probably would be the first to acknowledge that he was not a heavyweight when it came to

employee benefit plan issues.

Yet Mr. Rostenkowski's influence on the design of benefit plans was immeasurable. As chairman of the House Ways and Means Committee from 1981 through 1994 and through adroit deal-making, he presided over



Rep. Rostenkowski

passage of a series of tax bills with an impact on benefit plans that cannot be overstated. The thrust of those tax bills was as much about tax policy as it was tapping new revenue sources to help ease big budget deficits. For example, a sweeping tax measure, which originated in Ways and Means and passed Congress in 1986 with huge help from the Illinois Democrat, dramatically reduced the annual contribution limit for 401(k) plans and the maximum benefits that could be funded through defined benefit plans.

But the Chicago native also had his failures in the benefit arena. He was slow, for example, to sense employer backlash about a series of complicated nondiscrimination rules for health care plans contained in the 1986 tax law and was powerless to stop a drive to repeal those rules.

He also had his personal failures. In 1994, he lost a re-election bid after being indicted on corruption charges. He pleaded guilty in 1996 to mail fraud and was sentenced to 17 months in prison. President Bill Clinton pardoned him in 2000.

Often colorful and occasionally outrageous, **REP. PETE STARK**, D-Calif., has had enormous influence on employer-sponsored health plans.

It was Rep. Stark who in 1985 introduced and successfully attached a health care continuation proposal to a broader budget bill. That continuation measure—known simply as COBRA, the acronym for the



Rep. Stark

Consolidated Omnibus Budget Reconciliation Act—requires all but the smallest employers to extend health coverage for 18 months to employees who terminate employment and up to 36 months to dependents who lose coverage due to death, divorce or marital separation.

While exact figures are not available, COBRA coverage undoubtedly has been extended and taken by millions of health plan enrollees in the more than 20 years the law has been on the books.

As chairman of the House Ways and Means Health subcommittee, he was an early basher of a sweeping health care reform package proposed by President Bill Clinton, helping to assure that the package gained no traction in Congress.

A House member since 1973, Rep. Stark has let intemperate comments

slip from time to time, including describing a Ways and Means Committee member as a "fruitcake" and charging that another panel member got her health care issue knowledge through "pillow talk" from her husband, a physician.

In describing **REP. BILL THOMAS**, R-Calif., who retired in January and served six years as chairman of the House Ways and Means Committee, few congressional observers would disagree with brilliant and mercurial.

His knowledge of health care law and regulations was unmatched in recent years by any federal legislator or professional staff member.

But Rep. Thomas, who joined Congress in 1979, also could be temperamental. He once called in Capitol Hill police during a

failed effort to vote on a pension funding reform bill. While Republicans and Democrats disagreed on what triggered Rep. Thomas, he later tearfully apologized for his actions.

He was the prime sponsor of legislation that passed in 2003 to add a prescription drug benefit to the Medicare program, the single biggest expansion of Medicare in its history. He also fought successfully for provisions to create tax-favored health savings accounts.

He continued his support for HSAs during his final weeks as Ways and Means chairman, horse-trading with Democrats to add provisions in a so-called tax-extender bill that, among other things, allows bigger HSA contributions in many situations.

As chairman of the Senate Labor and Human Resources Committee from 1971 to 1980, **SEN. HARRISON WILLIAMS**, D-N.J., used that position to win passage of legislation that has had a huge effect on pension and health care plans.

Sen. Williams was the top Democratic backer in the Senate of what became the Employee Retirement Income Security Act of 1974, which set pension funding, vesting and participation rules.

In 1977, he introduced legislation that required employers to provide the same coverage in their health care plans for pregnancy and childbirth as other medical conditions. The passage of the Pregnancy Discrimination Act of 1978 meant hundreds, if not thousands, of employers had to revamp their health care plans.

In 1981, he was convicted of bribery charges in an FBI sting operation and received a three-year prison sentence. He died in 2001 at age 81.

—By Jerry Geisel
PHOTOS: ASSOCIATED PRESS

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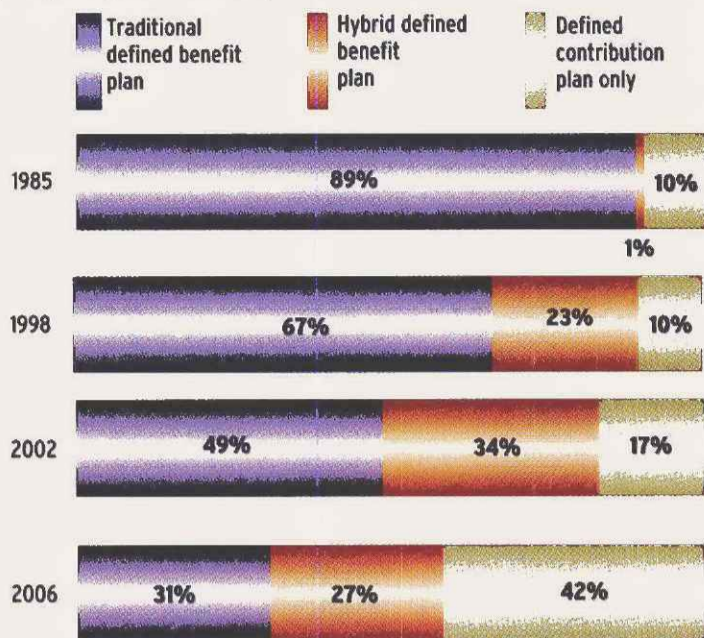
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RISE AND FALL

How defined benefit pension plans are declining and defined contribution plans are growing among Fortune 100 companies*



*Plans offered to newly hired salaried employees
Source: Watson Wyatt Worldwide

Defined benefit plans on the ropes, but show signs of small comeback

After years of uncertainty, cash balance design growing in popularity

By **JERRY GEISEL**

Dow Chemical Co. bucked a trend in July when it announced that new employees would be enrolled in a cash balance pension plan instead of a final average pay plan starting next year.

As recently as 25 years ago, a big company moving from one type of defined benefit plan to another would not have been noteworthy, since defined benefit plans once dominated the pension universe. And the most common type of defined benefit pension was the final average pay plan, which was so named because the benefits are based on years of service and employees' salary earned during the last years of employment.

In 1985, according to an analysis

by benefit consultant Watson Wyatt Worldwide, 89 of the Fortune 100 companies offered a traditional defined benefit plan, while just 10 companies offered only defined contribution plans, such as 401(k) plans.

In that same year, the Pension Benefit Guaranty Corp., the federal agency that protects workers' and retirees' basic benefits, insured more than 112,000 employer-sponsored plans. That was up from more than 95,000 plans five years earlier—a clear sign how companies at the time were adding defined benefit plans.

Today, the wheel has turned almost completely.

These days, many employers—from the very smallest to corporate giants such as IBM Corp., Hewlett-Packard Inc., Motorola Inc. and Sears Holdings Corp.—are freezing their plans by no longer enrolling new employees or halting benefit accruals of current employees.

While the defined benefit plan system is far from dead, it's a shadow of its former self.

By 2006, Watson Wyatt found that just 31 Fortune 100 companies offered a traditional defined benefit plan to newly hired salaried employees, while 27 offered hybrid defined benefit plans, typically a cash balance plan.

By contrast, 42 Fortune 100 companies offered only a defined contribution plan to new salaried employees, a more than four-fold increase since 1985.

And by last year, the PBGC insured fewer than 30,000 plans, a 75% fall from the 1985 high-water mark.

Among reasons why defined benefit plans have fallen from favor are employer concerns about the unpredictability of costs, as well as changing demographics, consultants and employers say.

As the U.S. economy has become based more on services rather than manufacturing, employees are far less likely than they were decades ago to spend all or most of their

careers at a given company. That has decreased the appeal of pension plans, especially final average pay plans, in which the bulk of benefits are earned only after many years of with the same company.

"The focus, in terms of plan design, was pretty much on the career employee," said Larry Sher, a principal and director of retirement policy at Buck Consultants L.L.C. in New York.

At the same time, employee expectations have changed.

"Talk to the younger generation of employees and they do not expect to be with one employer for their entire career," said Janet VanAlster, global benefits director for Dow Chemical in Midland, Mich.

The federal government has also played a significant but very different role in the decline of defined benefit plans.

On the one hand, Congress throughout the 1980s and well into the mid-1990s passed legislation changing defined benefit plan rules and forced employers to constantly amend their plans.

"There were so many rules and regulations, it became increasingly difficult to administer plans," said Alan Glickstein, a senior consultant in Watson Wyatt's Dallas office.

On the other hand, Congress, through the passage of legislation in 1978 and the Internal Revenue Service, through regulations issued in 1981, gave the green light to a savings plan—401(k)s—whose popularity has dwarfed any other type of retirement plan.

As defined benefit plans began their freefall, 401(k)s began to blanket the retirement plan landscape, with the number of plans rising from 30,000 in 1985 to more than 400,000 now, with the participant count now approaching 50 million, a five-fold increase since 1985.

Why the plans became so popular is easy to understand. From an

Continued on next page

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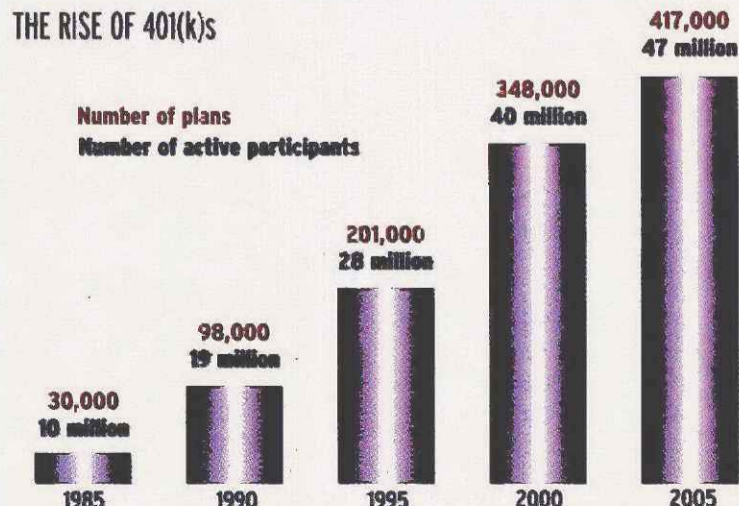


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THE RISE OF 401(k)s



Source: Investment Company Institute



CONTINUED FROM PREVIOUS PAGE

employer perspective, the plans offer predictable costs. From an employee perspective, the plans allow pretax contributions, employer matching contributions and—unlike final average pay plans—a rapid benefit buildup.

Added to that, employee appreciation of the plans was high because of the visibility of their account balances and because employees could take their account balances as a cash lump sum when they terminate employment.

"Employees see the money go in and increase in value. It is very visible. It became front and center on employees' minds," said Dow Chemical's Ms. VanAlsten.

The plans' popularity was enhanced after many employees' account balances grew significantly in the 1990s as the equities' markets boomed.

'There were so many rules and regulations, it became increasingly difficult to administer' defined benefit plans.

Alan Glickstein,
Watson Wyatt Worldwide

But not all employers were ready to give up on defined benefit plans.

Starting with Bank America Corp. in 1985, more than 1,000 employers have turned to cash balance plans—a design incorporating defined contribution plan features such as an easy-to-understand formula, benefits expressed as a cash lump sum and portability of benefits—and the defined benefit plan feature in which employers assumed investment risk. Typically, cash balance plans replaced traditional final average pay plans.

Cash balance plans provided a "more user-friendly benefit to the workforce of the future," said Jerrold Levy, a worldwide partner with Mercer L.L.C. in Chicago.

But by 1999, cash balance plan formation ground to a halt as lawsuits began to pile up that alleged that the design discriminated against older employees. At the same time, the IRS stopped issuing so-called determination letters—a kind of seal of approval—to employers starting new plans or converting existing defined benefit plans to cash balance plans.

Defined benefit plans received another blow when the Sept. 11, 2001, terrorist attacks triggered a big decline in the equities markets, while interest rates plunged. The two events—often called the percent storm—resulted in pension plans that had been overfunded for years becoming hugely underfunded. That resulted in employers—many for the first time in a decade—having to make major pension plan contributions.

For many employers, that was the final straw as large numbers froze

their defined benefit plans and beefed up their 401(k) plans.

But, today, however, many believe the wheel, if only a little bit, may again be turning with renewed interest in defined benefit plans. Employers, like Dow Chemical, are beginning to add new cash balance plans, which Congress protected last year from age discrimination suits as part of a pension funding measure, while several appeals courts dismissed age discrimination suits against existing plans.

In fact, experts say a rebound—if only a modest one—of defined benefit plans is likely, for several reasons. The plans, for example, offer a funding flexibility—allowing

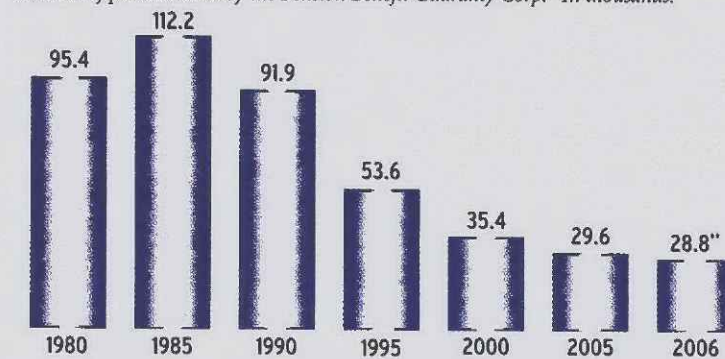
employers to pump in more money when they are doing well—that defined contribution plans do not.

At the same time, employers are starting to recognize that an all-defined contribution plan approach has its shortcomings. By shifting investment risk to employees, workers may retire a lot sooner or later than their employers expected depending on investment results. That may make it more difficult to hold on to talented employees, while other employers may stay longer than wanted.

"Managing workforce size and talent becomes a big issue," said Mr. Glickstein.

THE SHRINKING DEFINED BENEFIT UNIVERSE

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Well-trod path beaten in Washington

Employee benefits issues that businesses face today ring a tune both familiar and decades-old

By **JERRY GEISEL**

As I think back on my 30 years in Washington covering employee benefit and risk management issues for *Business Insurance*, a wonderful French saying comes to mind: *Plus ça change, plus c'est la même chose*, which means the more things change, the more they stay the same.

I thought of that expression recently when reporting on legislation to require group health care plans to provide the same coverage for mental health disorders as they do for other medical conditions.

On several occasions, business groups have described their efforts to work with parity proponents and legislators to try to reach an agreement on a compromise bill as a model for when Congress eventually takes up comprehensive health care reform legislation.

In fact, working with those on the opposite side of an issue is not exactly new. When I came to Washington in 1977, one of the first pieces of legislation I reported on was a newly introduced bill mandating that group health care plans provide the same coverage for maternity-related expenses as they did for other medical expenses.

In that era, it was not uncommon for health care plans to place a dollar cap, say \$500, on hospital expenses related to childbirth, while paying 80% of expenses for other medical conditions.

The issue that business groups, which generally abhor legislative benefit mandates, faced then was: Did it make more sense to try to work with legislative staffers to make the bill less objectionable—such as giving employers more time to comply—or fight and try to kill the legislation. The pregnancy bill eventually passed and business group input did make it more palatable from an employer perspective.

Now, 30 years later, business groups face the same dilemma on mental health care benefits parity legislation that confronted them in the 1970s on the pregnancy bill: Do they work to improve the bill and increase the chances that a measure they dislike will pass; or do they oppose it, with the knowledge that they could end up with a bill a lot more objectionable than if they hadn't gotten involved?

Weighing the pros and cons of a legislative strategy is one of many constants I've observed over the years. There are many others and here

are a few of them:

One person really can make a difference. That hit home for me back in the mid-1980s when the Senate Finance Committee was preparing to vote on a revenue-raising bill. One provision would have crippled the use of special trusts, which are known as voluntary employees' beneficiary associations, to fund employee benefit programs.

Sen. Robert Dole, R-Kan., then the panel's chairman, presented the proposal as non-controversial. Not so fast, countered Sen. Bob Packwood, R-Ore., another panel member. Sen. Packwood then read aloud a letter that was hand-delivered by Ed Davey, then executive director of the Assn. of Private Pension & Welfare Plans—now the American Benefits Council—detailing the damage the proposal would wreak.

Sen. Dole was forced to delay the vote, giving opponents time to work to modify the provision. Without Mr. Davey's fast action, clearly the anti-VEBA provision would have sailed through the committee, increasing the likelihood that it would have become law.

Bad ideas never die, the justification for them just changes. Take taxing employees on employer-paid health insurance premiums. When I came to Washington, the rationale for this idea was that if premiums over a certain amount were included in employees' taxable income, employees would opt for lower-cost policies with more cost-sharing and become better consumers of health care services.

Later, when the Treasury Department proposed a so-called health care tax cap, the rationale was simple: raising revenue. More recently, when Sen. Hillary Clinton, D-N.Y., proposed taxing higher-income individuals on a portion of corporate-paid premiums, the justification was generating money to help pay for coverage for the lower-income uninsured.

Of course, none of the proponents has been able to say how in the real world such a plan could ever be implemented. How the heck, for example, would a premium be calculated in a self-funded plan, where costs aren't known for many months after a plan year ends, to say nothing of such issues as how costs such as consultants' and third-party administrators' fees would be included in the value of

premiums.

Smart people can do dumb things. The prime example was something called Section 89, a part of a 1986 tax law that created non-discrimination rules for health care plans. The idea, which congressional and Treasury Department staffers devised, may not have been a bad one. But the staffers made it so complicated that the law would have been impossible to administer, and it was repealed before it ever took effect.

New administrations come loaded with conceit. A good example was the Clinton administration's attempt to enact comprehensive health care reform legislation. Led by then-First Lady Hillary Rodham Clinton, the plan was drafted in secret, was overly detailed, and no attempts were made to get input from outsiders, much less Congress. No surprise that it was a lousy plan—from a policy standpoint—and that it flopped.

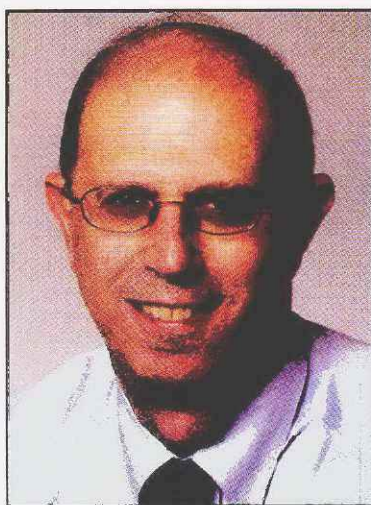
Finally, the old cliché, "**When in doubt, trust your instincts,**" really is true. Here is my example. I was on the job only a few months when an advertising executive called me to ask whether I could supply any proof about a product liability case involving a man who used a lawn mower as a hedge clipper and then sued and won a big award from the manufacturer, presumably for not warning, "Do not use lawn mower as a hedge clipper."

I asked the ad exec why he wanted to know. He said that his firm's client, a big insurer, had used the case in an ad calling for tort reform. Now, he said, some trial lawyers were asking questions about the case.

I told the advertising exec that while I had heard the case being bandied about, I couldn't prove it happened.

After I got off the phone, I said to myself, "This makes no sense. These guys created an ad and now they are asking for proof."

So I checked and, when all was said and done, neither the insurer nor its ad agency could prove that there was such a successful suit, much less that such an accident happened. I wrote a story about this and other exaggerations in the product liability field and—whether by coincidence or something else—the stories about crazy product liability suits came to an end and insurance rates for coverage started to come down.



Jerry Geisel is editor-at-large of *Business Insurance*, which he joined in January 1977.

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When employers' liability exposures were expanded by federal laws, such as the Civil Rights Act of 1991, the Americans with Disabilities Act and the Family and Medical Leave Act of 1993, several insurers began offering this coverage. While it got off to a slow start, it has since become a routine purchase for many risk managers.

ENTERPRISE RISK MANAGEMENT This practice, which is still evolving, first developed in the

1990s when some experts advocated that companies should take a broader view of all the risks that affected them.

ENVIRONMENTAL LIABILITY INSURANCE Following the passage of state and federal pollution legislation in the early 1980s, this coverage was introduced for environmental services organizations, but it has since been purchased by a wider variety of organizations.

ERISA PRE-EMPTION A provision in the Employee Retirement Income Security Act of 1974 that pre-empts state and local government laws and regulations that relate to employee

benefit plans.

FINITE RISK For more than 20 years starting in late 1970s, finite risk was a small but important sector of the insurance and reinsurance markets. Concerns about whether it was really insurance rather than an accounting tool surfaced periodically, but it was not until investigations by former New York Attorney General Eliot Spitzer and the U.S. Securities Exchange Commission over the past few years that the term became discredited.

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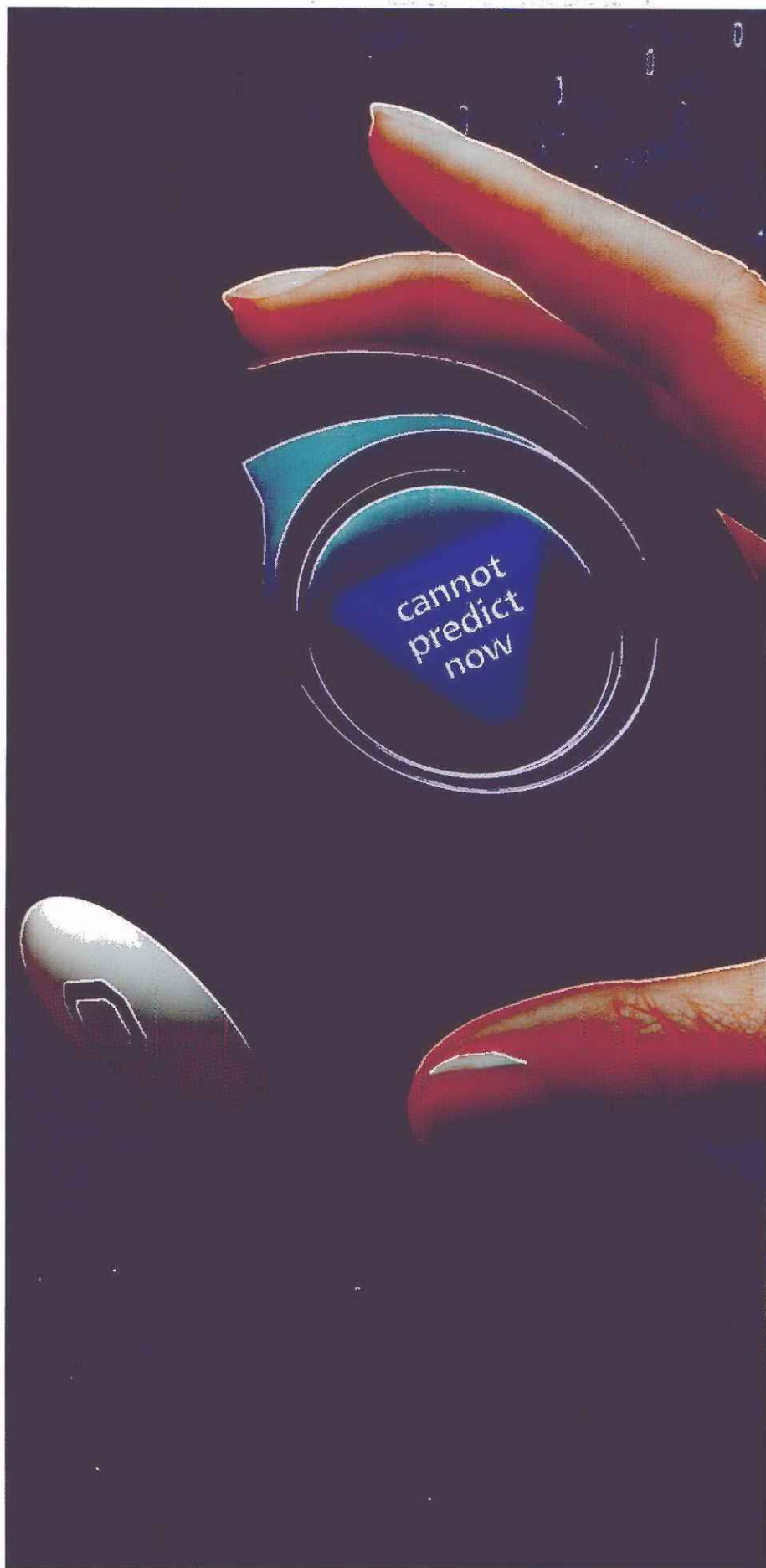
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A timeline of key events in employee benefits

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Good works helping rehabilitation efforts
Return-to-work approach aids charities, workers
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Buyers scramble for war coverages
Worker safety is top priority
Marine cargo premiums rise
Advocates of TRIA hang hopes on next year
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A fantasy called 'customer service'

Top-level executives have responsibility to keep the customer satisfied

By Myron M. Picoult

Webster's Collegiate Dictionary defines a customer as "one that purchases a commodity or service, usually systematically or frequently." There are numerous ways to define service, but "the work or action performed by one that serves" fits. Hence, "customer service" would connote help, assistance and/or insight into the needs of an individual or entity purchasing a product or service. Whatever the definition is, customer service today is generally lousy and getting worse.

There seems to be an in-the-suit attitude from most corporate entities when it comes to customer service. There is an unspoken belief that good service is too costly relative to the benefits. When a fish rots, it rots from the head down. The negative attitude toward any modicum of decent customer service comes directly from the executive suite or it comes via default.

Everyone has had numerous horrendous customer service experiences. They run the gamut from people in customer service departments to individuals in stores. The list involves everything from phone and cable companies, utilities, airlines, airport personnel, computer services and, yes, insurance companies—specifically health, auto and homeowners insurers.

When you call customer service, don't you just love the maze of phone prompts? And when you finally expect to speak to a human, you hear: "We are experiencing an unusually heavy level of calls today, please call back at a later time, leave a message and we will get back to you or wait for the next available service representative. Your approximate wait time is X minutes." Isn't it amazing that everyone in your neighborhood, state and region decided to call the service department at the same moment. Wouldn't it be refreshing to hear, "We have reduced our customer service staff by two-thirds, because we do not think it helps you or us...so be prepared for an extended wait"?

There are exceptions. I, too, have had some wonderful experiences, primarily with smaller companies that truly understand the concept and value of service. I have had exceptional service from Cabinetparts.com (cabinet hardware), Blum Inc. (cabinet hinges), the Sub-Zero Freezer Co. (refrigerators), Costco and Trader Joe's. On the flip side, entities such as Verizon, the Hilton Honors reservation operation, the Mattress Firm, Macy's online and AMC Entertainment Inc. have driven me crazy at times.

What starts out as something relatively

minor can quickly become a full-blown problem because the service representative does not fully understand your problem or does not care. It would be easy to blame the employee. While there is some accountability on the representative's part, blame lies with the person's employer. Poor management decisions and deficient training dictate low levels of service.

When was the last time the chief executive officer of the XYZ Corp. actually listened to some customer service calls to get a firsthand perspective? If the CEO punts on that question, then when was the last time their direct report in charge of that area listened in? Let's go further. When was the last time someone on a company's board asked incisive questions about customer service and studiously requested follow-up?

Satisfaction vs. loyalty

There is a material difference between customer satisfaction and customer loyalty. A satisfied customer will shop anywhere. A loyal customer will remain your customer and refer business to you. When a customer has a problem, no matter how small, it's an opportunity for an enterprise to turn that situation into a positive experience for both parties. Refusing to accommodate the customer exacerbates the entire situation.

Many businesses do not understand the difference between customer satisfaction and customer loyalty. Furthermore, they miss the point that anyone in an organization touches the customer and each can make or break a relationship. Customer service involves issues that are not easily answered. Clearly, there has to be a much higher level of responsibility at all levels to develop a strong customer service foundation.

Honesty is the best policy. If a company cannot satisfy the customer's needs, then a referral to a competitor might be the most productive path for both parties. The candor displayed and the notion that the customer's needs come first can pay dividends. What is clearly missing for most enterprises is the simple fact that the competitive edge a company has is how it treats its customers.

Where does the insurance industry fit into this equation? There are some unusual facets to contend with, such as unusual nomenclature, many consumers tend to lump virtually all phases of insurance into the same bucket and some consumers view insurance as an entitlement. Further complicating the situation is the intermediary. Specifically, who does the broker represent—the insurer or the client? A broker's misstep is ultimately viewed as a

negative for the insurer. The industry must do a better job of explaining what it does, how it does it and the rationale behind decisions.

In fairness, separate the auto, homeowners and commercial operations, notwithstanding the fact that many insurers write all of these segments. I am focusing more on personal lines, but the comments I have heard over the years from commercial policyholders mirror many of the same service problems experienced by individuals.

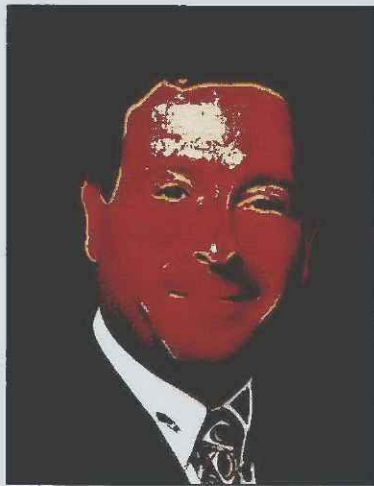
J.D. Power & Associates recently issued its 2007 National Auto Insurance Study. The study states "Policy retention is critical to the financial success of auto insurance carriers, and a customer's experience with their provider is the most important element—outweighing brand image—in generating policy renewals." The study measured customer satisfaction across five factors that included (in order of importance) interaction, policy offerings, billing and payment, price and claims.

The study showed that for the eighth consecutive year, Amica Mutual ranked the highest in customer satisfaction, followed by Erie, GEICO and State Farm. USAA, which provides insurance to U.S. military personnel and their families, was not included in the rankings, but its score was actually above Amica's. When one talks to a USAA

or Amica policyholder, the respondents laud the quality of the customer service provided. Likewise, when interfacing with individuals that have homeowner's policies with Chubb Corp., they acknowledge the higher cost (particularly of the Masterpiece policies), but they quickly underscore the unbridled belief that Chubb will be there (or has been there) when they needed them. Hence, the strong impact of both customer service and the certainty of payment.

The service and certainty of payment facet is clearly impacting the amount and quality of some commercial lines business, as evidenced by the ongoing shift to captives and the reluctance of some key CEOs and CFOs to limit their insurance exposure or not buy it at all, because of hassles they've experienced or envision on claims.

Earlier this year, I wrote that the property/casualty industry was being marginalized by its failure to embrace technological advances, raise the ante on knowledge, implement change and upgrade its service capabilities (BI, June 4). One other factor can be added. Over time, if insurers do not take care of their customers, someone else will.



Myron M. Picoult is an independent insurance consultant. An archive of Mr. Picoult's columns is available online at www.BusinessInsurance.com.

RISK & BENEFITS REDEFINED

Industry terms no one used 40 years ago

FLEXIBLE SPENDING ACCOUNTS FSAs are special accounts—which large numbers of employers began to offer starting in the mid 1980s—in which employees make pretax contributions. The contributions are withdrawn and used to reimburse employees for uncovered health

care and dependent care expenses.

GRACE PERIOD FLEXIBLE SPENDING ACCOUNTS

Approved by the Treasury Department in 2005, the modified FSAs allow employees to draw upon balances remaining at the end of a plan year to pay for expenses incurred during the first 10 weeks of the following plan year.

HEALTH MAINTENANCE ORGANIZATIONS While

their history can be traced back several decades, these health plans, which were designed to help rein-in health care costs, saw their first significant growth after they were embraced by the Nixon administration as part of a national health strategy in 1971.

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Employee health care benefits come full circle as costs rise

Consumerism evolves from once traditional indemnity plans to current consumer-driven health plans

By JOANNE WOJCIK

One continuous theme in employee health benefits over the years has been controlling costs. In fact, medical inflation has been behind virtually every health benefit innovation that occurred since the late 1960s.

And over the past 40 years, health benefits have come full circle: While in 1967, most employers offered indemnity plans with deductibles and coinsurance, today

employers increasingly are offering so-called "consumer-driven health plans" with—you guessed it—deductibles and coinsurance.

"I frequently begin speeches by asking 'Is anyone in the room old enough to remember the traditional indemnity plan?' Now we have an indemnity plan again but with a higher deductible," said Helen Darling, president of the Washington-based National Business Group on Health, who at one time served as

benefit manager for Xerox Corp. in Stamford, Conn. "The only real difference is specifically putting in prevention. It's indemnity with preventive coverage."

"Not only have health care costs been a problem for decades, but what we were trying to do to address the problem hasn't changed—including consumerism," said Joe Martingale, a consultant in private practice in New York, who served as benefit manager at retailer

J.C. Penney Co. Inc. in the late 1970s. He said that much of the justification for eliminating first-dollar coverage back in the mid- to late-1970s was a 10-year RAND study that found when people had high deductibles, their use of health care was inhibited. This same reasoning is being applied today.

Mr. Martingale likens the continual growth in health care costs to stepping off an escalator, letting two or three steps go by, and then

getting back on. When deductibles were raised, health care trend for employers was curbed briefly. When managed care was introduced, once again, health care trend slowed. Except for these few brief interruptions, employers have been forced to address the escalating cost of health care as long as they have been offering benefits.

Even the introduction of flexible benefits was in response to rising health care costs, according to Mr. Martingale.

"One of the reasons cited for creating choice was to acknowledge that the workforce was changing. In the 1960s, we were still a society where women didn't work, and men were the primary breadwin-

'Not only have health care costs been a problem for decades, but what we were trying to do to address the problem hasn't changed—including consumerism.'

Joe Martingale, consultant

ners. By the late 1970s, this changed dramatically," he said.

"But, behind the scenes, what really drove flexible benefits was rising health care costs...Flexible spending accounts...softened the impact of higher deductibles and coinsurance by allowing people to pay for them with pretax dollars," Mr. Martingale said. "We also realized we could make premium contributions on a pretax basis."

Coincidentally, "the same is true of health savings accounts today, but even better because of the rollover," he said.

By the mid- to late-1980s, however, "we were back on that escalator. Health care costs were not defeated. That's when we got into managed care," Mr. Martingale said.

Although the HMO Act of 1973 outlined federal requirements for the creation of health maintenance organizations, managed care didn't really take off until the late 1980s. One event in particular gave a significant boost to the fledgling movement: the introduction of a national point of service plan by Allied-Signal Corp., which also negotiated a multi-year contract with caps on annual rate increases with CIGNA Corp. The theory behind the POS plan was that it would get employees used to the idea of using a provider network by giving them the option of using doctors outside of the network, albeit for higher out-of-pocket costs.

"They couldn't introduce a closed-network health maintenance organization as the only plan design; (it) would cause a rebellion,"

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Health care: Employers embrace consumerism to contain rising costs

CONTINUED FROM PAGE 46

said Mr. Martingale, who as a consultant with Towers Perrin helped broker the deal between Allied Signal and CIGNA.

The savings from managed care lasted about a decade—until a backlash began in the late 1990s. Providers started the ball rolling when they won the ear of the media and lawmakers in some states and got any-will-it-g-provder laws passed. These laws required managed care plans to accept all providers that applied and met their requirements into their networks, said Paul Ginsberg, director of the Center for Studying Health System Change in Washington.

Later, plan members demonstrated their distaste for the plans by choosing to enroll instead in preferred provider organizations instead of HMOs, where doctors serving as “gatekeepers” could restrict the amount of care they could receive.

As a result, PFOs are now the predominant form of health care plan design in the United States, with nearly 60% of the U.S. insured population enrolled in such plans, followed by HMOs, with 21%; POS, 13%; CDHPs, 5%; and traditional indemnity plans, 3%, according to the 2007 Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Survey.

“By 2000, we knew that managed care had seen its day,” Mr. Martingale said.



That’s about the time “consumerism” came along with the introduction of the consumer-driven health plan by Minneapolis-based Definity Health, now a unit of Minnetonka, Minn.-based UnitedHealth Group. Initially, CDHPs were high-deductible indemnity plans that often provided first-dollar coverage for preventive care services. In some cases, the plans also had separate pharmacy benefit plans that provided coverage for drugs outside of the deductible. They also had health reimbursement arrangements, which are like FSAs in that money can be deposited into an account to pay for deductibles and coinsurance. However, unlike FSAs, the sums held in HRAs could be rolled over for use in future years.

But with the passage of the Medicare Prescription Drug, Improve-

ment and Modernization Act of 2003, many CDHPs shifted to health savings accounts, rather than HRAs, which do not allow separate coverage for prescription drugs. As a result, all benefits in CDHPs linked to HEAs, with the exception of preventive services identified by the Internal Revenue Service, are subject to a deductible that rises every year in step with inflation.

“It really is what goes around comes around....Where we are with consumerism today is where we were at back at J.C. Penney in the 1970s,” said Mr. Martingale.

The continuously rising cost of health care also prompted many employers to place greater emphasis on the benefit function, replacing so-called “personnel managers,” who basically enrolled new hires in their benefit plans, with people

who had experience working within the health care industry itself.

“In the beginning, most benefit managers were merely glorified personnel managers. But the cost of health care has changed the roles of benefit managers. They have to know more about health benefits,” said John Erb, specialist leader at Deloitte Consulting L.L.P. in Miami.

“Corporations learned that if you wanted to manage the industry, you should hire people who came from the industry,” Ms. Darling said.

In fact, it was this group of health care industry experts that led development of the Healthcare Effectiveness Data and Information Set, or “HEDIS,” a tool now used by more than 90% of America’s health plans to measure performance, according to Ms. Darling.

“We sat down with the health plans and said we would measure their performance,” she said. And to ensure health plan participation, “we said we would do it without them if they didn’t join the effort,” she said.

Benefits management became more complex as companies made every attempt to rein in costs. This led to a growth in outsourcing and the use of outside consultants, according to Jim Crockett, former manager of risk and benefits at Denver Water, a municipal utility. Mr. Crockett, who recently retired, started in the benefits business in 1967.

“Many companies even out-

sourced COBRA administration because of the liabilities companies would incur if they didn’t comply,” he said.

The Consolidated Omnibus Budget Reconciliation Act of 1985 required employers with 20 or more employees to make available continued health care coverage for a specified period to employees—and their qualified dependents—who terminate employment for reasons other than gross misconduct, as well as to dependents due to the death of an employee or due to divorce or marital separation.

Even self-funding, which was stimulated by passage of the Employee Retirement Income Security Act of 1974, is a product of health care inflation, according to Virginia Burke, counsel to the law firm of Edwards, Angell, Palmer & Dodge L.L.P., in Providence, R.I.

Although the original intent of ERISA was to protect pension benefits, it also provided pre-emption from state laws for self-insured welfare plans, including health benefits.

“ERISA pre-emption makes it cheaper for employers to offer health coverage,” she said, because self-insured employee benefit plans are not required to cover all of the benefits state mandates require insured plans to provide, such as chiropractic care or alternative medicine.

Today more than half (53%) of employers self-insure their health benefit programs, according to the KFF/HRET survey.

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Flexible benefits evolve as workforce changes

More employers implement work/life programs

By **TINA EICHNER**

The need for flexibility in work arrangements predates the advent of flexible benefit programs, but employers have made considerable strides in both areas during the past 40 years.

“Work/life balance is not new. It is the magnitude of the concept that has changed,” said Kathie Lingle, director of WorldatWork and the Alliance for Work-Life Progress, a national nonprofit association that helps employers with work/life issues. “The war today is a war for talent and that has helped bring about work/life balance.”

WorldatWork has chronicled workplace flexibility since the 1960s, with research showing the resurgence of women in the workforce was the first modern catalyst for family-friendly policies.

In the 1970s and 1980s, as more women joined the workforce, the federal government pioneered options for flexible work and benefits arrangements, with corporate America following suit. According to WorldatWork, employers had to

address a lack of affordable, quality child care at that time, and some responded by creating onsite child care facilities.

The 1990s brought increased growth in the number of dual-career households and a redefinition of working fathers. Both parents could commit to working outside the home and raise children as well.

Broader implementation of family-friendly policies in the '90s helped validate the needs of employees beyond basic work responsibilities. In recent years, there has been a trend toward work/life balance—regardless of gender or family status, according to WorldatWork.

In a comprehensive, ongoing study of practices, policies, programs and benefits to address changing workforce needs, the Families and Work Institute conducts its National Study of Employers every five years.

Of employers surveyed in 2005, 92% offered at least eight work/life

Continued on next page



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initiatives, including flexible schedules, family leave, child care and elder care assistance. Of these, 47% provided such initiatives to help recruit and retain employees, and 25% did so to boost productivity and commitment.

In addition to flexible scheduling, flex benefit programs typically offer workers a choice of coverage options, Ms. Lingle noted. For example, some employers offer a pool of credits related to a dollar value of benefits and let employees pick the benefits most relevant to them.

Work/life solutions such as employee assistance programs, including dependent care programs, also are growing rapidly. Elder care assistance is increasingly important due to greater longevity of people overall, with more employees requiring assistance and flexibility in taking care of elderly parents.

'The most desirable programs include flexibility and choice.'

Diane Burrus, WFD Consulting

"Elder care can cost employers \$3,500 per year in stress, strain and absenteeism for an employee taking care of an elderly parent or family member," said Ms. Lingle. She added that some people are even leaving the workforce to deal with these responsibilities.

Elder care is not the only family phenomenon impacting changing worker needs. The family looks very different today from even two decades ago.

"What is a family? Who is a dependent? Pick a demographic and it has changed," Ms. Lingle said. "We have domestic partners, nonmarried people living together, male single heads of households, elder care dependents," she said. "The family absorbs the responsibility for all of these situations."

Various studies show health care insurance is the single most-valued benefit offered to U.S. workers, though the percentage of companies offering health care benefits has remained stable in recent years. Families and Work Institute research shows that 95% of companies with 50 or more employees offer health insurance coverage for full-time workers. One change, according to the institute, is that 25% of employers now provide coverage for all unmarried partners.

Diane Burrus, a senior consultant with WFD Consulting in Newton, Mass., said creating an environment that supports people's abilities to be engaged through flexible work options is imperative for meeting recruitment, retention and satisfaction goals.

"Flexible work arrangements are increasingly desired and utilized by both men and women, and give control over where and when and how work gets done and keeps employees happy," said Ms. Burrus.

"The most desirable programs include flexibility and choice."

Today, all employees, not just those trying to manage family issues, desire flexibility. "Younger workers also want flexibility. It is a new career paradigm," Ms. Burrus said. "The younger generation has different values and ethics, among them control, interest and opportunity."

Part of this youth mentality is due to an employee base that has grown up with technology. "How we work today is very different. People can work at any time from anywhere. It is a virtual world and technology is shaping workplace flexibility," said Ms. Burrus.

Johnson Storage & Moving Co., a diversified transportation and warehousing company based in Denver, has had success with its flex programs.

After hearing a speech by Joan Williams, author of "Unbending Gender: Why Family and Work Conflict and What to Do About It," owner Jim Johnson implemented a flex-time program. Today, more than 30% of Johnson Storage's workforce utilizes it.

"We're a midsize company with approximately 225 employees, and many of our workers have responsibilities at home and to their families," Mr. Johnson said. "I felt the best solution is to allow our workers

to do their jobs from their home offices and still be eligible for all company benefits. Since implementing the flex-time program, our turnover is down, but most important, our employees are satisfied. Our work-at-home and flex-time programs are a low-cost/no-cost way for us to offer a benefit that remains uncommon and distinguishes us from those with whom we compete for talent."

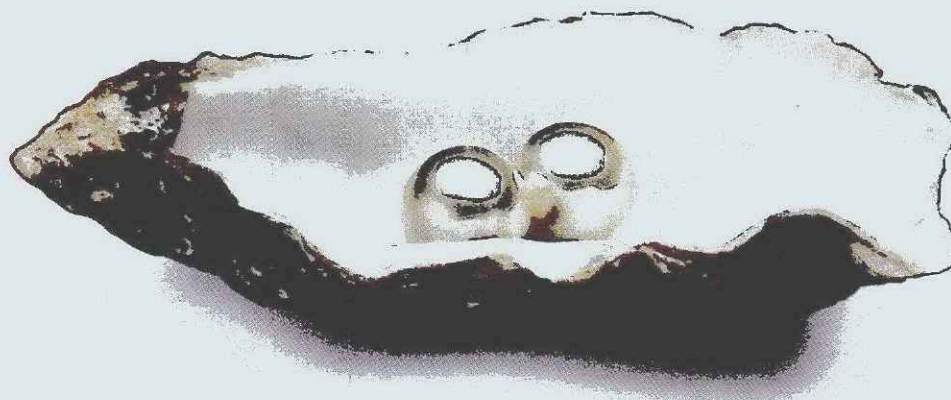
For companies hesitant to introduce flexibility, Ms. Burrus suggests a business-based approach.

"Employ a process where employees request flexibility without putting the reason out there," she said. An employer does not need to

know if the flexible schedule is requested so a parent can pick up a child or because an employee wants to finish early on a given day to train for a marathon. "Taking the reason out of the process helps solve the problem of inequity. All have access, just the outcomes are different. Decisions are not made because of the reason (that was given), they are made because of the business case, because the arrangement makes sense within the operation of the company," she said.

"Flexibility is the kingpin of work/life goals. It is difficult to implement at first, but it does not cost anything and the benefits are great," Ms. Lingle said.

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Maurice R. Greenberg

The enduring house that 'Hank' built

Despite bitter breakup, visionary chairman made AIG into a global powerhouse

By DOUGLAS McLEOD

Maurice R. Greenberg's 2005 departure from American International Group Inc. may have tarnished his reputation but it has not obscured his achievements in nearly 40 years at the insurer's helm.

Mr. Greenberg, known as "Hank," took over an insurance group that produced net income of \$13.4 million in 1969 and managed it into a financial services behemoth that generated \$11.1 billion in income the year before his departure.

AIG's phenomenal success is attributable in large part to Mr. Greenberg's astute strategic vision for the company, and to his insistence on setting clear performance standards for AIG managers and holding them accountable for meeting them.

The tough-minded culture that Mr. Greenberg fostered at AIG is likely to survive in his absence for some time, former AIG officials have predicted, even though the insurer and its longtime leader are now at war.

AIG has sued Mr. Greenberg to recoup most of its \$1.6 billion settlement of state and federal charges that it manipulated its financial results—the charges that led to Mr. Greenberg's exit. The two sides have also skirmished over C.V. Starr & Co.

Inc., a former agency affiliate of AIG that Mr. Greenberg now manages.

As chairman and chief executive officer of C.V. Starr, though, Mr. Greenberg continues to do what he has done his whole adult life: build an insurance enterprise.

As a young lawyer and veteran of World War II and the Korean War, Mr. Greenberg worked briefly at Continental Casualty Co. before being hired in 1960 by Cornelius Vander Starr, founder of the Shanghai insurance agency that would become AIG.

At the time, the company's main businesses were overseas life and property/casualty operations and American Home Assurance Co., a struggling P/C insurer that Mr. Starr had acquired in 1952 to expand into the U.S. domestic market. Mr. Greenberg was put in charge of American Home in 1962 and quickly restructured the company, scrapping its expensive agency force and turning it into a broker market for commercial lines. In the process, the insurer gained control of its underwriting and—by buying more reinsurance to back larger limits—the ability to control pricing.

Mr. Greenberg then led an acquisition drive that established AIG's domestic network and

included takeovers of New Hampshire Insurance Co., National Union Fire Insurance Co. of Pittsburgh, Pa., Lexington Insurance Co. and Commerce & Industry Insurance Co.

In 1967, following Mr. Starr's death, Mr. Greenberg took the company's reins. AIG, created that year as a holding company for the insurance operations, went public in 1969.

A series of firsts

Most of AIG's stunning growth still lay ahead, though. AIG was among the first insurers to add risk management services to its insurance products. The 1980s brought a rapid expansion into financial services with the acquisitions or startup of asset management, currency and commodity trading and finance units. AIG moved into personal lines in the 1990s with its acquisition of 20th Century Industries, and into the retirement savings business with the \$18 billion acquisition of SunAmerica Inc. In 2001, it added life insurance and pension giant American General Corp. in a \$23.1 billion deal.

Meanwhile, it was expanding aggressively overseas and was among the first U.S. companies to establish insurance operations in several former Soviet bloc nations. Its great milestone, though, came in 1992, when AIG became the first foreign insurer granted a license to operate independently in Shanghai, where Mr. Starr had launched the company in 1919. AIG had closed its offices in China in 1950 after the Communist takeover.

In the decades that Mr. Greenberg ran AIG as a public company, its net P/C premiums expanded from \$245.5 million to \$41.9 billion; life premiums grew from \$38 million to \$28.4 billion. AIG's overall revenues in 2004 were \$98.6 billion.

From the beginning, Mr. Greenberg ran AIG with several guiding strategies in mind.

One of these was insisting that AIG managers meet performance goals that included a 15% return on equity in all business lines, a combined ratio of less than 100% and maintaining the company's AAA credit rating.

Mr. Greenberg often complained, especially in soft markets, about competitors' predilection for "cash-flow underwriting," the practice of cutting rates and trying to make up for the resulting underwriting losses with investment income.

AIG units generally met Mr. Greenberg's goals—their managers could find themselves on the receiving end of his famously short temper if they did not—and AIG's traditionally heavy use of reinsurance sometimes helped.

In the 1980s, for example, AIG

units ceded so much of their business to reinsurers that some jokingly described the company as a broker. The huge ceding commissions that AIG subsidiaries collected actually allowed them to report negative expense ratios, turning "underwriting expense" into a profit center and dramatically reducing the insurers' combined ratios.

AIG also organized its business around product-focused profit centers, a 1999 Harvard Business School case study of the insurer noted. This encouraged product innovation—an AIG hallmark—and focused managers on their results.

Another of Mr. Greenberg's guiding strategies was to expand AIG, a company born overseas, as a global business. He carried on Mr. Starr's tactic of running overseas operations as local businesses, hiring local executives and encouraging the adoption of local customs.

Mr. Greenberg was also tireless in building relationships with foreign leaders. He made several dozen trips to China, for example, in the years before AIG won its license there, meeting with Zhu Rongji, mayor of Shanghai until 1991 and later the Chinese premier, among others.

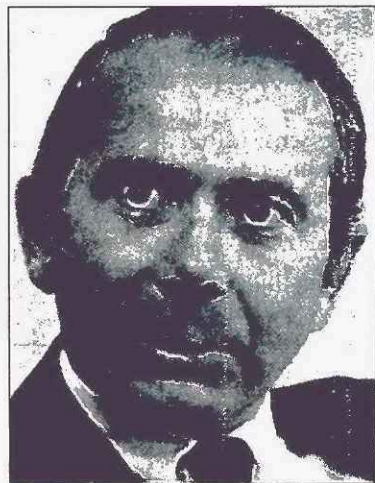
His resume underscores the global focus: He is a director of the Council on Foreign Relations, a trustee and former chairman of the Asia Society, and a member of several U.S.-Asian business councils.

Mr. Greenberg's drive to meet financial goals has more than once put AIG on a collision course with regulators, though.

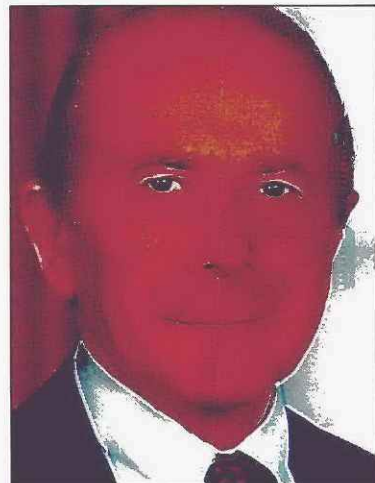
In the 1990s, regulators in several states launched investigations of Coral Reinsurance Co. Ltd., a thinly capitalized Barbados reinsurer that AIG helped form and that assumed uncollectible balances due from AIG's other reinsurers, allowing AIG to avoid writing those balances off. AIG insisted that its relationship with Coral Re was arm's-length, but eventually agreed to unwind its Coral Re treaties.

The ultimate showdown for Mr. Greenberg was with former New York Attorney General and now New York Gov. Eliot Spitzer, who focused on AIG after finding that it had participated with other insurers in a bid-rigging scheme organized by Marsh Inc.

Mr. Spitzer's fraud lawsuit against AIG and Mr. Greenberg went beyond the bid-rigging charges to allege multiple schemes by AIG officials to manipulate the company's results. While AIG settled—pushing out Mr. Greenberg in the process—the case remains pending against the man whose life's work was making AIG what it is today.



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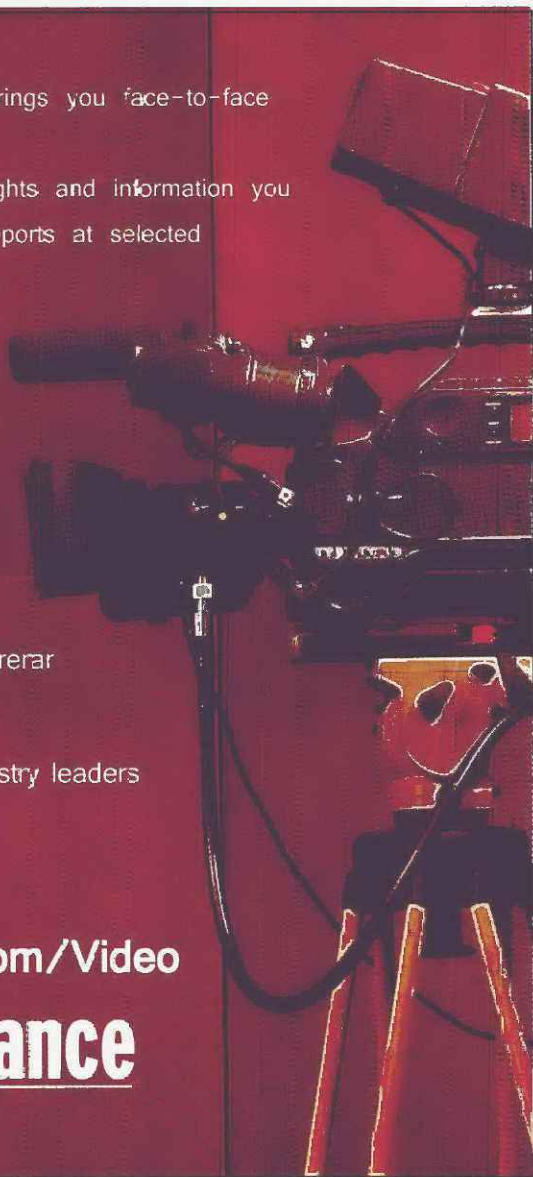
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Test your knowledge of employee benefits history



1. Which employer's disability plan led to a 1978 federal law that made it illegal for a corporate disability or health insurance plan to discriminate on the basis of pregnancy or childbirth?

- A) GENERAL ELECTRIC CO.
 B) IBM CORP.
 C) SEARS, ROEBUCK & CO.
 D) MOTOROLA INC.

2. Which employer was the first to set up a cash balance pension plan?

- A) IBM CORP.
 B) GENERAL MOTORS CORP.
 C) HEWLETT-PACKARD CO.
 D) BANK OF AMERICA CORP.

3. Which U.S. Treasury secretary proposed abolishing 401(k) plans?

- A) LLOYD BENTSEN
 B) G. WILLIAM MILLER
 C) JAMES BAKER
 D) DONALD REGAN

4. When did the Internal Revenue Service first propose its "use it or lose it" rule for flexible spending account balances?

- A) 1984
 B) 1986
 C) 1990
 D) 1992

5. On a per capita basis, which country has the highest health care costs?

- A) GERMANY
 B) UNITED STATES
 C) FRANCE
 D) CANADA

6. About what percent of U.S. residents lack health insurance coverage?

- A) 16%
 B) 10%
 C) 12%
 D) 14%

7. Which state has the highest percentage of residents who lack health insurance coverage?

- A) MISSISSIPPI
 B) TEXAS
 C) ALABAMA
 D) GEORGIA

8. What federal law authorized health savings accounts?

- A) ECONOMIC GROWTH AND TAX RELIEF RECONCILIATION ACT
 B) MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT
 C) TAX EQUITY AND FISCAL RESPONSIBILITY ACT
 D) TAX RELIEF AND HEALTH CARE ACT

9. About how many single-employer pension plans are insured by the Pension Benefit Guaranty Corp.?

- A) 50,000
 B) 29,000
 C) 31,000
 D) 41,000

10. What is the maximum amount of term life coverage employers can provide without adding the cost to employees' taxable income?

- A) \$100,000
 B) \$75,000
 C) \$50,000
 D) \$80,000

11. Under the Family and Medical Leave Act, what is the maximum number of weeks of job-protected leave that an employer must provide in a year to an eligible employee?

- A) SIX
 B) EIGHT
 C) 12
 D) 16

12. Under the most widely used 401(k) plan nondiscrimination test, the maximum average contribution, as a percentage of salary, made by highly compensated employees cannot exceed average contributions by lower-paid employees by no more than what percentage?

- A) 1 PERCENTAGE POINT
 B) 2 PERCENTAGE POINTS
 C) 2.5 PERCENTAGE POINTS
 D) 3 PERCENTAGE POINTS

13. Which is the world's largest employee benefit consulting firm?

- A) MERCER L.L.C.
 B) HEWITT ASSOCIATES INC.
 C) WATSON WYATT WORLDWIDE
 D) TOWERS PERRIN

14. What is the maximum time an employer must provide COBRA health care continuation coverage to the spouse of an employee who dies?

- A) 12 MONTHS
 B) 16 MONTHS
 C) 36 MONTHS
 D) 42 MONTHS

15. Which federal law gives new cash balance pension plans protection from age discrimination suits?

- A) RETIREMENT EQUITY ACT
 B) PENSION PROTECTION ACT
 C) SINGLE EMPLOYER PENSION PLAN AMENDMENTS ACT
 D) AGE DISCRIMINATION IN EMPLOYMENT ACT

16. Which county was sued for age discrimination because it provided smaller health care benefits to Medicare-eligible retirees than

younger retirees?

- A) ERIE COUNTY, PA.
 B) COOK COUNTY, ILL.
 C) LOS ANGELES COUNTY, CALIF.
 D) CHITTENDEN COUNTY, VT.

17. What company is the largest U.S. health insurer in terms of enrollees?

- A) AETNA INC.
 B) WELLPOINT INC.
 C) UNITEDHEALTH GROUP INC.
 D) CIGNA HEALTHCARE

18. Who coined the term health maintenance organization?

- A) HENRY J. KAISER
 B) PAUL ELLWOOD
 C) ALAIN ENTHOVEN
 D) DAVID DURENBERGER

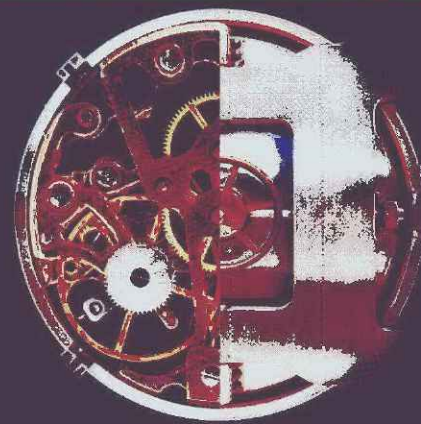
19. The termination of which company's underfunded pension plans became a catalyst for establishing a federal agency that would guarantee pension plan participants' basic benefits?

- A) LTV CORP.
 B) BETHLEHEM STEEL CORP.
 C) STUDEBAKER CORP.
 D) BRANIFF INTERNATIONAL AIRWAYS

20. Under the Health Insurance Portability and Accountability Act, what is the maximum time a health plan can exclude coverage for pre-existing medical conditions from the time an employee is first eligible to enroll?

- A) THREE MONTHS
 B) SIX MONTHS
 C) NINE MONTHS
 D) 12 MONTHS

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High rates, tight capacity ingredients for insurance fraud

Scam artists offering too-good-to-be-true coverage take advantage of lax regulation, cost-conscious buyers

By DOUGLAS McLEOD

Successful insurance frauds in the United States are like successful entrepreneurial ventures anywhere: they take advantage of opportunities.

When rates for a given line of coverage are high and capacity is tight, swindlers are quick to offer coverage at a discount. When regulation is loose or ill-defined in a given area—as has happened in the

surplus lines and self-funded health plan arenas—scam artists swoop in.

These are not claim frauds, the fake workers comp injuries and staged accidents that cost insurers and, indirectly, policyholders tens of billions of dollars a year. Instead, they are “company” frauds, in which the insurance company itself is in the business of defrauding its customers.

Company frauds have come in many forms over the last four

decades, and have themselves caused billions of dollars of losses to insurance buyers ranging from the corner grocery store owner to Fortune 500 companies.

Some have been “insider” frauds, in which con artists gain control of a licensed insurer and use it to plunder policyholders. Others have involved bogus insurers that the fraudsters themselves create in underregulated offshore jurisdictions. Still others have taken advan-

tage of regulatory gaps governing group health plans to create fraudulent health insurance entities.

What nearly all of them rely on is policyholders’ desire to save money on products that are otherwise costly or unavailable, with little or no regard for the security risks. These deals were all too good to be true.

In concept, insider frauds aren’t very different from organized crime “bust-out” schemes, in which criminals take over a legitimate business, find as many ways as possible to siphon money away from it, and abandon the bankrupt remains.

“Exhibit A” among insider frauds was Kenilworth Insurance Co., a struggling Illinois-domiciled auto insurer whose 1982 collapse was an eye-opener for state insurance regulators. Kenilworth’s liquidators discovered that the insurer had been secretly controlled by a group led by a convicted felon, John V. Goepfert, and that the same loose-knit band of agents, brokers and reinsurance intermediaries involved in Kenilworth’s demise had similarly looted several other insurers dating back to 1971.

With Mr. Goepfert in charge, Kenilworth had been bound to mil-

lions of dollars of money-losing surplus lines and reinsurance business. Premiums then disappeared, as the band of swindlers stripped off excessive commissions and phony fees; issued insurance certificates and billed additional premiums without reporting them to the company; and ceded Kenilworth’s own reinsurance to the likes of Universal Casualty & Surety Co. Ltd. of the Cayman Islands, which was operated by another convicted felon and which itself later collapsed.

Mr. Goepfert and several others, including Kenilworth’s president, were later convicted on federal fraud charges stemming from the insurer’s failure.

The 1980s brought a variation of the insider fraud, in which a licensed insurer is fleeced by its own managing general agent.

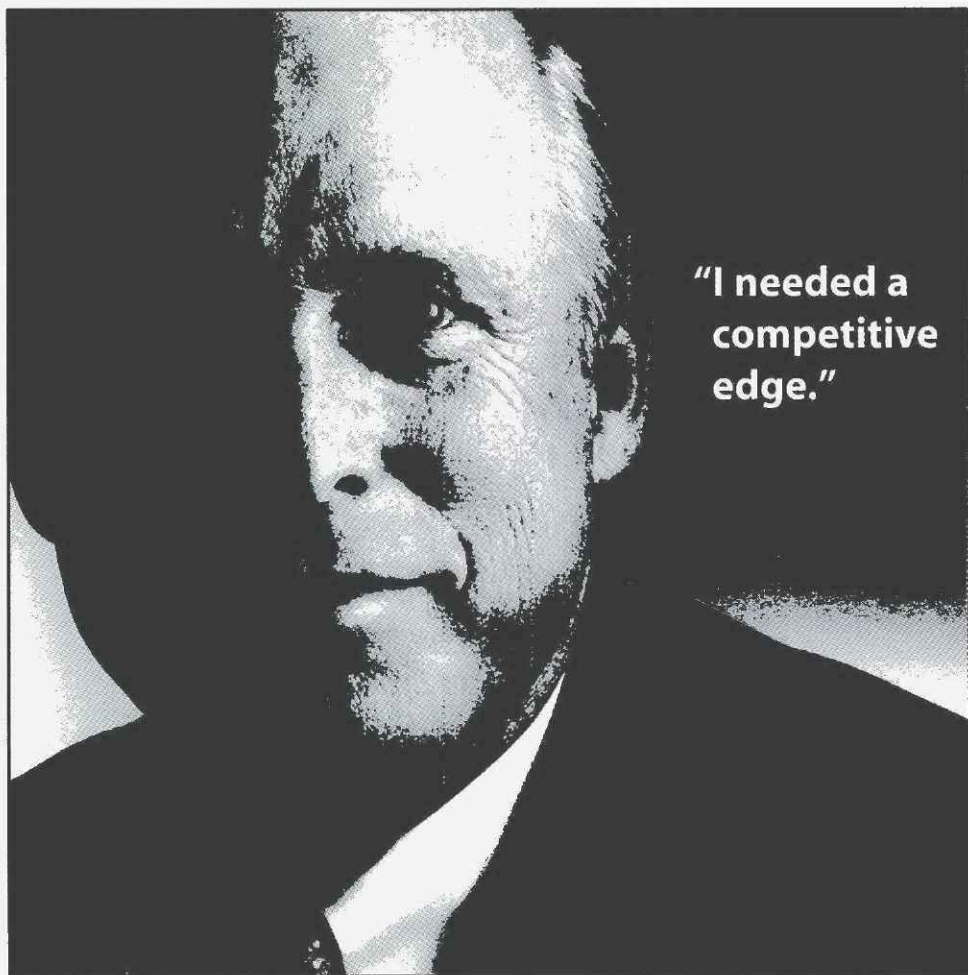
The largest such case involved Omaha Indemnity Co., a unit of Mutual of Omaha Insurance Co., and its MGA Royal American Managers Inc. of Kansas City, Mo. The insurer made the mistake of granting RAM—run by James R. Wining and Willie A. Schonacher—authority not only to bind business and pay claims but also to place Omaha Indemnity’s reinsurance on the business RAM wrote.

The result: The insurer discovered that by 1985, RAM had booked \$196 million in premiums but had reported only \$61 million to the insurer and actually remitted only \$7 million. Some of the money had been diverted to an offshore reinsurer controlled by Messrs. Wining and Schonacher; other premiums went into a “loss fund” that RAM controlled but seldom used for the supposed purpose of paying claims.

Omaha Indemnity suffered more than \$200 million in net losses because of the RAM fraud. Mr. Wining and Mr. Schonacher pleaded guilty to federal conspiracy charges in 1992.

Carlos I. Miro—a convicted swindler who testified in 1993 before a Congressional panel headed by Rep. John D. Dingell, D-Mich.—managed to pull off both types of insider fraud. As an MGA for the defunct Transit Casualty Co. in the 1980s, he contributed to Transit’s collapse by—among other things—arranging “looping” transactions in which Transit ultimately reinsured itself. Mr. Miro went on to set up Anglo-American Insurance Co., a Louisiana workers comp insurer, by bribing then-Louisiana Insurance Commissioner Sherman A. Bernard to issue the license. He was later jailed for looting Anglo-American to support his lavish lifestyle; the insurer left \$20 million in unpaid claims.

A licensed insurer is not the only, or even the most frequent, vehicle for company fraud. More common are bogus offshore insurers, operating as a kind of insurance Ponzi scheme: the companies rake in as much premium as possible in a



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FROM CEO TO CONVICT

Alan Teale’s career in the United States

1981: Alan Teale, a British citizen, comes to the United States to become the first chief executive officer of the Insurance Exchange of the Americas in Miami. He leaves the exchange at the end of his contract in 1984. The exchange later closes under weight of huge losses.

1989: Mr. Teale and his wife, Charlotte C. Rentz, settle charges that member companies of his International Underwriting Assn. wrote business illegally in Florida. Louisiana regulators take over an insurer associated with Ms. Rentz.

1991: A Pennsylvania bank denies holding a \$2.5 million trust fund for another insurer associated with Mr. Teale and Ms. Rentz. The husband and wife cite their Fifth Amendment right against self-incrimination in refusing to testify before U.S. Senate subcommittee. Senate investigators charge that Mr. Teale is “at the controls” of a worldwide network of firms into which millions of dollars in premiums disappeared. Regulators step up investigations of Mr. Teale and his associates.

1993: Mr. Teale and Ms. Rentz pleaded guilty to fraud, money laundering and conspiracy charges. Mr. Teale is sentenced to 17 years in prison and Mr. Rentz is sentenced to 13 years.

1994: Mr. Teale dies in prison at age 64.

Continued on next page



CONTINUED FROM PREVIOUS PAGE

short time; once the volume of incoming claims exceeds incoming premium, the company collapses, and the swindlers move on to the next scam.

Perhaps the largest single operator of these was the late Alan Teale. Mr. Teale, a former London broker and president of the now-defunct Insurance Exchange of the Americas in Miami, managed scores of fly-by-night companies from a suburban Atlanta office until the early 1990s.

All were incorporated in domiciles with light or no regulation, mostly Caribbean nations, but also Belgium and Ireland, which at the time did not regulate reinsurers.

To attract business, these companies needed to be able to show plausible financial statements to brokers, and Mr. Teale spent considerable time arranging these. U.S. Senate investigators and state regulators examining the companies found that their capital and surplus variously included worthless penny stocks that were "rented" from securities swindlers and reported at grossly inflated values, and Government National Mortgage Assn. securities that the insurers did not actually own.

Some of the insurers' assets weren't so plausible: two companies were capitalized with "treasury bills" issued by the Sovereign Cherokee Nation Tejas, a purported Indian nation created by a retired U.S. Air Force Colonel in the 1970s on a sand bar in the Rio Grande River.

Mr. Teale—who died in prison in 1994—was hardly the only operator of such companies. California's relatively loose surplus lines oversight and a tight market for auto and general liability business made the state a mecca for offshore scam artists until mid-1990s regulatory reforms. Bogus offshore companies continue to surface regularly, especially in tight markets.

Some swindlers, meanwhile, don't bother trying to create a realistic-looking fake insurer, but instead just borrow real insurers' names. In 2000 and 2001, a company called Tri-Continental Exchange Ltd., operated from Barbados, sold property/casualty coverages on behalf of "Nationwide Insurance," "Globe Indemnity & Casualty," "Transatlantic International" and other insurers. These companies were not related to very similarly named, U.S.-licensed insurers, but there was plenty of confusion about that among small commercial policyholders. Tri-Continental was operated by Matthew Wallace Schachter, a California man who used the alias "Robert L. Brown"; he died in 2005 while awaiting trial on federal fraud charges.

Con artists haven't contented themselves with bilking property/casualty policyholders. Group health care has been a big source of company fraud, with many of the scams until the 1990s taking the form of fraudulent multiple employer welfare arrangements. Bogus MEWA operators have typically lured smaller employers with offers of cheaper group health coverage, then siphoned away premi-

ums with excessive fees and administrative costs. For years, they also managed to slow regulators' efforts to shut them down by claiming to be exempt from state regulation under the Employee Retirement Income Security Act of 1974.

After Congress amended ERISA in 1983 to clarify state authority—and a series of courts affirmed state oversight of MEWAs—many swindlers moved in on another regulatory loophole: collectively bargained union health plans. Con artists set up their own bogus unions—one, for instance, was the "National Council of Allied Employees," started in New York by a convicted felon—and convinced small

employers to sign up their workers in return for the "union" health coverage. (The "unions" also agreed to do nothing inconvenient, like bargain over pay and work rules.)

Some things didn't change, though: the plans still claimed to be exempt from state oversight under ERISA and they left tens of millions of dollars of unpaid worker health claims after scammers drained funds with dues, fees and administrative costs.

The outbreaks of various types of fraud over the last four decades have often been answered with legislative or regulatory action to combat them.

The 1980s MGA scandals led the

National Assn. of Insurance Commissioners to develop its MGA Model Act, an effort to enhance regulators' and insurers' oversight of MGAs.

Scams like Mr. Teale's offshore empire led to the addition of insurance fraud provisions to the Violent Crime Control and Law Enforcement Act of 1994. Under that law, misappropriating premiums and filing false financial statements with regulators became federal crimes. The law also generally barred convicted felons from the insurance industry without written consent from a state insurance department.

Many insurance-related frauds continue to be prosecuted under

the federal mail and wire statutes used before the 1994 act, regulatory experts say.

The premium theft provision of the 1994 law has been used in cases against 220 defendants since 1997, according to figures compiled by the U.S. Bureau of Justice Statistics. The number includes only cases where insurance fraud was the most serious offense charged against a defendant.

Government action, though, typically comes only after victims have been damaged.

The best way to escape fraud losses is still to know that a deal that seems too good to be true probably is.



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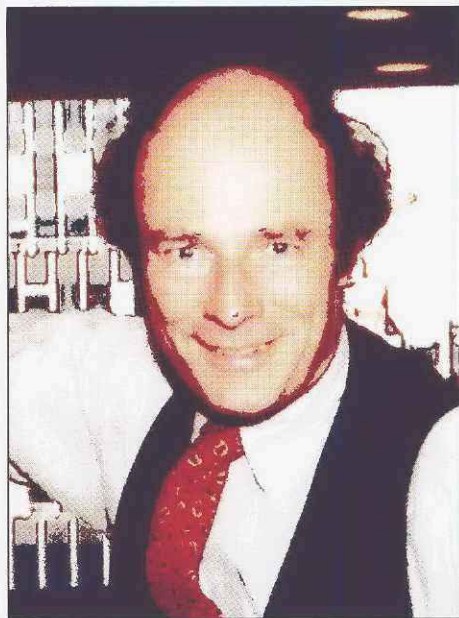


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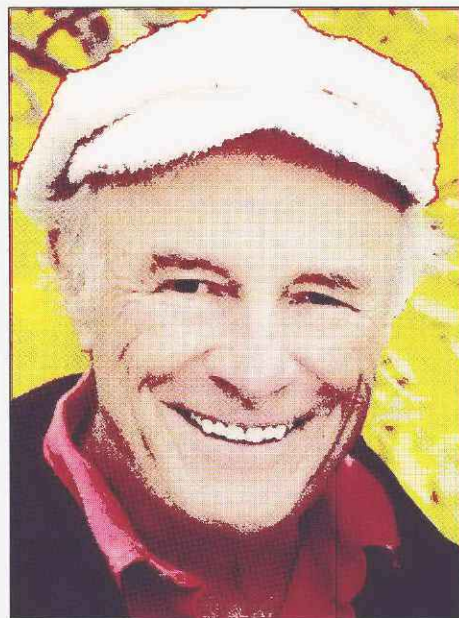
Robert Clements' innovative solutions tackle market disruptions

By **DOUGLAS McLEOD**

Robert Clements



Circa 1984



2006

Robert Clements has built a remarkable, five-decade career by finding innovative ways to deal with insurance market disruptions.

From the birth of ACE Ltd. and XL Capital Ltd. more than 20 years ago to the 2005 creation of Integro Ltd., Mr. Clements has made a habit of spotting opportunity in areas of the industry where others see too much risk.

And at 74, he shows no signs of slowing down: Late last year, he helped raise more than \$1 billion to capitalize Ironshore Inc., which specializes in writing commercial property coverage in catastrophe-prone regions of the U.S. where capacity dried up after Hurricane Katrina.

Mr. Clements' business is also partially a family enterprise. John Clements, one of his four children, is a partner in the Ironshore startup and worked with his father as a principal of MMC Capital Inc., the former insurance investment arm of Marsh & McLennan Cos. Inc.

Robert Clements' career started in 1957, when he got a job with Royal Insurance Co. as an underwriting trainee after graduating from Dartmouth College. Two years later, he joined the Toronto office of Marsh, where he stayed for 16 years before moving to Marsh's New York headquarters. There, he rose through a series of senior management posts to become chairman of Marsh's brokerage unit and later president of the parent company.

It was in the mid-1980s, though, amid a capacity crisis in the excess casualty market, that he made his mark as a creative force. With reinsurance capacity dwindling, the market for excess liability insurance in the mid-'80s tightened dramatically, and Fortune 500 companies were suddenly unable to buy high excess coverage.

With other executives at Marsh and JP Morgan & Co., Mr. Clements developed a novel solution: ACE. Unlike the group captives that had been formed to that point, ACE was structured as a policyholder-owned commercial insurance company, capitalized by 34 Fortune 500 companies that placed their own liability risks excess of \$100 million with the insurer. But ACE was also an open market, writing coverage for nonshareholders and soon expanding into the directors and officers liability line. By 1993, it had completed an initial public offering and begun the steady expansion that has seen it

grow from six full-time employees in 1986 to 9,000 employees worldwide, writing more than \$12 billion in net premiums last year.

ACE was a template for Mr. Clements' future ventures in capacity creation.

Soon after ACE's formation, he and the Marsh/JP Morgan team created the similarly structured XL, designed to write liability limits beneath ACE's \$100 million threshold, and XL has followed ACE's pattern of growth.

In 1992—after a series of catastrophes culminating in Hurricane Andrew devastated the cat reinsurance market—Mr. Clements led the creation of Mid Ocean Reinsurance Co. Ltd., the first of several reinsurance startups aimed at taking advantage of the tightened market. Mid Ocean was later acquired by XL.

The following year, he resigned as president of Marsh and became chairman of Marsh & McLennan Risk Capital Corp., a private equity arm that managed the Trident Partnership and successor Trident insurance investment funds. While there, he founded reinsurer Risk Capital Holdings Inc., which launched an IPO in 1995 and later became Arch Capital Group Ltd.

Mr. Clements left Marsh in 1996 to manage Arch, where he retired as chairman in 2005.

Over the 20 years that began with ACE's formation, Mr. Clements brought billions of dollars in capital to segments of the insurance and reinsurance market to stabilize pricing and capacity. By setting up many of these operations in Bermuda, to take advantage of its regulatory and tax advantages, he also helped make the domicile the worldwide insurance center it is today.

His retirement from Arch didn't mean he was actually retiring, though.

When the contingent compensation scandal erupted in late 2004, with bid-rigging and client-steering revelations souring risk managers' attitudes toward Marsh, Aon Corp. and other brokers, Mr. Clements saw another opportunity. With two other former Marsh executives, he raised \$300 million in a private placement to form Integro, a new broker specializing in large corporate property/casualty risks. In less than two years, Integro became the 56th largest broker of U.S. business based on 2006 revenues; it now has offices in 13 cities in the United States, Canada and overseas.

"We're not entering a field where there is

no room for another competitor," Mr. Clements, Integro's chairman, said at the time. "We wouldn't be doing this if we hadn't been encouraged...by large users of insurance who would like more choice, by underwriters who would like a more diverse distribution system...and by brokers themselves who...would also like additional choice about where to practice. We believe we offer a very attractive opportunity for all three constituencies."

Meanwhile, Mr. Clements and Integro have most recently spearheaded the creation of Ironshore Insurance Ltd., a Bermuda-based property insurer that raised \$1 billion from private equity investors and is specializing in catastrophe-exposed commercial property business. Ironshore's formation—like many of Mr. Clements' earlier projects—was born of a market dislocation, in this case the shortage of insurance capacity following Hurricane Katrina.

While Mr. Clements has crowded a few careers' worth of work into his life so far, he has other interests, among them education. The Clements Foundation—a charitable foundation that he created with his wife and that is managed by his daughter, Paula Sager—donated \$2.5 million in 2003 to endow a professorship of democracy and politics at Dartmouth.

"American democracy is a model for other countries to emulate, but that model faces challenges at home," Mr. Clements said at the time. "There's no longer a perfect equation between democracy and freedom...Democracy historically has led the way to the achievement of this universal objective but has become increasingly subject to manipulation. Too often, special-interest groups take advantage of an open political system to press parochial agendas at the expense of the public interest."

Other gifts from the foundation have gone to support Bill Moyers Journal on PBS stations; the Boston-area Thompson Island Outward Bound program; the Cambridge, Mass.-based Charles River Conservancy; and The Orion Society of Great Barrington, Mass., which supports environmental and cultural causes.

Mr. Clements is also chairman emeritus of the College of Insurance, a former chairman of the board of overseers of the School of Risk Management at St. John's University in New York and an overseer emeritus of the Rand Corp.'s Institute for Civil Justice.

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Employers first began to offer HRAs about five years ago. HRAs are accounts linked to high-deductible health insurance plans. Employees use the accounts, which are funded by employers, to pay for uncovered health care expenses. Unlike FSAs, unused HRA account balances are rolled over to the next plan year. But, typically, unlike their cousins—HSAs—HRA account balances are forfeited when an employee leaves, while employees also cannot contribute to HRAs.

HEALTH SAVINGS ACCOUNTS HSAs are tax-favored accounts linked to high-deductible health insurance plans. Employees can make pre-tax contributions to the accounts, while employer contributions are not added to employees' taxable income. Employees can withdraw funds tax-free to pay for health care expenses, such as those falling under the linked health insurance plan deductible.

INDIVIDUAL RETIREMENT ACCOUNTS Created by the Employee Retirement Income Security Act of 1974, Congress intended these tax-deferred retirement savings accounts for individuals not covered by employment-based pension plans. Several different variations

have been launched over the years including employer-sponsored IRAs and the Roth IRA.

MEDICARE ADVANTAGE PLANS Retirees who opt of the traditional Medicare program can enroll in managed care plans, typically health maintenance organizations, that contract with Medicare. As part of a 2003 law, legislators renamed what had been known as Medicare + Choice plans as Medicare Advantage plans and boosted federal funding. About 8.5 million people are enrolled in Medicare Advantage plans, which typically provide more generous benefits than traditional Medicare, though not as much provider choice for full benefits.

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FACE HOST OF NEW RULES
FROM IRS / PAGE 3**

**REP. ROYCE INTRODUCES
FEDERAL CHARTER
LEGISLATION / PAGE 3**

**401(k) ACCOUNT BALANCES
BENEFIT FROM BETTER
INVESTMENT RETURNS / PAGE 4**

In Brief
Blumenthal subpoenas reinsurers on practices
Connecticut Attorney General Richard Blumenthal last week said he is investigating anticompetitive practices in the reinsurance industry, with his office issuing about 20 subpoenas to companies thus far. Mr. Blumenthal declined to provide specifics of the investigation or identify companies subpoenaed.
House panel OKs adding wind cover to NFIP
The House Financial Services

Terror backstop renewal gains momentum
House subcommittee passes bill despite partisan differences; full panel expected to act this week
By MARK A. HOFMANN
WASHINGTON—Partisan disagreement over the shape of a continued federal terrorism insurance backstop does not endanger the program, according to proponents of an extended program.
Differences emerged between many Republicans and their Democratic counterparts on the House Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises when the panel approved the Terrorism Risk Insur-
Subcommittee chairman Paul Kanjorski, D-Pa., who offered the amended bill, also called for adding one representative each from the workers compensation insurance industry and the commercial real estate industry to a commission on terrorism risk insurance. The panel would make recommendations concerning the marketplace within five years of TRIREA's enactment and would issue a report eight years after the bill became law.
The subcommittee also approved an amendment offered by Rep. Richard Baker, R-La., that would

U.S. Rep. Paul Kanjorski, D-Pa., left, introduced revised terror backstop legis-

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Technology advances drive benefits data and delivery

Only within the past decade have most benefits departments embraced online capabilities

By JOANNE WOJCIK

In the beginning, there was paper. Lots and lots of paper. All of it sorted into manila folders that were also made of paper and arranged alphabetically in metal filing cabinets.

That was the level of technology available to benefit managers in 1967, the year *Business Insurance* was born.

It wasn't until the early 1980s—personal computers hit the market—that benefit departments began to become more automated. And even then it caught on very slowly.

Alan Williams, founder and president of Dallas-based Travis Software Inc., remembers those days all too well. He developed software to help employers manage their COBRA continuation benefits, but “I had to ask myself whether enough benefits departments had PCs to create a market for the software,” he said. “Typically, the accounting department got one, then it would spread to the profit centers, but HR and benefits were perceived as cost centers and usually got PCs last.”

Eventually, personal computers did open the door to the use of benefits technology, though the use

of the technology was generally confined to back-office administration. Benefits communication to employees and dependents was still paper-based until recent years.

Jeri Stepman, national business leader for health and welfare outsourcing at Watson Wyatt Worldwide in San Diego, said the use of technology in benefits departments was stimulated by the introduction of flexible benefits, which gave employees more choices.

Each year, benefit departments, working with their consultants, would produce workbooks that contained a personalized enrollment form that employees would complete by hand and then return to the benefits department.

“We would get the forms and manually key in the information,” Ms. Stepman said.

Delia Vetter, director of benefits at EMC Corp., a technology company based in Hopkinton, Mass., said that as little as 10 years ago, benefits at her company were still being delivered via paper.

“The provider directories were out of date as soon as they were printed. Summary plan descriptions, enrollment forms, newsletters—everything

was hard-copy printed,” she said.

By the early to mid-1990s, a new but short-lived technology called “Interactive Voice Response” became a popular method for making benefit elections, but it soon lost its luster when companies got used to using the Internet for other types of business communications.

“Most IVR systems weren't linked to online” technology, said Shawn Jenkins, president and chief executive officer of BenefitFocus.com Inc., a benefit technology firm based in Charleston, S.C. As a result, elections made over the phone often took days or even weeks to be implemented.

Because Internet technology was faster, easier and visual, it took over.

But even as the rest of the world was becoming increasingly wired, most employers were still concerned about Internet security, which further delayed its use by benefits departments. It's only been over the last five years or so that employers have warmed up to idea of using the Internet in both benefits administration and benefits communication.

“HIPAA may have helped,” Mr. Williams said, referring to the Health Insurance Portability and Accountability Act, which Congress passed in

1996. “This required data protection. HIPAA has forced software vendors to write software with safeguards.”

Another driving force in the use of benefits technology has been the rising cost of health care, which is requiring many benefits departments to streamline their operations as much as possible.

In fact, high health care costs are the primary impetus behind the current benefit technology trend: Analyzing the health status of plan participants to create health improvement programs aimed at those who are generating the most costs.

Both Ingenix, a unit of United-Health Group Inc. in Eden Prairie, Minn., and Ann Arbor, Mich.-based Thomson Healthcare have developed huge data warehouses of claims information from insurers and employers. The data warehouses are being used to create plan designs that encourage members to adhere to their drug therapies and to do value purchasing, which involves paying higher reimbursements to providers who provide the most cost-effective care.

“Now employers want to make every dollar count,” said Tim McDonald, director of health management consulting at Ingenix.

“Now you can drill down more specifically at what is driving the cost increases—is it price or utilization?”

For example, if the data analysis shows that employees are using hospital emergency rooms more than they should, the employer should raise copayments for ER use or contract with a medical office that stays open late to discourage people from using the ER after hours, he said.

He said the data warehouses are also being used by employers to make sure that employees enrolling in high-deductible health plans are still obtaining preventive services.

“That's the level of data we can provide,” Mr. McDonald said.

Taken together, all of these technological innovations have dramatically changed the way benefit departments function.

“Ten years ago, my staff was focused on answering phones, collecting forms, doing mailings—a lot of tactical day-to-day work that wasn't ...well-aligned with our business objectives,” Ms. Vetter said. “Now you have the same staff and can redirect their focus to be more innovative...and refocus efforts on delivering health management vs. health benefits.”

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Risk managers bringing data in-house to gain greater control

Technology allows some claims systems to truly go paperless

By JOANNE WOJCIK

Risk management information system technology began in the 1960s as a component of insurers' back-office accounting systems—on clunky mainframe computers that required armies of programmers to produce paper printouts that risk managers could only read.

But as policyholders assumed greater organizational risk, they wanted more control of their claims and exposure information, and started developing in-house RMIS operations that were independent of their insurers'.

The rise of personal computers, networked computers, the Internet and other technological developments since then have facilitated movement to user-owned and -operated RMIS. Today, risk managers can access such data anywhere at any time to track and analyze exposures and claims and manipulate that information to create customized reports.

In some cases, risk management information systems are being integrated with management information systems to manage risk across an entire enterprise.

Some of today's more sophisticated systems even can provide the data auditors need to ensure an organization meets the requirements of the Sarbanes-Oxley Act, said David A. Tweedy, managing consultant at Albert Risk Management Consultants in Needham, Mass., who has worked in the RMIS business since the early 1980s.

"The first RMIS systems—like that launched in 1967 by Corporate Systems—were all mainframe systems," said Robert Petrie, chief executive officer of CS STARS L.L.C., the RMIS division of brokerage Marsh Inc. New York-based Marsh acquired Corporate Systems to form CS STARS in 2004.

"In the early days, you had to know a programming language to operate a RMIS," Mr. Tweedy said. "But today, all you need is to know how to operate a PC."

James D. Hinton, vp-risk and insurance at HCA Inc., said the Nashville, Tenn., hospital system's first RMIS in the early 1980s was basically a claims system housed on a mainframe that used a programming language called Focus.

About four years ago, when HCA's information technology department said it would no longer support the system, Mr. Hinton led the transition to Marsh's Internet-based CS STARS system. After converting all of the data, programmers at Marsh spent more than a year customizing the new system to meet HCA's needs.

"The key is to go beyond claims handling and prevent claims from happening, and the key to that is data," Mr. Hinton said. "Another thing we did was to go totally

paperless with our claims system. That was a huge cost savings. We also can access it from virtually anywhere via the laptop."

Because data can be accessed from anywhere at any time, today's RMIS can help risk managers manage the data collection process, said Kathy Burns, CEO of Aon eSolutions, a unit of Chicago-based brokerage Aon Corp. Aon, which has been in the RMIS business since the mid-1980s, has continued to expand its RMIS operations, including the 2005 purchase of RMIS pio-

neer Risk Laboratories Inc. and the 2006 purchase of Valley Oak Systems.

For example, instead of having to telephone each location, risk managers can use their RMIS to broadcast e-mail alerts companywide asking location managers to report loss and exposure data using an online template. The RMIS also can notify risk managers which locations haven't reported, allowing them to send reminders with the push of a button.

"It makes risk managers users of

information rather than collectors of information," Ms. Burns said.

Although the biggest RMIS innovation in recent years is its ability to collect and distribute information widely, "the big leap that's happening now is combining data used for brokerage with traditional claims and loss" history to give risk managers a behind-the-scenes peek at the entire insurance placement process, said Mr. Petrie. "It gives a much richer level of detail and interaction."

In addition, Ms. Burns is seeing

more risk management information systems connect to other business information systems, including human resources, payroll and management.

By being the central access point, today's RMIS "puts the risk manager in a strategic position and raises his or her exposure in the organization," she said.

"If risk managers could harness the technology they have at their disposal today, they could make their way into the C-suite," said Mr. Tweedy.

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Models move from bright idea to mainstream tool

Probabilistic programs add scientific foundation to property catastrophe underwriting

By JOANNE WOJCIK

While working in the research department at Commercial Union Insurance Co. in the early 1980s, one young researcher came up with an idea for trying to predict the scope of hurricane losses using long-term historical data combined with current information on property exposure as a gauge.

"I had an idea of how to approach it and wrote a paper and submitted it to an actuarial society

meeting in 1985," said Karen Clark, who has an MBA with a specialization in economics and a background in "econometrics," or statistical modeling of business and financial information.

A broker at E.W. Blanch (now Benfield Group Ltd.) who was intrigued by Ms. Clark's hypothesis contracted her to develop the model becoming the first client of her newly formed company, which she aptly called Applied Insurance Research, or "AIR," for short.

That was in 1987—before the insurance industry experienced a chain of significant hurricane losses that would hit over the next couple of decades. Before the introduction of science-based catastrophe modeling, forecasting losses from such calamitous events was pretty much a crap shoot for insurers. So it was a tough sell for Ms. Clark, who even spoke to underwriters at Lloyd's to try and drum up business.

But when Hurricane Andrew struck south Florida in 1992, it cre-

ated a market for Ms. Clark's cat model. She predicted the storm would generate \$13 billion in losses—more than all of the premiums collected on properties along the coast where it struck. By the time all the losses were tallied, they totaled \$15.5 billion.

Since then, at least two other companies have gotten into the business: Oakland, Calif.-based EQECAT Inc. and Newark, Calif.-based Risk Management Solutions. Each of these companies employs



hundreds of meteorologists, seismologists, oceanographers, physicists, engineers, statisticians and other scientists and economists who are working collectively to calculate the probable maximum loss from catastrophes such as hurricanes, earthquakes, flash floods, wildfires, tornadoes, tsunamis, hail, blizzards and pandemics.

"After Hurricane Andrew was when modeling started to take off," said Richard Clinton, president of EQECAT, a subsidiary of ABS Consulting. EQECAT was originally part of EQE International, an Oakland-based firm that specialized in structural engineering and nuclear risk assessment. EQECAT's first model measured earthquake losses, while Boston-based AIR and RMS focused on hurricanes and windstorms.

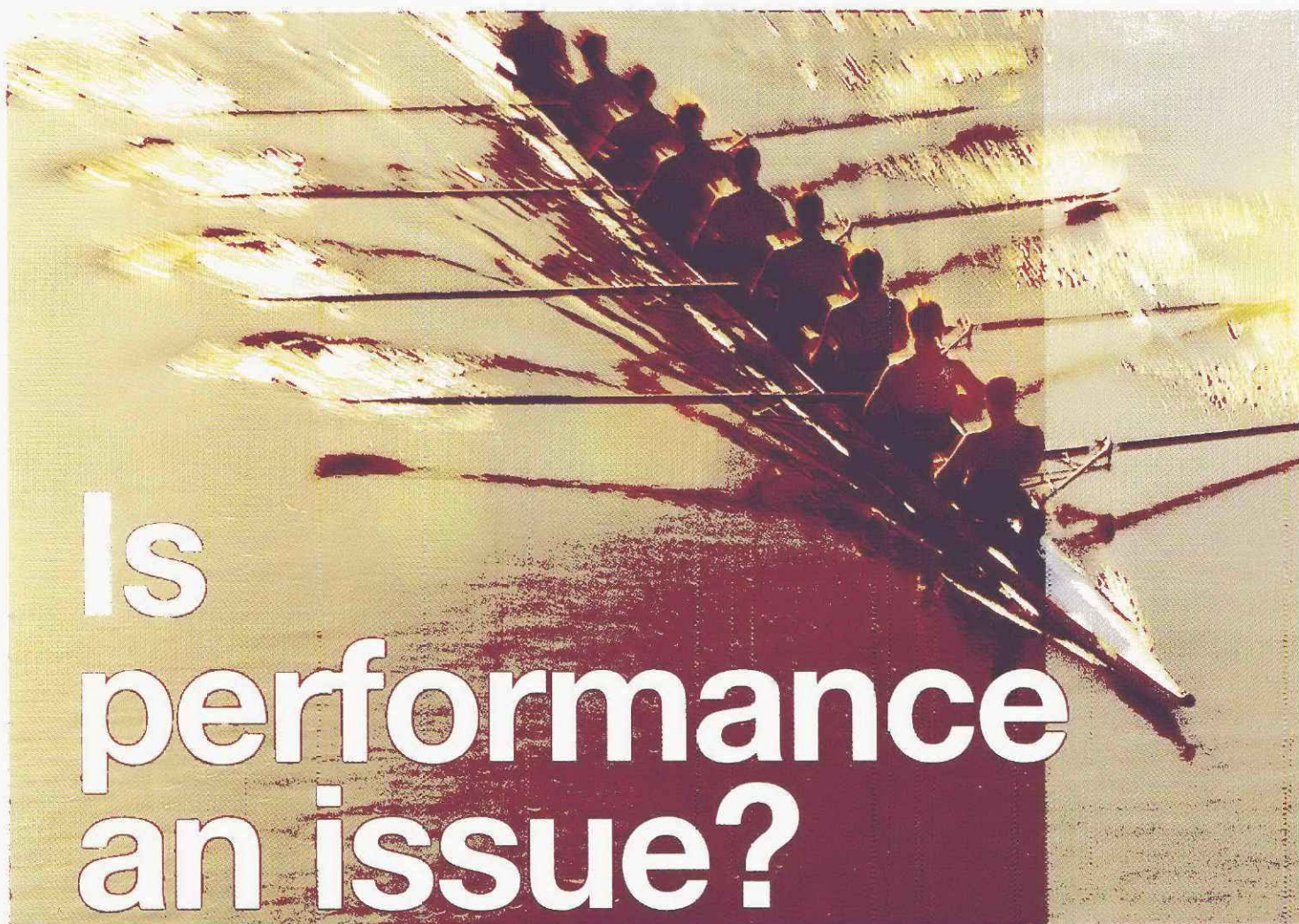
Today, most insurers, reinsurers, brokers and large corporations use one or more of these companies' models. Some of the models can even produce simulations, which can be a valuable tool for persuading insurance underwriters to rate risks properly and for property loss control experts to shore up vulnerable properties.

And the research is continuing with the growing acknowledgment of the potential for catastrophic loss. For example, RMS is currently building a volcanic risk model, according to Robert Muir Wood, chief risk officer based in London.

"There was a time when we had to explain to people why these models were a benefit," Mr. Wood said. "Now they understand the value and instead we have to explain how the model works, why certain scenarios were used and how the outcomes were reached, etc."

Unfortunately, Ms. Clark is concerned about the growing reliance on catastrophe modeling, which is why she left AIR earlier this year to form a consulting company dedicated to showing companies how best to use catastrophe modeling technology.

"Right after Katrina, there was a lot of criticism of the models. But the models are just one tool," she said. "To get good loss estimates, companies have to input good data. This information for many companies was incomplete, so they were not getting reliable estimates out of the model. They also had no processes in place to validate the models' output. These are models. They make assumptions. The modeling process has a lot of different steps and different things can go wrong with each step."



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Test your knowledge of risk management with our quiz

1. What was the original name of the Risk & Insurance Management Society?

- A) AMERICAN SOCIETY OF RISK MANAGERS
- B) AMERICAN RISK MANAGEMENT ASSN.
- C) U.S. RISK MANAGEMENT ASSN.
- D) AMERICAN SOCIETY OF INSURANCE MANAGEMENT

2. The collapse of what company ultimately led to the Sarbanes-Oxley Act?

- A) PARMALAT S.p.A.
- B) DELTA AIR LINES
- C) ENRON CORP.
- D) UAL CORP.

3. This state is the largest domicile for risk retention groups.

- A) VERMONT
- B) COLORADO
- C) HAWAII
- D) SOUTH CAROLINA

4. What was the largest insured manmade loss before the Sept. 11, 2001, terrorist attacks?

- A) 1993 WORLD TRADE CENTER BOMBING
- B) 1992 LOS ANGELES RIOTS
- C) 1993 LONDON FINANCIAL DISTRICT BOMBING
- D) 1988 PIPER ALPHA OIL RIG EXPLOSION

5. What's the first basic step in risk management?

- A) RISK AVOIDANCE
- B) RISK TRANSFER
- C) RISK IDENTIFICATION
- D) RISK COMMUNICATION

6. Benchmark used to show an insurer's underwriting profitability is called:

- A) EXPENSE RATIO
- B) LOSS RATIO
- C) PREMIUM TO SURPLUS RATIO
- D) COMBINED RATIO

7. Cornelius Vander Starr founded American International Group in this city in 1919:

- A) NEW YORK
- B) SHANGHAI
- C) TOKYO
- D) DRESDEN

8. In whose coffeehouse was Lloyd's founded in 1688?

- A) BUTCH MCGUIRE
- B) JUAN VALDEZ
- C) CHRISTOPHER LLOYD
- D) EDWARD LLOYD

9. The United States has how many elected state insurance regulators?

- A) 12
- B) 13
- C) 22
- D) 51

10. What is the most widely written form of reinsurance?

- A) FACULTATIVE
- B) TREATY
- C) FINITE
- D) RETROCESSIONAL

11. What Lloyd's underwriter ordered his agents to "pay all claims" from the 1906 San Francisco earthquake and fire?

- A) SAM MARKEL
- B) RALPH HISCOX
- C) CUTHBERT HEATH
- D) JOHN J. ANGERSTEIN

12. What Shakespearean work mentions the island of Bermuda?

- A) "AS YOU LIKE IT"

- B) "THE TEMPEST"
- C) "KING LEAR"
- D) "A MIDSUMMER NIGHT'S DREAM"

13. Risk securitizations often are priced according to what bank index?

- A) DOW JONES INDUSTRIAL AVERAGE
- B) FEDERAL FUNDS RATE
- C) S&P 500 INDEX
- D) LONDON INTERBANK OFFERED RATE

14. This form of D&O liability coverage reimburses the entity itself for indemnifying directors and officers:

- A) SIDE A
- B) SIDE B
- C) SIDE C
- D) SIDE D

15. An "experience mod" is applied to an employer's workers compensation rates to reflect this:

- A) NUMBER OF EMPLOYEES
- B) TOTAL YEARS OF JOB EXPERIENCE
- C) TOTAL PAYROLL
- D) LOSS EXPERIENCE

16. Whose 1960s treatise on cost of risk still influences the profession of risk management today?

- A) MAURICE GREENBERG
- B) PETER BERNSTEIN
- C) HOWARD WEBER
- D) DOUGLAS BARLOW

17. What's the largest line of insurance by premiums spent?

- A) HOMEOWNERS
- B) PRIVATE-PASSENGER AUTO
- C) COMMERCIAL MULTIPERIL
- D) GENERAL LIABILITY

18. What was the costliest insured earthquake loss?

- A) 1989 LOMA PRIETA
- B) 1995 KOBE

- C) 1994 NORTHRIDGE
- D) 1976 TANGSHAN

19. Which broker placed hull coverage for the Titanic's maiden voyage?

- A) JOHNSON & HIGGINS
- B) MARSH & MCLENNAN
- C) HUDIG-LANGEVELDT
- D) JARDINE MATHESON

20. Who was the first woman named Risk Manager of the Year?

- A) LUCILLE GALLAGHER
- B) EDITH LICHOTA
- C) MILLICENT WORKMAN
- D) JUDY LINDENMAYER

Answers can be found on page 60

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ANSWERS TO THE EMPLOYEE BENEFIT QUIZ:

1. a) General Electric Co.; 2. d) Bank of America Corp.; 3. c) James Baker; 4. a) 1984 ; 5. b) United States;
6. a) 16%; 7. b) Texas; 8. b) Medicare Prescription Drug Improvement and Modernization Act; 9. b) 29,000;
10. c) \$50,000; 11. c) 12; 12. b) 2 percentage points; 13. a) Mercer L.L.C.; 14. c) 36 months; 15. b) Pension Protection Act ; 16. a) Erie County, Pa.; 17. b) WellPoint Inc.; 18. b) Paul Ellwood; 19. c) Studebaker Corp.;
20. d) 12 months.

ANSWERS TO THE RISK MANAGEMENT QUIZ:

1. d) American Society of Insurance Management; 2. c) Enron Corp.; 3. a) Vermont; 4. d) Piper Alpha oil rig explosion; 5. c) Risk identification; 6. d) Combined ratio; 7. b) Shanghai; 8. d) Edward Lloyd; 9. a) 12; 10. b) Treaty; 11. c) Cuthbert Heath; 12. b) "The Tempest"; 13. c) London Interbank Offered Rate; 14. b) Side B; 15. d) Loss experience; 16. d) Douglas Barlow; 17. b) Private-passenger auto; 18. c) Northridge; 19. a) Johnson & Higgins; 20. b) Edith Lichota

Business Insurance's Editorial Staff 2007



Seated, from left: Gloria Gonzalez, Kevin P. Edison, Rupal Parekh, William Murphy and Amy R. Curtis.
 Standing, from left: Carrie A. Peinado, Gavin Souter, Charmain Benton, Katherine Downing, Joanne Wojcik, Douglas McLeod, Meg Fletcher, Joe Walker, Matt Scroggins, Paul D. Winston, Sally Roberts, Rodd Zolkos, Kathy L. Barnes, Roberto Ceniceros, Dave Lenckus,
 Mark A. Hofmann, Karen Brown Tucker, Jerry Geisel, Regis J. Coccia and *Business Insurance* Publisher Martin J. Ross III.
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SOLVENT SCHEME OF ARRANGEMENT
NOTICE OF FINAL CLAIMS SUBMISSION DATE
 By an Order dated 29 August 2007 the High Court of Justice of England and Wales sanctioned the solvent scheme of arrangement under section 425 of the Companies Act 1985 (the "Arrangement") between the Compagnie Européenne d'Assurances Industrielles s.a (the "Company") and its Creditors (as defined in the Arrangement). An office copy of the Order was delivered to the Registrar of Companies for registration on 27 September 2007, and the Arrangement became effective on that date (the "Effective Date").

Creditors are required to submit duly completed Claim Forms in respect of their Claims (as defined in the Arrangement) accompanied by the requisite supporting evidence by 11.59pm London Time on 25 February 2008 (the "Final Claim Submission Date") marked for the attention of Paul Corver at KMS Insurance Services Limited, 2nd Floor, America House, 2 America Square, London, EC3N 2LU, Fax no: +44 (0)870 600 7581 Email: ceaihelpdesk@kmsim.com. Failure to do so will result in the relevant Creditor's Claims being deemed to have been satisfied in full, and in that Creditor having no entitlement to payment in respect of such Claims.
 Claim Forms have been sent to all Creditors for whom the Company holds address details which are not believed to be incorrect. Any person who believes it is a Creditor but has not received a Claim Form, or who has any queries or requires assistance in relation to the completion and return of Claim Forms, should contact Paul Corver at KMS Insurance Services Limited, 2nd Floor, America House, 2 America Square, London, EC3N 2LU Telephone: +44 (0)20 7488 5460 Email: ceaihelpdesk@kmsim.com or visit the website on www.ceai.co.uk.

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International NEWS

Brokers' 2.5% charge raises buyer concerns

By ADRIAN LADBURY

GENEVA, Switzerland—Some European risk managers have raised concerns about brokers' plans to introduce a 2.5% charge on insurers for business placed in certain markets.

During a panel debate last week at the Federation of European Risk Management Assns. Forum in Geneva, Switzerland, the risk managers reacted to an explanation of the new fee by panel participant Sarah Turvill, chairman of Willis International, a unit of London-based Willis Group Holdings Ltd.

Willis and New York-based Marsh Inc. plan to introduce the levy on U.K. insurers this month, and Marsh also has commenced discussions with insurers in Germany.

An Aon Corp. representative said the broker is not involved in this drive for new revenue because it had in recent years introduced a similar 2.5% levy in the United Kingdom after consulting the London-based Assn. of Insurance & Risk Managers and insurance companies.

Ms. Turvill said the charge would be transparent, should not be confused with contingent commissions and would not present a conflict of interest. Many brokers ceased collecting contingents in the wake of then-New York Attorney General Eliot Spitzer's investigations into client steering and bid rigging.

"We are fully of the view that contingents and supplemental commissions are wrong and in principle create conflicts of interest. But that does not mean that we do not want to be paid for the service we provide, and, therefore, I do not have the slightest difficulty asking insurers for more commission," she said.

Ms. Turvill said if clients are unhappy with Willis retaining the commission, then the broker will share it or pass it on to the risk manager. "Everything we receive is completely transparent and in agreement with the clients. We approach the insurer and say (that) we would like more money. Our experience now is that insurers are willing to pay. Aon has been charging 2.5% (brokerage) for six-and-a-half years, and it has not meant that they are not competitive," Ms. Turvill said.

Buyers worried

Buyers at the FERMA conference, however, said they worry that if insurers agree to pay, they will simply pass the cost on to buyers. And several European and international insurers said this could be the case.

But Ms. Turvill said Willis believes that the insurers will carry the cost. "We believe that ultimately, (the

customer) will not be paying because probably the insurers will find it within their models to pay."

But panelist Jean-Paul Rignault, CEO of Paris-based AXA Corporate Solutions, disagreed. "I do not see any reason why AXA shareholders should go to the rescue of the large brokers' shareholders," he said.

He did say he is happy to pay for brokers' services if they are clearly identified and valued and not a blanket flat charge. "To pay a flat commission for unknown services is just a question of adding more cost to the market," said Mr. Rignault.

Peter den Dekker, corporate insurance risk manager at food company Stork N.V. in the Netherlands and vp of the Dutch risk management association Nederlandse Associatie van Risk & Insurance, said: "In this whole thing, no one is talking to the clients. If the brokers want additional commission, the client should be

EXTRA COMMISSION

Willis and Marsh plan to introduce this month a 2.5% charge on insurers for placing business in certain European markets. Aon in the U.K. already levies such a charge.

asked first about this, and the insurers and brokers should find a model, but talk to us—through FERMA and the national organizations."

Ralf Oelssner, president of the German commercial insurance buyers association Deutscher Versicherungs-Schutzverband e.V and vp of corporate insurance at Lufthansa A.G. in Cologne, said panelists were guilty of "skirting" the real issue.

"Where is the money ultimately coming from?" he said, speaking from the floor. "Is the underwriter going to load it into the premium?"

Peter Berring, head of group risk at cash handling company De La Rue P.L.C. in Basingstoke, England, who also spoke from the floor, said: "The question is how we avoid conflicts of interest. No one wants to destroy people that deliver a very important and valuable service, but we certainly do not want to pay for inefficiency. Some insurers will pay and others not, and will that influence where the business is placed?"

Ms. Turvill was not given the chance to answer that question, but panelist Dick Verbeek, chairman and chief executive officer of Aon Risk Services International, said Aon's brokerage service fee does not tempt it to steer business. "No way. It is completely never on the table."

Sarah Veysey contributed to this story.

E.C. targets subscription market

Commission says arrangements might lead to insurer collusion

By SARAH VEYSEY

BRUSSELS, Belgium—Findings by the European Commission that some subscription-based insurance arrangements might encourage collusion among insurers drew a wary reaction from European risk managers, insurers and brokers last week.

The subscription-based market allows for a diverse market and increased capacity and jeopardizing those arrangements could hurt commercial insurance buyers, some say.

Other observers, including the Federation of European Risk Management Assns., gave a more muted response, saying they need time to sift through the long-awaited report before commenting.

The report, released by the European Commission's competition directorate last month, was the result of a two-year probe into the commercial insurance sector.

One of the key findings was that certain co-insurance processes—in which multiple insurers underwrite a risk—may stifle competition.

Neelie Kroes, competition commissioner, warned the insurance industry that if certain aspects of the co-insurance process cannot be justified, they must be reformed.

The Commission raised several concerns about the process. In particular, it is concerned about the practice of following insurers on subscription business—such as coverage written in the London market—being unable to offer a different rate for a risk than that offered by the lead underwriter.

The Commission also voiced concerns about the use of so-called "best terms and conditions" clauses sometimes used in co-insurance and reinsurance contracts. Under such clauses, underwriters on a co-insured program can benefit from the best terms offered to another participant.

In its report, the Commission stressed that it had found no evidence of antitrust violations in co-insurance. But it added: "It is, nonetheless, of concern that the subscription practice in the way that it currently works may act, at least in theory, to underpin collusion."

While it said that "the existence of mechanisms allowing multiple (insurers and reinsurers) to each take a part of a given risk plausibly allows for greater capacity and risk diversification and results in lower prices and better terms for clients," the



EC/BERLAYMONT

Neelie Kroes, competition commissioner for the European Commission, says if certain aspects of the co-insurance process can't be justified, they must be reformed.

report added that "reform of these practices might well result in a better deal for clients," it said.

The European Commission also said that in 2008, it intends to review the Block Exemption Regulation, which enables the insurance industry to bypass some E.U. competition rules. And the issue of broker remuneration will also be subject of further scrutiny, the Commission said, adding that it still had concerns about transparency of broker pay and would investigate the issue further during a review of the Insurance Intermediation Directive.

Several organizations defended the subscription-based market.

The London-based International Underwriting Assn. said many risks in the London market are underwritten on a co-insurance or subscription basis. "This process has the enormous advantage of spreading and diversifying risk so that client capacity needs can be met without placing an overwhelming catastrophe exposure (on) any one single underwriter," it said in a statement.

"The London insurance market is probably the most competitive in the world and presents customers with a very efficient mechanism for covering risks," Stephen Riley, chairman of the IUA, said in the statement.

The London-based Assn. of Insurance and Risk Managers said in a statement that it would study the Commission's comments on co-insurance and differential pricing, but added: "As a general comment, however, we regard the subscription market an efficient vehicle for

spreading risk without reducing competition."

Other organizations said they were still reviewing the Commission's findings.

"It is important to go through (the report) and have a FERMA position," said Marie-Gemma Deque, the president of Brussels, Belgium-based FERMA. She said that there are three major issues raised in the report of concern to risk managers: pricing by following insurers, the role of intermediaries, and the block exemption.

The Comité Européen des Assurances, which represents the European insurance and reinsurance industry, said "CEA would urge the Commission to give full consideration to the explanation on the functioning of the co-insurance market before final conclusions are drawn."

"The Commission's comments on reinsurance and co-insurance raise some issues that will need closer study, with significant implications for both brokers and their clients," Aon Corp. said in a statement.

Reinhard Schwarz, chief sales officer in Europe for Allianz Global Corporate and Specialty, part of Munich, Germany-based insurer Allianz S.E. said that his company welcomed the Commission's comments. "It is positive for us. In many cases, the lead insurer gets the same premiums as the follower and the E.U. says very clearly there should be a benefit for the client as the follower pays less because they do not have the people, expertise, network, financial capability, rating, etc.," he said.

Guy Carpenter, Integro settle lawsuit

By JEFF CASALE

NEW YORK—Guy Carpenter & Co. Inc. has settled pending litigation against three former top London-based executives over their resignations to join Integro Insurance Brokers Ltd.

The suit was filed in May against two former leaders of Guy Carpenter's Worldwide unit—Julian Samengo-Turner and Ron Whyte—as well as against Marcus Hopkins, for-

mer head of Guy Carpenter's U.K. facultative reinsurance operations.

All three resigned from New York-based Guy Carpenter, the reinsurance brokerage unit of Marsh & McLennan Cos. Inc., on April 3. Two days later, New York-based Integro announced that it had hired them to form a new London insurance and reinsurance brokerage operation.

The suit, which was filed in U.S. District Court in New York, charged

that the three violated terms of MMC's incentive bonus plan and sought repayment of about \$370,000 in vested awards. The company also charged the three men with aiding Integro in soliciting at least eight other Guy Carpenter employees to join the rival company.

A Guy Carpenter spokeswoman declined to comment on the terms of the settlement. Integro declined to comment.

Market Moves

Rockhill to pay \$67.6M for RTW in merger

MINNEAPOLIS—Kansas City, Mo.-based Rockhill Holding Co. and Minneapolis-based RTW Inc. have agreed to merge in a deal under which Rockhill is to pay \$67.6 million in cash for all outstanding RTW stock, the companies said.

After the merger, which is subject to shareholder and regulatory approval, RTW is to be a wholly owned subsidiary of Rockhill. The companies said the transaction is expected to close by year-end.

Rockhill is an insurance holding company that writes specialty property and casualty business through its Rockhill Insurance Co. and Plaza Insurance Co. units.

RTW provides products and services to manage insured and self-insured workers compensation, disability and absence programs.

Hanover completes purchase of Professionals Direct

GRAND RAPIDS, Mich.—Hanover Insurance Group Inc. has completed the \$23.2 million purchase of Grand Rapids, Mich.-based Professionals Direct Inc., which provides lawyers professional liability coverage in about three-dozen U.S. states.

The purchase will complement Hanover's efforts in reaching small to midsize customers, the Worcester, Mass.-based property/casualty insurer and services provider said in a statement.

Brown & Brown expands its roster

DAYTONA BEACH, Fla.—Brown & Brown Inc. has acquired three entities with combined annual income of about \$5 million, the brokerage said.

Daytona Beach, Fla.-based Brown & Brown has acquired Security Insurance Inc. II, a Nashville, Tenn.-based agency serving the commercial property/casualty market; Security Risk Managers Inc., a Nashville-based wholesale broker specializing in builders and construction-related products; and Tavor Corp., a Denville, N.J., provider of trade

credit, ocean marine and international insurance.

The Nashville staffs will continue in their current location while Tavor's personnel and operations will be combined with Brown & Brown's existing Florham Park, N.J., office, the company said in a statement.

Aon, Arup form alliance focusing on cat risks

CHICAGO—Aon Corp. and Arup, a London-based engineering and consulting firm, have formed a strategic alliance to offer clients catastrophic risk management and consulting services.

Aon said the alliance will enhance its Rapid Response loss mitigation and claims advocacy service borne from hurricanes Katrina, Rita and Wilma in 2005. The alliance also will establish a consulting service, Rapid Response Engineered, to help clients prepare for and avoid catastrophic events, the Chicago-based brokerage said.

Send news of deals and alliances to Cherrain Berton at cbenton@businessinsurance.com.

Commentary

Health care costs going one way—up

When a friend of mine recently asked me how having 47 million uninsured people in the United States made health care and health insurance more expensive, I gave her the standard industry line on the cost shifting that occurs when providers are stiffed by uninsured patients.

Doctors and hospitals may say they're "writing off" this uncompensated care, but in reality they're jacking up prices for insured patients so they can recoup those losses, I explained. It's like the retail industry. They know they can expect a certain amount of theft, so they figure that into their pricing, I told her.

But, now, after interviewing several health care industry veterans for *Business Insurance's* 40th Anniversary issue, I'm beginning to doubt that solving the nation's uninsured problem will lower health care costs.

Demand for health care is essentially a "vertical line going straight up," Virginia Burke, a lawyer and former nurse, suggested to me, using gallbladder surgery as an example. Whereas back in the 1970s, patients with gallbladder disease usually waited until they could no longer stand the pain because removal was an invasive procedure with a slow recovery usually requiring several days of hospitalization, today gallbladder removal can be done using "keyhole" surgery, with the surgeon removing the diseased organ laparoscopically. In some cases, the surgery can even be done on an outpatient basis. So with such a simple procedure available, why not have it done as soon as possible? Even though the procedure costs less today, the volume of the procedures has grown, so the overall spending has actually increased, she said.

Maybe we could slow the rate of medical inflation by halting medical research, Ms. Burke quipped. If no new treatments are developed, spending would be limited to those that exist, she said.

A few of the other people I interviewed suggested that health care inflation is actually being curbed by our high uninsured rate because uninsured people don't seek medical treatment as frequently as those who have coverage. It reminded me of one conservative economic theory on wage inflation that prescribes maintaining a certain level of unemployment to keep wage increases in check.

Other people I interviewed for my report on the evolution of health benefits since 1967 said the creation of Medicare in the mid-1960s actually started the upward cost spiral. Besides boost-



JOANNE WOJCİK

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ing doctors' income by guaranteeing paying patients, the legislation drove medical school enrollment, churning out even more medical providers to treat the growing population of retirees. I wonder, could creation of a new pool of insured people cause history to repeat itself?

There are numerous other constituencies whose livelihoods depend on the health care system being in such dire straits, like the vendor I met at a conference a

Solving the uninsured problem may not actually reduce the cost of care.

few years ago who said he could save employers and insurers money by reviewing their durable medical equipment purchases. I asked him how he would do that, if not by denying such equipment to patients who surely needed it. It also seemed to me that his involvement would merely add another intermediary—and another expense—to the medical treatment acquisition process. Oh, no, he insisted. He said he would save them money by negotiating lower prices from the equipment manufacturers and keep a portion of those savings as payment.

Let's face it: Many of us have a vested interest in maintaining the status quo. According to researchers at PricewaterhouseCoopers, one in every eight U.S. residents has a job somehow connected to the health care system. No wonder it comprises 16% of the gross national product. Can you imagine the devastating impact that reforming the health care system would have on the economy?

Maybe it's time we just accepted the fact that there really are three—not two—certainties in life: death, taxes and now, medical inflation.

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Benefits: Owners find innovative ways to fund risks through captives

CONTINUED FROM PAGE 4

independent fiduciary to ensure that all Labor Department conditions are met.

The road map that the Labor Department provided in approving Columbia Energy's application has since been used by some of the nation's biggest and best known corporations, including A.J. Heinz Co., Alcoa Inc., Archer Daniels Midland Co., International Paper Co., Sun Microsystems Inc. and Wells Fargo Co., to do the same.

Meanwhile, Columbia Insurance Group Ltd.—now known as NiSource Insurance Co. Ltd., following Columbia Energy Group's acquisition several years ago by energy company NiSource Inc. of Merrillville, Ind.—is putting more benefit business in the captive.

Timothy Bucci, director of risk management and corporate insurance, said that several months ago, NiSource began funding group life insurance risks through NICL, with policies written by Prudential Insurance Co. of America.

Speaking last month at the 3rd annual Bermuda Captive Conference in Southampton, Mr. Bucci said funding benefits through a captive makes so much sense that he is surprised more employers aren't doing it, or at least exploring the captive benefit funding option.

When companies, for example, examine whether to fund long-term disability risks through their captives, many decide against it, reasoning that the commercial insurance market for coverage isn't that bad, said Brady Young, president of Waltham, Mass.-based Strategic Risk Solutions, which manages the NiSource captive.

"Do you really need a captive to better manage the risk? Theoretically, you don't, but the reality is, there is better management, Mr. Young said.

That better management, such as carefully tracking and keeping on top of claims, has helped reduce NiSource's LTD loss frequency and severity since the company began to fund the risk through its captive, Mr. Bucci said.

Still, there are obstacles to funding employee benefits through captives, Mr. Bucci said. For example, he said, it can be difficult to pry detailed claims information from insurers currently writing the risks,

which employers need to analyze to decide whether it makes economic sense to fund benefit risks through their captives.

In addition, there may be a political tug of war between the risk management and human resources departments at some companies, with HR fearing it will lose control if the program is funded through a captive, Mr. Bucci said.

While NiSource is well-known for its captive benefit funding program, NICL also funds a wide range of property/casualty programs, including workers compensation, general liability and auto liability.

The benefits of its captive include

insulating subsidiaries from volatility in the traditional insurance market by charging stable, actuarial-based premiums, while also assuming previously unfunded risks, Mr. Bucci said.

Other corporations have found unusual ways to use their captives. For example, General Motors Corp. uses its Bermuda-domiciled captive to reinsure insurance policies, such as auto insurance and credit life insurance for customers buying GM products outside the United States.

Max Reid, managing director-international reinsurance with GMAC Insurance in High Wy-

combe, England, told conference attendees that the captive, which now generates about \$118 million in annual premiums, promotes the GM brand with customers and can help to ensure the availability of products that would not be available in the traditional market.

While the captive has been extremely profitable for GM, employers selling consumer products should ask themselves several questions, including their appetite for taking on additional risk and whether they have the skill to manage such a program, before diving in, he said.

Captive conference draws 400

SOUTHAMPTON, Bermuda—More than 400 people attended the 2007 Bermuda Captive Conference held Sept. 16-19 in Southampton, Bermuda.

Topics covered during the various sessions included the role of captives in the soft market, Internal Revenue Service rulings affecting captives, new roles for captives and how Bermuda intends to keep its dominant position in the captive market.

The 2008 Bermuda Captive Conference will be held June 15-18, also in Southampton. For more information, contact Delma Parfitt, conference coordinator, at 441-295-1596 or by e-mail at info@bermudacaptive.bm.

—By Jerry Geisel

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A BEST

INCURRED BUT NOT REPORTED

This issue marks the first column of Gordon Stewart, former president of the Insurance Information Institute. Mr. Stewart will write a periodic column in Business Insurance about the intersection of the insurance industry and broad events and trends.

Ravens of recession: Flying here?

By Gordon Stewart

In today's public discourse on issues economic and political, euphemism reigns. Occasionally someone might "misspeak," but no one ever seems to have lied. Only rarely will we see people accept responsibility for doing anything wrong. At most they might acknowledge "mistakes" appear to have happened. We all know how it is...just take your eyes off every little detail for a second and those pesky mistakes start popping up everywhere, all by themselves!

So no matter how extensively Ben Bernanke, chairman of the board of governors of the Federal Reserve System, has written on The Great Depression, the "D-word" must forever remain a remote historical anomaly that, by definition of its definite article, can only happen once. Oh, the occasional "adjustment" or "correction" may be noted, so long as it implies painless progress to the even better times that must be sure to come.

Some may recall that before the age of warm spin cycles, World War I was called The Great War, implying it would be the only such war, until an even greater one followed it and both had to be given Big Roman Numerals. Now of course we no longer have wars, only conflicts, missions, interventions and operations with portentous code names.

All the more shocking, then, to watch the "R-word" escape last month from the keepers of double-speak, sparking anxiety inside our warm spa of soothing locutions. The Liscio Report's Recession Index, which counts articles mentioning recession and has a fine record of calling downturns in near-real time, showed a reading for September that was its second highest since the index began in 1980. The only sharper spike came after the October 1987 stock market crash.

More troubling, the Liscio Report's core research on state revenue trends, which seem to lead even consumption trends as an indicator, show many states revising their forecasts downward from already meager levels. Co-editor Philippa Dunne says, "Sales taxes around the country are at recession levels and the only good news comes from the very richest."

It's impossible to cite all the sightings of the ravens of recession in this space. They include the Labor Department's Sept. 7 announcement that, despite its peculiar "birth/death adjustment," August brought the first monthly contraction in jobs since 2003, the sharp rate rise in the \$1 trillion asset-backed commercial paper

market, the year-over-year contractions in the Conference Board's index of leading economic indicators, the worst slump in the U.S. housing market in 16 years, the spread of the housing debacle's negative wealth effect to consumer discretionary spending, and the highest levels of personal debt in U.S. history.

After years of shining reassurance, many now sense the shadow of recession enveloping the nation, much as the penumbra of an eclipse starts to darken the moon. But while any decent astronomer can predict the partiality or totality of a lunar eclipse, not even the wisest economist can chart the extent of an economic one. So in the meantime, as an ordinary existentialist would say, what can insurance folks expect to fear or cheer?

First some good news: Although when it became apparent that spreading subprime lending problems could not be quarantined from the economy by happy talk, with some commentators forecasting damage to the insurance industry with the scarcely concealed glee of weather anchors tracking a Category 5 hurricane, such speculations have been downgraded. A recent white paper by Steven Weisbart, chief economist of the Insurance Information Institute, notes, "The vast majority of insurance company assets are extremely safe and unaffected by the subprime mortgage market." He also concludes that there is unlikely to be much fallout even in the areas of mortgage guarantee insurance and liability coverages. His survey of analysts and rating agencies affirm his findings.

Subprime squeeze

Unfortunately, the fact that the subprime storm isn't making direct landfall on insurance shores doesn't mean that a following recession, or worse, won't do major damage. Life insurers today may not be making many direct loans to local farmers as they did before The Great Depression, but back then, millions of people had not invested billions of dollars in annuity products with minimum performance guarantees. Obviously it will pay to be well-capitalized, but how will that capital be replenished and grow?

On the asset side, Fed Chairman and Depression Maven Bernanke recently dropped the benchmark rate by a half percent. Continued weakness, especially in an election year, may prompt the Fed to push rates lower, which won't exactly boost insurers' interest income over time. Recall that Alan Greenspan dropped rates three times after Long Term Capital tanked, only a few of his many cuts that encouraged

the housing bubble that was never supposed to burst because it wasn't a bubble, but that didn't do much for insurance companies' returns.

Now some people like to call rare cuts "recession insurance." If it is, then with our humongous deficits, soaring oil prices and falling currency, we may have hit the policy limits. Sure, in the short run, stock markets may rise, but if a growing credit squeeze combines with income stagnation and other factors to reduce growth, equities could decline and make it even more difficult for insurers to generate adequate returns.

There is also a well-known correlation between disability claims and "economic downturns." (If you like that phrase, you'll love "growth recessions.") Here again, obligations could rise as good returns get tougher to realize. If that's not enough, most if not all life products are discretionary, and they are not very liquid. If more people feel squeezed by existing payments, can't get new credit, and have home or capital losses, how open to insurance marketing can they be? Finally, we know that health care costs will only go up, and it's a pretty good bet that workers will try to protect their families' health coverage ahead of a lot of other insurance they don't have to buy.

So now those forbidden "R" and "D" words are at last let slip like the dogs of war—hard to train, tough to restrain—as reality turns sour enough to evoke that unmistakable smug, vulture-smile smirks on the countenances of our commentators. And for all of us, insurers and civilians, a defining question of our moment is whether the economic eclipse will be only partial and short, or might we slide into the dull-copper shadow of totality known in economics and psychology as Depression?

But what a terrible way to end a column, especially a first one. No, it's simply unfair, and probably unwise. I much prefer to propose that even as we can imagine a Great Depression II, we can also envisage more ways out of one than massive explosions of government, or World War IV. Let us further suppose that such a new foundation would have the potential to create abundant opportunity for an alert, thoughtful, and engaged insurance industry. Though neither an astronomer nor an economist, I truly believe that such a future is not mirage of warm feeling but a physical phenomenon we could live to observe.

I've taken to calling it "The Next Deal" and it will be the subject of my next column.

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9-28-07

CDHP: High-deductible plan adoptions far slower than expectations

CONTINUED FROM PAGE 4

the incumbent players" he said, pointing to acquisitions of two of the first CDHP players: Alexandria, Va.-based Lumenos, which Indianapolis-based WellPoint Inc. has acquired, and Minneapolis-based Definity Health, which now is owned by Minnetonka, Minn.-based UnitedHealth Group Inc.

"High-deductible plans have grown a lot more slowly than people anticipated," Mr. Robinson said. As a result, the market is evolving to a new concept, which he called "managed consumerism," or "Consumer Driven Health Care 2.0."

Under Consumer Driven Health Care 2.0, intermediary intervention such as disease management is being welcomed to help manage chronic conditions, many of which are the result of unhealthy personal behaviors, Mr. Robinson said.

"They smoke, they eat the wrong things, they don't get the right exercise, they physically make lousy personal decisions and, honestly, giving them more Web sites and higher deductibles just isn't" all that is needed to make CDHP members better health care consumers, he said.

In addition, benefit design is changing to recognize that high-deductible plans "create too little coverage for low-cost, efficient services and too much coverage for high-cost, inefficient services," Mr. Robinson said. "Benefit design should take this into account. For example, medically necessary procedures should be covered at 100%."

Mr. Robinson also suggested that under Consumer Driven Health 2.0, deductibles and premium contributions should be tied to income so that lower-paid workers are not put

at a disadvantage.

During a later session at the conference, Greg Scandlen, president and founder of Consumers for Health Care Choices in Hagerstown, Md., and co-chair of the CDH conference, countered Mr. Robinson's remarks, calling Mr. Robinson's newly coined "managed consumerism" an "oxymoron."

"He thoroughly misunderstands what is happening in the market," Mr. Scandlen said.

He attributed the slowdown in the rate of increase in health care costs over the past few years to the emergence of consumer-driven health care, comparing the current

situation to the impact that managed care had in the early 1990s.

"The CDH movement is transforming health care," Mr. Scandlen said. "The products are being adopted faster than any other type of plan in my lifetime."

He said the reason consumers are selecting products with managed care networks is because that is all that insurers have been offering, but that will soon change.

Mr. Scandlen also took exception to the suggestion that the incumbent insurers have taken over this fledgling market. "Several of the original companies have been acquired, but the entrepreneurs are

busier than ever," he said.

Mr. Scandlen also asserted that the growing use of the Internet to seek out health information demonstrates that consumers are taking control of their own health decisions, and are not relegating them to case managers.

In a post-summit interview via e-mail, Clive Riddle, president of Modesto, Calif.-based Managed Care On-Line and co-chair of the summit, said that critics were invited to the conference because "there are notable criticisms leveled at consumer-driven care by a number of prominent stakeholders, and to ignore them would be to 'ignore the

elephant in the room.'"

Moreover, it provides an opportunity for CDHP supporters "to become well-versed in the criticisms of their movement, in order to be best positioned for the future," Mr. Riddle said. "Given that the summit desired to be a platform towards improving consumer-driven care, an open dialogue and exchange regarding the strengths and weaknesses of the movement is necessary towards identifying and addressing problems," he said. "The summit features a lot of policy and research presentations and information, and much of the 'back and forth' on this issue is within policy circles."



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Summit draws 300

WASHINGTON—Rep. Pete Stark, D-Calif., chairman of the House Ways and Means Health Subcommittee, was among featured speakers at the National Consumer Driven Healthcare Summit, at the Hyatt Regency Capitol Hill in Washington.

The summit, which attracted more than 300 participants Sept. 26-28, was founded to provide a forum on the impact of consumer-driven health care on employers, providers, health plans, pharmaceutical companies and financial institutions. In addition to plenary sessions, the program was divided into six tracks: employer case studies, policy and research, banking and technology, operational and technical, transparency, and provider issues.

The next Consumer Driven Healthcare Summit is Sept. 22-24, 2008, in Washington. For more information, visit www.consumerdrivensummit.com, or call 800-684-4549.

—By Joanne Wojcik

SCHIP: Employer provisions likely to survive despite veto

CONTINUED FROM PAGE 1

some members who voted against the bill to reverse their position.

And even if the veto stands, the provisions that affect employers are likely to survive efforts to craft a compromise measure to keep some kind of SCHIP program in place, observers say. The current program expires Nov. 16.

The State Children's Health Insurance Program is a joint federal-state program that provides health care for children in families with income above Medicaid-eligibility thresholds. The states establish and administer the program and receive grants from the federal government to fund a portion of the health care provided to members.

The bill would give states the option to provide premium subsidies for qualified employer-sponsored coverage to low-income employees with children eligible for both the government program and employer-sponsored plans. The provision targets a segment of uninsured children whose parents have access to coverage through their employers, but cannot afford the additional premiums for family coverage, said Paul Dennett, vp-health policy at the American Benefits Council in Washington.

Under the bill, employers must notify employees about their ability to enroll in state health insurance programs and provide information on premium assistance to employees living in the states that offer such assistance. For example, an employer in the District of Columbia whose employees live in several surrounding states would have to comply with the specific requirements of each state where its employees live.

"That can be a pretty complicated requirement even though at first glance it might not seem like it," said Susan Kornetsky, research consultant and attorney at Hewitt Associates Inc.'s Washington research office.

The bill also would create special enrollment periods for employees or dependents who lose eligibility for the government program or become eligible for premium assistance to join an employer health plan. Under the bill, the employee must ask to join the employer-sponsored health plans within 60 days of losing coverage in the government program or gaining eligibility for premium assistance.

"Anything that gives an additional trigger for special enrollment would be an issue" for employers, said Ann Marie Breheny, legislative associate for Watson Wyatt Worldwide in Arlington, Va.

Plan sponsors would also be required to disclose information about their benefit plans to states upon request, including information about eligibility for the plan, cost-sharing mechanisms and the scope of coverage. The bill, though, was unclear how extensive the disclosure would have to be to ensure compliance. Since health insurance programs vary from state to state,

employers would be forced to comply with different programs and varying requests for information, consultants say.

"It would be a patchwork set of requirements that employers would need to comply with," said Kelly Traw, a principal in Mercer L.L.C.'s Washington Resource Group in Washington.

FMLA change

The bill also would amend the Family and Medical Leave Act to provide for extended leave of up to 26 weeks in a one-year period for an employee to care for an injured member of the armed services. A separate provision would ban employers from denying these family members promotions, employment or benefits for a one-year period.

"That represents a significant expansion of FMLA," said Steve Wojcik, vp of public policy at the Washington-based National Business Group on Health. "To implement that seems like it would be administratively complicated."

The Society for Human Resource Management expressed concern about the "overly broad" wording of the amendments, which could have unintended consequences as the family leave law has had, said Lisa Horn, manager of health care in the government affairs department of the Alexandria, Va.-based organization. According to a SHRM study, four out of 10 human resource professionals reporting approving FMLA leave that they believed was not legitimate.

"FMLA isn't right now working on all cylinders," Ms. Horn said. "The concern is, you're building on an already broken framework."

Employers need to be aware of the provisions of the bill because President Bush's veto will not be the final word, employers and consultants say.

Even without a successful override vote, the provisions affecting employers likely will survive during future negotiations on a bill to reauthorize SCHIP because they were not controversial and President Bush's veto was related to other aspects, such as the income eligibility levels.

Some of the employer-related provisions directly addressed concerns President Bush had about the bill. For example, the subsidy provision would alleviate the potential "crowd-out" effect of the bill, in which parents choose to enroll their children in government health plans even though they have access to or were previously enrolled in employer-sponsored plans, Mr. Dennett said. "I don't see it going away," he said. "If anything, these provisions might be strengthened to create more balance in the options individuals have."

Future negotiations may give employers an opportunity to address certain concerns by lobbying for a centralized electronic database that would streamline the reporting process and alleviate the administrative burden of compliance, Ms. Kornetsky said.

Reserves: N.Y. plan targets catastrophes

CONTINUED FROM PAGE 1

hit."

The department estimates that the proposal would affect about \$5 billion in property premiums, the bulk of which—\$3.6 billion—is from homeowners coverage, said Mike Moriarty, New York's deputy superintendent for property. He said the department estimates that about \$250 million would be placed in catastrophe reserves annually.

If the catastrophe loads charged by insurers are intended to pay for catastrophes, which are long-term in nature, then they should be reserved long-term as well, Mr. Moriarty said.

He stressed this is "not a cat fund type of concept. Each company would set up its own reserves."

"There is a tax issue," said Mr. Moriarty.

"We've tried to address that by requiring the companies put up reserves net of any taxes they pay," he said. He noted that Mr. Dinallo said he favors "tax-deferred reserves for hurricanes, but the industry will only achieve that change if it acts first and gains credibility. Meanwhile, we need to start building protection against the potentially huge costs of hurricanes now."

"In the long run, this could reduce rate increases and volatility in premiums," said Mr. Moriarty, noting that catastrophe losses have often been followed by a "big spike" in rates.

The insurance department is circulating a working draft of the proposed regulation to the industry and consumers. It will then go through the formal proposal pro-

cess, which includes publication in the New York State Register and a 45-day period for written comments.

An insurer trade group representative noted that the actual language of the proposal was not yet available.

"I do not yet have the proposed regulation in hand," said Paul Tetrault, northeast state affairs manager for the National Assn. of Mutual Insurance Cos. in Beverly, Mass. "It's a work in progress."

Mr. Tetrault said the proposal seemed to "have some commendable goals," including the fact that it presents a "private-market solution rather than a significant, unwarranted government involvement" in the marketplace.

But he said some of the premises contained in the department's announcement raise questions. "Policyholder surplus exists for all sorts of contingencies," he said. The idea of segregated funds raises the question whether they, like policyholder surplus, could be used for other purposes, he said.

The "big question" is tax treatment, Mr. Tetrault said, with uncertainty over how this reserving requirement would work or whether it would actually change anything.

"We're just starting to look at the draft regulation," said a spokesman for the American Insurance Assn.'s northeast region in Albany, N.Y. "We're certainly willing to have a constructive dialogue with the department on the proposal."

"We do have some concerns that we will be looking at as we pursue

this dialogue," he said, adding that one issue was whether "it may restrict an insurer's ability to efficiently use its capital, which may result in less capacity in the market rather than more. We'll be looking to see if there are any tax implications and if there are any retaliatory tax implications for domestic companies in New York."

NAMIC's Mr. Tetrault said transparency seems to be the idea behind the proposal, which seems intended to promote consumer understanding about the exposure catastrophes pose to companies. "Whether this is an effective way will have to be determined and given some thought," he said.

"I think that most in the industry will agree what Mr. Dinallo's proposal is a welcome step," said Robert Hartwig, president of the Insurance Information Institute in New York. "The problem is that it creates some severe financial problem and obstacles for insurers."

"By creating an entirely new category of reserves earmarked in advance for catastrophe losses, but without any corresponding tax recognition, this proposal is probably on a collision course with the Internal Revenue Service, Mr. Hartwig said.

The proposal could be particularly burdensome for smaller insurers that operate only in New York, he said. If a small insurer had to move a few hundred thousand dollars into the reserve account, it might have some problems meeting the capital requirements set by rating agencies and would have to find ways to tap additional capital, he said.

Potential Medicare changes spark concerns about costs

WASHINGTON—Employers remain concerned about potential changes to Medicare originally included in a bill to reauthorize the State Children's Health Insurance Program because they would increase their benefit plan costs.

Although legislators agreed to omit the Medicare provisions from the SCHIP bill, Congress will likely consider these provisions as part of Medicare legislation by the end of this year, employers say.

"It's certainly a possibility," said Steve Wojcik, vp of public policy at the Washington-based National Business Group on Health. "It's not like they disappeared."

One provision would have extended the time frame of employers as the primary payers for treatment of end-stage renal disease from 30 months to 42 months. Kidney disease is currently the only condition where individuals under the age of 65 are eligible for Medicare coverage.

"It's a cost shift to employers to pay for higher Medicare rates

to ESRD providers and we have strongly objected to the cost shift, not to the increase in rates," said Paul Dennett, vp-health policy at the American Benefits Council in Washington.

Another provision would have established a comparative effectiveness research unit devoted to studying health care outcomes and identifying the most efficient preventive, diagnostic and treatment procedures. The unit was to be funded by fees on health insurance policies, which would have created an "unjustified" premium tax on employers providing employee benefit plans, Mr. Dennett said.

The House bill would also have mandated that formularies for Medicare Part D drug programs include all drugs in six pharmaceutical categories, including antidepressants, which would complicate negotiations between employers and pharmacy benefit managers and drug companies, employers say.

—By Gloria Gonzalez

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News In Brief

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that religion. But the state's highest court ruled last October that the organizations involved in this litigation are social service agencies—not churches—and thus not exempt.

UPS, Teamsters agree to pension changes

United Parcel Service Inc. would be allowed to withdraw from a huge multiemployer pension plan under a tentative agreement reached between the International Brotherhood of Teamsters and UPS. Under the agreement, Atlanta-based UPS would withdraw from Central States Pension Fund, which at the end of last year had more than \$20 billion in assets but is significantly underfunded, in exchange for a \$6.1 billion contribution. Under a 1980 federal law, employers withdrawing from underfunded multiemployer pension plans are required to pay a share of the plans' unfunded liabilities. As part of the agreement, UPS would set up a new plan, which would be jointly administered by UPS and the Teamsters. UPS would fully fund the new plan.

AmWINS IPO put on hold

Wholesale broker AmWINS Group Inc. has withdrawn its filing for an initial public offering of company shares. AmWINS, formerly American Wholesale Insurance Group, originally filed its registration statement with the Securities and Exchange Commission last November and amended the filing as recently as March. The company had said it planned to use the proceeds of the IPO to pay down \$166.8 million in debt under two credit facilities. In a letter to the SEC last week, though, AmWINS Chief Executive Officer M. Steven DeCarlo said the company had decided not to proceed with the IPO "at this time."

Hospital claims ease in 2007

The severity of hospital professional liability losses over the past year increased by 3.0% on average, according to a report produced by Aon Corp. in conjunction with the American Society for Healthcare

Risk Management. That compares with increases of 6.0% in 2006, 6.4% in 2005 and 8% in 2004. In addition, the frequency of claims for the 1,000 facilities—part of 80 health care organizations—that participated in the study did not increase for the third consecutive year. Facilities that are recognized for their patient-safety initiatives report lower liability costs, but frequency, severity and lost-cost statistics vary considerably by state, the report noted.

Crawford exec Bowman named president, CEO

Crawford & Co. promoted Jeffrey T. Bowman, who has been closely involved in the company's international expansion, to president and chief executive officer, effective Jan. 1. Mr. Bowman, who previously was chief operating officer of Crawford's Global Property & Casualty unit, succeeds Thomas W. Crawford, who was named CEO in September 2004 and will assume the role of chairman of the board for the claims management services provider. Jesse Crawford, current chairman, will step down from that role but will continue to lead the board's executive committee.

Noted

Commercial property/casualty insurance rates fell an average 15% in September compared with rates of a year earlier, according to MarketScout.... **Aon Corp.** has named a Microsoft Corp. executive, Christa Davies, as executive vp and chief financial officer. Ms. Davies, who currently is CFO of Microsoft's Platform & Services Division, will succeed current Aon CFO David P. Bolger in March 2008. Mr. Bolger recently was named chief operations officer for the Chicago Olympic Committee, which is chaired by Aon Executive Chairman Patrick G. Ryan.... **Marsh & McLennan Cos. Inc.** has James J. McNasby as general counsel of Marsh Inc., MMC's insurance brokerage and risk advisory unit. Mr. McNasby—who most recently served as senior vp of North America Legal for Kraft Foods Inc. and chief lawyer for Kraft's North American business—succeeds Richard J. Sullivan, who left MMC after he was appointed a federal judge.... London-based **Chaucer Holdings P.L.C.** has set up a new Lloyd's of London syndicate. Syndicate 1274, which will have capacity of £135 million (\$276.3 million) for 2008 and be managed by Chaucer, will write specialty insurance business including property, casualty, marine and aviation risks.

RIMS: Benchmark survey

CONTINUED FROM PAGE 3

said.

Many of the lessons learned from the 2005 hurricane season, such as the inflated cost of rebuilding when the cost of labor and building materials are taken into account, were factored into the models for forecasting earthquake premiums, thereby driving up the price, he said.

"The increases for the catastrophe-exposed business are nudging up the average premium," Mr. Bradford said.

Premiums for other lines were down on average.

Directors and officers liability posted the largest decrease, falling 3.9% compared with the same period last year. Mr. Bradford said that decline in part reflected a reaction to skyrocketing D&O premiums between 2001 and 2003. Furthermore, the loss experience in D&O has been stable, he said.

General liability premiums dropped 3.2%, while workers compensation premiums dipped by 1.5% on average.

Mr. Bradford said the survey

results generally aligned with third-quarter projections, although he said he was surprised property premiums were still on the rise.

Property a little surprising

"It's pretty much as we expected," Mr. Bradford said. "It tells pretty much the same story as we've seen the past several quarters. But I thought the increases in property premiums would have worked themselves out by now."

And the soft market is likely to continue. "Obviously, these are much better times for commercial buyers," he said. "From the buyers standpoint, it looks pretty good for the future because it's pretty certain (the premiums are) going to go even lower yet."

The softening still has "a ways to go before hits the bottom," Mr. Bradford said. "The insurance industry continues to be profitable. As long as that cap base continues to grow, it will just continue to fuel competition. There is too much capacity."

More information about the survey is available at www.rims.org/benchmark.

RRGs: Some criticize states for overzealous regulation

CONTINUED FROM PAGE 4

law.

Mr. Sheppard said risk retention groups might benefit from having a federal regulator, as would be created by legislation that would allow insurers to choose to be governed by optional federal charters. RRGs that chose the OFC might find "they don't get pushed around" by states if the federal regulator enforced the Liability Risk Reten-

tion Act, he said.

But Mr. Kehler he doubted that enactment of an OFC law would "change the regulation of risk retention groups." Most RRGs would be too small to take advantage of an OFC law and would thus remain state-regulated.

Wendy Fisher, corporate secretary/regulatory and business affairs for Aurora, Colo.-based National Home Insurance Co., a Risk Retention Group, moderated the session.

120 gather for NRRRA meeting

WASHINGTON—About 120 people attended the National Risk Retention Assn.'s annual conference and health care professional liability seminar in Washington.

Topics covered during the Sept. 26-28 meeting included insurance modernization, regulatory issues, fronting a risk

retention group as well as ethics.

The Minneapolis-based NRRRA promotes group insurance programs authorized by the federal Liability Risk Retention Act.

Further information on the NRRRA is available at www.nrrra-usa.org.

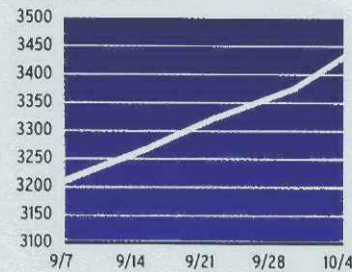
—By Mark A. Hofmann

Stock Index

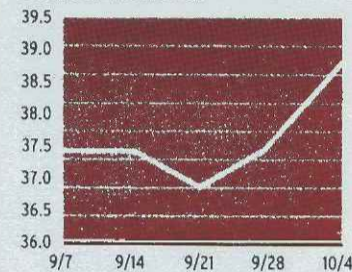
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Up-to-the-minute data for all 82 companies that comprise the BI Stock Index can be found at www.BusinessInsurance.com.

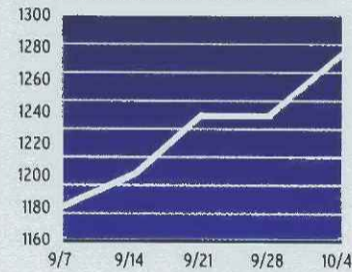
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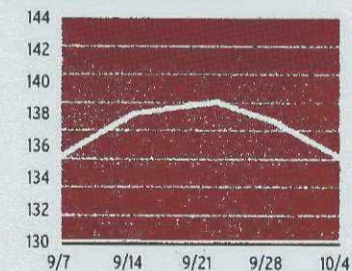
BI BROKERS INDEX



BI INSURER/REINSURERS INDEX



BI MANAGED CARE ORGANIZATIONS INDEX



Percentage change of BI Stock Index vs. key indicators

Indicator	Value	Change
BI/STOCK INDEX	3433.03	2.09%
DOW JONES	14066.01	1.23%
S&P 500	1557.59	2.02%

LARGEST GAINS

Tower Group Inc.	15.39%
Ambac Financial Group	11.44%
MBIA Inc.	11.02%
PMA Capital Corp.	10.32%
United Fire & Casualty	9.00%

LARGEST LOSSES

SCPIE Holdings Inc.	-5.17%
Health Net Inc.	-2.41%
UNICO American Corp.	-2.02%
Fairfax Financial Holdings	-1.74%
Allmerica Financial Corp.	-1.63%

Source: Financial Content Inc. <http://financialcontent.com>



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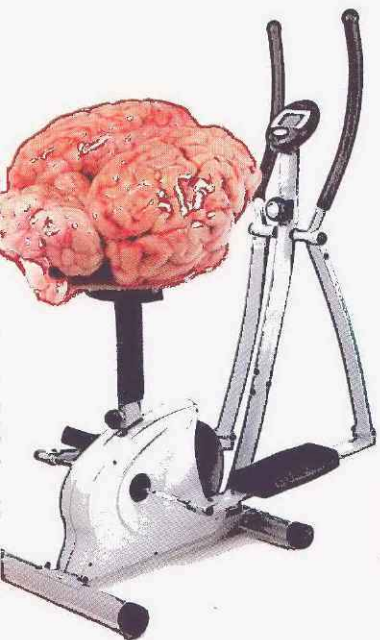
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Firm uses mind games to reduce LTC claims

A long-term care insurer is offering its policyholders access to a mental exercise program with the hope of delaying the onset of dementia-based impairment, which it says is one of the costliest causes of LTC insurance claims.

The computer-based Brain Fitness Program, developed by Oakland, Calif.-based Posit Science Corp., guides users through a series of exercises designed to improve memory, strengthen communication and sharpen thinking. Studies published by the National Academy of Sciences have found that Brain Fitness Program has improved cognitive function as much as 10 years among people age 60 and older.

The program is just one component of a comprehensive wellness program that Penn Treaty American Corp. soon will offer to all of its LTC policyholders, regardless of whether they have filed a dementia-related claim, said Steve La Pierre, senior vp of the Allentown, Pa.-based LTC insurer.

"We need to be more than just a financial safety net if your health declines; insurers also have a responsibility to coach policyholders in ways of living longer, healthier lives," Mr. La Pierre said.



Jets fan tries Hail Mary suit

Lifelong New York Jets fan Carl J. Mayer thinks he's been duped and he is demanding a \$184 million refund. Mr. Mayer is taking on the New England Patriots football team in a class action lawsuit, which he filed in federal court in New Jersey late last month. He says he filed the suit on behalf of himself and all Jets season ticket holders who have been cheated by the Patriots over the past seven years.

The filing comes on the heels of the NFL's investigation of the Patriots, which determined that the club had illegally videotaped defensive signals from Jets coaches during a game held Sept. 9, in which the Patriots defeated the Jets 38-14.

The NFL fined the Patriots \$250,000 and head coach Bill Belichick \$500,000 for violating league rules.

According to the suit, because the Patriots have been found to have illegally videotaped other teams, the class action seeks damages for all games played in Giants Stadium between the two teams since 2000.

Mr. Mayer calculated that fans paid upwards of \$61 million to watch eight "fraudulent" games between the two teams, in which they are entitled to triple that amount—\$184.8 million—in compensation under the Racketeer Influenced and Corrupt Organization Act, the New Jersey Consumer Fraud Act and the New Jersey Deceptive Business Practices Act.

According to court documents, Mr. Mayer claims that this "violated the contractual expectations and rights of New York Jets ticket holders who fully anticipated and contracted for a ticket to observe an honest match played in compliance with all laws and regulations."

The New England Patriots and its head coach, Bill Belichick, have been fined for breaking NFL rules.

Time travel claims fraud puts agent behind bars

Insuring the uninsured was Marry Arantes' job as a Progressive Insurance agent.

It seems though, that Ms. Arantes forgot one thing—to insure herself.

Ms. Arantes was sentenced to 30 days in jail and given three years of supervised probation for forging her own policy after a car accident in an attempt to have the incident covered.

Ms. Arantes pleaded no-contest to making the false claim in San Mateo, Calif., District Court late last month.

According to the San Mateo County District Attorney's

office, Ms.

Arantes was involved in a car accident but had no insurance coverage. With a little quick thinking, Ms.

Arantes, an authorized agent for Progressive West Insurance Co., decided to take out a policy at her Daly City, Calif., office and report the accident occurring two hours later than it actually did, to ensure the crash would be covered, according to prosecutors.

However, a Progressive Insurance claims office noticed the fraud and reported it to authorities.

Ms. Arantes was ordered by a judge to report to the San Mateo County Women's Correctional Facility on Oct. 27.



iPhone price cut makes N.Y. woman iRate

Looks like someone else is trying to take a bite out of the big Apple. Apple Inc., that is.

A New York woman is now suing the makers of the iPhone after the company lowered the price of their latest gadget by \$200 within two months of the product's launch.

According to a Sept. 24 lawsuit brought by Dongmei Li in Brooklyn federal court, Apple violated price discrimination laws when it reduced the price of the iPhone from \$599 to \$399 and phased out the 4 gigabyte model and began selling the 8 gigabyte model for the lower price.

Ms. Li is seeking \$1 million in damages from Apple and AT&T Inc., the exclusive phone carrier.

Neither Apple nor AT&T would comment on the suit.

Amid hundreds of complaints, Apple served up an apology one day after it lowered cut the iPhone price by \$200 and offered rebates to some purchasers.

But many, apparently, are still fuming over issues with the iPhone and multiple suits have been filed. A New Yorker has sued over thousands of dollars in roaming charges he incurred traveling outside the United States; three suits have been filed over iPhone batteries, which can be replaced only by Apple, and a California attorney is looking for claimants for a possible class action on third-party applications for the iPhone.

Apple Inc. is facing multiple lawsuits from customers with a variety of gripes about the company's iPhone.



iPhone

iPhone combines a breakthrough mobile phone, the best iPod ever created, and the Internet in your pocket.

Features

- Quad-band GSM phone
- Large multi-touch display
- Wi-Fi and EDGE wireless data
- Visual Voicemail
- Widescreen iPod with Cover Flow
- Rich HTML email
- Safari web browser
- Google Maps
- Intelligent keyboard
- Bluetooth capability
- Mac and PC compatible

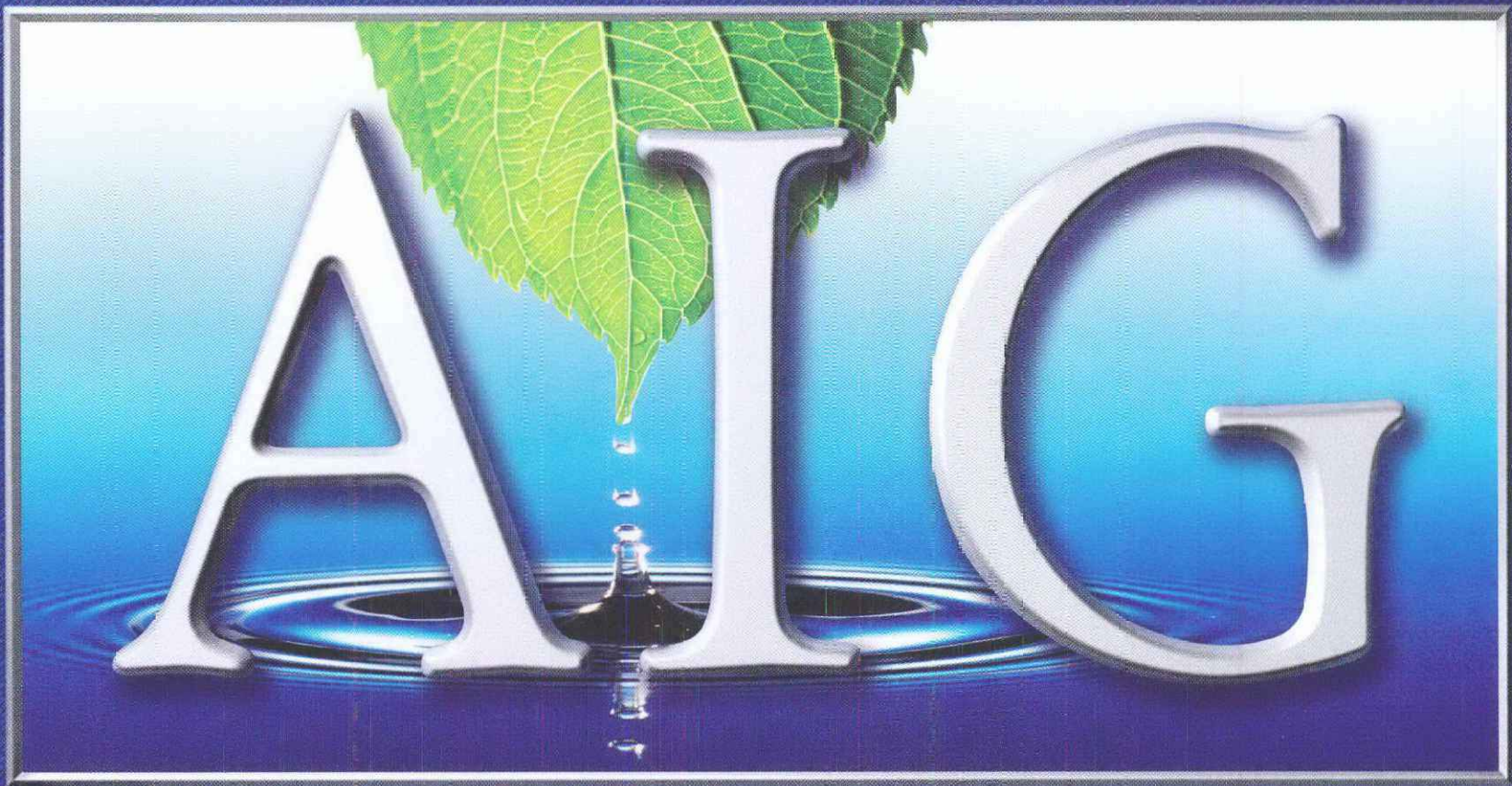
Includes

Stereo Headset with mic • USB Power Adapter

Dock • Dock Connector to USB 2.0 Cable

4GB \$299 8GB \$399

Some items, while available in stores, are not available in all areas. iPhone is a registered trademark of Apple Inc. All other trademarks are the property of their respective owners. Availability of features and accessories may vary by region. © 2007 Apple Inc. All rights reserved.



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