PBGC posts record deficit from recent big losses / 3

Construction buyers knock proposed GCL changes / 4

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School loss portfolio transfer at risk

Fremont insolvency raises questions about who will cover pool's liabilities

By ROBERTO CENICEROS

GLENDALE, Calif.—Loss portfolio transfer arrangements involving a defunct workers compensation insurer could leave a number of California school districts saddled with millions of dollars in unpaid liabilities.

School district risk managers and a pool manager who arranged the transfer are now consulting with their attorneys to determine who should pay the claims.

The problem could be particularly painful for the school districts because a fiscal crisis in California is taking a toll on school budgets.

"This is the worst time for this to accrue, given the financial situation of the schools," said Ed Godwin, risk manager for the Riverside Community College District in Riverside, Calif. "It is something of real concern."

Like many California school districts, Riverside Community College participates in a joint powers authority. JPAs are similar to purchasing groups or self-insurance pools.

In 1998, a JPA that Riverside Community College District participates in—the Community College/County Superintendent Self Insured Plan for Employees—paid $1.4 million to transfer about

See JPA/page 16

PHOTO: AP/WIDEWORLD

For 54 school districts, millions of dollars in unpaid liabilities resulting from the insolvency of Fremont Indemnity Co. could exacerbate problems they already face due to California's current fiscal crisis.

California employers fear litigation from new labor code law

By JUDY GREENWALD

California employers will face numerous lawsuits because of a new law that provides financial incentives for workers to sue their employers for labor code violations, observers warn.

The Labor Code Private Attorneys General Act of 2004, which has been dubbed the "sue your boss bill" by its opponents, took effect Jan. 1. The law permits employees to sue their employers—on behalf of themselves and present and former workers—for any alleged labor code violations that have not already been addressed by the state labor commissioner. The code governs such issues as wages, overtime and working conditions, and observers warn that even its most obscure aspects could serve as the basis for litigation.

As a result, employers should conduct audits to make sure they are in compliance with labor code to the fullest extent possible, attorneys say.

Under the new law, if there is no stated civil penalty for a particular labor code violation, employers can be fined $100 per "aggrieved" employee per pay period and $200 for each subsequent violation, in addition to attorneys' fees and costs. The aggrieved employees will receive

See LABOR/page 15

Current, future retirees to lose health benefits

Alcatel cuts cover for U.S. retirees

By MICHAEL BRADFORD

PLANO, Texas—Current and future retirees from a large telecommunications company will have to shoulder all the cost of their health insurance in an unusual and extreme benefit cutback.

High costs prompt cuts in retiree health care
page 4

Alcatel Inc., the Plano, Texas-based operation of the French telecommunications company, has begun to phase out its subsidy of health insurance for thousands of former U.S.-based employees. A company spokesman would not say how many retirees are affected by the move but confirmed that "several thousand" had worked for Alcatel operations across the United States.

Since the early 1990s, employers, amid soaring costs, have been paring back their retiree health care plans, significantly upping premiums paid by retirees and boosting deductibles.

And in many cases, employers have eliminated retiree health care coverage, but typically only for employees hired after a certain date. Rarely, though, have employers that aren't in extreme financial distress totally eliminated financial support for health care plans covering current retirees.

"It is a case of last resort, short of taking away coverage altogether,"

See ALCATEL/page 18

International

MOVES CAST DOUBT ON Rx IMPORTS

Page 13

Late News

PHOTO: UPI/EARL S. CRYER

California wildfires raised insured catastrophe losses in 2003.

Catastrophe claims hit $12.8 billion in 2003

Catastrophes caused an estimated $12.8 billion in insured property damage last year, according to the Insurance Services Office Inc.'s Property Claim Services unit. That made 2003 the third-costliest year of the past decade in terms of catastrophe losses, according to Jersey City, N.J.-based PCS. Last year's total included losses from the costliest fourth quarter in 10 years, representing an estimated $2.64 billion in insured losses, most of which stemmed from two California wildfires.

Aspen opening U.S. reinsurance unit

Aspen Insurance Holdings Ltd. is forming a Connecticut-based property reinsurance unit. Aspen Re America will operate from Rocky Hill, Conn., and will write proportional and excess treaty reinsurance. Brian Boornazian, formerly of XL Reinsurance America Inc., is joining Aspen Re as president and chief operating officer. The unit will give reinsurance buyers access to the London market through Aspen Insurance U.K. Ltd.

Official urges state to buy Canadian drugs

Matt Brown, secretary of state for Rhode Island, is urging Gov. Donald Carcieri to ask the federal government for permission to reimport Canadian prescription drugs for state employees and retirees. Under the U.S. Food, Drug and Cosmetic Act, it is illegal for anyone other than the original manufacturer to reimport prescription drugs into the United States. Congress recently passed a measure allowing the Secretary of Health and Human Services to issue waivers to individuals for drug reimportation, but only if safety standards are met.

See LATE NEWS/page 19

NEWSPAPER

XL to strengthen reserves after review of U.S. claims

HAMILTON, Bermuda—XL Capital Ltd. will take a $694 million pretax charge against its fourth-quarter 2003 earnings, mostly to bolster reserves for the North American reinsurance business it acquired in its 1999 takeover of NAC Re Corp.

The larger-than-expected reserve boost—coming on top of a smaller reserve addition in the third quarter of 2003—caused A.M. Best Co. to place XL's A+ financial strength rating under review and led both Standard & Poor's Corp. and Moody's Investors Service to lower their ratings of various XL units by one notch.

The latest charge resulted from a ground-up claims audit for the 1997 to 2001 underwriting years at XL Reinsurance America Inc. The audit included a review of 28 contracts with 17 ceding insurers representing 85% of the reinsurer's premium in certain "problem" classes of business, including directors and officers liability and medical malpractice, XL reported last week.

The $694 million charge includes $663 million related to XLRA, comprising $124 million in additional case reserves and $539 million for incurred-but-not-reported losses.

Also included in the total is a $31 million net charge for other reserve increases. XL is boosting reserves for its Bermuda and London reinsurance operations by $62 million and for its Bermuda casualty insurance operations by $150 million. Those increases are mostly offset, though, by a $181 million release of reserves for losses from the Sept. 11, 2001, terrorist attacks, which XL said it is drawing down because of the extensive participation of claimants in the federal Sept. 11 Victim Compensation Fund.

Since its acquisition of NAC Re, XL has not renewed 63% of the acquired business, restructured or repriced the remainder, exited such lines as aviation and accident and health, and shifted the portfolio to lower-risk classes of business, the company reported.

XL President and Chief Executive Officer Brian M. O'Hara said in a statement that the fourth-quarter charge resolves reserving questions on the acquired business and that "we do not expect any adverse effect on our financial results in 2004 and beyond."

XL meanwhile announced it will replenish its capital with a $750 million convertible securities issue during the first half of 2004.

Noting that the latest reserve charge followed a $184 million charge for North American business in last year's third quarter, Best placed XL's rating under review with negative implications pending completion of the capital-raising.

S&P cut its financial strength ratings of XL operating units to AA- from AA, while Moody's downgraded its ratings of XLRA and several affiliates participating in an intercompany reinsurance pool to Aa3 from Aa2.

XL shares on the New York Stock Exchange rose 3.4% the day of the announcement to close at $80.50. Shares closed Friday at $78.94.

—By Douglas McLeod

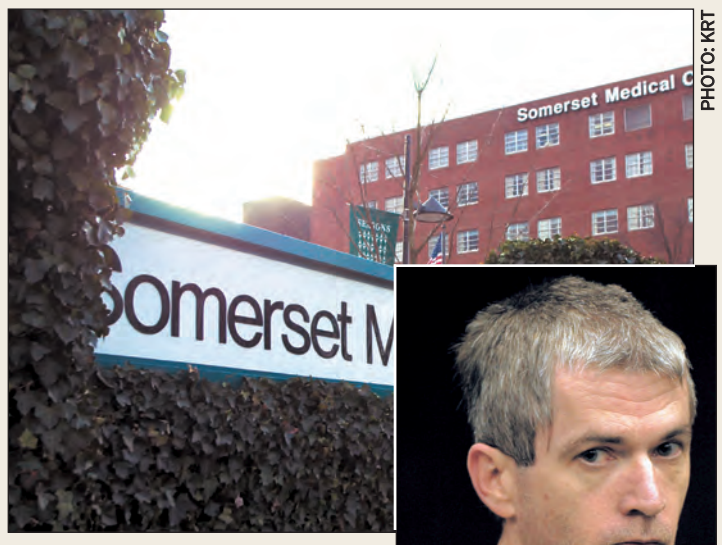

PHOTO: KRT

PHOTO: AP/WIDE WORLD

Registered nurse Charles Cullen has been charged with murder in the death of a patient at Somerset Medical Center in Somerville, N.J.

Patient deaths prompt close look at hospital employment practices

By SALLY ROBERTS

The medical profession's hiring practices are under scrutiny after a nurse admitted to killing up to 40 patients in a number of New Jersey and Pennsylvania hospitals over the course of a 16-year career.

Charles Cullen, a 43-year-old registered nurse, was arrested last month and charged with the murder of one patient and the attempted murder of another at Somerset Medical Center in Somerville, N.J. Authorities charge that he administered lethal doses of the heart medication digoxin.

After his arrest, Mr. Cullen reportedly confessed to killing up to 40 other patients while employed at 10 different medical centers. Some of the employers had fired Mr. Cullen for suspected wrongdoing.

Those revelations have not only resulted in a handful of legal actions against the hospitals that employed Mr. Cullen, but also have prompted new concerns over standard reference-checking procedures at hospitals.

"We are outraged that some hospitals who have hired this nurse and who may have conducted an investigation did not share the information with us or the proper authorities," Somerset Medical Center said in a statement.

Part of the reason for that silence, medical experts say, is fear of litigation.

Standard practice in the health care industry when hiring nurses includes checking references of past employers. But outside of providing the former employee's name, start date and end date—and in some instances whether the former employee is eligible for rehire—hospitals do not divulge other

See HIRING/page 16

Big losses push shortfall to record $11.2 billion

PBGC deficit swells in 2003

By JERRY GEISEL

WASHINGTON—Saddled with hefty new liabilities, the Pension Benefit Guaranty Corp. last week reported a record deficit for 2003.

In 2003, the PBGC assumed $5.4 billion in losses from the actual or probable terminations of underfunded pension plans. That helped produce an $11.2 billion deficit—the agency's biggest in its 29-year history—and more than three times its deficit of $3.6 billion in 2002.

And more big losses seem nearly certain, the PBGC warned. As of Sept. 30, 2003, the close of the PBGC's fiscal year, the agency said it faced a "reasonably possible" exposure of $85.5 billion, which represents the amount of unfunded benefits in plans sponsored by employers with a below-investment-grade rating.

That estimated exposure, which is heavily concentrated among employers in the financially distressed airline, primary metals and fabricated metals industries, is more than double the PBGC's 2002 estimate of its reasonably possible exposure of $35.4 billion.

The sharp deterioration in the PBGC's financial condition stands in stark contrast to the robust health it enjoyed only a few years ago. Buoyed by a lack of big losses and strong investment gains, the PBGC as recently as 2000 enjoyed a nearly $10 billion surplus.

But as the economy soured, the

See PBGC/page 16

REVERSAL OF FORTUNE

The PBGC's net financial position for its single-employer insurance program

Year	Position*
1998	$5.0
1999	$7.0
2000	$9.7
2001	$7.7
2002	($3.6)
2003	($11.2)

*Net position in billions of dollars
Fiscal years ending Sept. 30
Source: PBGC

Inside Business Insurance

Online

- The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info on your own event.
- Searchable **directories** of all the listings of industry vendors found in *BI*'s Market Sourcebook.
- New **Opinion Poll** for readers: Do you think covering the uninsured will emerge as a major campaign issue in the presidential race?

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS.

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PHOTO: GETTY

Large employers expressed satisfaction with the overall service, performance and cost savings of Walgreens Health Initiatives, whose parent operates the Walgreens chain of drugstores.

Employers give PBMs high service marks

But cost containment scores are lower

By JOANNE WOJCIK

A new survey of customer satisfaction with prescription benefit managers suggests that large employers are generally satisfied with PBM service but would like PBMs to do more to manage drug costs.

The survey also found that two smaller PBMs—Eckerd Health Services and Walgreens Health Initiatives, whose parent companies operate retail drugstore chains—led the pack in satisfaction with overall service and performance and in delivering promised savings. By contrast, Medco Health Solutions Inc.—the nation's largest PBM—was rated lowest by employers among the seven PBMs judged.

The findings are from the "2003 Pharmacy Benefit Manager Customer Satisfaction Report," the eighth annual survey of large employers conducted by the Pharmacy Benefit Management Institute, an independent research and consulting organization in Tempe, Ariz. A total of 468 large employers representing more than 10 million health plan members participated in the recently published survey, which was conducted in June 2003. They were asked to rate seven PBMs: Advance PCS, Caremark Prescription Service, Eckerd Health Services, Express Scripts Inc., Medco Health Solutions, Systemed and Walgreens Health Initiatives.

Overall, the report found that employers were more satisfied with core PBM services. On a scale of 1 to 10, respondents' average score for PBM retail pharmacy networks was 8.8; administrative functions, such as claims processing, rated 8.1 on average; and identification cards, 8.0. Lower average scores were given for service functions linked to cost containment, such as delivering promised cost savings, which was rated 7.2 on average, and formulary management and rebates, which was rated 7.0 on average.

"If there's an employer discontent, it appears that it is with PBMs' control of pharmacy costs and trends," observed Paul Wernick, senior consultant at Watson Wyatt Worldwide Inc. in Minneapolis. "They are less satisfied with that than with networks, customer service and account management."

But employers also might be unhappy with the savings because they didn't establish benchmarks in their PBM performance contracts, suggested Bridget Eber, pharmacy practice leader at Hewitt Associates Inc. in Lincolnshire, Ill.

"Employers really need to be focused on their cost management strategies," she said.

Indeed, the survey found that employers were more likely to be satisfied with the performance of PBMs that are aggressive in managing drug benefits.

Employers reporting their PBMs had a "very aggressive" level of intervention in benefit management gave PBMs an average rating of 8.2 on overall service and performance, while those who said their PBMs had only minimal intervention rated their PBMs an average of 7.0.

When surveyed employers were asked to list the services they thought PBMs needed to improve most, 28% listed disease management programs, followed by formulary management and rebates, cited by 24%.

"Employers are clearly really looking toward managing trend. It's been out of control for a while," Ivy Silver, president of the Commonwealth Consulting Group, a benefit consultant based in Philadelphia, said, referring to health care inflation.

She added that PBMs are in the best position for drug cost containment because they are in contact with members when prescriptions are filled, whereas

See PBMS/page 19

ISO seeking to narrow CGL cover for additional insureds

Construction companies call amendments too restrictive

By MEG FLETCHER

Proposed changes to commercial general liability insurance policies intended to curb the scope of coverage under the additional insured endorsement are being welcomed by insurers but are drawing criticism from construction industry groups.

The policy form revisions, which are being filed nationwide by the Insurance Services Office Inc., seek to limit coverage for additional insureds to liabilities that can be associated with the principal policyholder.

Currently, according to ISO, the endorsement provides coverage for liabilities arising from actions by additional insureds that have little or no connection with the principal policyholder.

ISO says that the changes reflect the original intent of the policies and are now needed because courts are too broadly interpreting coverage available under the current 1993 CGL endorsement.

But construction companies say that the amendments are unnecessarily restrictive and would lead to increased litigation.

While the impetus for ISO's revisions stemmed from insurers' problems with court interpretations of construction-related policies, the proposed revisions also would apply to other insurance arrangements in which additional insureds are named, including landlord-lessee and equipment owner-renter relationships, said Gary Grasmann, ISO's assistant vp-general liability.

The identity of an additional insured varies, depending upon the policyholder's needs. For example, a general contractor may be required to include a building owner as an additional insured on the contractor's CGL policy. Alternatively, a subcontractor may be required to include a general contractor as an additional insured on its CGL policy.

See ISO/page 18

Rising costs spur employers to look at retiree benefit cuts

By JERRY GEISEL

As the cost of offering retiree health care coverage grows at a double-digit rate, many employers are considering terminating coverage for future retirees and boosting cost-sharing for current participants.

Costs associated with offering retiree health plans increased by an average of 13.7%—to a total of $20.6 billion—between 2002 and 2003, according to a survey conducted by the Kaiser Family Foundation and Hewitt Associates Inc. The results, which are based on responses from 408 large employers—those with at least 1,000 employees—were released at a briefing last week in Washington.

Among surveyed firms, retiree health care costs represent more than a quarter of their total health

See RETIREES/page 9

BENEFIT COSTS PER RETIREE

Average monthly premium costs for retiree health care plans*

	Employer contribution	Retiree contribution	Total
Pre-65 single coverage	$261	$166	$427
65+ single coverage	$129	$ 83	$212
Pre-65 coverage for retiree and spouse	$500	$345	$845
65+ coverage for retiree and spouse	$245	$174	$419

*For employees retiring on or after Jan. 1, 2003
Source: Kaiser/Hewitt

Louisiana HMO allowed to pursue subrogation against participant

By DAVE LENCKUS

WASHINGTON—A Louisiana health plan may subrogate against a plan participant who received multiple insurance awards for a single injury, after the U.S. Supreme Court last week declined to hear an appeal of the case.

However, the high court's refusal to hear the case leaves unresolved some apparent conflicting opinions among federal appellate courts over whether federal law allows such subrogations, attorneys say.

The Supreme Court addressed subrogation in a January 2002 ruling. The high court ruled that federal law allows health plans and insurers to seek only equitable restitution from plan participants. Equitable restitution is available when money or property that clearly belongs to a plaintiff can be "traced to particular funds or property in the defendant's possession," the court explained (*BI*, Feb. 11, 2002).

In declining, without comment, to review this recent case, the Supreme Court lets stand a Dec. 8, 2003, ruling by a panel of the 5th U.S. Circuit Court of Appeals. The panel held that a health maintenance organization could subrogate against a Louisiana plan member.

The Supreme Court's refusal to review the 5th Circuit decision was the latest in a series of court actions in the case, some of which also have raised questions about whether such disputes should be resolved in state or federal courts.

In July 2003, the full 15-judge 5th Circuit court overturned a ruling by a 5th Circuit panel as well as the court's own previous test for determining whether the Employee Retirement Income Security Act of 1974 pre-empts state law and compels litigants to resolve their disputes in federal court. Court jurisdiction is an important issue, because federal courts are more likely to interpret ERISA in favor of insurers and self-funded plans that are involved in coverage disputes with

See ERISA/page 18

New Jersey offers employee benefits to domestic partners of state workers

TRENTON, N.J.—New Jersey has enacted a law that makes domestic partners of state employees eligible to receive state health care and retirement benefits.

Under the Domestic Partnership Act, domestic partners of New Jersey state employees are eligible to receive certain health care and retirement benefits. The law applies to workers' domestic partners who are either of the same sex and at least 18 years of age or, if of the opposite sex, at least 62 years old.

The law, which was signed Jan. 12 by New Jersey Gov. Jim McGreevey, does not apply to private employers or to state counties and municipalities.

Whether companies choose to offer benefits to employees' domestic partners depends on several factors, including cost. However, most companies are finding that the costs of providing benefits to domestic partners are not higher than those related to offering equivalent benefits to spouses, according to Mike Thompson, health care consultant for PricewaterhouseCoopers Human Resources Services in New York.

"The costs have been very manageable for those companies that have offered the benefits to domestic partners," he said.

Mr. Thompson did note that a key issue in determining the costs of such benefits is that employee benefits provided to domestic partners are still taxable, whereas spousal benefits are tax-free under federal law.

The efforts of states such as New Jersey to provide legal status to domestic partners may encourage more companies to offer domestic partner benefits, in part because such moves help clarify legal issues regarding who is considered a domestic partner.

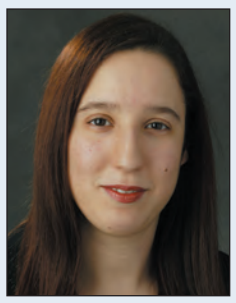
"It's easier for companies to adapt that legal status and implement it into their programs," Mr. Thompson said.

—By Gloria Gonzalez

BI adds to NY staff

NEW YORK—Gloria Gonzalez has joined *Business Insurance* as an associate editor in its New York bureau.

Ms. Gonzalez will report on risk management and employee benefit issues for both the weekly newsmagazine and *BI*'s Daily News on *www.businessinsurance.com*.



Ms. Gonzalez

Ms. Gonzalez most recently was a freelance reporter and editor for several trade magazines and Web sites. Prior to that, she worked as a reporter for BridgeNews, a financial newswire based in New York.

Ms. Gonzalez holds a bachelor of arts degree in magazine journalism and political science from Syracuse University in Syracuse, N.Y.

She can be reached by phone at 212-210-0143 and by e-mail at *gagonzalez@crain.com*.

Paul Winston

Forewarned, but hardly forearmed

A broker last week drew my attention to an example of the increasingly common practice of relying on warning signs as a cheap substitute for more effective risk management measures.

The object of his scorn? The "Danger—Falling Ice" signs posted throughout urban landscapes as buildings collect and then shed their claddings of ice and snow when winter temperatures fluctuate. Faced with a potential hazard to people entering and exiting buildings, property owners throw these signs out as a deterrent to lawyers cruising up and down the city streets looking for potential torts.

What if people truly heeded these warnings? No one would approach these danger zones, cars would make wide detours, buildings would remain empty until spring, and businesses would go into hibernation until the risk had passed.

Paul Winston

Those already inside when the warnings went up would be trapped, milling about the lobbies like panicked herd animals until their numbers grew to unruly mobs. Sure, a few might make a reckless dash through the doors—just as our animal flight reflex prompts some to jump from a burning building or a sinking ship. Some might even make it to the safety of the curb without being struck by falling chunks. Most, though, would stay inside and wait for help.

Eventually, folks would take elevators back to their cubicles, make emotional calls to loved ones, and organize teams to manage their self-preservation. Individuals would be detailed, for example, to search parties to look for leftover holiday Chex mix and other forms of sustenance for the long haul, while others would be put in charge of rationing toilet tissue and analgesics.

Eventually, after several days of being stranded in these modern igloos, caring building owners would call in Coast Guard rescue helicopters. And in a scene reminiscent of the deck of the Titanic, people would queue up on rooftops to be rescued from these icy death traps.

We all know that would never happen, though, because no one at risk really pays attention to these signs. And, despite the signage, some people do get hurt each winter by falling chunks or sheets of ice. Some of them, no doubt, are at risk of being struck because they notice the signs, stop and look up.

If building owners really wanted to minimize the risk, rather than engaging in a lame attempt to cover their posteriors, the broker suggests, they could take a number of simple steps. For example, they could steer people to alternative exits. Or they could provide a covered canopy at exits. Such measures would go a lot further toward minimizing the risk of injury, keeping businesses operating at full steam, and ensuring that the dregs of holiday Chex mix last well into spring.

Caution: The following may drive you crazy

Warning signs, sadly, have become a necessary evil in our litigious society. Many businesses go to absurd lengths to warn consumers of unlikely hazards in an effort to defend themselves from liability, no matter how remote. Plaintiffs attorneys have managed to twist the absence of warnings into the equivalent of encouraging people to misuse a product and harm themselves. As a result, the "Can't Say We Didn't Warn Ya!" defense has gained prominence.

The Michigan Lawsuit Abuse Watch, a nonprofit organization devoted to battling excesses of litigiousness, recently reported the winners of its seventh annual Wacky Warnings Competition on its Web site. M-LAW gathered the entries, and listeners of a Detroit radio station chose the winners.

Drumroll, please:

- Grand prize was awarded for a label on a drain cleaner that cautioned: "If you do not understand, or cannot read, all directions, cautions and warnings, do not use this product."
- Second place was the label on a snow sled that warned "Beware: sled may develop high speed under certain snow conditions." This exercise in the obvious must have come right after the reminder that the sled also requires an incline.
- Third place was the label on a foot-high storage rack for CDs that stated: "Do not use as a ladder." But it makes a fine cheese grater.
- Fourth place was a label on a Daredevil fishing lure with a treble hook that put customers on notice: "Harmful if swallowed." If only smallmouth bass could read.
- Fifth place was garnered by a smoke detector label that advises: "Do not use the Silence Feature in emergency situations. It will not extinguish a fire."

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Editorial

Save captives from bad rap

ARE CAPTIVE INSURANCE companies no more than tax dodges?

If one relied on a reading of the mainstream financial press, one could come to such a conclusion.

Take, for example, an article in last week's Wall Street Journal that described captives as "insurance subsidiaries that allow companies to magnify and accelerate their tax deductions when they self-insure."

The article, in a swipe at Democratic presidential candidate Howard Dean, labeled captives as "tax avoidance schemes" that he promoted when he was governor of Vermont, the nation's largest captive domicile. It would be easy to dismiss the article as misinformed, which it is. But that would be a mistake. No matter how off base, articles have helped shape policymakers' opinions.

A tax avoidance label sounds awful, but what does it mean? If it means captives can help an employer legally reduce its taxes, there is nothing wrong with that any more than with 401(k) plans, which tens of millions of Americans legally contribute to and in so doing reduce their taxes. No doubt some captives have been used to evade taxes. Such instances are rare, though, and the Internal Revenue Service is well-equipped to take action.

But to suggest that tax savings or avoidance is the principal motivation behind captives is absurd. If it were, how could one explain the formation of hundreds of captives in recent years by such nonprofit entities as hospitals, universities and municipalities for whom taxes are not an issue? Captive formation, in fact, has surged not because of tax issues but because employers and other insurance buyers increasingly understand captives' financial and other advantages.

When the traditional market unfairly or irrationally prices coverage, setting up a captive to take on risk can dramatically lower costs for buyers. And establishing a captive gives access to the reinsurance market that would not be possible with, say, pure self-insurance.

Mr. Dean, to his credit, supported the captive movement as Vermont governor. That was not just good business for Vermont, which has benefited from the jobs created by the private sector infrastructure—captive managers, accountants, actuaries and others—but perhaps for the economy overall as companies reducing insurance costs through captive arrangements will have more money to spend on equipment and personnel.

Captive proponents must not let these misperceptions stand. They must articulate the financial benefits that these arrangements are generating.

Pension changes needed

THE LATEST REPORT on the financial condition of the Pension Benefit Guaranty Corp. makes a strong case for reforming pension funding laws.

As we report on page 3, the difference between the assets the PBGC holds and the value of benefits promised to participants in plans it has taken over—widened three-fold in the last year to a record $11.2 billion.

It is no mystery why the PBGC's financial condition has weakened so dramatically. It has been hit with a series of enormous losses—$3.9 billion alone from the takeover of failed Bethlehem Steel Corp.'s pension plan—as companies have gone out of business, leaving massively underfunded plans in the PBGC's lap.

As grim as the PBGC's results have been, the worst is probably yet to come. The PBGC faces a potential exposure of more than $85 billion in losses, according to its own estimates, from financially weak employers—those with below-investment-grade ratings.

There is no immediate crisis, as the PBGC has sufficient assets—for now—to pay promised benefits. But with the agency paying out about $3 billion annually, against annual premiums of about $1 billion from employers with defined benefit plans, eventually it will run out of money and no longer be able to honor its commitments to hundreds of thousands of retirees. Clearly, that would ignite a political firestorm—surely Congress would not let that happen. What to do?

One response might be a taxpayer bailout, but that would anger taxpayers and employers that have adequately funded their plans. Another way would be to raise employer premiums, but that would do far more harm, as it would discourage sponsors of well-funded plans from staying in the defined benefit plan system.

The best approach, we believe, would be for legislators to fairly but effectively tighten funding rules to ensure that companies contribute what is necessary to fund promised benefits. That is an essential first step in maintaining the health of the nation's pension system.

Schillerstrom

Letters to the Editor

Surplus lines industry wrongly blamed in scam

To the editor: Cary L. Cheldin's letter, appearing in the Dec. 22, 2003, edition of *Business Insurance,* is a cynical and bogus effort to malign the surplus lines business and impugn the integrity of the California Insurance Department. Mr. Cheldin asserts that a fraud scheme involving the issuance of around 200 fake Lloyd's policies to restaurant and bar owners somehow reflects an inherent problem with the surplus lines industry and is due to lax enforcement of California surplus lines regulatory laws.

Such assertions are simply not true. This incident is criminal in nature and is currently under investigation by state and federal law enforcement authorities. The false polices could have been issued in the name of any carrier—admitted or nonadmitted. The fact that Lloyd's or its underwriting syndicates are eligible surplus lines insurers in California is only incidental to the fraud and has nothing to do with the nature of the surplus lines market or the quality of its regulation.

Mr. Cheldin's letter is just another episode in his long-running anti-surplus lines crusade. This "holy war" has included a lawsuit against the Insurance Department that the courts found baseless as well as the use of various negative and erroneous statements about the California surplus lines market and its regulation such as the ones found in his letter. In fact, his zeal to sully the name of the surplus lines industry and its regulation is so intense and overwhelming that he cites a story that actually never appeared in *Business Insurance* (see editor's note below).

In his letter, Mr. Cheldin sees similarities between "unpaid riot claims of small-business owners" that surfaced in the aftermath of the 1992 Los Angeles riot and the current situation with the issuance of fake Lloyd's policies. While the two situations, I believe, are quite different, the one clear similarity between the two circumstances is the expropriation, by the perpetrators of the fraud, of legitimate franchise names in order to advance or cover the nefarious activity.

In 1992, the words "surplus lines" were invoked by the wrongdoers to give legitimacy to the nonexistent or fake companies that provided the policies to the business owners. In the current situation, the name of Lloyd's is being used to attract and defraud insureds. The policies issued in 1992 were no more surplus lines policies than the policies being issued in the current fraud are Lloyd's policies.

After the Los Angeles riots, Commissioner John Garamendi, supported by the surplus lines industry, secured passage of legislation aimed at establishing a roster of eligible alien surplus lines insurers. This became known as the list of eligible surplus lines insurers, or LESLI. With the creation of LESLI, policies issued

See LETTERS/page 17

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Retirees: Employers cut, reduce cover

Continued from page 4

care plan costs, with some employers reporting that retiree health care plan costs now exceed those for providing coverage to employees.

Such costs represent a burden a growing number of employers say they can no longer afford. Ten percent of respondents said they terminated coverage for future retirees—typically, those employees hired Jan. 1, 2003, or later—while 20% said they are very likely or somewhat likely within the next three years to terminate retiree coverage for employees hired this year or after.

PHOTO: GETTY

Moline, Ill.-based equipment maker Deere & Co. is one employer that has reduced its retiree health care offerings in recent years.

Nearly all employers with retiree health care plans, though, say they will maintain those plans for their current retirees. Just 2% of employers said they are very likely or somewhat likely to eliminate coverage for current retirees.

Still, there are exceptions. Alcatel, the French communications giant, is eliminating health care coverage for current retirees who were employed by its Dallas-based subsidiary (see story, page 1).

More representative of employers with retiree health care plans is Deere & Co., the Moline, Ill.-based agricultural, construction and grounds care equipment manufacturer.

Late in 1997, the company eliminated retiree health coverage for future hourly employees, and three years later it eliminated coverage for future salaried employees. However, it retained coverage for current retirees and for employees hired before the cutoff dates.

"It is a balancing act," said Mertroe Hornbuckle, Deere's vp-human resources, who spoke at the briefing.

Mr. Hornbuckle noted that Deere historically has provided a generous benefit package—including retiree health care—to its employees, whose well-being it considers vital to the company's success. However, as health care costs have increased and competition has intensified from other employers—many of which do not offer retiree health care—Deere has faced difficult decisions about its program, he said.

Retirees whose former employers offer post-employment health care coverage can expect to pay more for the coverage and receive less generous benefits, according to the survey.

In the last year, for example, 71% of respondents boosted retirees' premium contributions, while 53% increased cost-sharing requirements. Eighty-six percent of employers with the plans say they are very likely or somewhat likely to increase retirees' premium contributions within the next three years.

On average, plan participants who retired on or after Jan. 1, 2003, paid an average of 39% of the total premium for their coverage. The total monthly premium for new retirees under 65 opting for retiree and spousal coverage averaged $845 a month, while the monthly premium for retirees and spouses 65 and older averaged $419, a reflection of the role played by Medicare in providing coverage and picking up costs for older retirees.

And Medicare's role is going to get even bigger as a result of legislation passed by Congress last year that, starting in 2006, will offer coverage for a portion of retirees' prescription drug expenses.

Although respondents were not asked about how an expanded Medicare program would affect their retiree health care programs, Frank McArdle, a Hewitt consultant in Washington and an author of the study, said the expansion is likely to encourage employers to maintain retiree plans.

Under the law, employers that offer retirees prescription drug benefits that are equal to what Medicare provides will receive direct federal subsidies of more than $70 billion over 10 years, a powerful financial incentive to continue offering coverage.

Still, many employers haven't formulated their plans because so many details, such as how and when they would be paid by the government, have yet to be worked out, Mr. McArdle said.

Copies of "Retiree Health Benefits Now and in the Future: Findings from the Kaiser/Hewitt Survey on Retiree Health Benefits," are available at: www.kff.org/medicare/011404 package.cfm.

How TRIA is implemented key to its scope

Cover for chemical, biological, radiological and nuclear attack must be ensured

By Mark E. Miller

Perspective

The president and Congress believe that one of the more significant terrorist threats we face as a nation is the threat of chemical, biological, radiological or nuclear attack. So-called "CBRN terrorism" is being taken quite seriously by the Department of Homeland Security and others in the federal government, with billions of dollars being spent to counter the threat.

The insurance implications of a CBRN attack are substantial. The presence of a small amount of a biological agent such as anthrax, or the spread of radiation from a

radiological—or "dirty"—bomb could injure persons, destroy property and trigger business interruption losses. To protect against such threats, many policyholders paid additional premiums for terrorism insurance provided for under the Terrorism Risk Insurance Act of 2002. Unfortunately, it is unclear whether all of these policyholders obtained the full breadth and scope of coverage afforded under the new law, as many insurers appear to have taken the position that the TRIA coverage they offer does not cover CBRN exposures.

TRIA is quite clear as to what types of losses it covers and what type of terrorism insurance must be provided by insurers subject to mandatory participation in the program.

Coverage provided under TRIA flows from its definitions of "insured loss," and "act of terrorism." Under the law, an "insured loss" includes "any loss resulting from an act of terrorism that is covered by primary property and casualty insurance, including business interruption coverage." Coverage applies when the secretary of treasury, the secretary of state and the attorney general together certify that an act of terrorism carried out on behalf of a foreign interest has occurred. To be certified, such terrorism must, among other things, be "a violent act or act that is dangerous to (i) human life; (ii) property; or (iii) infrastructure." There are no limitations excluding CBRN risks from coverage, and it appears that a significant CBRN attack on U.S. soil would undoubtedly be certified as an act of terrorism by the federal government.

The obligation of property/casualty insurers to provide coverage under the new law is provided in the act's "mandatory participation" section, which states that an insurer participating in the program:

- "Shall make available in all of its property and casualty insurance policies…coverage for insured losses"; and
- "Shall make available property and casualty insurance coverage for insured losses that does not differ materially from the terms, amounts and other coverage limitations applicable to losses arising from events other than acts of terrorism."

Under the law, insurers must offer coverage for all "insured losses," which includes any certified act of terrorism, including those that relate to CBRN attacks.

The most common method of implementing TRIA is to offer policyholders an endorsement that deletes newly inserted terrorism exclusions from the policy. This endorsement states—as do most endorsements—that all other terms and conditions of the policy remain unchanged. A problem arises because most policies contain broadly worded boilerplate nuclear, biological, chemical and environmental exclusions that do not explicitly except TRIA-related losses. Under these policies, where the policyholder paid additional premium for TRIA coverage, an insurer could argue after the fact that coverage is not provided for CBRN terrorist activities, even though such activities are covered under the federal program and have been certified as covered by the government.

The correct way to implement

Continued on next page

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TRIA coverage is to endorse the policy to say that it is amended to cover all acts of terrorism certified by the government and covered under TRIA. That way, if the government certifies a terrorist act, coverage would be provided—period. Anything short of this creates unnecessary confusion and leaves coverage for CBRN attacks subject to unnecessary difficulty in adjustment. For this reason, many policyholders have sought to negotiate full TRIA coverage before accepting a faulty TRIA endorsement.

If an insurer is unwilling to provide full TRIA coverage, policyholders have three potential recourses. They can:

- Switch to another insurer;
- Leave things as they are and fight the battle later if a loss occurs; or
- Take an active role in correcting the problem now by raising inequities—either individually or collectively—with the Treasury Department, which is actively monitoring the implementation of the "make available" requirements of TRIA.

Undoubtedly, the approach taken by individual policyholders will vary, but inaction may prove not to be the best approach.

Mark E. Miller is a shareholder in the Washington office of the international law firm of Greenberg Traurig L.L.P.

All should use greater care handling underwriter info

By Akos Swierkiewicz

Perspective

One of the tenets of insurance law is that parties to an insurance policy are expected to deal with each other in utmost good faith. Applicants for insurance or their brokers must disclose all relevant underwriting information fully and accurately to prospective insurers. If the application contains any misrepresentation or omits information that could affect the underwriting decision of the insurer, the standard of utmost good faith is not met and the insurer may deny coverage for claims or rescind the policy.

Allegations of misrepresentation or omission usually surface during claim investigations by insurers. In many instances, the ensuing litigation may result in denial of the claim or recision of the policy. Even when misrepresentation or omission is not proven, litigation inevitably causes significant delays in claims adjustment and direct and indirect expenses to the parties.

Misrepresentations or omissions primarily originate from negligence by the applicant or broker during the course of obtaining underwriting information or completing the application.

One of the major functions of brokers is to obtain accurate and

complete underwriting information, which requires their active involvement in the process of gathering, preparing and communicating such information to the insurers, rather than just being the conduit to pass information from applicants to insurers. Brokers should also take the initiative and explain major provisions or conditions of the policy to policyholders to minimize negative surprises when a claim occurs.

State insurance laws generally allow the insurer to deny claims or rescind the policy due to misrepresentation or omission, including the concealment of a fact or an incorrect statement, if:

- It was material either to the acceptance of the risk or to the hazard assumed by the insurer.
- A reasonable insurer would have acted differently had it known the facts—it would have charged higher premium, restricted coverage or declined to issue the policy.

While most misrepresentations or omissions are unintentional, the insurer's right to deny claim payment or to rescind the policy is not limited to intentional or fraudulent misrepresentation under a number of state laws when either of the above two criteria applies.

The following are examples of alleged misrepresentations or omissions involving litigation:

- The broker asked the prospective policyholder to sign a blank application form, completed and released it to the insurer before the prospective buyer had chance to review it.

See PERSPECTIVE/next page

Commentary

Once upon a time, there was a CEO...

With the year just beginning, it remains to be seen what kind of story the insurance industry writes in 2004.

But insurers' generally strong 2003 prompted concerns last week that there are some ready to trade in the disaster saga the industry penned over the past couple of years for a fairy tale.

Moderating a chief executive officer roundtable last week at the Property/Casualty Insurance Joint Industry Forum in New York, Edward B. Rust Jr. noted the recent change in some insurance executives' tone.

"It's amazing what a year does," said Mr. Rust, chairman and CEO of Bloomington, Ill.-based State Farm Mutual Automobile Insurance Co. "We've gone from 'A Perfect Storm' to 'Goldilocks.'"

Rodd Zolkos

The culprits in the chiller from which the industry is emerging were numerous, of course. Undeniably, the attacks of Sept. 11, 2001, were a key element of the story. But, as is widely recognized, the Sept. 11 losses only exacerbated the situation.

Even before Sept. 11, a market hardening was inevitable, driven by years of underpricing of coverage and loosening of terms and conditions, the burst of the stock market bubble, falling interest rates and mounting asbestos claims. It wasn't too long before corporate governance scandals and a growing number of credit defaults applied additional pressure.

Now, though, comes the fairy tale Mr. Rust and others fear some are eager to write. That story is based on improved pricing and an increased focus on profitable business, relatively modest losses in 2003 and an improving stock market. Already signs of renewed competition are emerging in some areas of the market, and, with them, concerns over whether insurers will be able to maintain the underwriting discipline they've professed over the past two years.

One of the CEOs on the panel, Michael S. McGavick, chairman, president and CEO of Safeco Corp. in Seattle, told of how difficult it was to achieve that underwriting discipline "with people who hadn't experienced it before." The good news, he suggested, was that continued low interest rates might force companies to maintain that discipline and help "lock in behaviors."

And, while many companies have improved their bottom lines over the past two years by narrowing their focus to profitable business, Lord Peter Levene, chairman of Lloyd's of London, cast those moves in a less than congratulatory light. Trying to focus on writing business that will make money, he noted, "doesn't seem to me like a stroke of genius. But, if you look at what we've had in the past, perhaps it is."

The message, then, from some CEOs is that even as the insurance industry's tale seems to be growing more cheerful, there won't be many happy endings for companies that see the improved conditions as an opportunity to rush headlong into the past.

While many insurers have turned around their performance, they're not out of the woods yet, and those woods are still full of all sorts of potential balance-sheet evils. Still lurking are such nasties as asbestos litigation and a generally challenging tort climate, continued low interest rates, and terrorism risk and the scheduled 2005 sunset of the Terrorism Risk Insurance Act.

Then there's the much feared "next asbestos," whatever that might be. Plus, there's no guarantee that 2004 will be an uneventful year on the natural catastrophe front.

Beyond that, companies need to make investments in their businesses' infrastructure. The insurance industry still is widely seen as lagging other sectors of the financial service industry in embracing technology.

As the forum's dinner speaker, American International Group Inc. Chairman and CEO Maurice R. Greenberg ran through a litany of issues confronting the industry. Ultimately, though, he described himself as "a little optimistic" for 2004 and 2005. Still, he cautioned his audience, "Just don't get too enthusiastic, people."

And, given the challenges and potential threats still facing the industry, caution is probably well advised. Even in fairy tales, unsuspecting characters often have a way of running afoul of wolves or witches or ogres.

Much as Goldilocks found a bowl of porridge and a bed to her liking, there are elements of the current environment that are understandably appealing to insurers. But it's good to remember that Goldilocks ultimately suffered a bit of a rude awakening at the paws of the three bears. Similarly, insurers too eager to embrace a fairy tale might be setting themselves up for a bit of a shock.

Senior Editor Rodd Zolkos can be reached at rzolkos@crain.com.

Perspective: Underwriting data

Continued from previous page

- The prospective policyholder did not review an application prepared by the broker, which contained a misrepresentation or omission.
- The broker did not ask the prospective policyholder about past losses and provided the wrong answer in the application.
- The buyer and broker did not communicate clearly regarding the coverage and limits to be sought by the application.
- An application question was ambiguous to the buyer and the answer proved to be incorrect.
- The insurer did not seek clarification of an ambiguous response to an application question.

The need for greater care is not limited to policyholders and brokers. Insurers should ask all pertinent questions in the application form, because, in many instances, the prospective policyholder may be aware of important underwriting information but does not disclose it simply because it was not asked.

Application questions should be limited to seeking factual information rather than eliciting the opinion or judgment of the applicant. For example, when the prospective buyer answered "no" to a professional liability application question as to whether future claims were expected, based on the prospective buyer's opinion or judgment, the insurer concluded the response was a misrepresentation or omission just because a claim did occur.

In some instances, there may be an appearance of misrepresentation or omission due to the failure by the insurer to clarify responses. When presented with ambiguous or conflicting information, it behooves insurers to seek clarification prior to binding coverage or issuing the policy. For example, when a prospective policyholder found an application question inapplicable to his business, he amended it in a good-faith attempt to provide accurate and complete information, and the insurer issued the policy without seeking clarification. When a claim occurred, the insurer denied it, citing the answer to the modified question as evidence of misrepresentation.

In certain circumstances only litigation can resolve allegations of misrepresentation or omission. However, the exercise of greater care in obtaining and preparing underwriting information by applicants or brokers, and the clarification of ambiguous information by insurers can substantially reduce the number of cases requiring litigation and inevitable delays and costs.

Akos Swierkiewicz is president of Morrisville, Pa.-based IRCOS L.L.C., which provides insurance and reinsurance consulting and outsourcing services.

Guidelines on submitting a Perspective to *BI*

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

The section is intended to be a forum for reader opinions and discussion of technical topics that do not lend themselves to a news story. Therefore, Perspective articles should take a point of view, offer advice and/or explain a technical subject. They should not present case studies or promotional information.

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

To submit an article:

- Send us a letter describing the topic you would like to address. You might want to suggest alternative topics. For each topic, briefly describe what you want to say and accomplish in the article.
- You will receive from us an acceptance or declination of your article idea.
- If accepted, we will respond with comments and request the full article, which generally should be 700 to 750 words in length.
- All articles are to be accompanied by a photograph of the author and a brief biography.
- We will notify you of any questions we have about your article or any substantial editing we think is necessary.

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Employer moves occur amid debate over government's benefits burden

German firms cut future pensions

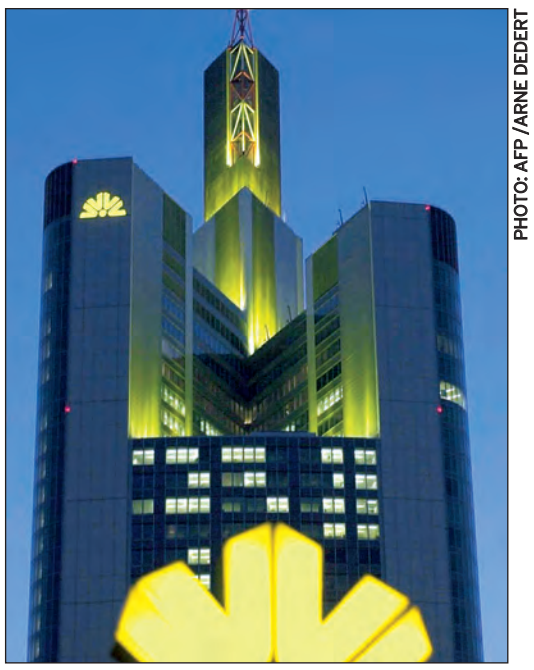

PHOTO: AFP /ARNE DEDERT

Frankfurt, Germany-based Commerzbank plans to close its pension plan to new participants, starting in 2005.

By SARAH VEYSEY

Several major German employers are reducing or eliminating their private pension plans, at a time when the country's government is also considering changes to state-provided retirement benefits.

Many companies in Germany offer pension plans—particularly for highly compensated employees—to supplement the government-provided pension, which provides retirees with up to 70% of their final salary, depending on how long they have worked.

But in recent months, some large German employers have said they will shut down their pension plans—which generally are defined benefit style plans—because of tough economic conditions.

For example, Frankfurt-based Commerzbank A.G., one of Germany's largest banks, said that, beginning in 2005, it will close its pension plans for German workers, as part of a cost-cutting drive.

Current employees will receive benefits accrued up to Jan. 1, 2005, but will not accrue benefits after that date, a spokeswoman for Frankfurt-based Commerzbank explained. The change will affect about 26,000 employees in Germany.

The affected plans include those into which both employers and employees contribute, as well as employer-contribution-only plans, the spokeswoman said.

In a letter to employees, the bank's board said the decision "has not been an easy one for the management board to take, since it represents a painful cut into the pension provisions of our employees." The board added that the move was made because of "difficult economic conditions."

Gerling Group is also cutting back pension benefits. Effective Jan. 1, 2004, the company began reducing the future pension benefits of some Gerling employees, a spokesman for the Cologne-based insurer said. He noted that benefits already accrued will not be affected.

The move was made because future pension obligations appeared onerous financially, the spokesman explained. And problems with Gerling's reinsurance arm, which recorded large losses in recent years (*BI*, Feb. 25, 2002; July 28, 2003), have added to the financial burden on the company and played a part in the decision to re-

See GERMANY/next page

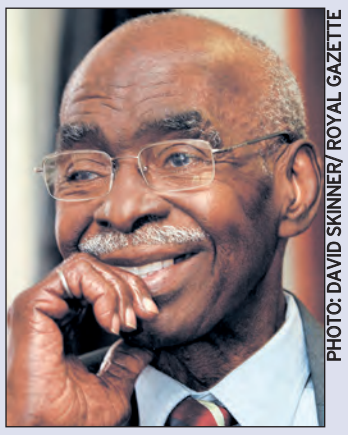

PHOTO: DAVID SKINNER/ ROYAL GAZETTE

Eugene Cox, Bermuda regulator, dies at age 75

HAMILTON, Bermuda—Eugene Cox, Bermuda's finance minister, has died.

Mr. Cox, 75, died Jan. 9 at a clinic near Boston, where he was being treated for stomach cancer.

He remained in office until his death, carrying on his duties in a position he held at the end of a long career in politics. Since becoming politically active in the 1960s, Mr. Cox was elected to the island's House Assembly and Senate, served on numerous committees and held the position of deputy leader of the Progressive Labour Party until a split in the party led to the resignation of former Premier Jennifer Smith last year.

Mr. Cox is recognized in Bermuda for his work in race relations as well as his efforts to keep the island's economy vibrant.

—By Michael Bradford

Canadian drug controversy generating new side effects

By GLORIA GONZALEZ

OTTAWA—A move by Canada's largest medical liability insurer to limit its exposure to claims involving the reimportation of prescription drugs to the United States has cast further doubt on the future of the practice.

The Canadian Medical Protective Assn. will soon announce that Canadian doctors who co-sign prescriptions for U.S. patients will not be covered under its liability insurance policies if the doctor is sued for malpractice over the prescription. About 95% of all doctors licensed to practice in Canada are insured by the CMPA.

While some industry experts believe this action will deter Canadian physicians from co-signing prescriptions and slow down illegal drug reimportation to the United States, others say that determined doctors will try to find ways to continue the potentially lucrative practice.

Meanwhile, one drug maker announced last week that it may cease supplying prescription drugs to Canadian retailers and wholesalers if it finds evidence that its products are being exported to the United States.

The Ottawa-based CMPA, which provides Canadian doctors with liability insurance and legal defense against malpractice suits, has changed its policy because Canadian regulatory agencies now ban the practice of co-signing prescriptions without performing a direct physical examination of the patient, according to Dr. John Gray, president of the CMPA.

Previously, CMPA guidelines left open the possibility of coverage for doctors who were sued in relation to a co-signed prescription, but the organization for many years has had concerns about whether such lawsuits can be defended, he said.

PHOTO: KRT

Concern about the growing reimportation of prescription drugs from Canada by U.S. buyers is resulting in a backlash from a Canadian medical malpractice insurer and pharmaceutical companies.

"The exposure for us has been increasing," Dr. Gray said. "We're just trying to ensure that our physicians are not going to be involved in liability issues that are unnecessary."

The policy change could have a significant impact on drug reimportation because of the proportion of Canadian doctors insured by the CMPA.

"If 95% of the Canadian physicians have no E&O coverage for issuing those prescriptions, I think that's going to have a dampening effect," said Claude Dorais, an attorney with Goleta, Calif.-based Dorais, McFarland, Grattan & Polinsky, which specializes in insurance law. "The fact that the liability is on physicians very significantly increases the potential that it's going to have a significant impact on cross-border prescriptions."

Under Canadian law, any prescription signed by a foreign doctor must be co-signed by a Canadian physician before a Canadian pharmacy can fill the prescription.

"Clearly, it puts some pressure on the Canadian doctors that are writing these prescriptions, because it increases their liability," said Sean Brandle, a vp at benefit consulting firm The Segal Co. in New York. "Each doctor will have to weigh the consequences vs. how much revenue they are getting."

Tom McGinnis, director of pharmacy affairs with the office of the

See CANADA/page 15

World Updates

Willis to purchase Danish intermediary

London-based insurance brokerage Willis Group Holdings Ltd. has agreed to acquire Copenhagen, Denmark-based reinsurance intermediary Kirecon A/S. Terms were not disclosed. Kirecon has annual revenues of about $3 million, sources said. Willis' reinsurance brokerage operation, Willis Re, ranks as the world's third-largest reinsurance intermediary, with revenues of $462 million in 2002.

Generali acquires ZFS business in France

Zurich Financial Services Group has completed the sale of some life and nonlife insurance operations in France to Assicurazioni Generali S.p.A. Trieste, Italy-based Generali has purchased ZFS' life operations as well as parts of the Zurich, Switzerland-based insurance giant's personal and commercial lines nonlife business in France. Terms of the deal were not disclosed.

Fortis to spin off U.S. unit in IPO

Dutch insurance group Fortis said it plans to raise between $1.6 billion and $1.76 billion through an initial public offering for its U.S. operations. According to a filing with the U.S. Securities and Exchange Commission, Fortis will sell about 55% of the subsidiary's shares for between $20 and $22 a share. The U.S. unit, Fortis Inc., will be renamed Assurant Inc. Fortis said that the IPO is in line with its plan to focus on its activities in Europe and Asia.

Brit buys Creechurch property business

Brit insurance Ltd. has completed its purchase of the property business of Creechurch Holdings Ltd. Brit expects the portfolio to generate about £20 million ($37 million) in gross premiums in 2004. In addition, a team of eight underwriters has joined Brit from Creechurch. Terms were not disclosed.

Briefly noted

London-based reinsurance brokerage Benfield Group Ltd. has acquired **Airs Re Pty. Ltd.**, a Sydney, Australia-based reinsurance intermediary. Terms were not disclosed....Lloyd's of London has named **Steven Burns**, chief executive officer of Limit Group, to the market's Franchise Board. Mr. Burns replaces **Andrew Kendrick**, a non-executive member of the Lloyd's board who joined ACE Global Markets, a unit of Bermuda-based ACE Ltd.

Germany: Employers reducing, eliminating pensions

Continued from previous page

think pension benefits, he noted.

The decision to reduce pension benefits was made in conjunction with Gerling's workers' council, the spokesman said.

Until the end of 2003, Gerling offered three pension plans. One applied to all employees who joined the company before 1986, one applied to those who joined between 1986 and 1998, and one applied to employees who joined after 1998.

"The future pension benefits are now all the same for everybody, on the basis of that 1998 pension," he said.

Of the roughly 7,500 employees who participate in Gerling's pension plans, 2,500 were already in the 1998 pension plan and will not see any change in the benefits they can expect to receive, while the rest generally will see reductions of up to 30% in their future benefits, the spokesman said.

In addition, Berlin-based pharmaceutical firm Schering A.G., this month announced that it plans to cut pension benefits. Schering said it would consult with employees on the changes, which will affect about 8,000 workers in Germany.

Schering currently bases pension benefits on how much an employee earns in his or her final five years of employment, up until age 60. Under the proposed change, benefits would be based on how much an employee earns over his or her entire career, Schering said in a statement.

But while some companies are rethinking their occupational pension plans, many others continue to operate defined benefit-style plans to augment employees' state-funded benefits.

'Historically, Germany has had a very generous social security system providing pensions.'

Simon Dudley
Watson Wyatt Worldwide

"Historically, Germany has had a very generous social security system providing pensions," according to Simon Dudley, practice director at Watson Wyatt Worldwide in Reigate, England. As a result, "most people up to middle-management level would get a pretty adequate retirement benefit linked to their salary when they retired after a full career."

Employers' reductions in pension benefits come at a time when the German government is seeking to reform the state-based retirement system, and any changes made will likely reduce state-provided retirement income, consultants say.

To address the problem of an aging population, the German government has sought to encourage both employer-backed and personal saving for pensions. In addition, it is seeking to raise the retirement age by two years to 67.

Among reforms introduced is the so-called Riester plan, which is a hybrid pension plan implemented in 2002. Under Riester plans, named for the government minister who developed the concept, the government contributes to Germans who voluntarily invest in individual retirement savings programs. The individual also would still be eligible for a state pension benefit, but at a lower level. For the 2002-03 period, the government will contribute 38 euros ($48.80) per month to these personal pensions.

Another change in recent years is that tax changes have been made to enable companies to set up defined contribution-type plans, Mr. Dudley said.

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2520 By-Pass Road
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ANNOUNCEMENT

A NEW WORKERS' COMPENSATION INSURER FOR BUSINESSES SITUATED IN NEW YORK STATE

On December 9th, 2003 First Pavilion Insurance Company published its intention to form a stock insurance corporation under the provisions of the Insurance Law of the State of New York. The Company plans to write excess insurance policies with a primary concentration in the worker compensation market. Its business plan is directed at qualified self insured companies, group trusts and the development of captive insurers with excess coverage and fronting needs.

First Pavilion anticipates filing for flexible retro, retention and uniquely collateralized large deductible plans in NY and anticipates finalization of its licensing and capitalization requirements in early Spring 2004. Preunderwriting, applications and Program Administrator inquiries will be accepted beginning December 22, 2003.

First Pavilion's principal offices are located in New York City and Glen Rock, New Jersey.

Contact: Michael A. Paone
266 Harristown Road, Suite 200
Glen Rock, NJ 07452
mpaone@firstpavilion.com

LEGAL NOTICE

No 4690 of 2002
No 4689 of 2002
No 4693 of 2002
No 4694 of 2002
IN THE HIGH COURT OF JUSTICE
CHANCERY DIVISION
COMPANIES COURT
IN THE MATTER OF

TOWER INSURANCE LIMITED
CONTINENTAL MANAGEMENT SERVICES LIMITED
CORNHILL INSURANCE PUBLIC LIMITED COMPANY
DOWA INSURANCE (EUROPE) LIMITED

AND IN THE MATTER OF THE COMPANIES ACT 1985, SECTION 425

NOTICE OF FINAL IMPLEMENTATION

NOTICE IS HEREBY GIVEN in the matter of Tower Insurance Limited, Continental Management Services Limited, Cornhill Insurance Public Limited Company and Dowa Insurance Company (Europe) Limited (the "Pool Companies") that, following the implementation of the schemes of arrangement (together the "Scheme") on 2 January 2003 and the subsequent payment of all Established Pool Liabilities (as defined in the Scheme), the Scheme has been finally implemented.

All Pool Creditors' cheques and payments by telegraphic transfers have been dispatched.

The Scheme has been implemented in accordance with its terms and, accordingly, it has been terminated and no further payments shall be made to Pool Creditors by the Pool Companies in respect of Established Pool Liabilities. Should you have any questions regarding this Notice, please address them to Nick Gallon at:

Global Resource Managers Limited, 77 Gracechurch Street, London EC3V 0DL, United Kingdom
Telephone: +44 (0) 20 7548 1151
Facsimile: +44 (0) 20 7220 7468

Labor: Employers may face flood of new lawsuits

Continued from page 1

25% of these penalties, with 50% going to the state's general fund and 25% to the state Labor and Workforce Development Agency.

The legislation states that the change is in the public interest because staffing levels for state labor law enforcement agencies have generally declined over the last decade.

Barry Broad, a Sacramento-based attorney and lobbyist who represents several unions, said labor law often involves good statutes but poor methods of enforcement. "Every law should have an equitable remedy," and all this law does is create one, he said. It "doesn't make anything illegal that wasn't illegal before, and people who are not criminals or don't break the law have nothing to fear."

However, critics of the law say that it does not require employees to prove they have suffered any harm because of the alleged violation. In addition, they note that the state's voluminous labor code is full of obscure, outdated and often-ignored provisions that aggressive plaintiff attorneys will find and use in litigation.

Many observers expect the law to give rise to lawsuits against employers.

"It just opens up too many doors for litigation, and it's a windfall for attorneys," said Jeffrey W. Pettegrew, vp-risk management and insurance for Westaff Inc., a temporary staffing firm in Walnut Creek.

Indeed, the law "could unleash a litigation monster…the likes of which, who knows?" said Mark Pulliam, an attorney with Latham & Watkins in San Diego.

"The impact is going to be devastating," said William H. Truesdell, president of The Management Advantage Inc., a Walnut Creek consulting firm.

Mike Belote, a business lobbyist with Sacramento-based California Advocates, said he has already heard anecdotal reports of people who were "poised to file actions immediately with the new year."

Employer attorney Lindbergh Porter Jr. said that, previously, prescreening by the labor commissioner's office could result in dismissal of meritless claims before a formal complaint was even filed, while those that did reach the complaint stage could lead to an expedited, efficient resolution without attorneys' involvement.

"These features or safeguards can be bypassed now," said Mr. Porter, an attorney with Allen, Matkins, Leck, Gamble & Mallory in San Francisco.

"It's just a free ticket to go straight to court," said Julianne Broyles, a lobbyist for the Sacramento-based California Chamber of Commerce. "You're going to be spending a lot of time and money in court over what are likely to be very nonsensical claims."

However, Sam McAdam, an attorney with Seyfarth Shaw in Sacramento, said he believes it will be more common for charges of labor code violations to be tagged onto existing lawsuits. "I don't suspect that we'll see these claims for statutory penalties standing alone," he said.

Critics charge that the law encourages plaintiff attorneys to scour the labor code in search of little-known, unenforced provisions they can use as grounds for lawsuits. They point as an example to Section 431, first introduced in 1937, which says employers that require applicants to sign job applications—which is universal—must file a copy of the application with the Division of Labor Standards Enforcement. Few, if any, employers do so, say observers.

The provision has never been enforced, said Mr. Pulliam. "You can almost turn to any page and find something like this," he said. "There's a lot of this stuff because nobody's enforced it, nobody's really questioned it, nobody's really thought of it. It may be horribly ambiguous as well as antiquated, but now these things could be the subject of lawsuits."

"It's a legislative hunting license," said Brian Ashe, an employer attorney with Seyfarth Shaw in San Francisco. It allows employees to get finders fees "for the most miniscule technical, legal 'gotcha' that they can find."

However, Mr. Broad said "despite that Chicken Little stuff" the "vast majority" of suits filed under the new law will focus on actual abuses, such as employers' failure to pay overtime or the minimum wage.

Employers should conduct audits to minimize their potential liability under the new labor code law, say observers.

"They have to get there and be proactive and do their own internal audit to find out if they have any compliance issues," said Jennifer Brown Shaw, an attorney with Jackson Lewis in Sacramento.

Companies should review their personnel polices and any handbooks that are distributed to employees "to make sure there's no statement in the handbook that contravenes some law or regulation, because that could be the basis of an action," Mr. Porter said.

For instance, the labor code's Section 232 says employers cannot require employees to refrain from disclosing their wages. But some employers have policies that discourage or prohibit employees from discussing their pay because salaries or wages are privately negotiated, said Mr. Porter.

Canada: Drug reimportation

Continued from page 13

commissioner of the U.S. Food and Drug Administration in Washington, said he believes the CMPA's action will effectively stop the practice of co-signing, because Canadian doctors will not risk being sued over a prescription without liability insurance.

For their part, Canadian regulatory officials say they hope that adoption of uniform standards, as well as the CMPA's policy change, will help end prescription co-signing, but they warn that there are ways to circumvent the new policy. Physicians who want to continue co-signing prescriptions can try to obtain liability coverage from sources other than the CMPA. For example, if Canadian doctors have liability insurance in the United States, they can argue that they are covered under that policy.

"It might not be a deterrent," Dr. Gray said of the policy change.

Some doctors may even choose to ignore the risks associated with the lack of liability coverage if they deem the co-signing of prescriptions profitable enough to warrant taking such a risk.

"I think its impact on the trade is debatable," said Jeff Poston, executive director of the Ottawa-based Canadian Pharmacists Assn. "It will stop the physicians who are primarily engaged in other medical practices. For those who earn the bulk of their income by signing, it puts them in a little more difficult position."

Drug reimportation has become a popular practice in the United States because prescription drugs generally cost between 30% and 80% less in Canada due to government-imposed price controls. Canadian trade associations estimate that the total value of prescription medicines being diverted from Canada to the United States was U.S. $800,000,000 in 2003 and will exceed U.S. $1 billion in 2004.

"The financial incentives for pharmacies to become engaged in it are enormous," Mr. Poston said.

Under the U.S. Food, Drug and Cosmetic Act, it is illegal for anyone other than the original manufacturer to reimport prescription drugs into the United States. But several U.S. state and local governments have been pushing to change the law, and Congress recently passed a measure allowing the Secretary of Health and Human Services to issue waivers for individuals for drug reimportation, but only if safety standards are met.

A spokeswoman for Illinois Gov. Rod Blagojevich said CMPA's decision would not deter the state in its efforts to persuade the federal government to launch a pilot program (*BI*, Jan. 5). "If we had a legal system, it would remove any concerns or doubts that the insurers might have," she said.

While public entity employers, such as the city of Springfield, Mass., have been purchasing drugs in Canada (*BI*, Sept. 1, 2003), industry analysts note that private employers generally do not reimport prescription drugs due to the legal barriers and their ability to negotiate discounts with drug companies. Uninsured U.S. citizens are seen as the most likely to be affected by the CMPA decision, because of the possibility that Canadian doctors will stop co-signing their prescriptions, observers said.

Drug makers also have begun taking steps to curb reimportation.

In a letter dated Jan. 12, Quebec-based Pfizer Canada Inc. told pharmacists that its distributors would be required to report each pharmacy's current and historical order patterns. If Pfizer finds any evidence that a pharmacy has breached its terms of sale by exporting Pfizer products out of Canada, the company reserves the right to suspend sales to the pharmacy or instruct its distributor to cease sales, the letter states.

The letter notes that Pfizer distributors can only deal with pharmacies approved to buy Pfizer products. Approved pharmacies are not allowed to export drugs outside of Canada or sell products to any person or organization that they know will export the drugs.

"We're concerned about the potential for drug shortages in Canada" stemming from such actions such as Pfizer's, said Mr. Poston.

Comings & Goings

Insurers

Allied World Assurance Co. Ltd. has named **Scott Carmilani** as president and chief executive officer. He succeeds Michael I.D. Morrison, who will serve as director and vice chairman. Before joining Hamilton, Bermuda-based AWAC, Mr. Carmilani was president of the mergers and acquisitions insurance division of American International Group Inc.

London-based Royal & SunAlliance Insurance Group P.L.C. has appointed **George Culmer** as its chief financial officer. Mr. Culmer previously was head of capital management for Zurich Financial Services Group.

Michael Schozer has been named president of ACE Guaranty Corp. in New York. Previously, he was a managing director at Ambac Financial Group Inc.

North Carolina Mutual Life Insurance Co. of Raleigh has named **James H. Speed Jr.** as president and CEO. He previously was senior vp and chief financial officer for Hardee's Food Systems Inc.

Mr. Speed

Reinsurance:

Hamilton, Bermuda-based XL Capital Ltd. has named **Rich Banas** as global practice leader for XL's professional liability operations; in addition, he has been given executive management responsibility for professional liability operations in the United States. Previously, Mr. Banas was CEO of XL Environmental Inc. and XL Programs.

William Jewett, chief operating officer of Endurance Reinsurance Corp. of America, has been promoted to president of the Tarrytown, N.Y.-based reinsurer. Former President Steven Carlsen will lead a new unit, Endurance Services Ltd.

Willis Re, the reinsurance brokerage arm of Willis Group Holdings Ltd., has named **Bob King** as senior vp in New York. He previously was senior vp at Maiden Lane Intermediaries.

Other suppliers

Risk Enterprise Management Ltd., a Cranbury, N.J.-based provider of property/casualty third-party administration services, has named **Mike Riney** as president and CEO. Before his promotion, Mr. Riney was president of REM's TPA operations.

Robert A. Nero has been appointed president and CEO of Okemos, Mich.-based Innovative IT Solutions Inc., a provider of producer management technology and services to the insurance industry. Before joining Innovative IT, Mr. Nero was CEO of Interface Systems.

Coalition America Inc. has named **Tina Ellex** as chief operating officer. Previously, Ms. Ellex was director of operations for the Atlanta-based health care claims management company.

Karla Witherby has been named controller of Upland, Calif.-based Cost Containment Solutions, a medical management programs provider. Before joining CCS, Ms. Witherby handled accounting functions at an Upland-based certified public accountant.

Risk Management Services Corp. has named **C. Jeffrey Rausch** as COO. He previously was vp of the Louisville, Ky.-based TPA.

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers. Please send news of recently promoted, hired or appointed senior-level executives to: Joe Walker, Business Insurance, 60 N. Michigan Ave., Chicago, Ill. 60601-3806; jwalker@crain.com.

PBGC: Reports record deficit

Continued from page 3

PBGC was hit with a string of massive losses as underfunded plans were terminated. In 2002, for example, it recorded its biggest loss—$3.9 billion—when it took over the pension plan of failed Bethlehem Steel Corp.

And last year, it terminated and took over pension plans sponsored by Weirton Steel Corp., a bankrupt steel producer; and US Airways Inc., the financially ailing airline. Those terminations cost the agency about $1.4 billion.

Despite the massive losses, the PBGC is in no imminent danger of running out of money to pay benefits owed to plan participants. Currently, the PBGC has more than $34 billion in assets.

But the future of the agency, which is funded through premiums paid by employers with defined benefit plans, currently appears bleak. The PBGC collects about $1 billion annually in premiums, but now is paying out about $3 billion a year in benefits.

However, help could be on its way.

PBGC Executive Director Steve Kandarian said the administration soon will present a comprehensive reform package, which is expected to include provisions to tighten pension funding rules. Such a change would reduce the likelihood of plans being so drastically underfunded if their employer sponsor gets in financial trouble, which could trigger a PBGC takeover.

On Capitol Hill, Rep. John Boehner, R-Ohio, chairman of the House Education and the Workforce Committee, said lawmakers' goal is to put the PBGC on a sound financial footing.

Chris Bone, chief actuary for Aon Consulting in Somerset, N.J., said that while funding rules may need some tightening, the rules should not be so stiff as to discourage employers from offering defined benefit plans. If employers turned away from the plans, that would drain the PBGC's premium base and exacerbate the agency's financial problems, he noted.

JPA: School loss transfer at risk

Continued from page 1

$900,000 in long-tail workers compensation liabilities in a loss portfolio transfer deal with Glendale, Calif.-based Fremont Indemnity Co.

A loss portfolio transfer enables a self-insured entity to sell a portfolio of incurred claims to a third-party, such as an insurer, which typically invests the sale proceeds to pay the claims and make a profit.

But in June 2003, the Department of Insurance obtained a conservation order for insolvent Fremont Indemnity. About $600,000 of the $900,000 in long-tail liabilities the JPA included in the loss portfolio remained unpaid by Fremont, Mr. Godwin said.

As none of the premium was returned, the JPA lost nearly $1 million as a result of Fremont's insolvency, which is equivalent to about one-third of its existing assets, he said.

Ultimately, the school districts participating in those JPAs can be assessed to cover any liabilities that the joint powers authorities cannot meet, Mr. Godwin said.

"So, for some of us, this is our worst nightmare come true," said Mr. Godwin, who said he opposed the loss portfolio transfer but was overruled by the JPA's board of directors.

Mr. Godwin said he opposed the arrangement because of the price tag and because he believed that the JPA was adequately funded for its long-tail workers comp liabilities. Additionally, a regulator from California's Self Insurance Plans at the time questioned the legitimacy of such arrangements, Mr. Godwin added.

Torrance, Calif.-based Keenan & Associates arranged the deal and others like it for other school districts. The broker also manages a number of California school district JPAs, including the one in which Riverside Community College District participates.

Five community colleges, 54 school districts and three offices of education involved in seven separate loss portfolio transfers have been affected by Fremont Indemnity's insolvency, said David J. De Wenter, executive vp and chief operating officer at Keenan & Associates. The LPTs were arranged during 1997 and 1998.

Keenan & Associates is making every effort to help those clients, Mr. De Wenter said. For example, the brokerage hired the Los Angeles firm of Roxborough Pomerance & Nye to help convince the California Insurance Guarantee Assn. to cover the liabilities that Fremont Indemnity purchased. CIGA is the state insurance guaranty fund.

Attorney Nicholas Roxborough said the Department of Insurance regulated Fremont, and the insurer went into liquidation, so CIGA should be responsible for paying off the insurer's liabilities.

CIGA, however, is rejecting the claim. In 1998, the state's labor code was silent on whether public entities can participate in loss portfolio transfers, Mr. De Wenter said. But he said the labor code was amended in 2000.

CIGA is rejecting the claim because the transfers were not recognized insurance policies at the time they were arranged, according to a Department of Insurance spokesman.

CIGA officials could not be reached for clarification.

"If we can't go after CIGA, we will figure out who else we can go after, but we are certainly not going to sit here idle and let the school districts get hammered," Mr. Roxborough said. "That is just not going to happen without a large fight."

Through agreements worked out by Keenan & Associates, school districts paid about $16 million to transfer their workers comp claims liabilities through loss portfolio transfers that are now in dispute, he said.

Not all of the LPTs were directly placed with Fremont, Mr. De Wenter said. Fremont acquired some of the liabilities in a deal worked out with another insurer, a unit of WellPoint Health Networks.

Several school district risk managers are sharing information and consulting attorneys about the possibility of forcing Keenan & Associates to fund the liabilities, Mr. Godwin and others said.

Terry Norwood, president of the Sacramento-based California Assn. of Joint Powers Authorities, said that in the late 1990s he turned down a pitch by Keenan & Associates to participate in an LPT arrangement.

"I was just a little uncomfortable with it," and his JPA's loss reserves adequately covered its liabilities, Mr. Norwood said. He is also chief administrative officer for Southern California Schools Risk Management, a Colton, Calif.-based JPA.

In 2001, however, Mr. Norwood entered into a loss portfolio transfer agreement with Discover Re, a Farmington, Conn.-based unit of The St. Paul Cos. Inc. By then, regulators had ruled that the transfers were acceptable insurance arrangements, he said.

The agreements became an established practice among joint powers authorities, Mr. Norwood added. But JPAs that entered into them earlier might have done so too soon.

"Those that were conservative and watched the concept of loss portfolio transfers develop and made their placement after the insurance department ruling are sitting well," Mr. Norwood said. "Those early innovators found out that maybe that wasn't a good idea because it hadn't all been put to rest or determined by the Department of Insurance, and now they are suffering the consequences."

LPTs arranged in the 1990s followed an open rating law. "Astronomically low rates" that did not cover projected future claims costs became available, he recalled. And school districts that had previously self-insured then purchased insurance.

Likewise, for outstanding long-tail liabilities, schools found that LPTs in some cases beat their reserve cost estimates, Mr. Norwood said.

"If I beat my reserve rate, I can come out with cash in hand," he said. But the low rates offered by insurers at the time have also been blamed for several insolvencies in California's workers comp market.

Hiring: Deaths spur look at practices

Continued from page 3

information, experts say.

"We've always had the threat of the problems in giving too much information when people call for references," said Peggy Nakamura, assistant vp, chief risk officer and associate counsel for Adventist Health System/West in Roseville, Calif. "It's difficult to blame employers when they've had that threat of litigation on the other side if they've provided too much information."

But Ms. Nakamura is quick to point out that patient safety must remain the primary consideration of health care employers.

"We have to keep that mindset because we're not just talking about someone messing up at a manufacturing plant, we're talking about patients being injured by this criminal misconduct," she said. "When patients are under our care, we have an absolute obligation to protect them, and that's a little different than other industries."

In terms of minimizing the chance of hiring employees who would harm patients, as Mr. Cullen allegedly has, Ms. Nakamura said, "In my opinion, it comes down to background checks and, I think, doing a little better job in reference checking and doing some investigation into employment history. Not that that will always identify problem individuals, but at least it's a start, particularly when you're talking about individuals who are going to have access to medications or potentially damaging or lethal procedures or treatments for our patient population."

Experts point out that until hospitals are given some immunity for sharing more detailed information about nonphysician employees to prospective employers, changes in practices are unlikely.

In contrast, experts point to the rigorous credentialing and peer review process that hospitals undertake when hiring physicians.

"As part of the (physician) credentialing process, you sign a legal release that authorizes anybody and everybody to release any and all information about you in your prior positions and whether or not you've had any problems and difficulties and you give them immunity that you won't assert any claims or challenges to the people who provide that information," said Mark Kadzielski, a health care attorney at Fulbright & Jaworski in Los Angeles.

"We don't really credential our nurses, particularly in nursing homes, as well as we do credentialing for physicians and other people who get clinical privileges in hospitals," Mr. Kadzielski said.

"I've seen cases where hospitals respond honestly and forthrightly about a physician's abilities and let another hospital know that the physician lost his or her privileges for one reason or another," said John C. West, a senior consultant in the health care management division of AIG Consultants Inc. in Atlanta. "That's been held to be qualifiedly immune under the Health Care Quality Improvement Act because it's a message to the performance improvement and peer review process of the other hospital."

While Mr. West noted there are varying interpretations of the law, "I'm not aware of any privilege that attaches to ordinary correspondence about a nurse's performance," he said.

"Absent any state protections, I think hospitals are going to probably continue to give name, rank and serial number—just give the minimum information necessary," he said.

'We've always had the threat of the problems in giving too much information when people call for references. It's difficult to blame employers when they've had that threat of litigation on the other side if they've provided too much information.'

Peggy Nakamura
Adventist Health Systems/West

Earlier this month, Sens. Jon S. Corzine, D-N.J., and Frank R. Lautenberg, D-N.J., called on the Senate Health, Education, Labor and Pensions Committee to hold hearings into the current system of screening health care professionals.

In a letter to Sens. Judd Gregg, R-N.H., and Edward Kennedy, D-Mass., the chairman and ranking minority member of the HELP Committee, the New Jersey senators noted that Mr. Cullen had been fired by five hospitals and one nursing home for suspected wrongdoing, but reference checks failed to stop him from gaining employment at successive hospitals.

"We must act in the interest of promoting patient safety," Sen. Lautenberg said in a statement. "And we must give hospitals and health care facilities the ability to share vital information without fear of being punished. The health and safety of patients should and must be our top goal."

Meanwhile, lawsuits are starting to mount in Mr. Cullen's case.

In one of the latest examples, Easton, Pa.-based Two Rivers Hospital Corp., the former owner of Easton Hospital, filed notice Jan. 9 that it plans to sue Healthforce, a Harrisburg, Pa.-based temporary staffing agency that supplied Easton Hospital with Mr. Cullen.

Donald R. Auten, a partner in the Philadelphia law firm of Duane Morris L.L.P., who represents Two Rivers, declined to comment about its lawsuit. He did confirm, however, that Easton Hospital has been named in a malpractice lawsuit filed by the family of a 78-year-old patient who died in 1998. Mr. Cullen is a suspect in the death.

Letters to the Editor

Continued from page 8

by nonadmitted alien insurers could no longer be represented as surplus lines policies unless the company's eligibility had been approved and the company was found on the list.

The existence of LESLI has clarified the distinction, in California, between eligible and legitimate surplus lines companies and other unlicensed entities that might be presented to the insurance buying public as surplus lines insurers. Unfortunately, even with the existence of LESLI, the miscreants simply use—or misuse—the name of a listed company such as Lloyd's and create phony policies in the company's name in order to accomplish their criminal fraud.

As president of a California admitted company, Mr. Cheldin may not like the surplus lines market. But he should avoid misconstruing facts and circumstances simply to create an opportunity to disparage the market or attack the California Insurance Department because it doesn't do his bidding.

Richard Bouhan
Executive Director
National Assn. of Professional
Surplus Lines Offices Ltd.
Kansas City, Mo.

Editor's note: Mr. Cheldin's letter references "Bogus Insurance Policies Under Investigation," an article published Nov. 8, 2003, by the Los Angeles Times, not by Business Insurance.

Consider presenter's aim when criticizing captive info

To the editor: Charlie McAlear's letter in your Dec. 22/29, 2003, edition criticized Karen Cutts' Risk Retention Group Directory & Guide for publishing unhelpful financial information about risk retention groups. RRGs are a subset of captive insurance companies. I find this letter surprising for two reasons and also find that it suggests an opportunity.

In my time as an analyst of captive insurance companies, a journalist reporting on captives and a member of the extensive service businesses that make money from the owners of captives, I often tried to find out detailed information about captives and railed against the lack of it when I couldn't. I, too, called "meaningless" (Mr. McAlear's term) the basic data on captives promulgated by domiciles and even by well-meaning selective analysts.

All of us who made an effort to publish information about specific captives received these same kinds of criticisms in the past. I certainly did when I tried publishing "selected" financials on 15 to 20 Bermuda captives back in the 1980s. Arthur Andersen did when it published Vermont captive statistics in the 1990s.

My critics mainly criticized the paucity of the information, wanting lots more detail, which I didn't have and wouldn't have been able to get from the companies. Sometimes they criticized my presenting too much information when there were some things that could be construed as unfavorable.

These criticisms came to me one by one and privately. I am sure any other information collector and collator such as A.M. Best Co. or Standard & Poor's Corp. receives the same kind of criticism, and frequently. The two surprises to me, then, were, first, that Mr. McAlear chose to address this rather ordinary and oft-repeated criticism of "not enough information" to a different publication—yours—instead of directing it to the Risk Retention Group Directory & Guide. The second is that you published it in the context of the debate about RRGs that seems to be coming out of the Nation Assn. of Insurance Commissioners; there is an article about that matter elsewhere in the same issue. He must have been seeking to make a more general point; I can only hope you are, too, and not taking sides in the RRG debate.

But it seems to me also that Mr. McAlear's reason for criticizing the "meaningless" general financial data reveals the kind of laziness I encounter all too often these days, the unwillingness to do one's own analysis. It also seems to consciously ignore the objective of the presenter of the data. That objective, it seems to me, is not to show all possible details about every RRG, nor is it to do the work of every lazy analyst.

While I couldn't do much about those who criticized my revealing their weak numbers, I always responded to the other critics that there is a reason for not trying to give a lot of information about each and every captive (in this case RRGs). That reason has nothing to do with secrecy or hiding things. It is because they are so different from each other. When you get to the bottom of detailed analysis, each one is unique. That's the way their owners consider them, and I happen to agree with them. The more detail you start giving about each individual captive insurance company, the more the differences emerge. Fewer broad conclusions can be made, and the value of the detailed data—the comparative value—is diluted.

What this leads me to point out is that the presentation of information about captives responds to the objectives of the analyst (or journalist or rating agency) undertaking the presentation. Here, the objective was to back up the publication's long-held thesis that RRGs are here to stay, are growing in number and importance and compare favorably as a whole to the rest of the risk financing industry. The basic financial data given are just enough to support that presentation, with an amount of detail on each individual captive that, incidentally, is more than can be found in the presentations of "data" by any captive domicile.

The opportunity, obviously, is in the selective collecting and making available of the public information on RRGs that can be found in their filed statements, which is what Mr. McAlear wants. As long as the objective of such a presentation is clear, I think there is a chance that critics of it would be fewer and paying customers numerous. One example might be: "This information is presented in such a way as to help outsiders decide whether or not to accept a certificate from an RRG." The presentation would be different from "This information is presented in such a way as to reveal reliance of RRGs on reinsurance." And I believe that if the raw data are backed up by some comparisons to "standards" (not the same standards applied to profit-for-shareholder insurers called for by Mr. McAlear), then there is an opportunity to add value as well.

D. Hugh Rosenbaum
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London

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Alcatel: U.S. retirees to lose health care benefits

Continued from page 1

said Nancy Ross, a partner at the Chicago law firm of McDermott, Will & Emery. "I'm not so sure you can call it a trend because it's not so widespread," she said of employers ending subsidies for retiree health coverage, "but it's happening."

Ms. Ross said she has clients, which she did not identify, that have stopped subsidizing health insurance for current and future retirees. It is more common, though, for employers to remove subsidies for future retirees and "grandfather in the existing retirees," she said.

Alcatel will offer a single health plan to retirees, replacing a dozen it had provided after mergers with other U.S. telecommunications companies that began in the early 1990s. Current retirees that choose to participate will pay increasingly higher amounts for coverage until they bear the entire cost in 2006.

The spokesman said retirees "will still have the ability to access the insurance" that will offer a choice of coverage options. He could not provide details on coverage costs to retirees and declined to say how much Alcatel expects to save by shifting the cost to former workers. Alcatel has about 60,000 employees worldwide and gross sales of 16.55 billion euros ($21.26 billion).

Ms. Ross pointed out that, in one respect, retirees likely are thankful that coverage is still available. Many probably would not be able to find or afford health insurance if Alcatel did not offer a plan, she explained.

Joe Martingale, national leader for health care strategy at Watson Wyatt Worldwide in New York, pointed out that the cost of retiree health care can become a competitive disadvantage for some employers. "If Company A has a retiree medical plan and Company B does not, Company A faces a big challenge in pricing its products and services," he said.

While "it sounds draconian," shouldering the huge expense of such coverage might be enough to put a company out of business unless it lowers or eliminates those costs, Mr. Martingale said.

In the fiercely competitive telecommunications industry, Alcatel is not the only company to make changes to retiree health plans. Last year, Lucent Technologies Inc. ended some, though not all, subsidies to its management retirees. The company also made other retiree benefit changes in an effort to save $75 million annually.

Nor is the trend limited to the telecommunications industry. A survey of more than 400 large employers released last week by the Kaiser Family Foundation and Hewitt Associates Inc. shows widespread efforts among large employers to reduce and eliminate retiree health care benefits, though only a handful said they intended to eliminate coverage for current retirees (see story, page 4).

"The way it's playing out," said Mr. Martingale, "is that employers are decreasing the value of the benefit in every way you can think of," including limiting eligibility, making coverage available to fewer employees and "lowering the generosity of the benefit design."

Ms. Ross said that "until we get medical inflation under control and a turnaround in the economy," more employers will consider ending all subsidies as Alcatel is doing.

ISO: Form seeks to focus additional insured liability

Continued from page 4

ISO is recommending revisions because courts have been interpreting current endorsement wording, which provides additional insureds liability protections "arising out of" a policyholder's "ongoing operations," to include protection for an additional insured's "sole negligence."

"This is contrary to the original intent of the additional insured endorsement," an ISO spokesman said.

For example, ISO said the revised endorsements would continue to protect a building owner from "vicarious liability" for a general contractor's actions, such as splashing water on a staircase that causes a pedestrian's fall.

The endorsement would exclude coverage, though, for liabilities arising out of a building owner's sole negligence, such as a pedestrian's fall on a staircase that was not under construction nor under the general contractor's control, ISO's experts said.

By the end of this month, Jersey City, N.J.-based ISO expects to complete filings to every insurance department in the United States. ISO is proposing to revise its existing CGL endorsement forms and have the new ones go into effect no sooner than June 1. ISO's forms are optional for insurers.

"ISO has identified a very serious issue," according to a spokeswoman for The Hartford Financial Services Group Inc.

According to the spokeswoman, "At first glance, ISO's changes look good," though company attorneys are still reviewing the filing. "It's likely that we will adopt it," as part of the insurer's own CGL form, which is broader than ISO's, she said.

But some construction industry representatives oppose ISO's proposed revisions.

"We can understand why some insurance companies want to do this," said William S. McIntyre IV, chairman and chief executive officer of Dallas-based American Contractors Insurance Group Inc., the management company for a Bermuda-based contractor-owned captive. "We are fighting a lot of court battles with insurers of our subcontractors that are trying to weasel out of providing coverage to the additional insureds of our subcontractors," who are members of the contractor's captive, Mr. McIntyre said.

'We are fighting a lot of court battles with insurers of our subcontractors that are trying to weasel out of providing coverage to the additional insureds of our subcontractors' who are members of the contractor's captive.

William S. McIntyre IV
American Contractors Insurance Co. Inc.

American Contractors, which writes $100 million in premium for CGL and related coverages, provides "full additional insured coverage upstream to building owners and we look downstream for our subcontractors to do the same for us," Mr. McIntyre said. American Contractors' coverage, which is based on a broader 1985 ISO endorsement, includes coverage not only for additional insureds sole negligence but also for completed operations, he said.

The extensive coverage by all parties in a construction project helps to reduce insurance-related disputes, Mr. McIntyre said.

"We are not being magnanimous about it, but rather find that approach avoids a lot of legal fees stemming from splitting hairs," he said.

In addition, the extensive coverage helps contractors maintain good relationships with owners, Mr. McIntyre said. American Contractors' members are involved in constructions projects valued at $9 billion.

"We find it increasingly difficult to get our subcontractors to provide that degree of coverage, but we take a pretty hard line and are getting it—and intend to continue doing so," Mr. McIntyre said.

Wheeling, Ill.-based Kenny Construction Co. also opposes ISO's proposed changes.

"I think the proposed revision will do more harm than good," said Dan Zarletti, vp and chief risk officer. "It will drag out frivolous litigation at a time when contractors are trying to focus on quality completion of their work."

ISO filed the revisions late last month in every jurisdiction but New Mexico and Oregon. ISO currently is reviewing those two states' indemnification statutes and expects to make a similar filing there by the end of this month, Mr. Grassmann said.

ISO also introduced an "Optional Amendment of Insured Contract Definition" endorsement, which amends the definition to remove coverage for an additional insured's sole negligence.

"In those states that allow for such recovery under a hold harmless agreement, this will serve as an optional underwriting tool," an ISO spokesman said.

ERISA: Court allows subrogation to stand

Continued from page 4

plan participants, attorneys agree.

In the case, Ochsner Health Plan Inc. of New Orleans demanded reimbursement of the $180,000 of medical benefits it paid to an HMO participant who was injured in a traffic accident and later recovered more than $1.1 million from several other insurers. Plan member Julio C. Arana argued that a Louisiana law bars such demands.

Disagreeing with an August 2002 5th Circuit panel ruling on court jurisdiction over the dispute, the full court first found that Mr. Arana was trying to resolve a benefit dispute, even though Ochsner did not deny any benefits. That meant ERISA Section 502(a) "completely" pre-empted his state court claim, the en banc court found.

In previous cases, however, the 5th Circuit had also analyzed whether a conflicting state statute at the center of a dispute regulates insurance and therefore is "saved" from pre-emption under ERISA Section 514. Previously in the 5th Circuit, when a state statute was "saved," the appeals court found that a state court had jurisdiction over the dispute.

Here, however, in reviewing rulings by the U.S. Supreme Court and another federal appellate court, the 5th Circuit determined that an ERISA Section 502(a) pre-emption alone warranted moving a plan dispute into federal court.

The 5th Circuit then remanded the case to the three-judge appellate panel for further proceedings on the merits of Mr. Arana's claim that Louisiana law bars Ochsner's attempted subrogation.

The panel last month ruled that Mr. Arana's claim "fails as a matter of Louisiana law."

The panel explained that the Louisiana law that Mr. Arana argues bars insurers from reducing benefits owed to plan participants does not apply to HMOs.

Even if Louisiana considered HMOs as insurers, the law Mr. Arana cites bars only the coordination of benefits, or the process of reducing a plan participant's benefits before paying them to take into account the participant's recovery from other insurers, the 5th panel explained.

That restriction is irrelevant in this case for two reasons, according to the panel. It said that Louisiana's insurance code allows HMO to coordinate benefits and allows insurers and HMOs to subrogate against plan participants, which means they can—as Ochsner did—seek reimbursement for benefits already paid.

While attorneys say some federal appellate rulings apparently conflict over whether insurers and health plans may subrogate against plan participants, Ochsner's attorney questioned the significance of those conflicts.

Rulings that seem to severely restrict or prevent subrogations were issued before the Supreme Court outlined in its January 2002 opinion when insurers and plans may subrogate, observed Perry Staub of Taggart, Morton, Ogden, Staub, Rougelot & O'Brien L.L.C. in New Orleans.

Mr. Arana's attorney did not return calls.

Julio C. Arana vs. Ochsner Health Plan, 5th U.S. Circuit Court of Appeals; No. 01-30922, Dec. 8, 2003.

ADVERTISER INDEX

Issue of January 19

Late News

Continued from page 1

Employers boost work/life offerings: Survey

Despite the sluggish U.S. economy, a majority of employers recently surveyed said they have increased the number of work/life programs they offer over the past two years. Fifty-one percent of the 646 employers surveyed by Mellon Financial Corp.'s Human Resources & Investor Solutions said the number of work/life programs they offer increased during the last two years. Forty-five percent said such offerings remained the same, while 5% said the number decreased.

Bill would let captives join guaranty fund

Georgia's House Insurance Committee has passed a bill that would allow Georgia-based captives that write workers compensation coverage to participate in the state's insurance guaranty fund. H.B. 1076, sponsored by state Rep. Ben Harbin, R-80th, would give Georgia captives writing workers comp insurance the same guaranty fund protections as admitted companies.

Canada Life sells U.S. group business

Jefferson-Pilot Corp. has agreed to buy the U.S. group life, disability and dental business of Canada Life Assurance Co. Terms of the deal were not disclosed, but Jefferson-Pilot said the purchase price and the additional capital it planned to commit to the acquired business would total about $200 million. Jefferson-Pilot has about $625 million of premiums in force related to group life, disability and dental business, and the Canada Life business will add about $350 million in premiums, a Jefferson-Pilot spokesman said.

Company setback stress not compensable

Employee stress resulting from an employer's declining stock value or a downturn in the employer's business is not compensable, a California appeals court ruled. The decision overturns a workers compensation appeals board finding that daily interactions with irate customers, company downsizing and concern about the employer's future, as well as employer stock value losses and the impact on an employee's retirement funds were predominant causes of a compensable psychiatric injury.

Casino closed over failure to pay union benefits

Federal marshals shut down Binion's Horseshoe Hotel & Casino's gaming operations and seized about $600,000 last week to pay unpaid medical and pension benefits to union employees of the landmark Las Vegas casino. The casino had

PHOTO: ZUMA

Binion's Horseshoe Hotel & Casino was shut down by federal marshals for failure to pay union benefits.

owed a union trust fund $2.3 million in medical and pension benefit contributions since June 2003, according to D. Taylor, secretary-treasurer of Culinary Union Local 226, which represents about 400 union employees of the Horseshoe.

Limiting med mal liability has small cost impact: CBO

Limiting medical malpractice liability will have only a small impact on overall health care costs, according to a recent analysis prepared by the Congressional Budget Office. "Evidence from the states indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise," said the CBO in "Limiting Tort Liability for Medical Malpractice." "But even large savings in premiums can have only a small direct impact on health care spending—private or governmental—because malpractice costs account for less than 2% of that spending."

Briefly noted

A.M. Best Co. has upgraded its financial strength ratings of several **Aetna Inc.** subsidiaries, including Aetna Life Insurance Co., to A from A-. Best said Aetna has completed a financial turnaround, is generating excellent returns and has a well-conceived growth plan....Pointing out that the lack of health insurance causes roughly 18,000 deaths every year in the United States, the Institute of Medicine is urging lawmakers to adopt **universal coverage** by the year 2010. To help policymakers, elected officials and others judge and compare proposals to extend coverage to the nation's 43 million uninsured, the Institute of Medicine of the National Academies offers a set of guiding principles and a checklist in a new report, "Insuring America's Health: Principles and Recommendations," available at *www.iom.edu*....The Supreme Court on Tuesday heard oral arguments in *Tennessee vs. Lane*, a case reviewing state governments' immunity from having to pay monetary damages awarded under the **Americans with Disabilities Act**. A decision is expected by the end of June.

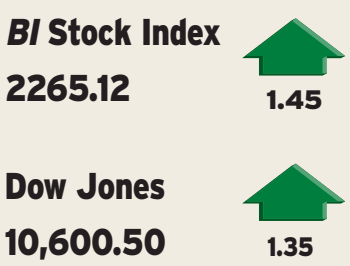
Check out BusinessInsurance.com

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

Online Poll

[1/12-1/16]

When do you expect that average general liability insurance rates will start to decline?



They already are 15.8%
2004 18.0%
2005 42.9%
2006 or later 23.3%

BI Stock Index

[1/12 - 1/16]

Up-to-the-minute data for all 87 companies that comprise the *BI* Stock Index can be found at *www.businessinsurance.com.*

Percentage change of *BI* Stock Index vs. key indicators

***BI* Stock Index**	**2265.12**	**1.45**
Dow Jones	**10,600.50**	**1.35**
S&P 500	**1139.83**	**1.60**

Largest gains

Humana Inc.	11.00%
Meadowbrook Ins. Group	10.35%
SCOR	9.41%
Sierra Health Services	7.28%
Axis Capital Holdings Ltd.	6.72%

Largest losses

Trenwick Group Ltd.	-56.00%
ESG Re Ltd.	-5.71%
UNUM Corp.	-3.38%
Selective Ins. Group	-2.81%
SCPIE Holdings Inc.	-2.61%

Weekly change by market segment

Brokers	2.56%
Insurers/Reinsurers	1.41%
Managed Care Organizations	4.95%

Source: FinancialContent Inc. *(http://financialcontent.com)*

PBMs: High marks for service

Continued from page 4

health plans often don't receive information about a patient's prescribed drug treatment until after processing a claim, which can be weeks or even months later.

Interestingly, the two PBMs owned by retail drugstore chains scored the highest of the seven PBMs in several areas, with ratings of 8.0 and higher. Eckerd received the highest score for delivering promised savings, with an average rating of 8.3, while Walgreens scored 8.0 in this category.

At the other end of the spectrum, Medco was rated lowest in nearly every category, the survey found. Medco's lowest ratings were for delivering promised savings, where it scored an average of 6.8, and disease management services, where it received an average of 6.5.

Michael Deskin, PBMI president, said he was not surprised that Eckerd was the leader in the 2003 survey. The Pittsburgh-based company has scored consistently well in the past five PBMI customer satisfaction surveys, he said.

"It's somewhat easier for small PBMs to provide consistently high service than large PBMs," he said. "The larger PBMs, they have a different view of the marketplace. They may go out and chase certain blocks of business, but they're not as concerned about maintaining those as they are their other blocks. As such, they've developed classes of care, and some clients get less attention than others."

"We grew up as a company out of retail, where service is pre-eminent. Otherwise, people don't walk through your door anymore," said Lloyd McDonald, vp-marketing and product development at Eckerd Health Services in Pittsburgh. "We are very execution- and operationally oriented. We do what we say we are going to do."

In response to the survey findings, a spokeswoman for Medco said that company executives did not think the PBMI survey was representative "of our thousands of clients who endorse our services every day by virtue of our extraordinary 95% client retention rate."

"We have just had a historic contract renewal with UnitedHealth Group, and we ranked first in most criteria, including service and quality in network, mail order and administrative capabilities in the Commonwealth of Virginia's search for a PBM," she added.

Sean Brandle, a vp at The Segal Co. in New York, also was skeptical that the PBMI survey provided an accurate picture of PBM performance. "I see one survey, with two PBMs scoring well. But they aren't leaders in terms of responses," he said, pointing to the number of employers that rated Eckerd and Walgreens.

Thirty-eight employers representing 535,000 plan members enrolled in Eckerd's PBM, and just 15 employers representing 219,000 members enrolled in Walgreens' plans participated in the survey. This compares with 80 employers representing almost 1.9 million members in Medco's PBM.

Ralph Kimmich, director of benefits and compensation at Southwest Airlines in Dallas, also criticized the survey, saying it's difficult to easily quantify the effectiveness of PBMs because there are so many variables.

"We don't know what the contract terms were" for these employers, Mr. Kimmich said. As for cost savings, "we found that the price of ingredients is the slowest-growing portion of drug costs. It's utilization, new drugs and an aging workforce" that are contributing to higher prescription benefit costs, he said.

Copies of the "2003 Pharmacy Benefit Manager Customer Satisfaction Report" are available from the Pharmacy Benefit Management Institute for $150 each. They can be ordered online at www.pbmi.com.