

**Insurers, reinsurers split  
on reserving: S&P/ 3**

**Bad-faith claims rising  
in work comp cases/ 3**

# Business Insurance

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\$5

## Tiny comma has big impact on dispute

### Court: Plan language shows SBC can deviate from pact

By DAVE LENCKUS

**ST. LOUIS**—A federal appellate court ruling underscores the importance of not only pension plan language but also punctuation in resolving benefits disputes.

In a 3-0 decision, an 8th U.S. Circuit Court of Appeals panel ruled last month that, among other things, the placement of a comma in a pension plan provision gives a plan administrator the license it took in interpreting that provision.

The Jan. 12 ruling, which overturned a lower court's September 2002 decision, could have a wide-ranging impact on the Baby Bell telephone company spinoffs from

AT&T Corp., because it allows one Baby Bell to avoid fully complying with a pension portability agreement among all the spinoffs, said plaintiff's attorney Justin D. Pulikkan of Seaman Stoll Mustoe & McCrummen P.C. in Kansas City, Mo.

Last week, Mr. Pulikkan petitioned for a rehearing before either the 8th Circuit panel or the full appellate court.

The case revolves around whether one Baby Bell that hired an early retiree from another Baby Bell must recognize a three-year service credit enhancement that its plan participant received from the other

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PHOTO: REUTERS / ADREES A. LATIF

A panel of the 8th U.S. Circuit Court of Appeals has upheld an SBC plan administrator's interpretation of a provision in a company pension plan.

## Late News

### MRM sues Hancock over reinsurance dispute

Mutual Risk Management Ltd. is charging in a lawsuit that John Hancock Life Insurance Co. intentionally refused to pay reinsurance claims in an effort to force financially troubled MRM to renegotiate the reinsurance treaties' terms. From 1992 until 2000, John Hancock reinsured workers compensation carve-out risks written by MRM subsidiary Legion Insurance Co., retroceding the business to other reinsurers, the suit says. John Hancock in 1999 halted claim payments to Legion, which is now in liquidation, amid a rising tide of disputes among many participants in the carve-out reinsurance market. John Hancock declined to comment.

### Senate panel passes COLI tax provision

Employers would be taxed on proceeds from corporate-owned life insurance policies unless certain conditions were met, under legislation passed last week by the Senate Finance Committee. Under the bill, COLI policy proceeds would continue to be tax-exempt when the proceeds are paid to the employer to cover a worker who had worked for the employer at any time within 12 months before his or her death, or if the benefits were payable to an employee's family, trust or estate.

### Medicare HMOs cutting premiums

Aided by big rate increases from the federal government, managed care plans providing coverage to beneficiaries who opt out of the traditional Medicare program are boosting benefits and cutting premiums. Nearly all managed care plans surveyed by the Washington-based AAHP-HIAA said they would use the additional revenues provided by legislation Congress passed last year to lower monthly premiums.

### Willis sees gains in profits, revenues

Willis Group Holdings Ltd. has reported double-digit growth in top- and bottom-line results for 2003. Total revenues at the London-based broker, whose stock is traded on the New York Stock Exchange, rose 12% to \$1.1 billion. See **LATE NEWS/page 19**

## 20 years later, ERC's role in GE may be near end

By JUDY GREENWALD

**OVERLAND PARK, Kan.**—Employers Reinsurance Corp. is not expected to remain a General Electric Co. subsidiary over the long term.

Although ERC is expected to remain under GE's umbrella for at least the next two years, it will eventually either be spun off in an initial public offering or sold to a buyer, with the former the more feasible, predict many reinsurance observers.

Risk managers say they plan to closely monitor the situation.

ERC, which GE acquired in 1984, has not always been held in the highest regard by its par-

ent. In 2002, after ERC caused GE to take a \$1.4 billion aftertax reserve charge, GE Chairman and Chief Executive Officer Jeff Immelt announced the company planned to explore "strategic options" for the reinsurer.

Subsequent rumors pointed to Omaha, Neb.-based Berkshire Hathaway Inc. as a potential buyer. Others said GE planned an initial public offering for ERC. Neither event materialized.

Then, in November, Mr. Immelt told analysts, "I haven't changed my mind in terms of how I look at reinsurance for the longer term in this business. But I think you ought to count on

See **ERC/page 18**

## Treasury proposes conversion mandate

### Cash balance rules spark controversy

By JERRY GEISEL

**WASHINGTON**—Employers that convert their pension plans to cash balance plans would be hit with a new and unprecedented benefit mandate if a Treasury Department proposal becomes law.

Released last week at a Treasury budget briefing, the proposal goes far beyond what Congress ordered when it directed Treasury officials to come up with draft legislation that would ease transition problems faced by older and longer-service employees when their employers convert traditional pensions to cash balance plans.

Despite the mandates, the proposal also would allay some employer concerns. The proposal makes clear that cash balance plans

are a legitimate pension plan design and do not—contrary to a 2003 federal court decision—violate federal age discrimination law, as long as they provide equitable pay credits.

Additionally, the proposal would give employers more flexibility in crediting employees' account balances with interest.

But the good in the proposal may be far outweighed by a new benefit guarantee requirement that could chill employer interest in the plans and set an ominous precedent for other benefit programs, some benefit consultants warn.

"There are some extremely good things and some things that are intolerable," said Eric Lofgren, global director of benefits consulting at Watson Wyatt Worldwide in

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## International

### SOCCER LOSSES HIT INSURERS

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# FDA forces policy changes on drug import programs

By GLORIA GONZALEZ

**TEMPLE, Texas**—Three companies that the U.S. Food and Drug Administration has accused of facilitating the illegal reimportation of prescription drugs from Canada say they will inform their members that they must deal directly with Canadian pharmacies.

The policy change is in response to pressure from the FDA, which last month wrote to Expedite-Rx, Employer Health Options and SPC Global Technologies accusing the three Temple, Texas-based companies of facilitating reimportation of prescription drugs to U.S. consumers. Such reimportation is illegal under federal law.

Expedite-Rx, which managed a

reimportation program for the city of Montgomery, Ala., has begun informing members that import medications that they must deal directly with their selected exporting pharmacies. The company has also agreed to discontinue receiving from members any documents involved with reimportation practices and to remove statements from its Web site that allegedly imply that reimported prescription drugs are safe.

“By doing this, Expedite-Rx will be distanced from and excluded from the letter’s alleged acquisition process and thus any implications that Expedite-Rx may be involved in shipping and/or causing those shipments of imported drugs,” the company said in its response to the

Food and Drug Administration.

The decision will not stop Montgomery from reimporting prescription drugs, said Jeffrey Downes, executive assistant to Montgomery Mayor Bobby Bright. Between 200 and 300 employees and retirees participate in the program, which is expected to save \$400,000 to \$500,000 in its first year, Mr. Downes said.

A spokesman for the three companies said they decided to address the agency’s concerns to avoid giving the FDA a basis to shut down their operations. He did not know whether the FDA would be satisfied with the changes or make additional requests.

FDA officials could not be reached.

# Bad-faith lawsuits challenging exclusive-remedy provisions

By ROBERTO CENICEROS

Bad-faith lawsuits by injured workers against workers compensation insurers and self-insured employers are rare, but recent legal cases show ongoing attempts to circumvent state exclusive-remedy laws.

The exclusive-remedy doctrine in most states bars employees from suing employers in civil court for work-related injuries and mandates that state workers comp systems adjudicate those claims.

But some plaintiffs continue to attempt end-runs around those provisions with bad-faith claims.

In Kentucky, “there is a constant attempt by plaintiffs attorneys to pierce workers comp protections” with arguments that land employee injury cases in civil court, said John Hinkle, the president of the Kentucky Retail Federation in Frankfort.

Currently, a Kentucky woman is in mediation proceedings with a workers comp claims management unit of Bentonville, Ark.-based Wal-

Mart Stores Inc. The woman filed a civil suit alleging bad faith because of Claims Management Inc.’s handling of her workers comp claim for a back injury, according to the plaintiff’s attorney.

A spokeswoman for Wal-Mart declined to comment because of a gag order imposed by the mediator, but she confirmed the claim against CMI. The plaintiff’s attorney, Tracy Frye of Frye Law Offices in Russell, Ky., also declined to discuss specifics of the case.

But Ms. Frye did not dispute a recent report that CMI ruled the claim compensable but later refused to pay some of the plaintiff’s medical costs and hired a private attorney to discredit her claim.

Civil lawsuits stemming from work injuries remain rare in Kentucky, according to Ms. Frye and the Kentucky Office of Insurance. But Ms. Frye said she expects to see more of them.

“More workers comp claimants are attempting to file these kinds of

actions because the workers comp system really doesn’t provide you with the type of remedy you can get in circuit court,” Ms. Frye said.

Insurer defense attorney James Pinderski, a partner at Tressler Soderstrom Maloney & Priess in Chicago, said he has already seen a “dramatic increase” in attempts to circumvent exclusive-remedy provisions by filing separate tort claims outside the workers comp system.

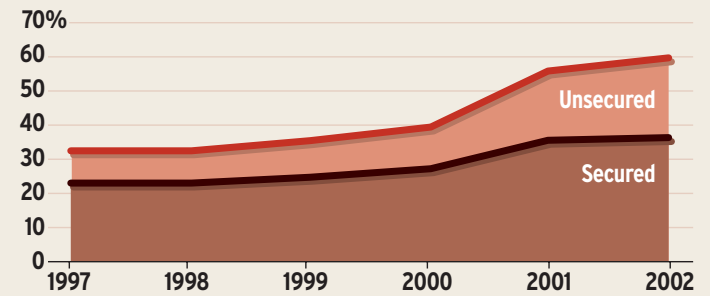
“I think they are increasing, because we have certainly seen situations where they have been awarded a substantial amount of money,” Mr. Pinderski said.

Often, both the employer and the employer’s insurer are named in such lawsuits, Mr. Pinderski said. The two defendants can have competing legal interests over several issues. Those issues include whether the employer participated in claims management decisions or provided the insurer with adequate information, and whether the insurer will

See **BAD FAITH**/page 19

## SECURED VS. UNSECURED REINSURANCE

As percentage of the U.S. primary insurance industry surplus



Source: Standard & Poor's Corp.

# Cedents, reinsurers face growing tension over asbestos losses

By DOUGLAS McLEOD

Insurers’ relationships with reinsurers will become increasingly strained as huge asbestos and other liabilities trigger coverage disputes and threaten potentially large unrecoverable reinsurance balances, Standard & Poor’s Corp. warns.

Big asbestos reserve increases and settlements by insurers, often undertaken without input from reinsurers, are creating new tensions, particularly as reinsurers fail to respond with their own reserve increases, according to a report by the New York-based rating agency.

Evidence of deteriorating relationships so far is anecdotal, but “we talk to lawyers and talk to companies, and it just seems like the temperature is rising,” said Steven J. Dreyer, managing director and practice leader, financial services ratings, North America insurance at S&P.

“It really has to happen, given the way ceding companies are making these (reserve) provisions without consulting with their reinsurers,” Mr. Dreyer said.

“That dynamic infers a day of

reckoning at some point,” Mr. Dreyer said.

Highlighting the unrecoverable reinsurance problem, S&P noted in its report, “Insurers and Reinsurers: The Context for Conflict,” that Liberty Mutual Insurance Co. last year established a bad-debt provision for 55%—or \$158 million—of its asbestos reinsurance receivables after a review of its exposures.

By contrast, the property/casualty industry as a whole, carrying almost \$200 billion in reinsurance recoverables at year-end 2002, generally assumes that only 10% of that total will become bad debt, S&P notes. Recognition of larger-than-expected shortfalls in recoveries will trigger disputes between ceding companies and reinsurers, the rating agency predicted.

Many ceding insurers continue to focus on reinsurers’ financial strength ratings alone in assessing their recovery risk, rather than looking also at reinsurers’ demonstrated willingness to pay asbestos and other claims, Mr. Dreyer observed.

“For companies to assume credit risk is the only risk is

See **S&P**/page 19

## Inside Business Insurance

### Conference tackles health care cost issues

A recent Towers Perrin conference explored employer concerns about rising health care expenses and some possible solutions. **Page 4**

### NAIC questioning weather derivatives

A recent NAIC white paper raises questions on whether weather derivatives are insurance. **Page 4**

### Coverage opportunities abound for innovators

Recent events offer underwriters ample opportunity to present unusual new coverage solutions, writes Paul Winston. **Page 6**

### Medicare + Choice gets overdue revamping

A program that benefits employers got a much-needed shot in the arm, this week’s editorial says. **Page 8**



### Allianz, HIH liquidator settle purchase dispute

Germany’s Allianz and the liquidator of failed Australian insurer HIH have settled a dispute over Allianz’s purchase of an HIH unit. **Page 14**

## Online

• The searchable **Datebook** allows visitors to post upcoming industry seminars and meetings of interest to *BI* readers.

• Searchable **directories**, including *BI*’s most recent annual list of third-party administrators, can be viewed.

• New **Opinion Poll** for readers: Should Congress consider legislation this year that would allow insurers to seek federal, rather than state, charters?

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### REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

# Status of weather hedges debated

By MEG FLETCHER

A dispute is heating up over a proposal by state insurance regulators that temperature-related weather risk hedges be reclassified as insurance products and their sale be limited to state-regulated insurers.

Central to the debate is a draft issues paper written by the National Assn. of Insurance Commissioners' Crop Insurance Working Group that recommends the reclassification as insurance certain weather derivatives used to hedge temperature-related risks. The paper does not make specific recommendations about hedges for other weather-related risks.

The working group maintains that the temperature-related hedges share many characteristics with insurance contracts and, thus, should be regulated in the same way as insurance.

However, the trade organization for weather risk management has criticized the proposal's reasoning as flawed. In addition, that group and other observers—including some NAIC members—note that the working group's position appears to contradict other state insurance regulators' stance on weather derivatives.

The proposed reclassification would cause an upheaval in the \$16 billion weather risk market, because commodity traders and others now write an estimated 70% of these risk hedges as contingent commercial contracts, such as derivatives, explained Valeria Cooper, executive director of the Washington-based Weather Risk Management Assn. Insurance industry companies write the remainder of the hedges as weather insurance policies.

These markets sometimes overlap, such as when reinsurers offer

hedges as either insurance or derivatives.

The proposed change "would limit the market substantially and not allow buyers to hedge risks in a fiscally responsible manner," Ms. Cooper said.

According to the NAIC working group's paper, "The principle purpose for purchasing a weather derivative is (to) spread the risk of financial loss from a peril that is normally associated with insurance products—namely the occurrence of temperature extremes."

For example, for a heating oil supplier, financial risks may result if mild temperatures depress the demand for heating oil or extremely cold temperatures cause demand to rise and strain the company's capacity to meet contractual obligations. To protect against either event, the supplier may enter into a contract that provides a financial

hedge against temperatures that are too high or too low.

The NAIC working group's paper concludes that weather derivatives and weather insurance products are both "temperature protection coverages" and share several common elements, though derivatives "appear to be disguised as non-insurance products to avoid being classified and regulated as insurance products."

Because such products are not treated as insurance, "the insuring public is missing out on many solvency and market regulatory benefits that state insurance regulation provides," the NAIC paper says. In addition, "states are missing out on premium tax revenues, and the purchaser does not have the benefit of knowing that adequate reserves are maintained and monitored for solvency purposes," it said.

See WEATHER/page 13



Colder-than-average winter temperatures present financial risks for some companies, and products such as derivative contracts and insurance are available to hedge that exposure.

## Armstrong challenges panel ruling

By DOUGLAS McLEOD

**PHILADELPHIA**—Bankrupt Armstrong World Industries Inc. has asked a federal judge to vacate an arbitration award that would deprive it of \$40 million in coverage for asbestos bodily injury claims under policies written in the 1970s by Liberty Mutual Insurance Co.

An appellate arbitration panel last month ruled that Armstrong is barred by a Pennsylvania statute of limitations from recovering anything more than the \$4 million plus defense costs it has already collected under Liberty policies in force between January 1973 and January 1977.

The panel overturned a 1999 ruling in Armstrong's favor by a trial arbitrator, who found that the statute of limitations did not apply.

Armstrong is now asking a Philadelphia federal court to throw out the appellate arbitrators' decision, arguing that they exceeded their authority under terms of the 1985 Wellington Agreement governing the arbitration.

Liberty Mutual wrote nine general liability policies covering Armstrong between 1973 and 1982. The policies included annual aggregate limits applicable to asbestos product liability claims but no aggregate limits for nonproducts claims.

As part of the Wellington accord, Armstrong and Liberty Mutual agreed to place a \$40 million aggregate cap on nonproducts claims for the January 1973 to January 1977 policies, but no

See ARMSTRONG/page 13

## 2004 Annual Employee Healthcare Conference

# Soaring drug costs spur benefit changes

By GLORIA GONZALEZ

**NEW YORK**—The rising cost of prescription drugs has forced employers to implement a variety of cost-control strategies.

Benefit managers described their efforts to overhaul their prescription drug programs at the 2004 Annual Employee Healthcare Conference, held last month in New York.

Melissa Metzgar, director of global benefits for Starwood Hotels & Resorts Worldwide Inc., said her company opted to replace its three-tiered copayment system with a coinsurance system requiring participants to pay 25% of the costs for generic medications and 35% for brand medications.

"We weren't necessarily trying to

do a lot of cost-shifting," she said. "We really wanted people to start understanding the price tag."

White Plains, N.Y.-based Starwood has roughly 33,000 benefits-eligible employees.

Key to Starwood's plan was the introduction of reference-based pricing, Ms. Metzgar said. Under that approach, a single maximum price is set for all drugs in a thera-

peutic class. The coinsurance requirement applies up to the reference price, and the member must pay any amount in excess of the reference price.

The reference prices Starwood is introducing are \$100 for proton pump inhibitors and \$40 for nasal steroids, although the prices will be reset twice a year, she said. The company will pay 75% of drug costs under its reference price while the employee will pay 25% coinsurance, as well as any costs over that price, she said.

For example, she explained that for the proton pump inhibitor omeprazole, the cost breakdown of a prescription for a 30-day supply of the generic form, which costs about \$70, will be \$52.50 for Starwood

and \$17.50 for the employee. The costs of a prescription for a 30-day supply of name-brand Prilosec, which costs about \$140, will be \$75 for Starwood and \$65 for the employee.

Reference-based pricing provides an incentive for members to consider drug costs and seek lower-priced alternatives, she said. It also serves as a hedge against pharmaceutical manufacturers pricing policies, she said.

Reference-based pricing has been successfully implemented in Canada, France, Germany, Italy and Japan, although the practice is still relatively new in the United States, she said.

Ron Fontanetta, a principal with

See DRUGS/page 16

Additional conference coverage appears on page 16

## 2004 Annual Employee Healthcare Conference

# Employee surveys aid in tailoring plans

By GLORIA GONZALEZ

**NEW YORK**—Several companies are using employee surveys to tailor benefit packages, incorporating the benefits employees value most while attempting to reduce benefit costs.

Dr. Miles Snowden, director of health services for Atlanta-based Delta Air Lines Inc., discussed how his company used a recent employee survey to reorganize its benefit package at the 2004 Annual Employee Healthcare Conference, sponsored by Towers Perrin and WebMD.

The decline in its revenues after the Sept. 11, 2001, terrorist attacks forced the company to rethink its approach to benefits, which make up one-third of the airline's controllable expenses, Dr. Snowden said.

"The industry is in a crisis mode," he said. "In 2002-2003, you could do a lot in the airline industry, so our thought was, 'This is a window of opportunity to reset our benefits expense.' The environment basically allowed us to go out and say, 'We can't afford the benefits package that you have anymore.'"

Company officials came up with a goal to reduce benefits expenses by \$300 million—a 28% reduction—by 2005 but did not want to unilaterally change the benefit package, so they developed a Web-based survey to explore employee attitudes toward benefits, Dr. Snowden said.

Delta has 59,984 active employees and 36,983 eligible retirees, survivors and inactive employees, he said. About 36%, or 22,307 employees, completed the survey, which

revealed that 23% of employees valued their pension packages the most, Dr. Snowden said. Seventeen percent valued their medical benefits the most, while 15% valued their prescription drug benefits the most, according to the survey.

Based on these results, Delta made several changes to its benefits package, he said. The company converted its pension program from a traditional defined benefit plan to a cash balance plan but instituted a seven-year transition so that about 30% of its employees could retire without a change in their pension plan, he said.

"We're going to recognize significant expense reduction now for pensions, but not on the backs of at least a third of our workforce," Dr. Snowden said.

In 2002, Delta's health care

costs per employee averaged \$8,976, because the company's previous package required a \$10 copayment but no premiums or employee contributions beyond the copays, Dr. Snowden said.

Under Delta's new plan, the copay was increased for office-based medical services to \$20 from \$10 for primary care physician visits and \$25 for specialist visits, he said. The employee contribution for hospital-based services was changed to a deductible and coinsurance arrangement from a copay, and an out-of-pocket maximum was established for medical services, he said.

Drug copays were maintained without the establishment of any drug deductible or coinsurance, and a three-tier system was established. Employee contributions were added

See SURVEY/page 16

## Conversion: Plan controversy

Continued from page 1  
Philadelphia.

One "intolerable" provision, as Mr. Lofgren put it, involves cash balance plan conversions. Typically, cash balance plans are replacing traditional defined benefit plans that employers already had, rather than being set up as new plans.

Older employees say such conversions can be an economic disaster if they were on the edge of earning a big benefit under the old plan and won't have enough work time remaining to earn a significant benefit in the cash balance plan.

To deal with that potential problem, some employers voluntarily have given veteran employees a choice of remaining in the traditional plans, while others have given them enriched benefits in the cash balance plans. A few have offered a choice between the two plans to all current participants.

The Treasury proposal, though, would mandate what it calls a "hold harmless" period after each conversion. During this five-year period, benefits earned under the cash balance plan by any participant—regardless of age or length of service—would have to be at least equal to what the participant would have earned under the old plan if the conversion had not occurred.

As an alternative to this requirement, employers could provide every current plan participant with a one-time opportunity to choose between the two plans.

In justifying the "hold harmless" period, Treasury says the "reasonable expectations" of older and longer-service employees have to be protected, while not being so burdensome that an employer decides to freeze its current plan.

"A five-year period strikes this balance," Treasury says.

But some benefits experts say the

requirement goes far beyond what is needed to protect the expectations of long-service employees.

"If the purpose is to protect older, longer-service employees, why talk about something that would affect participants who are decades younger?" Mr. Lofgren asked.

Some worry that if such a hold harmless requirement were imposed for cash balance plans, it could be just a matter of time before such mandates were applied to other benefit plans.

"Where would you draw the line? Would the next step be you can't change retiree medical or a 401(k) plan for five years? This is more akin to European-style benefit entitlements that have led to markedly higher structural unemployment than in the United States," said Ethan Kra, chief actuary for Mercer Human Resource Consulting in New York.

"I am very disturbed about a precedent for what are now voluntary plans," said James Klein, president of the American Benefits Council in Washington.

"It would be the first time that Congress would mandate the rate of a future benefit accrual," said Jeff Davis, a director with the human resources unit of PricewaterhouseCoopers L.L.P. in Washington.

Faced with such a mandate, some employers might simply freeze their traditional plans or terminate them and set up defined contribution plans for which such requirements would not apply, leading to yet more erosion of the defined benefit plan system.

"If you have to protect everyone, no one on earth would go to a defined benefit plan," Mr. Lofgren said.

But some benefit managers say—as Treasury maintains—that the mandate strikes a reasonable bal-

ance between protecting projected benefits for all current participants and no protection at all.

"It may be a version of a middle ground," said Michael Pikelny, benefit consultant and corporate actuary with apparel manufacturer Hartmarx Corp. in Chicago.

Furthermore, the five-year hold harmless provision would not have that great of an impact, because younger, shorter-service employees, in nearly all cases, would likely accrue richer benefits in the cash balance plan and, essentially, be unaffected by the mandate, Mr. Pikelny said.

Employers welcome, with reservations, Treasury's recommendation that cash balance plans automatically be considered not age discriminatory so long as they provide—as most currently do—the same or greater pay credits for older employees as for younger employees.

That issue has tied up courts with conflicting decisions. In the most recent decision—one that involved IBM Corp. and that generated enormous publicity—a federal judge in July 2003 ruled that IBM's plan discriminated against older employees because the credits they received would purchase a smaller annuity at retirement than the same credits provided to younger employees.

But the Treasury proposal would not, as currently written, provide IBM with any relief from the litigation it faces, nor, for that matter, for any other employer now sponsoring a cash balance plan that faces similar age discrimination lawsuits.

That is because the proposal would apply only prospectively, continuing to leave it to the courts to try to resolve the issue for current plan disputes. This decision angers many benefit experts, who say that Treasury for years gave its blessing, through so-called determination letters, to plan designs like IBM's.

"Hundreds of plans were led to believe that they were OK," said Larry Sher, a principal and director of research at Mellon's Human Resources & Investor Solutions in New York.

Despite objections to parts of the Treasury proposal, there are uniform accolades for Treasury's recognition that cash balance plans are a legitimate and necessary way to provide benefits.

"Cash balance plans can be a better option, particularly for today's younger, more-mobile workforce," said Treasury Secretary John Snow.

"It is refreshing that Treasury recognizes the fundamental legitimacy of cash balance plans," said Mercer's Mr. Kra.

Few benefit observers, though, believe Congress will accept, as is, the Treasury proposal, with legislators likely viewing it instead as a first step in fashioning permanent legislation.

"It is a starting point in the debate," said Scott Macey, a senior vp with Aon Consulting in Somerset, N.J.

"This will help to move the debate forward," added Janice Gregory, a vp with the ERISA Industry Committee in Washington.

## Paul Winston

### New risks are just new opportunities

The history of commercial insurance is truly one of innovation and creative response to risk. That continues to be true today, as new risks emerge and present new opportunities.

From its early days, insurance has responded to a growing variety of perils, helping spread loss and minimize its catastrophic impact. In ancient Babylonia, about 5,000 years ago, merchants organized a way to pool the risk of their caravans being attacked by bandits. About 4,000 years ago, the seafaring Phoenicians adopted principles of insurance to protect shipping commerce from loss. In the Middle Ages, the concept spread to fire, flood and theft losses. Over the years, it has been refined, expanded and improved upon by other organizations, markets and companies.

Of course, not all insurance buyers appreciate the creativity involved. That's especially true when a new risk creates a new exclusion from a previous type of coverage and a new endorsement or policy for an additional premium.

And not all buyers will agree that insurers are willing to embrace new risks. But note that I did not say anything about the speed at which this occurs.

While it may take time and cost plenty, when presented with a thorny problem and sufficient demand, insurers eventually recognize a commercial opportunity to insure a new risk.

In the interest of expediting this process of risk selection, I have identified several emerging risks that could provide an opportunity for insurers to help policyholders and earn a buck before the market gets too crowded:

● **Wardrobe malfunction insurance.** Until the halftime show of Super Bowl XXXVIII, I'm sure many of you were unaware of the risk of a "wardrobe malfunction." That is what Justin Timberlake blamed for his dance step that resulted in exposing Janet Jackson's breast to an audience of hundreds of millions on live television.

Nor did anyone know how much could be at stake financially as a result of such a garment glitch.

MTV, which staged the halftime show, has been banished from organizing future National Football League events, leaving it to ponder a bleak future in which it might derive revenues only from broadcasting music videos. Justin and Janet are unlikely to garner any prime time TV spots in the near future.

And days after the clothing flap, the performers, MTV, its parent company Viacom and broadcaster CBS all were hit with a lawsuit

seeking class action status. The plaintiff, a Tennessee woman, seeks unspecified damages from the defendants for purposely uncovering Ms. Jackson and thereby exposing family viewers to this and "other lewd and sexually explicit conduct."

Other celebrities and networks are sure to demand insurance protection for the risk of their revenues or reputations being ruined by similar defects in clothing and/or judgment.

● **NOW you tell me insurance.** In recent weeks, several high-profile officials have begun distancing themselves from claims that Iraq possessed weapons of mass destruction, which was President Bush's stated purpose in invading

Iraq to oust Saddam Hussein. First, arms inspector David Kay announced that faulty intelligence was given to Bush about the existence of WMDs, evidence of which Mr. Kay was unable to discover. Then CIA Director George Tenet last week acknowledged possibly flawed info but also said the intelligence agency never claimed there

was an imminent threat from Iraq. No doubt the president, his advisors and key allies such as Britain's Tony Blair are starting to feel a little lonely and perhaps foolish. What head of state wouldn't like to have a little security blanket in the form of a policy that would protect him from the failure to find a single WMD to justify having gone to war—and the consequential loss of reputation?

● **Red rover, red rover, send the signals over insurance.** After spending billions of dollars to send two rovers to take pictures of the angry red planet, NASA was embarrassed by problems getting the first of the costly cameras on wheels to work. Intermittent signals and long periods of silence are sure to give mission control managers heartburn at the prospect of getting more money for a manned mission to Mars in 2015.

Before any more taxpayer expenditures, a little insurance for interplanetary travel and transmissions would be welcome. With many other nations in the space race, including Brazil, China, the European Union, Japan and Russia, it could be a lucrative new sideline for the space insurance market.

Of course, not all risks are insurable, nor is insurance the answer for every risk. But with a little time, I'm sure the insurance industry could come up with a response to these modern problems.

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Paul Winston

## Bush revives proposal to ease 401(k) testing

**WASHINGTON**—The Bush administration is recycling an earlier proposal to make it easier for 401(k) plans to pass a basic nondiscrimination test and, as a result, for highly paid employees to defer to the plans.

As part of its budget package released last week, the administration proposed liberalization of the 401(k) nondiscrimination test that compares salary deferrals of highly compensated employees—those making at least \$90,000 annually—with those of other employees.

The test is used to ensure that the average deferrals of highly compensated employees do not exceed the average deferrals of rank-and-file employees by more than the permitted amount. Generally, the average deferral percentage, or ADP, of highly compensated employees can be no more than two percentage points higher than the rate of

nonhighly compensated employees.

This test is so difficult to pass, consultants say, that roughly 40% to 50% of employers have to make some kind of adjustment—the most common being limiting deferrals by highly compensated employees.

But under the administration's proposal, 401(k) plans, which would be renamed Employer Retirement Savings Accounts, the average deferral rate of highly compensated employees could be as much as double the deferral rate of rank-and-file employees and a plan still would pass the nondiscrimination test.

Additionally, if the ADP of rank-and-file employees were to exceed 6%, a plan would be exempt from the nondiscrimination test.

Last year, Congress failed to act on the proposals.

—By Jerry Geisel



# 'Pollution exclusion' definition still elusive

By Deborah Deitsch-Perez  
and William A. Brewer

Because of the enactment of the Comprehensive Environmental Response, Compensation and Liability Act of 1980 and the large damages and cleanup requirements that can be imposed under it, litigation over insurance coverage for CERCLA and other pollution claims remains fierce.

Still in dispute is the scope of the pollution exclusion included in most comprehensive general liability policies between 1970 and 1985. Specifically, insurers and policyholders clash over what is covered under the exception to the pollution exclusion for "sudden and accidental" releases of pollution.



temporally quick or short. The insurers' strategy includes publishing a steady stream

of articles falsely proclaiming a "trend" in the courts rejecting coverage for policyholders. There is, though, an increasing body of case law to the contrary that insurers have sought to obscure by settling cases in which courts have ruled favorably for policyholders on the condition that such favorable rulings and opinions be vacated. Risk managers should therefore take the insurers' assertions with a healthy dose of skepticism. There are several avenues for coverage of gradual pollution as long as the pollution was unexpected and unintended from the standpoint of the policyholder.

The first avenue to obtain coverage is simple contract construction. Because the first rule of construction is to give words their common and ordinary meaning, policyholders should ask the court to construe the words in accord with their dictionary definition. In the dictionary, "sudden" is defined as "unexpected" or as "quick." Accidental is defined as "unintended."

Therefore, simply reading the policy leads to two reasonable interpretations of "sudden and accidental": "unexpected and unintended" or "quick and unintended." Most jurisdictions have rules of construction for insurance contracts that require that when a policy provision has more than one reasonable interpretation, the interpretation favoring coverage must be adopted.

The second avenue for coverage is to construe the policy in light of the circumstances in which it was drafted. Most of the CGL policies issued between 1970 and 1985 were not individually drafted or negotiated. Rather, in 1970, the form policy with the pollution exclusion was drafted by the insurance industry trade associations, which then obtained approval for use by their member insurers in each state based on

certain representations.

Specifically, the insurance industry associations responsible for obtaining approval expressly represented that the pollution exclusion would not change existing coverage and was intended only to "clarify" that intentional or willful polluters would not have coverage. Many insurers also

**There are several avenues for coverage of gradual pollution as long as the pollution was unexpected and unintended from the standpoint of the policyholder.**

made such representations individually. Knowing how to find these materials in discovery is critical in coverage litigation.

Public literature, case law and industry publications at the time the pollution exclusion was up for approval—1970—make it clear that before the introduction of the pollution exclusion, gradual polluting events that caused damage that was unexpected and unintended by a policyholder were covered. This is the coverage that the insurers represented to policyholders and state insurance commissions as preserved by the 1970 pollution exclusion.

Because the insurers represented that they were not reducing coverage, they sought and obtained the right to keep premiums the same, even with the introduction of the 1970 pollution exclusion. Accordingly, if the pollution exclusion is construed in light of its drafting and approval history, as most jurisdictions will allow, it plainly provides coverage for gradual but unexpected and

unintended pollution.

A third avenue for coverage arises out of the unfairness of the insurers attempting to now take a position on the meaning of the pollution exclusion that is different from the position they successfully asserted to get approval for the pollution exclusion with no premium reduction. Most jurisdictions have doctrines, such as estoppel, quasi-estoppel, equitable estoppel, judicial estoppel or regulatory estoppel, that can be invoked to bar an insurer from taking a position contrary to one from which it previously benefited. Courts do not appreciate parties who play fast and loose with the facts.

A fourth avenue for coverage is to attempt to fit within the insurers' definition of sudden and accidental. Insureds should obtain expert guidance from engineers and other scientists as to whether any of the discharges at issue are temporally quick or short, in addition to being unexpected and unintended.

Finally, a policyholder should carefully scrutinize the insurers' correspondence for misrepresentations about the coverage. Insurers have been known to overstate the effect of policy exclusions, to misstate what exclusions are in a policy and to fail to disclose that unapproved variations of exclusions have been used in a policy. In many jurisdictions, these types of misrepresentations can serve as the basis for a common law or statutory bad faith claim. In short, don't take "no" for an answer without a thorough investigation, because sometimes "no" means "yes."

*Deborah Deitsch-Perez is a partner in the Dallas law firm Lackey Hershman L.L.P. William A. Brewer is a partner in the Dallas law firm Bickel & Brewer.*

# Workers comp fraud reports increasing

## Dramatic rise in compensation claims, higher legal, medical costs affect industry

By Derrick Amato  
and Tewabe Joro Ayenew

Can't find affordable workers compensation insurance? You are not alone. There's been a dramatic increase in fraudulent workers comp claims—up to 40% to 50% higher in 2003 alone, according to some insurers. And as if that wasn't enough, the fraud is compounded by skyrocketing legal and medical costs. The result of cost increases is insurer consolidations and closings and, ultimately, workers comp insurance rates that are affecting the bottom line of virtually everyone in the industry.

So what's the solution? One tactic working for a growing number of organizations is taking a new approach to litigation management.

First, a look at some of the causes impacting costs. While the phenomenon of rising workers comp costs is nationwide, the exact causes vary by region. For example, a study by the Cambridge, Mass.-based Workers' Compensation Research Institute found that benefit delivery costs in California were 13% higher than those in other states, largely because of more litigation and greater

attorney involvement resulting from fraudulent claims. California employers also spent more than \$350 million in 2002 defending medical claims decisions. And while California is getting a lot of attention, it isn't the only state with problems. Florida is also undergoing major reforms.

It must also be recognized that workers comp fraud historically has increased during tough economic times. Both the Insurance Information Institute and the Coalition Against Insurance Fraud note significant increases in fraudulent claims during recessions and after major catastrophes.

While ongoing developments in legislation have helped to stem some of the problem, much can be resolved at the individual claim level if all stakeholders—employers, claims administrators, insurers and attorneys—work together to obtain favorable outcomes.

Following are four steps that employers can use to establish effective litigation management practices:

- **Change the ground rules.** Insist on experienced adjusters on the front lines who can effectively analyze cases for their profit/loss margin and determine how much a claim ultimately will cost. Defend with reason—no one benefits when a \$5,000 claim

is denied and \$10,000 is spent to fight it. Also, look beyond the win-loss column when choosing a legal team. Consider the firm's ability to conclude the claim quickly and avoid excessive legal fees.

- **Don't hide behind data—use it.** Insurers and claims service providers are positioned uniquely today in that they can hold law firms accountable for their charges. Where the mass of paper associated with claims and legal proceedings once was overwhelming, reports and correspondence now can be transmitted electronically. Tools also are available to better track how a law firm uses its time. Claims managers today also can gain better perspective on the total cost of their claims, analyzing the loss based on the type of claim, the jurisdiction and its severity.

- **Know the attorney working on the claim.** While you may be drawn to a particular firm because of its lineup of hard-hitting senior partners, don't be surprised to find work assigned to new associates. Experienced adjusters can offset any problems that may occur when working with an inexperienced associate, but it's also important to match the right lawyer with the right case. Where one associate may excel at compensability issues, another associate may be better suited to coverage or jurisdictional issues.

- **Develop a game plan.** Insist upon a formal plan of action agreed to by the employer, claims company and law firm, and

then review it regularly. The plan should clearly outline each party's responsibilities, and any changes should be clearly communicated. One leading insurer, for example, conducts onsite performance reviews of defense firms—typically every 12 to 24 months, depending on the outcome of prior evaluations—to look at cases, compare them against the original plan and determine whether all agreed-upon guidelines were met.

More so than any other type of coverage, workers comp is a triage business because of the dynamics of the system in which these claims are adjudicated. While the vast majority of claims remain valid, incidents of fraud have been increasing at troubling rates. Therefore, the balance must be monitored carefully. Claims managers must quickly identify cases with the highest potential exposure. Risk managers—as representatives of the employer—must get involved early in the legal process to ensure that the proper course of action is taken and handled effectively. The smart manager is one who arms himself or herself with the best information, selects the right legal team and fosters a team approach that uses the expertise and talents of all parties involved.

*Derrick Amato is senior vp-operations of field claim services for Cambridge Integrated Services Group Inc. in North Providence, R.I. Tewabe Joro Ayenew is relationship development manager at Visibillity Inc. in Chicago.*

## P/C accounting obscures current profitability

By Howard C. Alper

A version of this article originally appeared in the June 27, 1988, edition of *Business Insurance*, and the concept is as sound today as it was then.

It doesn't make much sense to assume a commercial property risk for \$100,000 one year and for \$70,000 the next, particularly when the risk is larger. Yet that is exactly what is beginning to happen today.



Must we repeat our industry's mistakes? That's where we're heading unless we instill some sanity into our business.

Yes, there are market forces, and the hard/soft market cycles appear to be inevitable, but insurers certainly should be able to

moderate the "swings" and not massacre themselves. Let's not forget the many 100-year-old major insurers that are gone.

There are few "new" accounts born to satisfy property/casualty insurers' insatiable appetite for volume in the soft market. Almost 50% of total commercial volume is now in alternative risk transfer vehicles. Accounts are churned among insurers, at expensive processing and reunderwriting costs.

Pricing accounts is difficult, and rate adequacy is elusive. But these problems are the essence of the insurance industry's existence. The biggest detractor to stability of

operations and sound underwriting seems to be insurers' accounting system.

Consider this "fairy tale" illustration:

There was a time when rates were steady and good underwriting profit—plus investment profit—was produced.

One underwriter—let's call him Brilliant Underwriter, or BU—decided that if he slashed rates, he'd attract more business, have better selection, spread fixed costs and make more money.

Writing \$12 million in premium a year, BU cut rates in half and doubled his monthly volume to \$2 million—albeit at 50% rates—by assuming four times as much risk. At the end of that month, BU still showed a profit. So he decided to do it again.

The next month, BU wrote \$3 million of volume at 33% rates and still showed a profit. So he continued at the 33% rates. He figured he didn't have to cut rates any more, unless his competitors decided to play the same game. Of course, they did.

Four months later, BU found he was losing money. His loss ratio was so bad he doubled the rates. After a month, BU's results weren't much better, so he doubled them again.

BU thought he'd increased annual underwriting profit to \$1.63 million from \$1.2 million. Very commendable, except for three flaws:

- BU's operating figures include many months of higher-priced business, thereby

continuing to flow previously developed profit through to the last 12 months' results.

- BU assumed claims would continue at 60%, the same as his seasoned book of business. But they won't, of course, because he's underwriting more units at lower premiums.

- BU thought he'd be a better underwriter than most. But he won't be, as during volume-building periods, underwriting procedures are de-emphasized.

Finally, realizing where he was, BU doubled the 33% rates to 66% and, after a month, doubled them again to 133%. Now, he'll make some real money. And that established the next cycle!

While this fairy tale is exaggerated, it

illustrates precisely what occurs in real life, albeit at a slower pace.

The flaw in property/casualty insurers' accounting system is the use of the last 12 months' operating results to measure current profitability. Prior results have no bearing on projected results if there have been price changes.

Underwriters should use industry operating data—not financial reporting records—to make sound business judgments. With price changes—and every 12-month period has them—insurers need to revalue their on-the-books business before they can intelligently project results.

Insurers can experiment with different

computer rate levels without the agony of real combat suffered by our BU. They can obtain the prior loss experience, project loss costs and divide by whatever factors they want to achieve parity rates.

Insurers are better able to price existing business. So why do they cut prices to get new accounts, when they don't know them as well as existing accounts?

Practically all property/casualty insurers showed substantial improvement in 2002 operating results over 2001 results. That's because they overreacted to the late 1990s soft market and pushed prices excessively high to stop their near-death bleeding. Some insurers' huge price increases are excessive because they adjust for inadequacy. Producers always push for lower price; underwriters need to do their job and intelligently evaluate each risk, regardless of market conditions.

So, will underwriters gradually reduce prices—practically month by month—by measuring the last 12 months' results? Many insurers are now enjoying healthy profits from recently overpriced business. Are we destined to repeat the soft market massacre?

Above all, insurers should forget "market share" and "cash flow" underwriting. Who needs a share of an underpriced book of business? And how will insurer CEOs explain to their boards why they managed the company into such a large operating loss—or oblivion? When are insurers going to realize what they are doing? Before or after the government takes control?

*Howard C. Alper is president of Chicago-based AuditRate Inc., an insurance cost-reduction consulting firm.*

## 'Kimchi' dishes up recipe for global success

By Mark A. Hofmann

"The Kimchi Matters"

By Marvin Zonis, Dan Lefkowitz and Sam Wilkin

Agate Publishing, distributed through Consortium Book Sales & Distribution  
1045 Westgate Drive  
St. Paul, Minn. 55114  
[www.cbsd.com](http://www.cbsd.com)  
\$25.95

Risk managers reading "The Kimchi Matters" will find it isn't a book about risk management in the way they usually think about it. The book doesn't deal directly with insurance coverage issues, policy limits or traditional loss control. But make no mistake, "The Kimchi Matters" does deal with risk.



The risk in question is that which any enterprise faces as it considers doing business abroad. This is more than political risk or currency inconvertibility—it's the risk of being burned because you don't understand the unique characteristics and dynamics that determine how a country or society really works.

termine how a country or society really works.

### Book review

This perspective got obscured by the hype surrounding globalization not that many years ago, according to the authors. "Even as the globalization boom took hold, the dynamics of local politics continued to operate. In fact, far from subsuming local politics, globalization actually served to amplify local politics, bringing the problems of distant, dysfunctional states uncomfortably close to home, so that the lives and pocketbooks of people around the world came to be buffeted by obscure political developments in faraway lands."

The authors demonstrate how this works through a sort of socio-political-historical travelogue. "Kimchi" is the book's chosen metaphor—fiery fermented cabbage that is Korea's "unofficial national dish," as the authors put it. They acknowledge that it "has its charms. But it is, at least for now, an acquired taste, a very local dish." They note that "one lesson of Sept. 11, 2001, is that the small stories, the regional politics and the local struggles cannot be overlooked. Everyone eats Big Macs, but the kimchi matters more than ever before."

The authors—all Chicago-based—bring a wealth of expertise to the subject. Marvin Zonis is a professor of international political economy at the University of Chicago's graduate business school. Dan Lefkowitz is associated with Marvin Zonis & Associates, a politi-

cal risk consultant. And Sam Wilkin is a trade credit and political risk country advisor at Aon Corp.

Ranging from the politics of software in South Korea to Kemal Ataturk's continuing legacy in Turkey to the reasons for Botswana's relative wealth and stability in a poor and unstable region, the authors again and again un-

derscore the point that U.S. businesses cannot approach the world with a one-size-fits-all philosophy. To ignore the kimchi can mean taking unnecessary—and, potentially, quite costly—risks.

*Mark A. Hofmann is a senior editor in Business Insurance's Washington bureau.*

## Interested in submitting an article for the Perspectives section of *BI*?

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

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

To submit an article for the Perspective section:

- Send us a letter describing the topic you would like to address. Briefly describe what you want to say and accomplish in

the article.

- You will receive from us an acceptance or a decline of your article idea.

- If accepted, we will respond with comments and request the full article, which generally should be no more than 800 words in length.

- All articles are to be accompanied by a black-and-white photograph of the author and a brief biography.

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

All authors must assign the copyright on the article to *Business Insurance*.

To submit a Perspective article query or for more information, send a note to [biweb@crain.com](mailto:biweb@crain.com).

## Between the Lines

Compiled by Joanne Wojcik



### Boys in blue (movies)

A San Diego police officer has been given the green light to sue his employer for wrongful termination even if his off-duty activities are considered off color by the department.

The 9th U.S. Circuit Court of Appeals ruled Jan. 29 that the policeman, who moonlighted as a stripper and sold videotapes of his performances on eBay, can proceed with a lawsuit claiming his off-duty activities are protected by his First Amendment right to free speech.

The policeman sued the San Diego Police Department and the city after he was fired for allegedly violating department rules by engaging in conduct unbecoming an officer, court records show. A trial court dismissed the suit, finding that his employer did not violate his constitutional rights.

But two appeals court judges disagreed and ruled that the policeman's "expressive conduct," no matter how unseemly, was directed at the general public and that he was not acting in his capacity as a police department employee. Furthermore, the uniform he wore in the videos was not the one he had been issued as a police officer, court records show.



### Beauty is in the eye of the policyholder

A new insurance policy fills the gaps in health insurance should a plastic surgeon nip a little too much on that tummy tuck.

For just \$132 per procedure, CosmetAssure will cover the cost of treating medical complications following elective cosmetic surgery, which generally is not covered by standard health insurance policies.

Available in 38 states, CosmetAssure was developed by board-certified plastic surgeons to increase patient awareness of the possibility of complications.

"More than 6.6 million Americans had plastic surgery in 2002 alone, and just as with any surgery, these patients are at risk for complications," explains a press release announcing the launch of the coverage.

CosmetAssure is underwritten by the National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of New York-based American International Group Inc.



### 'Ronald & Me'

Although judges in several states have dismissed as frivolous lawsuits accusing the fast-food industry of harm, an independent filmmaker has set out to prove them wrong.

"Super Size Me: A Film of Epic Proportions" follows the 6-foot-2, 185-pound Morgan Spurlock on a month-long gastronomic odyssey through 20 cities where he ate all his meals exclusively at McDonald's restaurants.

By the end of his project, during which he subsisted mainly on Egg McMuffins, Big Macs, Chicken McNuggets and french fries, Mr. Spurlock says he gained 24 pounds, his liver became toxic, his cholesterol soared, he suffered headaches, he lost his libido and he became clinically depressed.

Facts and statistics about the obesity epidemic faced by America's increasingly sedentary society are provided throughout the film,

which was likened to a Michael Moore-style documentary by critics viewing it at the recent Sundance Film Festival.



Independent filmmaker Morgan Spurlock ate nothing but McDonald's food for one month.

Tips and feedback from readers are welcomed. Please send information to [joajcik@crain.com](mailto:joajcik@crain.com).

## Products & Services

### Liberty Mutual introduces FMLA compliance product

**BOSTON**—The Liberty Mutual Group has designed an administration tool to help benefit managers comply with federal and other Family and Medical Leave Act requirements.

The Boston-based company offers a dedicated unit and proprietary database that can identify an employer's specific federal, state and union requirements; manage its FMLA and short-term disability programs; and produce a range of reports online.

More information about the FMLA administration product can be obtained by contacting Tom Harrington, product manager of Liberty Mutual's marketing and product management division, by telephone at 617-357-9500, ext. 42820, or by e-mail at [thomas.harrington@libertymutual.com](mailto:thomas.harrington@libertymutual.com).

### Blue Cross offers health savings account

**EAGAN, Minn.**—Blue Cross & Blue Shield of Minnesota has launched a health savings account program designed to offer more affordable health care coverage for employees and more tax breaks for employers.

HSA's were designed to give employees more control over their health insurance decisions; the money can be withdrawn from an HSA for health care expenses as needed. Unlike a flexible spending account, an employee's account

does not expire at year end. The balance is rolled over and can earn interest or be invested.

The plans are available to groups of any size. Both an employer and an employee can contribute to an HSA account in the same tax year. The tax advantage allows employers to save on FICA taxes and permits employees to make pre-tax deductions.

For more information, contact Kathy Kelly, director-product management, by telephone at 888-878-0139, ext. 22940, or by e-mail at [kathy\\_kelly@bluecrossmn.com](mailto:kathy_kelly@bluecrossmn.com).



### Program provides coverage for high-risk occupations

**NEW YORK**—American International Group Inc.'s Domestic Accident & Health Division and AIG Global Energy unit introduced a new employee benefit program for workers who perform hazardous jobs.

The insurance program, On-the-Job Accident Protector, offers accidental death and dismemberment coverage for employees with dangerous

occupations who may have more difficulty finding accident and health coverage.

The On-the-Job Accident Protector does not interfere with other policies the employee may hold and consists of traditional AD&D elements. The coverage also includes noninsurance benefits, such as financial consulting and bereavement counseling. The policy can also be expanded to include commutation coverage, which insures the transportation of employees to remote locations, such as offshore oil rigs.

For more information, contact Ronald Clarke, vp of accident and health at AIG Global Energy in New York, at 212-770-2305 or visit the company's Web site at [www.aandh.aig.com](http://www.aandh.aig.com).

### Application streamlines crisis management planning

**GLENDALE, Calif.**—The National Notification Network, a provider of mass communication and mass notification products, has developed a crisis management program to help businesses manage disaster recovery and business continuity plans.

Glendale, Calif.-based 3N designed the emergency notification system for organizations to respond rapidly to high-risk circumstances—such as natural disasters, terrorist attacks and fires—and temporary interruptions such as the loss of telephone service.

The applications for the 3N notification system include evacuations of buildings, notification of emergency crews, verification of the location and safety of employees and contact of security and crisis management personnel.

More information about this product can be obtained by contacting James Keen, vp-sales, by telephone at 888-366-4911, ext. 223, or by e-mail at [jamesk@3nonline.com](mailto:jamesk@3nonline.com).

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February 9, 2004

## Weather: Status of hedges debated

Continued from page 4

The WRMA, however, maintains that the weather derivatives do not constitute insurance. Such contracts are not insurance because they do not require proof of loss to trigger payouts, and many do not require the buyer to provide up-front payment—such as a premium—to execute coverage, the organization said in a statement.

**'The NAIC draft white paper came as quite a surprise to the weather risk management industry.'**

Valeria Cooper

Weather Risk Management Assn.

In addition, the WRMA notes that oversight by insurance regulators is not needed, as some transactions are regulated by entities like the Commodity Futures Trading Commission.

The Crop Insurance Working Group's analysis has raised questions about its recommended solution, including whether state insur-

ance regulators would be the best entity to oversee such transactions, said South Dakota Insurance Department Director Gary Steuck, who chairs the working group.

"The NAIC draft white paper came as quite a surprise to the weather risk management industry, given the precedent opinions previously laid out by the New York Insurance Department," the WRMA's Ms. Cooper said in a statement.

New York insurance regulators previously concluded that weather derivatives are not insurance contracts "where the amount of the payment need not bear a relation-

ship to the purchaser's loss," according to Michael Moriarity, the New York department's director of capital markets.

The NAIC's review of the issues paper began at the behest of now-NAIC President Ernst Csiszar. In a letter presented at the organization's December meeting, Mr. Csiszar wrote that the working group's conclusion appears to contradict the position taken by the International Assn. of Insurance Regulators and that of the NAIC itself in a previous letter to the General Accounting Office. In addition, he urged that the NAIC's Insurance Se-

curitization Working Group review the draft paper before the Property and Casualty Insurance Committee—the Crop Insurance Working Group's parent committee—considers adopting it.

During a conference call last week, members of the Insurance Securitization Working Group echoed some of New York's concerns and recommended against adoption of the white paper.

In addition to the IAIS, the Financial Accounting Standards Board and the International Accounting Standards Boards "have all taken steps to distinguish weath-

er derivatives from weather insurance," according to a recent memo from Mr. Moriarity, who acts as chair of that working group for New York Insurance Superintendent Gregory Serio.

In addition, "we feel we could be heading down a slippery slope," if the white paper were adopted, he said. Those comments will be presented to the Property and Casualty Working Group during the NAIC's spring quarterly meeting in New York, March 13-16.

Given the negative reaction to the Crop Insurance Working Group's paper, "I don't think they have a leg to stand on," said Paul Forrest chief financial officer of Heating Oil Partners L.P. in Darien, Conn.

## Armstrong: Asbestos

Continued from page 4

cap was imposed on the succeeding years' policies, court records show.

Armstrong launched arbitration proceedings against Liberty Mutual and other insurers in 1996 to resolve several issues, including what proportion of its asbestos liabilities should be considered nonproducts claims. Liberty Mutual countered with several defenses, including that claims under the 1973-1977 policies are time-barred under the Pennsylvania statute of limitations.

A trial arbitrator ruled in 1999 that 74% of Armstrong asbestos bodily injury claims resolved through 1996 should be considered nonproducts claims. He also rejected the insurer's statute of limitations defense.

Last month, though, a three-member appellate panel reversed the earlier ruling, finding the statute of limitations applies, barring further coverage of Armstrong under the four policies.

As a result, Armstrong will lose its right to \$40 million in coverage for nonproducts claims under the policies, the Lancaster, Pa.-based insulation company says. The ruling will also force Armstrong and Liberty Mutual to litigate most of the same coverage issues for the 1977 to 1982 policies, which provide unlimited coverage for nonproducts claims, Armstrong argues.

An Armstrong suit against Liberty Mutual on the 1977 to 1982 policies has been on hold in a Philadelphia federal court since 2002 pending the outcome of the arbitration.

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# Clubs' missed financial goals hitting insurers

## Woes put finance deals in question

By CAROLYN ALDRED

Several insurers have become embroiled in the financial problems of some of Europe's cash-strapped soccer clubs.

The soccer deals that have left insurers exposed to some large losses take two principal forms, observers say. The first offers financial guarantee coverage for the future television and sponsorship revenues of some troubled clubs, while the second involves insurers in financing multimillion-euro player transfer deals among top European clubs in a market that has seen player values plummet.

One of the financial guarantee coverages involves Trieste, Italy-based insurer Assicurazioni Generali S.p.A. and the bankrupt Italian food company Parmalat S.p.A.

Generali is among 15 Italian insurers that provided financial guarantee insurance for the 95 million euro (\$118.5 million) securitization of television and sponsorship revenues for the Italian top-league club Parma A.C. in 2002. Parmalat is the club's main sponsor and its majority shareholder.

According to documents outlin-

ing the securitization, 40.9 million euros (\$51.0 million) of Parma's sponsorship revenues during the three-year structure to September 2005 are from Parmalat.

Generali confirmed that it leads the financial guarantee insurance for the bonds issued by Fiordillate Srl, a company set up as part of the securitization deal, but would not comment in detail.

A source said, though, that a "counterguarantee," or cash-back promise, reduces Generali's potential exposure under the contract and noted that the first principal payments of 23.5 million euros (\$29.3 million) were paid by Parma in December 2003 and that two-thirds of the remaining payments are backed by television rights.

Stelvio Bo, the head of securitization at Milan-based Abaxbank S.p.A. who helped structure the deal, noted that Parma had agreed to set aside part of the financing raised as security for Generali. Mr. Bo would not specify how much cash has been put aside as a counterguarantee, but he said that the television payments were secure as long as Parma remained in Italy's top league, the Serie A.



PHOTO: EPA

**Italian soccer team Parma is one of several European clubs whose financial troubles have snared insurers that wrote financial guarantees backing securitization deals used to raise capital.**

Parma's future in the game remains uncertain, though. Its board of directors resigned en masse last month; its financial losses last year totaled 77 million euros (\$96.1 million); and Parmalat, its main shareholder and sponsor, is bankrupt and under criminal investigation following the discovery that billions of euros were missing from its accounts.

Securitization of future ticket sales, merchandising, sponsorship and television income has been

used as a means of raising financing by more than a dozen clubs in Italy and England. Several of the clubs, including Italy's AC Fiorentina and England's Leicester City, Ipswich and Leeds United, are in or have been through serious financial difficulties.

Most of these securitizations were not backed by financial guarantee insurance, according to Stuart Brinkworth, a specialist football financing lawyer with the London

See **CLUBS**/next page

## AIDS/HIV hurting employers

Increased employee benefit costs, lower productivity and increased absenteeism are among the biggest effects HIV and AIDS are having on businesses in South Africa, a study reveals.

A survey of 1,006 South African companies, sponsored by the South African Business Coalition on HIV and AIDS and conducted by the South African Bureau for Economic Research, found that 39% of respondents said HIV/AIDS had reduced labor productivity and increased absenteeism, while 33% said employee benefit costs had increased because of the country's epidemic.

About 5.3 million people—or one in five adults—are living with HIV/AIDS in South Africa, according to SABCOHA.

Roughly one-quarter of survey respondents said they have in place a policy against discrimination, among other things, for workers with HIV/AIDS, while 41% said they have a workplace awareness program.

Eighteen percent of respondents said they have voluntary counseling and testing programs; 13% said they have instituted HIV/AIDS care, support and treatment programs; and 6% said they provide anti-retroviral therapy in the workplace.

Copies of the survey are available online at [www.sabcoha.co.za](http://www.sabcoha.co.za).

—By Sarah Veysey

## Allianz to pay HIH liquidator to end spat over joint venture

By ELIZABETH FRY

**SYDNEY, Australia**—Allianz A.G. Holding has agreed to pay \$120 million Australian (\$90.0 million) to settle its financial obligations stemming from a joint venture it entered with HIH Insurance Ltd. prior to the Australian insurer's collapse.

The New South Wales Supreme Court late last month approved a deal under which Allianz will pay HIH's liquidator—Tony McGrath of KPMG L.L.P.—\$120 million Australian to resolve Allianz's 2000 purchase of one of HIH's biggest and most profitable businesses.

Munich, Germany-based Allianz had originally offered \$325 million Australian (\$182.0 million) for a 51% stake in a joint venture comprising HIH's personal lines and compulsory third-party liability businesses, and a portion of Allianz's small commercial business, but it withheld payment once HIH went into provisional liquidation in 2001.

Mr. McGrath said that accepting the settlement was preferable to overturning the transaction and starting over. "The joint venture was too complicated to unwind. Tax issues plus a put/call provision, which allowed HIH to sell or Allianz to buy the JV at any time, meant that we had already taken two-and-a-half years to reach a settlement,"

Mr. McGrath said.

In September 2000, a cash-strapped HIH agreed to contribute its retail operations into a joint venture with Allianz. At the time, HIH's 49% share of the venture was valued at between \$125 million Australian and \$500 million Australian (\$70.0 million and \$280.0 million),



**German insurer Allianz has reached a settlement with HIH's liquidator.**

depending of its future performance. Because HIH was contributing its FAI Insurance Ltd. and CIC Insurance Ltd. units to the joint venture, Allianz had agreed to pay \$200 million Australian (\$112.0 million) over the minimum price of \$125 million Australian to obtain a controlling stake. But instead of paying that \$200 million Australian to HIH, it was placed into a trust to form part of the reserves of the new joint venture.

In March 2001, when HIH was facing the prospect of regulatory control, the put/call option was triggered when HIH "put" its 49% stake back to Allianz for the minimum value of the HIH interest, \$125 million Australian. Under the terms of the original deal, Allianz would have been able to purchase the joint venture at an even lower price in the event of HIH's liquidation.

But HIH was placed in provisional liquidation before the \$125 million Australian payment was made.

The court-approved \$120 million Australian settlement is all Allianz will pay for the HIH business, because it regained control of its \$200 million Australian "top-up fee" when HIH surrendered its 49% stake to Allianz, explained John Sheahan, insolvency liquidation specialist at Sydney-based Sheahan Lock Ltd., who is not involved in the HIH liquidation.

If HIH's creditors want to pursue Allianz for funds beyond those provided in the settlement, they will have to sue Allianz, he said.

"There is no doubt that the only way for HIH creditors to achieve a sensible result, is to through the courts," Mr. Sheahan said.

According to the Royal Commission investigating the collapse of HIH, the terms of the joint venture caused a severe cash flow problem at HIH and hastened its demise.

## World Updates

### U.K. bans former execs over accounting

The United Kingdom's financial services regulator has banned six former insurance executives from working in the U.K. market for their role in misrepresenting company accounts. The six individuals were all, at varying times, directors of London-based Chiyoda Fire & Marine Insurance Co. (Europe) Ltd., now known as Aioi Insurance Co. of Europe, a subsidiary of Japanese insurer Chiyoda Fire & Marine Insurance Co. Ltd. The London-based Financial Services Authority said in a statement that the directors had all played a role in distorting accounts during 1999 and 2000.

### U.K. encouraging pension participation

The U.K. Department for Work and Pensions has unveiled proposals designed to boost employee participation in occupational pensions. Among the DWP's proposals is requiring employers to automatically enroll new hires into company pension plans unless the individuals elect to opt out. Secretary of State for Work and Pensions Andrew Smith said the government would work with employers, labor unions and the financial services industry to find ways to encourage employees to join employer-sponsored plans. The DWP paper can be viewed online at [www.dwp.gov.uk/publications](http://www.dwp.gov.uk/publications).

### Fortis U.S. unit brings \$1.76 billion in IPO

Fortis A.G. raised about \$1.76 billion Thursday in an initial public offering of its U.S. operations. Fortis said that it offered 80 million shares of the unit, Assurant Inc., on the New York Stock Exchange at \$22 per share. Shares closed Thursday at \$24.70, up 12.3%. Fortis, which is based in Brussels, Belgium, and Utrecht, Netherlands, said that about \$700 million of the IPO proceeds would be used to recapitalize Assurant. The New York-based unit includes a risk management arm and an operation offering group disability, life and dental insurance.

### Briefly noted

Stockholm, Sweden-based **Skandia Group** has sold its Japanese operations to Tokio Marine & Fire Insurance Co. Ltd. for 1.4 billion Swedish kronor (\$203.1 million). For 2002, Skandia Japan posted a 313 million Swedish kronor (\$42.4 million) aftertax loss. Skandia said in a statement...Russell Blong has been appointed to **Benfield Group Ltd.**'s natural hazards research team in Australia. Mr. Blong formerly was director of a natural hazards research center at Macquarie University in Sydney.

February 9, 2004

## Clubs: Insurers facing losses

Continued from previous page

law firm of Ashurst. Insurers, particularly life and pension companies, are big investors, though, in the bonds resulting from such securitizations, he said.

Most worrying among the U.K.-based deals at the moment is Leeds United, said Mr. Brinkworth. Leeds, currently at the bottom of the English Premier League, has been in negotiation with its major creditors in an effort to fight off bankruptcy.

According to Leeds, New York-based Metropolitan Life Insurance Co. and Teachers Insurance & Annuity Assn. and London-based PrudentialM&G, the fund management arm of London-based Pruden-

tial P.L.C., invested in the issue of £60 million (\$109.5 million) worth of bonds secured against the club's future ticket sales.

Leeds is also at the center of one of the player leasing contracts that are also troubling insurers.

One of the club's other main creditors is Gerling General Insurance Co. Ltd., the London unit of Cologne, Germany-based Gerling Group. Gerling insures a Guernsey-based operation, Registered European Football Finance Ltd., which leased several players to the club.

Under the leasing arrangements, players' contracts are bought through special purpose vehicles using bank-financed funding. An

insurance company guarantees lease payments to the SPVs. The selling club obtains payment in full while the buying club is able to make its payments over the duration of the players' contracts. But as transfer values have fallen, if a club must cash in the contracts by selling players, it often cannot recoup the amount that it has committed to pay for the player.

Under its leasing deal, Leeds owes £21 million (\$38.3 million) to REFF, sources say. Under a standstill agreement in December, Gerling agreed to defer £1.7 million (\$3.1 million) in capital and interest payments until January to allow Leeds time to seek additional funding, the

club stated. According to a club spokesman, Leeds now has raised sufficient capital to see it through the end of the season, but its future rides on whether the club can avoid relegation to a lower division.

London-based broker Benfield Group Ltd. and Gerling were market leaders in player transfer leasing, which was a "big boom" market for a few years, said Dan Jones, a director of the Manchester-based sports business group of the accounting firm of Deloitte & Touche L.L.P.

Deloitte & Touche estimates that about £120 million (\$219.0 million) of player leasing financing had been placed in the U.K. insurance market by 2002. Banking sources estimate that more than 50 players have been bought through player leasing deals by more than a

dozen of the United Kingdom's largest soccer clubs.

Gerling, which no longer writes the business, has taken losses on players leased with Leicester City and Bradford City. Leicester entered bankruptcy in October 2002, when its revenues plummeted after it was relegated to a lower division, and Bradford entered administration in May 2002.

Gerling confirmed that its U.K. branch "was a provider of insurance to a finance program which assisted Leeds United in funding the acquisition of new players" but would not comment further.

A spokesman from Benfield confirmed that Benfield Greig Football Finance was set up in 1999 to establish player leasing deals but said it stopped placing the business "several years ago."

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### LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT  
SOUTHERN DISTRICT OF NEW YORK

In re  
Petition of Board of Directors of  
LUDGATE INSURANCE COMPANY LIMITED,  
Debtor in a Foreign Proceeding.

### LEGAL NOTICE

In a Proceeding Under  
Section 304 of the  
Bankruptcy Code  
Case No. 04-B-10590 (RDD)

NOTICE IS HEREBY GIVEN that, in connection with the Petition filed on January 30, 2004, pursuant to section 304 of the Bankruptcy Code (the "Petition"), with respect to Ludgate Insurance Company Limited (the "Company"), the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") has issued an Order to Show Cause for Preliminary Injunction, dated January 30, 2004 (the "Order"), pursuant to which a hearing will be held on February 19, 2004 at 2:00 p.m. before the Honorable Robert D. Drain in Room 610 of the Bankruptcy Court, One Bowling Green, New York, New York (the "Hearing"), to consider the Petitioner's Request for a Preliminary Injunction on the terms as substantially set forth below:

1. Enjoining all Scheme Creditors (as defined in the Order) from: (a) seizing, repossessing, transferring, relinquishing or disposing of any property of the Company in the United States, or the proceeds of such property; (b) commencing or continuing any action or legal proceeding in connection with any Claim (as defined in the Order) (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever), including by way of counterclaim, against the Company or any property in the United States that is involved in the foreign proceeding, or any proceeds thereof, and seeking discovery of any nature against the Company; (c) enforcing any judicial, quasi-judicial, administrative or regulatory judgment, assessment or order or arbitration award obtained in connection with any Claim against the Company, and commencing or continuing any act or action or legal proceeding in connection with any Claim (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) or any counterclaim to create, perfect or enforce any lien, attachment, garnishment, setoff or other claim arising out of a Claim against the Company, or any of the Company's property in the United States, or any proceeds thereof, including, without limitation, rights under reinsurance or retrocession contracts; (d) invoking, enforcing or relying on the benefits of any statute, rule or requirement of federal, state, or local law or regulation requiring the Company to establish or post security in the form of a bond, letter of credit or otherwise as a condition of prosecuting or defending any proceedings (including, without limitation, arbitration, mediation or any judicial, quasi-judicial, administrative or regulatory action, proceedings or process whatsoever); (e) drawing down any letter of credit established by or at the request of the Company in excess of amounts expressly authorized by the terms of the contract or other agreement pursuant to which such letter of credit has been established; and (f) withdrawing from, setting off against, or otherwise applying property that is the subject of any trust or escrow agreement or similar arrangement in which the Company has an interest in excess of amounts expressly authorized by the terms of the trust, escrow or similar arrangement;

2. Requiring all persons and entities in possession, custody or control of the Company's property in the United States or the proceeds thereof, to turn over and account for such property to the Petitioner or Scheme Advisors (as defined in the Order); and

3. Requiring every Scheme Creditor that has a claim of any nature or source arising out of a Claim against the Company and that is a party to any action or legal proceeding (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) in which the Company is or was named as a party, or as a result of which a liability of the Company may be established, to place the Petitioner's United States counsel (Chadbourne & Parke LLP, 30 Rockefeller Plaza, New York, New York 10112, Attn: Francisco Vazquez, Esq.) on the master service list of any such action or other legal proceeding and to take such other steps as may be necessary to ensure that such counsel receives (i) copies of any and all documents served by the parties to such action or other legal proceeding or issued by the court, arbitrator, administrator, regulator or similar official having jurisdiction over such action or legal proceeding and (ii) any and all correspondence or other documents circulated to parties named in the master service list.

All parties-in-interest opposed to the Petitioner's Request for a Preliminary Injunction must appear at the Hearing at the time and place set forth herein. All papers submitted for the purpose of opposing the Petitioner's Request for a Preliminary Injunction shall be filed with the Bankruptcy Court with a copy to Chambers of the Honorable Robert D. Drain and served on Chadbourne & Parke LLP (Attn: Howard Seife, Esq.) so as to be received on or before February 17, 2004 at 5:00 p.m. New York time. The Order and supporting papers will be made available upon request at the offices of the Petitioner's United States counsel at the address below:

**Chadbourne & Parke LLP**  
Attorneys for the Petitioner  
30 Rockefeller Plaza  
New York, New York 10112  
(212) 408-5100  
Attn: Howard Seife, Esq.

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## Drugs: Changes in benefits

Continued from page 4

Towers Perrin in New York who oversees the firm's health plan management practice, estimated that only about a dozen companies are currently using RBP, in part because of its complexity. Mr. Fontanetta said, though, that he believes more companies will begin to implement the approach.

"We think it will get more focus and attention because of its ability to drive down health care costs," he said. "It has the potential of shifting consumption behavior to lower-cost alternatives."

Atlanta's Emory University revamped the prescription drug benefits for its 18,000 employees due to the high costs of its program, said Theresa Mee, senior director of compensation and benefits. In 2002, the cost per prescription for Emory employees was 30% higher than the average for other CIGNA Corp. clients, and

the university averaged 28% more prescriptions per member, Ms. Mee said.

Emory's main objective was to achieve savings by providing employees with a financial incentive to request lower-cost alternatives, including generics, Ms. Mee said. The university hired Birmingham, Ala.-based Caremark Rx Inc. to begin managing its new pharmacy benefits program in January 2003, she said.

The university went from a standard three-tiered drug program to a four-tiered program, with generic drugs in the first tier and personal-choice drugs—those used for conditions not affecting a person's health—in the fourth, Ms. Mee explained.

Under the new system, the retail copays are: \$12 for tier-one drugs, \$22 for tier-two drugs, \$42 for tier-three drugs and \$62 for tier-four drugs, she said. Emory, which spent

\$16.5 million on prescription drugs in 2003, will save an estimated 11%—or \$2 million—in 2004 due to the changes, she said.

Although the program targets expensive drugs such as Prevacid, Lipitor and Nexium, decisions on tier levels are often medically driven, she said. For example, Lipitor, which is used to treat high cholesterol, will remain in tier two because alternative medications are not as effective and because 1,300 university employees are currently using the drug, she said.

Although there is great demand for personal-choice drugs, Ms. Mee said there has not been much backlash to the decision to put these drugs in the most expensive tier.

"I think people realize that having foot fungus is not the same as having asthma," she said. "They are accepting the need for these changes as being driven by the high costs of drugs."

## Survey: Plan design

Continued from page 4

for the first time, and the monthly premium for family coverage went from \$0 to \$123, Dr. Snowden said.

The company made these changes because the survey showed Delta employees were willing to increase their own contributions to keep their health plans intact, a fact that surprised company officials, he said.

"These people are, in my opinion, overinsured and happy to be there," he said. "They are extremely risk-averse."

The company also eliminated subsidized retiree medical insurance and survivor benefits for all future hires because the survey showed that employees did not value these

benefits as highly as they valued pension and medical benefits, Dr. Snowden said.

Involving employees in the discussion on benefit costs as Delta did is important because most employees still do not see how increases in health care costs can affect their employers' ability to succeed as a business, according to the 2004 Health Care Consumer Poll conducted by Towers Perrin.

"Only half understand that employers can't absorb all the increases in cost," said Mark Schumann, a Stamford, Conn.-based Towers Perrin principal and the moderator of the session. "We haven't made the progress that we need to make in terms of employees understanding that context for change."

### 2004 Annual Employee Healthcare Conference

## ABC plan takes aim at rising health costs

By GLORIA GONZALEZ

**NEW YORK**—The president of the American Benefits Council presented a 10-year plan to reduce health care costs, provide more Americans with quality health care and ensure that more than 90% of nonelderly Americans have health insurance.

James Klein, president of the Washington-based organization, described the plan to about 250 attendees of the 2004 Annual Employee Healthcare Conference, held last month in New York.

The plan focuses on achieving its three goals by the year 2014.

The first goal is to return annual health care cost increases to a single-digit rate that tracks overall increases in the gross domestic product, he said. Health care spending is currently increasing more than three times the GDP's growth rate, Mr. Klein noted.

To achieve this goal, the council recommends increasing incentives for individuals to live healthier lifestyles through health plan design and reimbursement changes, he said. There is also a need for medical liability reform with reasonable limits on damages and a strengthening of the Employee Retirement Income Security Act of 1974 pre-emption and elimination of state mandates that interfere with more-affordable coverage for both the self-insured and fully insured, Mr. Klein said.

The second goal is to have at least 50% of Americans with coverage enrolled in a health plan design that provides user-friendly comparative information on the quality and quantity of health care provided, Mr. Klein said. Currently, only 1% of Americans are enrolled in some type of consumer-driven health plan, he said. The council is promoting the development of clear, publicly disclosed information that consumers can use to compare providers and an increase

in the number of health plans that reward individuals for becoming more engaged in health care decisions, Mr. Klein said.

The council's third goal is for 243 million nonelderly Americans, or 91%, to have some form of health insurance by 2014, he said. Currently, 43 million nonelderly individuals are uninsured, and the council would like to see that number reduced by half, Mr. Klein said. The council hopes to achieve this goal by promoting tax incentives for lower-income people to buy employer-sponsored or individual health care coverage and allowing retirees to pay for health insurance premiums out of retirement plan distributions on a pre-tax basis, he said.

The council, an advocate of employer-sponsored benefit programs, will release more details on the plan in about a month, Mr. Klein said.

"These are only initial policy recommendations," he said. "They don't solve all the problems, but...they will hopefully help bring down the costs to more-manageable levels."

### 2004 Annual Employee Healthcare Conference

## Employees aid in cost cutting

By GLORIA GONZALEZ

**NEW YORK**—Several companies have significantly cut the rate of increase of their health care costs by encouraging employee involvement in health care decisions and offering incentives for healthier lifestyles.

Benefits managers described their efforts to curb escalating health care costs to about 250 attendees of the 2004 Annual Employee Healthcare Conference, presented by the Conference Board and sponsored by Towers Perrin and WebMD.

Some companies promote a consumer-driven approach to coverage—which has the employee, not the employer, control the purchase and use of health care services—as a way to reduce cost increases.

"We need to move them from this entitlement mentality to engagement," said Megan Broderick, a manager of health and welfare for the Pepsi Bottling Group based in Somers, N.Y. "We need to move them from company responsibility for managing and paying for health care to shared responsibility."

In late 2002, Whole Foods Market opted to implement a consumer-driven health plan because the company experienced significant unexpected claims costs increases that year and because employees did not like the previous health plan, according to Paula Labian, national director of benefits and compensation for the Austin, Texas-based grocer.

"People were getting disengaged," Ms. Labian said. "They didn't want any part of this health plan. It wasn't working. It was too expensive for all of them."

The company, which has about 28,000 employees, moved from offering three health plans to one preferred provider organization with a \$1,500 deductible (\$1,000 for medical and \$500 for prescription drugs), 80% coinsurance and an out-of-pocket maximum contribution of

\$4,500, Ms. Labian said.

Whole Foods also developed a personal wellness account with a debit card with funds that can be applied to the deductible, copayments or any qualified health expenses not covered under the plan, Ms. Labian said. The amount allocated to each employee is based on service time, she said. For example, an employee with 10,000 hours, or roughly five years, of service would receive \$1,800 on the card.

Since the plan was implemented, medical claims have decreased about 13%, pharmacy claims have fallen 30% and hospital admissions have declined 22%, Ms. Labian said. Officials are optimistic about these changes and expect the annual rate of increase in health care costs to drop from 30% to a "tolerable" level of about 10% to 14%, she said.

IBM Corp. is facing its fourth consecutive year of double-digit increases in health care costs, according to Diane Gherson, vp, compensation and benefits for the Armonk, N.Y.-based information technology company. IBM, which has about 140,000 active employees and 123,000 retirees in its health care program, spends well above \$1 billion per year on health care, she said.

The company is now embarking on a project to create a sustainable benefit structure for the next seven years, Ms. Gherson said. The company created a PPO plan, which has a \$500 deductible for individual coverage and \$1,500 for family coverage, while preventive care has no deductible, she said. About 20% of employees have signed up for the PPO, but there has been some employee resistance due to the cost of the deductibles and an attachment to the health maintenance organization-based system, she said.

"A lot of employees still can't get their heads around the fact that they don't have to overinsure," she said.

Some companies are offering fi-

nancial incentives to encourage employees to lead healthier lives and reduce health care costs. IBM recently began offering \$150 rebates to its nonsmoking employees and those who successfully complete a smoking cessation program, Ms. Gherson said. Employees who take part in a fitness routine three times per week are also eligible for a rebate.

"What we want to reward is fitness," she said. "If you want to smoke, you'll pay more. If you don't want to have a fitness routine, you'll pay more."

Companies such as IBM and Florida Power & Light have also tried to shift costs to the companies that employ the spouses of their employees. IBM introduced an "opt-out" credit for the first time, while FPL introduced dependent coverage surcharges for spouses employed by other companies. FPL saved almost \$1 million in 2003 due to the spousal surcharge clause, according to Andrew Scibelli, manager of health promotion for the Juno Beach, Fla.-based utility.

FPL, which has 11,800 active employees and 4,500 retirees, saw annual increases in health care costs that averaged 21% over the last three years, Mr. Scibelli said. The company introduced a new point-of-service plan, three employee contribution levels based on salary and lower out-of-pocket costs and deductibles to encourage employees to move to managed plans. FPL has saved about \$9 million by revamping its program and believes it can slow the rate of increase in health care costs in 2004 to 7.4%, he said.

Making their employees understand the true cost of health care was a key part of FPL's plan, Mr. Scibelli said. "Most of them had a sense, but I don't think they truly understood the magnitude of it," he said. "We really had to make the appeal that the national problem was affecting the company."

### Conference draws 250 attendees

**NEW YORK**—About 250 people attended the 2004 Annual Employee Healthcare Conference, held Jan. 29-30 at the Waldorf-Astoria hotel in New York.

"Benefiting from Experience—the Next Wave in Employee Healthcare" was the theme of the event, which presented by the Conference Board and sponsored by Towers Perrin and WebMD.

The date and location of next year's conference have not been determined.

# SBC: Court allows deviation from pact

Continued from page 1  
AT&T spinoff.

In the case, Reba Hebert worked for AT&T and then Baby Bell Pacific Telesis Group of San Francisco for about 18.5 years before taking advantage of a PTG early retirement offer in 1990. Under the offer, PTG gave Ms. Hebert a three-year service credit, which was designed to increase her pension benefit.

She then immediately went to work for Southwestern Bell Telephone Co., a subsidiary of Baby Bell SBC Communications Inc. of San Antonio. Ms. Hebert transferred her pension benefits to the SBC plan, as allowed by the pension portability agreements stemming from the 1984 breakup of AT&T. After about nine years with SBC, Ms. Hebert retired in 1999.

But in calculating Ms. Hebert's pension benefit, SBC did not recognize the three-year service credit from PTG.

According to court papers, SBC contended that it must calculate each plan participant's pension benefits using one of two formulas and that the plan must pay each

participant the greater benefit.

One formula would have factored in the early retirement credit, but the formula would have arrived at Ms. Hebert's total benefit by adding her benefits from 21 years of accredited service at PTG and AT&T to the benefits she earned while employed at SBC for nine years.

That calculation would have been disadvantageous to Ms. Hebert, SBC and Mr. Pulikkan agree. While PTG gave her a three-year service credit, it also discounted her benefit for retiring 14 years before the minimum retirement age of 55.

Under the alternative formula, SBC considered Ms. Hebert's 27 and one-half years of total actual service at the two Baby Bells and AT&T as having accrued at SBC. SBC contends that that formula does not require the company to recognize the three-year service credit.

Still, the latter formula is the more advantageous of the two for Ms. Hebert, because the penalty for retiring five years shy of the minimum retirement age is substantially less, according to court documents

and Mr. Pulikkan.

Court documents show that the SBC plan provision at issue, paragraph 8.2.1(b), states that a plan participant's pension benefits shall equal "the monthly pension benefit determined for all service credit included in (Hebert's) Pension Service Credit under (the PTG Plan) and all Pension Calculation Service during which (Hebert) was covered by (the SBC Plan), in accordance with the provisions of the Plan."

In supporting SBC's interpretation of its plan provision, the 8th Circuit panel wrote: "Two interpretations arguably exist regarding the calculation of Hebert's PTG Pension Service Credit under paragraph 8.2.1(b), because a comma separates the phrase 'in accordance with the provisions of the Plan' from the remainder of the sentence. The phrase 'in accordance with the provisions of the Plan' clearly refers to the SBC Plan. Under one interpretation, the phrase 'in accordance with the provisions of the Plan' could modify the phrase '(Hebert's) Pension Service Credit under the (PTG Plan)'. Under this interpretation,

SBC looks to the SBC Plan's Pension Service Credit definition to determine whether Hebert's three...years are used to calculate her benefits under the SBC Plan, and the Pension Service Credit clearly does not include the three extra...years."

The problem, Mr. Pulikkan said, is that the plan provision on which SBC relied contains an error—the omission of a comma after the word "determined"—that SBC made in crafting the provision. The provision does not comply with the intent of the wording found in the AT&T divestiture agreement and the subsequent pension portability agreement among the Baby Bells, he said.

If SBC had adopted the same language or, at least, had honored the intent of those agreements, it would have both recognized the three-year service credit and calculated Ms. Hebert's benefit as if she had worked exclusively at SBC, Mr. Pulikkan asserted. That would have added \$374 to her monthly pension benefit, he said.

Mr. Pulikkan said that similar provisions in the plan offered by

PTG, which SBC subsequently acquired, are worded and punctuated in accordance with the divestiture and pension portability agreements.

Pension and benefits law attorney Nancy G. Ross, who represents employers, said the court reached the right decision, given the language and punctuation of the SBC plan.

"The real impact of this case is that the court is saying it can come down to the difference of a comma, and it's going to be determined by the plan administrator and not us," if the administrator's interpretation is reasonable, said Ms. Ross, a partner with McDermott, Will & Emery in Chicago.

If plans "were written clearly to begin with, there'd be no questions" like the one posed in the 8th Circuit case, Ms. Ross added.

Meanwhile, the San Diego-based TELCO Retirees Assn., a year-old group that represents about 2,000 of PTG's 30,000 retirees, is alerting groups representing retirees from other Baby Bells about the decision and its impact.

SBC would not comment.

*Reba Hebert vs. SBC Pension Benefit Plan, 8th U.S. Circuit Court of Appeals, Nos. 02-3671/03-1072; Jan. 12.*

# ERC: Role in GE may be ending

Continued from page 1

this business being part of GE for the next couple of years."

ERC Chairman, President and CEO Ron Pressman said insurance will account for only 15% of GE's revenues with the sale of its financial guarantee insurance operation, New York-based FGIC Corp., and the planned IPO for Genworth Financial Inc., which comprises most of GE's life and mortgage banking business. Although the largest piece of ERC's business is property/casualty reinsurance, the group also has primary operations through its divisions of Global Life & Health and GE Commercial Insurance.

"Time will tell" as to whether ERC will fit within GE's strategy, said Mr. Pressman, who joined the reinsurer from another GE unit in 2000. Meanwhile, Mr. Immelt is "focusing on us running the business well," he said. "Right now, our shareholders feel pretty good about us," he said. The next couple of years, he said, "should be good, solid years within GE" for ERC.

Results have already improved. ERC reported \$481 million in net income for 2003, compared with 2002's \$1.79 billion loss. It is expected to earn about 10% more next year, according to Mr. Immelt.

Most observers still do not expect ERC to remain a GE unit over the long haul, though. They point out that there is a history of noninsurance parents eventually disposing of their insurance units. These include ITT Corp. and Hartford Financial Services Group Inc. and Xerox Corp. and Crum & Forster Holdings Inc.

Todd Bault, a research analyst at Sanford Bernstein & Co. in New York, said, "Unless GE can come up with a rationale for why a reinsurer would fit into its portfolio, I think a

spinout of Employers Re is inevitable, and I don't really see how it does fit into their portfolio," which consists primarily of stable, high-growth businesses.

"That's not reinsurance," said Mr. Bault. "Reinsurance is an unstable and, hopefully, highly profitable, business."

"I think they intend to exit the insurance business," agreed John L. Ward, chairman of the Cincinnati-



**'Right now, our shareholders feel pretty good about us.' The next couple of years 'should be good, solid years within GE' for ERC.**

Ron Pressman  
Employers Reinsurance Corp.

based Ward Group. Mr. Ward noted that GE's stock price has plunged from around \$50 in 2001 to around \$30 today, "and there's no question that insurance has had a lot to do with that.

"It's not the only factor, but it has hurt the value of the franchise, largely because of the lack of predictability and the volatility the insurance industry brings to the table and...it makes it difficult for them to do well," said Mr. Ward. "It's pretty clear (Mr. Immelt) is not entirely comfortable with the insurance business and the volatility that it brings."

Not everyone believes GE will necessarily shed ERC, though. Steve Miller, vp and chief operating officer for Seattle-based Pemco Mutual Insurance Co., a personal lines in-

surer that has reinsured its business with ERC since 1958, said GE may keep the reinsurer if it can demonstrate "that, in fact, they can clean themselves up in the short period of time they have and be profitable over the long haul."

Most observers who believe GE will dispose of ERC say it is most likely to be spun off in an initial public offering rather than sold, largely because of its size. In a 2003

to risks they otherwise could not, said John Wicher of San Francisco-based John Wicher Associates, an insurance investment bank. "I'm not sure who's the natural buyer," he said.

Mr. Ward said, though, that he would not rule out a buyer for ERC. "I would not be surprised to see an acquisition by an investor group or one of the other reinsurers rather than an IPO. It could go either way," he said.

Mr. Ward said he believes it may be the only way to win ERC's business. "The other major reinsurers could go into the marketplace and fight to get the business to switch over, but I think Employers Re is a very solid name, an excellent franchise, and while that strategy might work for a financially troubled competitor, I don't think that's going to work with Employers Re, because I think they have the wherewithal to fight back and retain value in the franchise," he said.

"It's a great company, and I think change is in the works there, but I think they'll manage it very effectively and work the timing to their advantage. There's no question about it," said Mr. Ward.

Alain Karaoglan, managing director at Deutsche Bank Securities in New York, said an ownership change would have little impact on ceding companies or risk managers. ERC "has started to do what makes sense" in terms of bringing in a new management team and achieving certain goals, and that should continue if the company goes public, he said.

Jim Perry, vp, risk management at Houston-based Waste Management Inc., which uses ERC unit Industrial Risk Insurers as a lead on its property business, said if ERC's ownership does change, his reaction "would really depend on their rating." Mr. Perry said, though, that he does not "see it as an issue at this point."

Ted Schlert, vp, risk management services and chief risk officer for Newton Square, Pa.-based Catholic Health East, an integrated health care delivery system that has ERC as the lead reinsurer on its excess program, said, "I felt very good about finding out GE has committed at least for another two to three years to keeping ERC." He noted that "there was certainly a whole lot of speculation the last 12 to 24 months about what was going to happen" as GE made changes in its portfolio.

He said he does have "some concerns," though, about what will happen long term. "We've had almost a 19-year relationship with ERC, and we've always found them to be a terrific partner...and we'd like that to continue."

Mr. Schlert said that no matter what decision is ultimately made about ERC he would prefer that its senior management team remain in place. "Any financial transaction would be a solid financial transaction," he said. "My concern—my wish—would be more that the well-qualified folks that are there would remain."

## ADVERTISER

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February 9, 2004

## Late News

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Exchange, rose 20% to \$2.08 billion, while profits jumped 97% to \$414.0 million.

### CIGNA posts profit, plans job cuts

CIGNA Corp. reported profits of \$667.8 million for 2003, compared with a loss of \$397.7 in 2002, and announced plans to cut 3,000 jobs as it continues to restructure its operations. CIGNA's loss in 2002 stemmed largely from special charges.

Revenues at the Philadelphia-based insurer declined 2.8%, to \$18.8 billion, in 2003. Meanwhile, a federal judge has approved a \$540 million settlement between CIGNA Healthcare and approximately 700,000 physicians around the country who had sued the managed care company for allegedly cheating them on payments.

### Sarbanes-Oxley impact on lawsuits mixed: Study

Court dismissals of class action securities litigation have dropped by one-third since the passage of the Sarbanes-Oxley Act, but the average settlement amount in such cases has

declined, a study has found. The average settlement in 2003 was \$19.8 million, down 15% compared with 2002, while the median settlement declined by 14% to \$5.4 million, according to the study by NERA Economic Consulting, a unit of Marsh & McLennan Cos. Inc.



### Reserve boost puts UnumProvident in the red

Reserve strengthening and investment losses helped fuel a loss of \$386.4 million at UnumProvident Corp. for 2003. In 2002, the disability insurer posted net income of \$401.2 million. Contributing to the 2003 loss was a \$286 million aftertax reserve boost for the insurer's group long-term disability business. The strengthening was needed in part because of an increase in claims frequency and severity resulting from a "continuing jobless economic recovery," the company said in a statement.

### Five states to consider broad tort reform: ATRA

The American Tort Reform Assn. expects at least five states to consider comprehensive civil justice reform legislation this year. Sherman

Joyce, ATRA's president said the organization expects comprehensive civil justice reform packages to be considered in Mississippi, Ohio, Oklahoma, South Carolina and Wisconsin this year. In addition, obesity lawsuit legislation has already been introduced in seven states, medical malpractice liability reform legislation in three states and jury participation legislation in 10 states, he said.

### Premium, investment gains boost ACE profits

ACE Ltd. reported profits of \$1.39 billion for 2003, compared with \$77 million in 2002. The steep increase in profits stems from several factors, including: a 27% growth in net premiums to \$10.22 billion; \$229 million in net realized gains on investments, compared with a \$489 million loss in 2002; and a \$354 million reserve increase in the fourth quarter of 2002 that dragged down the results for that year. The insurer reported gross premiums of \$14.64 billion in 2003, a 14.2% increase over 2002.

### Briefly noted

Illinois Insurance Director **J. Anthony Clark** has resigned, effective Feb. 13, according to a spokeswoman for Gov. Rod Blagojevich. The governor appointed Mr. Clark to the post in February 2003....**Swiss Re Life & Health America Inc.** has agreed to buy part of the individual life

insurance business of CNA Financial Corp. for \$690 million. The Swiss Reinsurance Co. unit will acquire the term, universal and permanent life, and individual annuity business of CNA, but CNA will retain its individual long-term care and structured settlement business....Itasca, Ill.-based **Arthur J. Gallagher & Co.** has paid a \$50,000 fine to settle Missouri Insurance Department charges that it sought to place medical malpractice business with an unlicensed insurer based in St. Croix, U.S. Virgin Islands. Gallagher paid the fine—the largest ever levied in the state against a broker—without admitting fault in its alleged marketing of Security Trust Insurance Co. Ltd. and its AmeriStar malpractice division. Missouri and Kentucky regulators barred the unlicensed Security Trust from writing business in their states last June....**Average annual renewal rates** for property/casualty insurance business placed through Internet portal Marketscout.com increased 11% in January, the company reported.

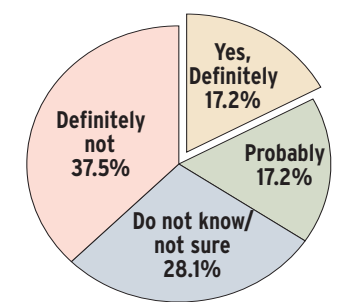
### Check out BusinessInsurance.com

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

## Online Poll

[ 2/2-2/6 ]

Would your organization consider funding its employee benefit programs through a captive?



## BI Stock Index

[ 2/2 - 2/6 ]

Up-to-the-minute data for all 87 companies that comprise the *BI* Stock Index can be found at [www.businessinsurance.com](http://www.businessinsurance.com).

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

<b>BI Stock Index</b>	2308.26	↑ 1.23
<b>Dow Jones</b>	10593.00	↑ 1.00
<b>S&amp;P 500</b>	1142.76	↑ 1.03

### Largest gains

Trenwick Group Ltd.	25.00%
Gainsco Inc.	22.22%
Unico American Corp.	15.38%
Argonaut Group	11.19%
AFLAC Inc.	7.78%

### Largest losses

ESG Re Ltd.	-15.00%
Clark Inc.	-11.07%
CIGNA Corp.	-8.82%
PMA Capital Corp.	-8.02%
PacificCare Health Systems	-6.91%

### Weekly change by market segment

Brokers	0.09%
Insurers/Reinsurers	1.68%
Managed Care Organizations	-2.34%

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

## S&P: Tension grows

Continued from page 3

shortsighted," he said. Meanwhile, though many primary insurers have been bolstering reserves for asbestos and other claims—in some cases by billions of dollars—reinsurers have "lagged far behind" in recognizing these liabilities, setting the stage for future disputes, the S&P report adds.

"In 2003, reserve increases by reinsurers were nowhere near the levels of the previous two years, and way below the colossal actions taken by the primary companies since the fourth quarter of 2002," S&P analyst Laline Carvalho noted in the report.

In large-scale settlements of asbestos claims, "ceding companies are making these decisions unilaterally and assuming that the reinsurers will play along," Mr. Dreyer added in an interview. "Reinsurers may say, 'You should have fought those claims harder.'"

Another sign of the deteriorating relationship is cedents' growing demand for collateral from reinsurers. In 2002, the portion of U.S. ceding insurers' reinsurance recoverables secured by collateral continued to climb while the unsecured portion remained flat, S&P reported.

While insurance regulators have long required non-U.S. reinsurers to secure their obligations with collateral, some insurers have also tried to get U.S. reinsurers to post collateral—or allow cancellation of contracts—if the reinsurers' financial strength falls below specified levels.

Ceding companies have recently begun backing off demands for collateral from U.S. reinsurers, Mr. Dreyer said.

Indications of growing tension between cedents and reinsurers are also emerging as the reinsurance industry deals with its own financial pressures. Investment losses, underwriting losses on underpriced business from the 1990s and other factors have contributed to a sharp decline in reinsurer ratings since mid-2001, S&P notes. While five global reinsurers carried S&P AAA ratings in 2001, only one—Berkshire Hathaway Inc.—retains the rating.

The past two years have also seen several large reinsurers depart the U.S. market—including AXA Corporate Solutions, Gerling Konzern, PMA Re and Trenwick Group Ltd.—and the divestiture of reinsurance operations by primary companies such as Hartford Financial Services Group Inc. and CNA Financial Corp., S&P notes.

One result, the report observes, is that cedents are often no longer dealing with the active reinsurers they initially placed their business with, "a recipe for more disputes and delay," Ms. Carvalho noted. "It used to be that (insurers and reinsurers) would make money together and lose money together," she said. "Not any more. The old saying that an insurer has a bank with its reinsurer no longer applies."

The report is available by e-mailing [marc\\_eiger@standardandpoors.com](mailto:marc_eiger@standardandpoors.com).

## Bad faith: More suits

Continued from page 3

provide the employer's defense.

While Mr. Pinderski sees an increase in such cases, several insurers and other defense attorneys say that bad-faith civil lawsuits filed by employees and stemming from work injuries remain a rarity and are not increasing.

Only about 25 states allow bad-faith lawsuits for the egregious mishandling of workers comp claims, said Donald T. DeCarlo, a workers comp expert and partner at Lord, Bissell & Brook L.L.P. in New York.

States that prohibit the claims usually have found that insurers stand in the employer's shoes. Therefore, exclusive-remedy provisions protect employers and their insurers, he explained.

About 15 years ago, a surge in bad-faith lawsuits stemmed from workers comp claims, Mr. DeCarlo said. But recently he has seen few such cases.

Last month, though, a federal district court jury in Rapid City, S.D., awarded \$12 million in punitive damages and \$600,000 in compensatory damages to a former nursing home cook. She originally filed a workers comp claim for a carpal tunnel injury.

The injury generated about \$8,000 in losses, including medical expenses, lost work time and permanent physical impairment, said her attorney, Michael Abourezk of the Abourezk Law Firm in Rapid City, S.D.

A unit of Travelers Insurance Co.,

Constitution State Services, rejected the claim, Mr. Abourezk said. So the woman sued Travelers, the insurer's claims services unit and Insurance Co. of the State of Pennsylvania, a subsidiary of American International Group Inc.

The AIG unit sold the policy, while Travelers managed the claims, Mr. Abourezk said. The insurers declined to comment on the case. But Mr. Abourezk said the defendants have already filed court papers to either appeal the decision or have the punitive damages reduced.

The former cook also sued her employer, Fort Smith, Ark.-based Beverly Enterprises Inc., but the employer reached an out-of-court settlement. Beverly Enterprises declined to comment, citing a confidentiality agreement.

There have been few workers comp bad-faith cases in South Dakota, Mr. Abourezk said. But the size of the award in the case could draw other attorneys to make similar arguments.

To win the case, Mr. Abourezk argued that claims adjusters received bonuses for denying claims, an argument he borrowed from personal lines disputes. The practice angered jurors, Mr. Abourezk said.

But insurer defense attorneys say Travelers was unlikely to engage in such a practice. "Travelers, a publicly traded company, is not going to be out paying bonuses to deny claims, believe me," Mr. DeCarlo said.