California passes hikes in comp benefits/ **3**

Pension reforms more likely in wake of Enron / **3**

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February 11, 2002 (In two sections)

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Request to fund benefits in captive may spur other employers to follow

ADM sows seeds of trend

By JERRY GEISEL

WASHINGTON—In a move that could have broad implications for other employers seeking new uses for their captive insurance companies, agribusiness giant Archer Daniels Midland Co. is asking the U.S. Department of Labor for approval to use its captive to reinsure group life insurance benefits.

Decatur, Ill.-based ADM wants to use its 14-year-old Vermont captive, Agrinational Insurance Co., to reinsure life insurance policies now written by Minnesota Life Insurance Co. for ADM salaried and hourly employees.

If the Labor Department approves ADM's application, yet another barrier would be removed for employers that want to fund employee benefit risks through their domestic captives. Employers have long discussed expanding their captives for a variety of reasons, including cost savings and broadening their captives' premium base.

Through the captive funding arrangement, "we can reduce costs and pass those savings to employees through improved benefits," said Michael Lusk, corporate vp-global risk management and insurance at ADM.

But that approach, until recently, has been blocked by regulatory obstacles. One barrier was a 1979 Labor Department rule that said at least 50% of a captive's business must be third-party risks for the parent to fund employee benefit

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More policy changes needed to limit terrorism losses: ISO

By MEG FLETCHER

Risk managers with commercial property in the 30 jurisdictions using standard fire policies can take comfort from the fact that most direct fire-related losses from terrorism are generally still insured under their basic policies—at least for now.

This particularly applies if a policyholder's coverage is underwritten using a typical standard form approved by those states' legislators—or regulators in Texas and Washington—for admitted insurers' use. A few states, however, also require surplus lines insurers to use the same form.

Because 70% of the premium volume for property insurance nationally requires adherence to those minimum coverage standards, those laws substantially reduce the effectiveness of new terrorism exclusions that seek to cap insurers' exposure for losses, according to a working draft of a position paper by the Insurance Services Office Inc.

Such coverage may be lost, however, if ISO is successful in encouraging insurer trade associations to lobby states to eliminate the near-uniform coverage in those 30 states in the wake of the Sept. 11 terrorist attacks, which caused the industry's largest-ever loss.

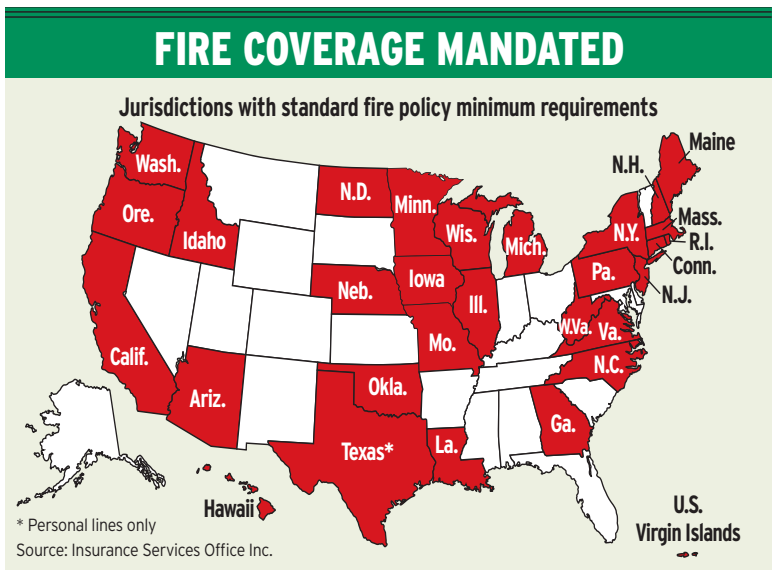
Although no insurer trade associations have signed on so far, ISO's proposed plan would be its latest step to help protect insurers' financial stability, said Carole J. Banfield, executive vp of Jersey City, N.J.-based ISO.

Without a federal backstop plan in place, insurers are grappling with their radically altered perceptions about the potential magnitude of future unanticipated losses (*BI*, Dec. 24/31, 2001). Terrorism is not a traditional insurance problem, but "a social problem," Ms. Banfield said.

At the same time, state insurance regulators are concerned that future losses may overburden insurers' resources to pay claims as well as reduce their appetite to write coverage (*BI*, Jan. 14). Diminished capacity already is creating availability and affordability problems for risk managers.

Several observers—including

See FIRE/page 17



Airlines plan RRG to cover war risks

By DOUGLAS McLEOD

WASHINGTON—Major U.S. airlines are developing plans for a Vermont-domiciled risk retention group to provide war risk liability coverage, which was drastically cut back by commercial aviation insurers in the wake of the Sept. 11 terrorist attacks.

Members of the Air Transport Assn., a Washington-based air carrier trade group, are working with broker Marsh Inc. to form the RRG, tentatively dubbed Equitime.

Equitime would offer up to $1.5 billion in combined limits for passenger and third-party war risk liability, retaining a portion of the limit and reinsuring the balance with the federal government, Marsh officials confirmed. Equitime's organizers plan to have the RRG running during the second

See RRG/page 22

Special Take-Out Section

BENEFITS MANAGEMENT

Late News

Two insurers may rescind Enron D&O cover

Two Enron Corp. directors and officers liability insurers are asking a bankruptcy judge's permission to notify the company that they may rescind coverage for "material misrepresentation" of Enron's financial condition. Royal Insurance Co. of America and St. Paul Mercury Insurance Co., which together wrote $50 million in excess limits on the $350 million program, have put Enron and its officials on notice that they are reserving their rights to rescind the coverage. Royal, a unit of Royal & SunAlliance Insurance Group P.L.C., said in its court filing that "based upon the current information...it appears that material misrepresentations were made to Royal during the underwriting process for the Royal policy." The insurer was given Enron financial reports for 1998 through 2000, which the Houston company later restated, triggering its slide into bankruptcy. St. Paul Mercury, a unit of The St. Paul Cos. Inc., likewise says "it has determined that the policy was issued based upon material misrepresentations."

Quackenbush won't face federal charges

Federal investigators do not have sufficient evidence against Chuck

Quackenbush to bring criminal charges against the former California insurance commissioner, according to a spokeswoman for the U.S. Department of Justice. The Department of Justice had been investigating Mr. Quackenbush for the past several months because of allegations that he used his office to derive money from insurers to help further his political career. That investigation is now closed. The California attorney general's office, however, has not closed its investigation into Mr. Quackenbush's activities while he served as insurance commissioner. A spokeswoman for Attorney General Bill Lockyer declined to comment further or to provide details about the progress of the

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Inside

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REPORTING WEEKLY ON CORPORATE RISK, EMPLOYEE BENEFIT AND MANAGED HEALTH CARE NEWS

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CONTINUED FROM PAGE ONE
investigation.

W.R. Berkley forms underwriting manager

W.R. Berkley Corp. has formed Berkley Capital Underwriters L.L.C., a reinsurance underwriting manager that will write on behalf of Berkley Insurance Co. The new unit, Berkley Capital Underwriters, will write a "proportional form of reinsurance, with a strong emphasis on commercial and specialty casualty lines of insurance," according to a W.R. Berkley statement. Tom N. Kellogg, who retired last year as president and chief operating officer of General Reinsurance Co., was named president of the new company. He also will serve as chairman of Signet Star Holdings Inc., Berkley Insurance Co.'s parent.

Late News

PHOTO: REUTERS

Blackpool, England, was battered by a Jan. 28 windstorm.

European windstorm losses tallied

Aon Risk Consulting in London estimates that insured losses from European windstorm Jennifer will be less than £100 million ($141.8 million). That estimate is in line with the Assn. of British Insurers' £100 million projection for the Jan. 27-28 storm, which pounded parts of Northern Britain and Northern Europe with winds of up to 140 mph. However, Aon Risk Consulting said that the £100 million figure applies only to wind and rain damage to buildings and contents. Losses from ongoing river flooding are not included, nor are losses from two other, less severe windstorms from around the time Jennifer struck, Aon said.

Polygon exits marine, third-party aviation

ST. PETER PORT, Guernsey—Aviation insurer Polygon Insurance Co. Ltd. has completed its exit of the third-party aviation and marine insurance markets and now will act only as a group captive for its airline shareholders. Polygon stopped writing third-party aviation insurance in January 2001 and last month did not renew its final marine contract, said Richard Tee, director of finance at the St. Peter Port, Guernsey-based insurer. "The aviation market has not had good results for a significant period, so we decided to withdraw," he said. Polygon's owners are KLM Royal Dutch Airlines, Scandinavian Airlines System, Swissair, Austrian Airlines and Finnair.

WTC, other losses reduce AIG's profits

American International Group Inc. reported a 19.2% drop in net income for 2001 to $5.36 billion, due in part to acquisition-related charges and losses stemming from the Sept. 11 terrorist attacks. Net premiums written at the New York-based insurer increased 14.7% for the year to $20.10 billion. AIG's combined ratio for the year was 100.7%, compared with 96.7% in 2000. AIG's results reflect, among other things, $533.0 million in losses stemming from the destruction of the World Trade Center, $57.2 million in Enron-related surety losses by AIG and its Transatlantic Holdings Inc. subsidiary, as well as a $20.4 million provision for claims related to the 1994 Northridge earthquake, AIG said in a statement.

Charge, losses stifle CIGNA profit growth

A $62 million aftertax restructuring charge and $65 million in investment losses held down CIGNA Corp.'s profits for 2001. The Philadelphia-based health insurer posted $989 million in net income for 2001, a 0.2% increase from the previous year. The $62 million aftertax charge, which was announced in January, is primarily related to the consolidation of CIGNA's health care centers into regional service centers. During the fourth quarter, CIGNA also realized aftertax losses of $65 million primarily related to investments in collateralized debt and, to a lesser extent, investments in failed Enron Corp. and certain Argentine securities. CIGNA reported $19.12 billion in 2001 revenues, a 4.4% decline.

Allianz profits lowered by Sept. 11 losses

Losses from the Sept. 11 terrorist attacks contributed to a more than 50% drop in net income at Allianz A.G. Holding. 2001 net income fell to 1.7 billion euros ($1.52 billion), largely due to net Sept. 11-related claims of 1.5 billion euros ($1.34 billion), the Munich, Germany-based insurer reported. Gross premium volume, however, rose by 8.1% last year, to 74.2 billion euros ($66.15 billion). Property/casualty premiums grew by 8.7%, to 40.9 billion euros ($36.46 billion), led by strong growth in Germany, France, Britain and Spain, Allianz said. Life/health premiums rose by 7.4%, to 33.3 billion euros ($29.69 billion).

Briefly noted

The Florida Insurance Department "does not intend to approve" industry-requested **terrorism exclusions** for commercial property policies "unless market conditions deteriorate and require further consideration," a spokeswoman for the department said. Such exclusions have been approved for use in 49 jurisdictions, including 46 states, the District of Columbia, Guam and Puerto Rico. California has rejected the exclusions, and New York is still negotiating with insurers....**GAINSCO Inc.** is discontinuing its commercial lines business in the wake of heavy losses. The Fort Worth, Texas-based insurer wrote around $70 million in gross commercial lines premiums last year and will stop writing new and renewal business as soon as state laws and contracts allow....The U.K. High Court has approved a plan to cap at £1 billion ($1.42 billion) the pension liabilities of failed U.K. insurer **Equitable Life Assurance Society**. Under the plan, policyholders with guaranteed annuity rate pensions would receive an increase in their pension benefits that would average 17.5%, in exchange for surrendering their guarantees. Other policyholders would receive an increase in the value of their funds that would average 2.5%.... Clive Tobin has been named president and chief executive officer of **XL Winterthur International**, a unit of XL Capital Ltd. Mr. Tobin, who was previously deputy CEO and chief underwriting officer of the unit, replaces Willi Suter, who will lead "an international strategic development" for XL, an XL statement said.

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All the material in the Late News column, as well as other content in this week's issue, is generated from daily news postings that appeared on the Web site in the previous week.

Unlikely allies agree that asbestos cases must be viewed objectively

Asbestos coalition proposes legislation

By MARK A. HOFMANN

WASHINGTON—An unusual coalition hopes the time has arrived to persuade Congress to change the way that claims for asbestos-related illnesses are handled.

The group, known as the Asbestos Alliance, consists of expected reform proponents, such as employers and insurers, as well as some rather unexpected allies: members of the plaintiffs' bar.

"There is an irony" to working with the likes of the National Assn. of Manufacturers and the American Insurance Assn., said Stephen Kazan, an Oakland, Calif.-based attorney who has represented victims of asbestos-related diseases since 1974.

"My basic position is that we find ourselves with a common interest. I have no vested interest in the survival of any of these companies. If there are companies that can't afford to meet their obligations to the people they've really hurt, they belong in bankruptcy and we go from there," said Mr. Kazan, who is founder and senior managing principal of Kazan, McClain, Edises, Abrams, Fernandez, Lyons & Farrise, a professional law corporation.

The Asbestos Alliance
Seeking a Fair Asbestos Solution

"On the other hand, there are a lot of companies that can meet these obligations, but cannot meet those obligations that the legal system can impose with respect to people who are not injured in any meaningful way," he said.

He noted that a British barrister referred to such people as "the worried well." Mr. Kazan said they were not even worried because they never knew they had a case or were even exposed to asbestos until they were solicited.

Representatives of the alliance plan to meet with members of Congress and their staffs in the near future, perhaps as early as this week, to promote legislation that would ensure the fair compensation of people who become sick from exposure to asbestos-containing products. Such a measure also should help to keep defendant companies financially secure so they can pay claims to both the currently ill and those who might become sick in the future.

The proposed legislation would:

- Establish objective medical criteria for asbestos-related claims.
- Liberalize statutes of limitation and other technical rules to remove the incentive for premature filings.
- Eliminate the consolidations that create what the group calls "bet-the-company" situations, "which lead to shotgun settlements with thousands of people who are not sick," according to the group's Web site.
- Eliminate abusive forum shopping, "which today concentrates thousands of claims in jurisdictions that have no connection whatsoever with those claims," according to the group.

See **ASBESTOS/page 18**

Enron hearings show broad legislative support for plan changes

401(k) reform targeted

By JERRY GEISEL

WASHINGTON—Enron Corp.'s bankruptcy and the resulting devastation of the energy giant's 401(k) plan are almost certain to lead to sweeping federal reform legislation.

While it is too early to say exactly what the post-Enron reforms will look like, it became clear at the first hearings on the Enron failure and its implications for 401(k) plans that congressional Republicans, Democrats and the Bush administration are united on the need for reform.

"The members of this committee have wide-ranging views on this topic, but we all agree we have a responsibility to act," said Rep. John Boehner, R-Ohio, chairman of the House Education and the Workforce Committee, which held two days of hearings last week on Enron and 401(k) plan issues.

"As Enron demonstrates, a worker's retirement savings can quickly become vulnerable if there are inadequate employee rights and protections. Clearly, today's outdated pension rules are putting employee nest eggs at risk," said Rep. George Miller, D-Calif., the committee's ranking minority member.

The hearings unfolded amid a wave of Enron 401(k)-related legislation. For example, Reps. Ben Cardin, D-Md., and Rob Portman, R-Ohio, introduced legislation—largely mirroring a measure advanced by the Bush administration—to eliminate long waiting periods that many companies impose on 401(k) participants before they can sell company-contributed stock.

Meanwhile, Rep. Boehner was preparing to introduce the administration proposal, while Senate Minority Leader Trent Lott, R-Miss., and Sen. Kay Bailey Hutchinson, R-Texas, introduced a measure that would allow participants to sell

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PHOTO: GETTY

Labor Secretary Elaine Chao, testifying last week at a congressional hearing on the need for 401(k) plan reforms, advocated investment flexibility for plan participants.

Health plan ruling criticized

High court narrows right to recovery

By DAVE LENCKUS

WASHINGTON—A U.S. Supreme Court ruling that restricts health plans' recovery rights against plan participants who obtain third-party damages to cover medical costs could drive up plan costs and lead to long benefit delays and coverage reductions.

Benefit delays created by plans that decide as a result of the ruling to hold back benefits until plan participants use third-party damages to cover their medical costs also would hurt health care providers by substantially delaying their payments, attorneys say.

"It's a lose-lose-lose situation for everybody," said George Pantos, Washington-based counsel for the Self Insurance Institute of America.

SIIA members have been "doing a lot of talking" with benefits consultants about how they should modify their plan language in light of the high court's Jan. 8 ruling, Mr. Pantos noted.

At issue in the case was who had the rights to a $649,000 settlement that a health plan participant negotiated with third parties she claimed were responsible for her injuries. Hyundai Motor Co. and other defendants agreed in 1994 to pay the settlement to a trust set up for Janette Knudson, who had sued the defendants after she was paralyzed in a June 1992 car accident.

Before the settlement, Ms. Knudson's insured group health plan had covered more than $411,000 of her accident-related medical expenses. Earth Systems Inc., which employed Ms. Knudson's then-husband, sponsored the plan.

Under a plan provision, participants who recovered damages from third parties were required to reimburse the plan up to the amount of the benefits they had received.

The plan assigned its claim-handling rights under the reimbursement provision to its insurer, Denver-based Great-West Life & Annuity Insurance Co.

Under Ms. Knudson's $649,000 settlement, a special-needs trust created under California law received nearly $257,000 to cover Ms. Knudson's future medical needs.

The remainder of the settlement was disbursed to her attorneys, who kept nearly $373,500 as fees and disbursed less than $14,000 to Great-West and $5,000 to California's Medicaid program.

Great-West sued the Knudsons to recover the plan's entire $411,000 in expenses, but a federal district court

See GREAT-WEST/page 21

Regulator, insurer cooperation key to Sept. 11 response: Serio

By MEG FLETCHER

CHICAGO—The worst terrorist attacks in U.S. history spurred unprecedented cooperation between insurance regulators and insurers, while at the same time raising significant issues that are now affecting claims handling and underwriting practices.

Mr. Serio

The insurance industry performed extremely well in the days after Sept. 11 and it continues to serve policyholders well now five months later, said New York Insurance Superintendent Gregory V. Serio during a symposium in Chicago earlier this month, sponsored by the Property Loss Research Bureau, an affiliate of the Alliance of American Insurers in Downers Grove, Ill.

Initially, insurance industry representatives cooperated in a public/private partnership that played an important role in the New York State Insurance Disaster Coalition, said Deputy Superintendent Lou Pietroluongo, who also spoke at the symposium.

Key features of the New York response plan included some duplicate office facilities in Albany for the industry's Insurance Emergency Operations Center as well as extensive use of the Internet for online reporting of data and issuing temporary adjuster permits.

Insurers themselves quickly set up temporary claims offices in mobile vans and other facilities in Manhattan so that policyholders in the 20-block area around the World Trade Center could quickly access their insurers and obtain payments for undisputed claims, Mr. Serio said. As of late January, more than 100 property/casualty insurers had paid, or were expected to pay, more than $15 billion in claims, including more than $3 billion for business interruption losses and $153 million for workers compensation losses, he said.

In all, he said, property/casualty insurers have reported receiving more than 25,000 claims, including about 17,500 related to commercial property losses, 7,200 related to personal property and 1,200 related to personal auto.

Despite the volume of claims, the New York Insurance Department has received only 119 complaints, Mr. Serio said. While many were related to commercial lines policies, the most frequent complaint involved trip cancellation disputes.

"We should all have a shared sense of accomplishment together because what this means is…the public has been

See CLAIMS/page 16

California passes comp measure

Bill to increase benefits will raise costs, employers fear

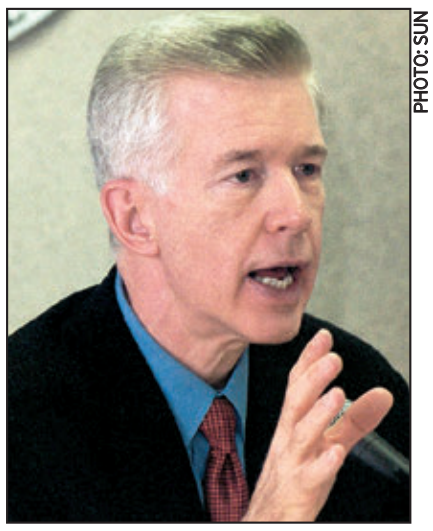

PHOTO: SUN

Gov. Gray Davis is expected to sign a bill that would increase workers comp benefits.

By ROBERTO CENICEROS

SACRAMENTO—California employers renewing their policies at midyear could see the first premium hikes stemming from a workers compensation benefits increase approved last week by state legislators.

Under A.B. 749, which cleared both chambers of the Legislature last Monday, California employers would see four years of set benefits increases beginning in 2003, after which certain benefits would increase in accordance with a weekly wage index**.** However, some employers could be hit with premium increases later this year because of a provision in the bill allowing hikes on policies with an inception date prior to Jan. 1, 2003. Such increases would require regulatory approval, though.

Gov. Gray Davis, who has rejected three previous attempts to mandate a workers comp benefits increase in the state, has not said whether he will sign the bill. But Sacramento observers widely expect the measure to be enacted, noting that Gov. Davis worked with labor and claimants attorneys to negotiate much of the bill's language.

Employers and insurers oppose the bill, which they say will increase workers comp costs considerably while introducing few of the system reforms they have sought to help keep costs in check.

The bill would raise workers comp costs statewide by $3.5 billion annually beginning in 2006, according to the state's Workers' Compensation Insurance Rating Bureau. That figure reflects both the benefits hikes and the increased use of the comp system that the measure's changes will drive, according to the San Francisco-based WCIRB.

Particularly troubling to employers is

See CALIFORNIA/page 21

Self-insurer not bound by insurer statute: Court

By JUDY GREENWALD

SANTA ANA, Calif.—The self-insured University of California is not an insurer, which means it does not have to get a doctor's approval before settling a malpractice claim involving one of its medical facilities, says a state appellate court.

The decision by the Santa Ana-based 4th District Court of Appeal in *Israel P. Chambi vs. the Regents of the University of California* "reaffirms the notion that self-insurance is not insurance, that a self-insurer is not an insurer, and that a statute that applies to insurers does not necessarily apply to self-insurers," said Regents attorney Paul Fogel of Crosby, Heafey, Roach & May in San Francisco.

Originally issued Jan. 9, the unanimous decision by the three-judge panel was published later at the Regents' request, which means it may be cited in future cases.

According to the decision, the Regents had agreed to indemnify Dr. Chambi when he was hired at the University of California at Irvine and at its medical center. In 1996, the Regents—without Dr. Chambi's consent—settled a medical malpractice action filed against him. Dr. Chambi filed suit, saying this violated the law. A lower court granted the Regents summary judgment dismissing the case, which was upheld by the appellate court.

According to the decision, one provision of the state's Business and Professions Code states that "notwithstanding any other provision of the law" an insurer must obtain a policyholder's consent before settling a malpractice claim. Another code provision covers self-insured public entities, but "notably absent" is any requirement that the public employee physician's consent be obtained, says the decision.

Dr. Chambi's contention that a self-insured public entity is an insurer "is worthless," says the decision. "If self-insurance is insurance and self-insured public entities are insurers, there was no reason for the Legislature to adopt a separate statute" for self-insured public entities, it says. "It is axiomatic that self-insurance is not insurance."

Dr. Chambi's attorney, Philip Toomey of Torrance, Calif.-based Artiano, Guzman & Toomey, said he is considering an appeal to the California Supreme Court.

"I thought it was a bad decision," said Mr. Toomey. "I think that it leaves physicians that are within the…system at risk of having cases settled for reasons other than the merits of the lawsuit."

The same physician and the exact same set of circumstances would have required the physician's consent had they occurred in a different setting, but here the physician is not given the opportunity to say "no" to a settlement, said Mr. Toomey, who noted Dr. Chambi must now disclose the settlement on insurance and employment applications.

Mr. Toomey said that the Regents' self-insured program functions like an insurer. "If it walks like a duck, talks like a duck, it's likely a duck, meaning this is the exact same type of activity that an insurance carrier engages in," he said.

'Public entities sometimes want to settle claims against their employees to minimize costs. After all, they're on the hook because this is public money.'

Paul Fogel
Crosby, Heafey, Roach & May

He said also he believes the phrase "notwithstanding any other provision of the law" in the section covering medial malpractice insurers is intended to cover self-insured public entities as well, which means the physician's consent to a settlement must be obtained.

Mr. Fogel disagreed. The Legislature probably reasoned "that public entities sometimes want to settle claims against their employees to minimize costs. After all, they're on the hook because this is public money that is at issue," which makes them different from insurers.

Israel P. Chambi vs. the Regents of the University of California, California Court of Appeal, 4th Appellate District; No. G024554.

Errors & omissions

- A story on page T14 of the Benefits Management Take-Out Section in this issue reports that CIGNA HealthCare plans to launch a consumer-driven health care plan. CIGNA unveiled its plan last week, after the section went to press.
- Due to a production error, a chart in the Feb. 4 issue on the largest captive managers in Dublin contained incorrect information. A corrected version of the chart appears on page 17.
- A Feb. 4 article on insurance for the Winter Olympic Games omitted the name of Aviation Insurance Services of Utah Inc., which was selected to place aviation coverages.

Commentary

An eye-opening visit to Lloyd's

"You've got to make a pilgrimage to Lloyd's at least once if you're going to work in this business," said the man seated next to me.

I was at one of the many insurance conferences I attend each year as a reporter for *Business Insurance*.

"You make it sound like going to Mecca," I replied.

That made me wonder: Could working in the insurance field be a vocation, like a calling to the priesthood?

Maybe that's why I've been working for *Business Insurance* for so long.

After all, I come from a long line of devout insurance believers: My Uncle Hank is a district manager for Farmers Insurance Co. in San Diego, my Uncle Art is a retired Farmers agent. My brother, Chuck, is a Farmers agent in Frankfort, Ill. My cousin, Fred, is an adjuster for Allstate Insurance Co. in Fairfax, Va. And several other cousins of mine are insurance agents for either Farmers or Allstate.

Joanne Wojcik

It was Uncle Hank who introduced us to the faith when he began selling insurance more than 40 years ago. Almost like an evangelical minister, he recruited the others, and our family gatherings soon turned into insurance "revivals." I understood the concepts of loss ratios and deductibles before I finished high school.

Maybe that's why I ended up writing about insurance, though it was never my intention. My dream was to become a reporter for the Chicago Tribune.

But when I got out of school in the late '70s, journalism jobs were scarce, so I took what was available, and what was available was an entry-level position at this weekly trade magazine in Chicago.

I decided that I'd work there just long enough to gain the experience I needed to move on to a newspaper job, which I did, for a while anyway. Less than five years after I left the fold, I was back, like a proverbial prodigal daughter.

"Isn't it something how insurance has held this family together?" Uncle Hank said to me after I was named *Business Insurance*'s Los Angeles bureau chief in 1990.

So now, after two tours of duty and a collective 17 years at *Business Insurance*, the suggestion that I make my pilgrimage to Lloyd's was beginning to make sense. After all, it is the mecca of the insurance world, and insurance is practically the Holy Grail to my family.

So the day after Christmas, I set off for London with three of my cousins.

"Yeah, we're a bunch of insurance geeks," said Louise, an Allstate agent from Chula Vista, Calif.

We even prepared ourselves spiritually for the quest, on Christmas Eve gathering around Uncle Hank's TV to watch the 1936 film "Lloyd's of London." The film stars Tyrone Power as the entrepreneurial Jonathan Blake, the first name to insure such unconventional risks as dancers' legs—the beginning of the nonmarine market, perhaps? Jonathan's best friend is Horatio Nelson, the legendary British admiral who led England to victory over France in 1805. But he wouldn't have been able to do so had it not been for Lloyd's, which insured his fleet.

Today, Admiral Nelson's silver collection is on display at Lloyd's, as are other historical artifacts, such as the Beatles' personal accident policies from when they first traveled to America in 1964. Two bound volumes of marine losses, written in quill pen and ink, are displayed on an altar-like perch beneath the Lutine bell, which is rung on special occasions, such as significant happenings in the market.

As we passed the books, one current and the other from 100 years ago, I felt the urge to genuflect. All around us underwriting boxes stood like pews. Outside, a vestige of the old Lloyd's, the facade of the 1928 building, stands like a monument in a church graveyard.

After we paid our homage, we had coffee in the legendary coffeehouse with Adrian Beeby, Lloyd's communications director.

But as I peered up over the rim of my green-and-white paper cup at the cathedral ceiling of the cavernous glass-walled structure, I felt a little bit disillusioned, as is often the case when I first encounter something I've romanticized for so long.

There I was, thousands of miles from home and 314 years after Edward Lloyd founded the coffeehouse where underwriting was born, sipping a latte from...Starbucks.

Senior Editor Joanne Wojcik's Commentary appears periodically and on www.businessinsurance.com. She can be reached by e-mail at jwojcik@crain.com.

150 million adults worldwide have diabetes.
That number should double in just 25 years.
We'll double our commitment to reinsuring them.

With our help, clients of GeneralCologne Re insure thousands of substandard life insurance risks every year. Our advice is based on medical advances and the collective expertise of our people worldwide. We enable companies to make evidence-based, competitive decisions and support them with sophisticated electronic underwriting tools, as well as information services.

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 Source: *Diabetes Atlas 2000*

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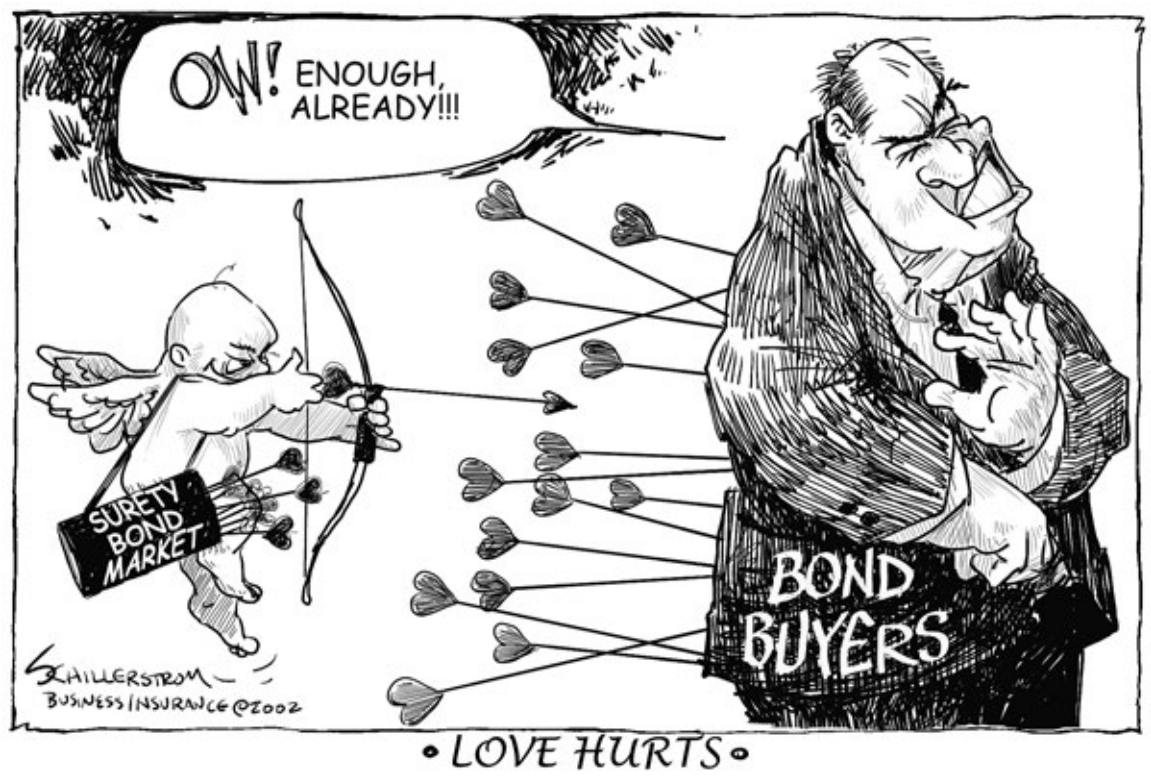

Editorial

Time to change brokers' handling of premiums

IN TODAY'S HARDENING MARKET, insurance buyers should question whether it still makes sense to pay their premiums to brokers instead of sending them directly to insurers.

While the practice originated as a way for insurers to reward their agents by giving them a chance to earn interest income on premiums before the insurer collected them, this bonus comes at buyers' expense. It also makes no sense for the buyer's money to be held by anyone for 30 to 45 days before it is due. With the ability today to transfer funds and to perform banking instantly and electronically, why should insurance buyers still park their own money with a middleman?

Recent events have also shown that the premiums held in trust can be a temptation for some brokers to dip into, especially in some states where they are not required to be segregated from other accounts held by the firms.

Michael Segal, chairman and chief executive officer of Near North National Group, last month was arrested on federal fraud charges for allegedly using as much as $20 million of the firm's premium trust funds to cover operating and personal expenses. Mr. Segal denies the charges, but stepped down from the helm of the Chicago-based firm that he owns (*BI*, Feb. 4).

As the Near North allegations came to light, however, it became evident that the alleged misuse of funds is hardly an isolated phenomenon.

Insurance agency consultants estimate that nearly 30% of the country's thousands of small and midsize agencies routinely dip into these funds to cover their operating expenses. No doubt it also happens at larger agencies and brokers. With many insurance agents and brokers privately held, though, the practice remains generally hidden from public scrutiny.

Some may argue that no one is hurt by this use of funds in trust, as the premium shortfalls are covered by the firms and forwarded to insurers and as the buyer's insurance coverage is not impaired in any way. Furthermore, even a sum as large as $20 million, for example, would represent only about 2% of gross premiums collected annually by a firm the size of Near North.

While no one may be directly harmed, that is not the same as saying this is authorized or approved by the buyer or the insurer. Dipping into these funds still violates the trust that policyholders place in the broker to handle the funds for the benefit of the client. And operating out of trust to cover agency or brokerage expenses clearly uses client funds in a manner for which they are not intended.

It also begs the question of why the buyer—which already is paying sharply higher premiums to finance its risks—should be providing the broker with the means to earn an additional form of compensation.

That's what fees and commissions are supposed to cover. And if they are inadequate, banks offer all sorts of credit lines and loans that would be a more appropriate means of funding brokerage operations than is dipping into client funds. Insurers, too, are often willing to loan their agents and brokers funds to meet their operating expenses.

If this practice is as widespread as agency consultants say, it is very likely that regulators have been aware of it for some time, yet they have not done more to protect the interests of policyholders. In the case of the alleged use of funds by Near North's chairman, it is notable that the charges were brought by federal authorities rather than state insurance regulators.

There's something wrong when an illegal practice becomes so routine that it goes unchallenged by all sectors of the marketplace. Brokers, the majority of which do not engage in these transgressions, should demand changes to assure their reputation is not tainted by the actions of a few.

Most importantly, buyers should demand changes to protect the integrity—if not the earning power—of their own premiums. Given how long this questionable practice has been allowed to continue at some agencies and brokerages, it's clear that no one else is going to step in to protect the buyer's interest.

Letters to the Editor

Congress wants proof; RIMS is providing it

To the editor: As the Feb. 4 *Business Insurance* editorial "Congress Seeks Proof from Insurers" aptly explained, word from Capitol Hill is that "lawmakers need facts, not anecdotes" as they consider the need for terrorism reinsurance relief.

The Risk & Insurance Management Society Inc. is facing this dilemma head on.

RIMS member companies, representing more than 4,000 commercial policyholders, are facing exorbitant premiums on property/casualty insurance coverage for significantly reduced coverage. Now, they are taking this message to our nation's decision-makers.

Since Sept. 11, RIMS leaders have met on several occasions with congressional lawmakers and the Treasury Department to urge action on terrorism reinsurance legislation. RIMS member companies also have written to members of Congress, highlighting their individual needs for government action. RIMS members have sent written statements to the General Accounting Office describing the impact that the absence of a federal terrorism risk-spreading mechanism is having on the U.S. economy, and their business in particular.

The time to act is now. Not only for businesses to provide evidence but also for the Senate to follow the House and pass a bill.

As President Bush declared in his State of the Union address, one of his top three goals is to "revive our economy."

With economic stimulus legislation fragmenting, the country needs a terrorism reinsurance bill to support the fragile infrastructure underlying our economy.

David L. Mair
President
Risk & Insurance
Management Society Inc.
New York

Letters to the Editor

Business Insurance welcomes letters to the editor. This section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Please send your letters to Letters to the Editor, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; fax: 312-280-3174; e-mail: pwinston@crain.com

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New attitudes may affect industry most

By Peter J. Gakos Jr.

The Sept. 11, 2001, terrorist attacks hastened the hardening of the insurance market and the resulting reduced capacity, increased prices and tightened coverage terms have become more severe since the Jan. 1, 2002 insurance and reinsurance renewals.

While the attention to costs and terms is understandable, a third factor may actually have a longer impact on insurers. That is because the catastrophe may have a lasting impact on the behavior of risk managers.

In response to the cost increases, major businesses, particularly those with complex and high-risk operations, may increase their risk retention levels, purchasing insurance only for catastrophic losses. Another factor driving this decision will be the concerns about purchasing coverage from insurers whose financial security is questioned. Businesses are now more closely scrutinizing insurers' financial security.

While risk managers are willing to retain a greater portion of traditionally insured risk, they are only willing to do so up to certain aggregate dollar amounts. Such upper limits represent the maximum financial impacts that businesses are willing to have on their income statements during the fiscal year.

Additionally, many businesses will not be able to establish sufficient reserves on their balance sheets to address this increased exposure. Companies in this situation need an insurance vehicle to cover unusual loss frequency and severity during the fiscal year.

One possible solution can be found in blended insurance programs. These programs are so named because they are structured as a blend of traditional risk transfer and "finite risk" techniques—measures that blend elements of timing risk, financial risk and limited traditional risk transfer. These structures typically include such features as: multiple-year coverage periods; coverage for multiple risk exposures on a bundled or integrated basis; and a formal partnership between the insurer and policyholder in which each shares a portion of the risks and the rewards, with traditional risk transfer responding at a predetermined level of loss activity.

The policyholder effectively "rents" the insurer's balance sheet to establish reserves to fund its retained losses over time, by retaining a major portion of its risk through the finite element of the contract. This can provide the policyholder with certain accounting and tax advantages that it probably cannot achieve solely through a self-insured retention. The major benefit is to spread the impact of a loss or series of losses over a period of time.

In short, these structures provide a seamless approach, combining risk transfer and risk financing in order to obtain more comprehensive risk management solutions. These programs have been implemented by many businesses.

The changes anticipated for the commercial insurance market resemble what has already occurred in the reinsurance market. Many major insurers and reinsurers have aggregate excess-of-loss finite risk programs in place in response to reduced traditional reinsurance capacity, concerns about security, and increased exposure to risk.

For several years, the insurance industry has appeared to be on the verge of entering the market for blended products, designing various innovative solutions for major companies, but few programs have entered the mainstream market. Perhaps the aftermath of the September terrorist attacks will create the economic conditions that will foster a renewed demand for such programs.

Beyond the economics, a change in attitudes about blended products will also be needed—first, among corporate buyers. We are already seeing that change, as more risk managers adopt the mindset that such insurance is not a temporary stopgap purchase, but a long-term, strategic risk management commitment. Fueling this change is the increased involvement of senior financial managers who see risk management as part of a bigger, integrated effort to manage the balance sheet.

Insurers also need to change their attitude. Most insurers are comfortable providing traditional risk transfer capacity for individual risk classes and single loss events, but effective blended insurance structures incorporate traditional risk transfer capacity across multiple risks, providing both aggregate and single-event coverage.

Underwriters that develop such programs must understand that there must be sufficient underwriting risk in the final structure to ensure that the contract will be treated as insurance from an accounting and tax standpoint. Moreover, the insurers that succeed in the market for blended risk management products will require the combined efforts and ideas of both their alternative risk transfer staffs and their traditional underwriters.

Most significantly, insurers that deliver such products must be willing to commit capacity over several years for each program. Because multiyear commitments are required, insurers generally must use net capacity without relying on reinsurance support. The long-term nature of such contracts and the fact that significant dollar amounts of premium or loss funding may be provided by either the policyholder or the insurer, leads to an inherent requirement that both parties be financially secure.

Peter J. Gakos is senior vp in The St. Paul Companies Inc.'s Morristown, N.J., office.

Converted individual policy not subject to ERISA

An individual insurance policy that was converted from an earlier group policy is not governed by the federal Employee Retirement Income Security Act, according to the 9th U.S. Circuit Court of Appeals in San Francisco. Thus, a policyholder's suit against a health insurer brought under state law was not preempted by ERISA, the court held.

Barbara Waks obtained insurance coverage from Empire Blue Cross & Blue Shield under an ERISA-regulated group insurance plan covering employees of her husband's company, SCS Systems. When SCS ceased operations, Ms. Waks applied for individual coverage with Empire under the conversion rights of the group policy. Empire issued Ms. Waks a "Tradition PLUS" individual policy for comprehensive hospital and medical benefits effective Feb. 2, 1993. In 1996, Empire authorized Ms. Waks' emergency admission to a hospital based on her doctor's determination that she had a life-threatening condition. Empire subsequently denied her insurance claim for the hospital costs, and Ms. Waks sued the insurer in federal court, charging breach of contract. The insurer argued that her suit was subject to ERISA and that her state-law claims were pre-empted. The trial court ruled for the insurer.

The appellate court, however, said that an employee benefit plan must cover at least one employee to constitute an ERISA benefit plan. According to the court, Ms. Waks' converted policy covered her as an individual and not as an employee of SCS or any other employer. Therefore, the court said, her converted policy was not an ERISA plan. The court also concluded that claims arising under a converted individual policy are not related to an ERISA plan for purposes of ERISA pre-emption. The court emphasized that her ERISA pre-emption would be an absurd result because there is no ERISA plan and no administrator. The trial court decision was reversed.

Waks vs. Empire Blue Cross & Blue Shield, 9th U.S. Circuit Court of Appeals, Aug. 20, 2001 (*BI*/05/F-$10)

Legal briefs

Retiree with work-related injury eligible for full compensation

An employee's retirement did not preclude workers compensation benefits for an injury arising out of and in the course of employment, according to the Supreme Court of Tennessee.

James Mackie installed asbestos insulation for much of his working life between 1948 and 1988. His last injurious exposure to asbestos occurred while he was working for Young Sales Corp. in 1973. Mr. Mackie stopped working sometime in 1989 or 1990 because he wanted to retire. In January 1993, he was diagnosed with asbestos-related malignant mesothelioma. He died from the illness in May 1993. His widow, Dorothy, sued seeking workers compensation benefits for the death of her husband. The trial court awarded temporary total disability benefits for the period Jan. 23, 1993, to May 15, 1993, as well as death benefits. She was awarded the maximum weekly rate of $318.24. The appeals panel modified the judgment to reflect a minimum weekly compensation rate of $35 because Mr. Mackie was voluntarily retired at the time of his diagnosis. His widow appealed.

On appeal, the employer argued that Mr. Mackie was not entitled to compensation based on the maximum weekly rate because he was voluntarily retired and lost no earnings because of the work-related illness. The court said that the schedule of compensation under the Tennessee code is to be determined without regard to loss of earning power or wages. Where an employee establishes all of the elements for benefits, the court said, an employer may not rely on the fortuitous timing of an employee's retirement to avoid the responsibility for providing compensation. The court agreed with the trial court's award of benefits based on the maximum weekly rate.

Mackie vs. Young Sales Corp., Supreme Court of Tennessee, March 1, 2001, Rehearing Denied April 6, 2001 (BI/04/F.-$10)

Home modifications covered under Missouri comp law

In an issue of first impression in that state, the Missouri Court of Appeals ruled that an employer was responsible for all medically necessary modifications to a paralyzed employee's home.

Kenneth Hall was a truck driver for Fru Con Construction Corp. In September 1994, Mr. Hall was injured while unloading a trailer for his employer. A 1,000-pound pipe rolled off the truck and struck Mr. Hall in the back, and his injuries resulted in total paralysis of his lower extremities, loss of sensation below his ribs, and loss of sexual function and control of his bladder and bowel functions. He was hospitalized until November 1994. In May 1995, Mr. Hall returned to Fru Con, working four hours per day as a dispatcher. He started full-time work in July 1995, but was laid off in July 1998. Mr. Hall applied for and was awarded permanent total disability benefits, which included past and future nursing care and home modifications, such as making the bathroom shower and bedroom closets wheelchair-accessible. His kitchen also had to be modified to make appliances accessible, and a wheelchair ramp was added to the front of the home. The Industrial Commission affirmed the award. The employer appealed.

On appeal, the employer argued, in part, that the commission erred in entering an award for the modifications to Mr. Hall's home because such modifications are not considered medical treatment or artificial devices. The court said the purpose of the Workers' Compensation Act is to place on industry the losses sustained by employees because of their employment. Given that wheelchairs fall under the act, the court said, it would logically follow that modifications to an employee's home should be covered under the act to allow him to use his wheelchair. These modifications, according to the court, would improve his medical condition and allow him to function more independently and require less nursing care. The court emphasized that an employee's efforts to remain independent should not be thwarted. The benefit award was affirmed.

Hall vs. Fru Con Construction Corp., Missouri Court of Appeals, March 27, 2001. (*BI*/03/F.-$10)

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available, at $10 each, by sending a check payable to Mayo H. Stiegler, to Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Provide the listed number for each opinion ordered.

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Comings & Goings

Brokers:

Construction Insurance Partners, a new insurance brokerage in St. Louis specializing in controlled insurance programs, has made four senior executive appointments:

- **John J. Campbell**, formerly executive vp and national wrap-up leader at Arthur J. Gallagher & Co. in St. Louis, has been named executive vp and chief operating officer of the new broker.
- **Terry Schlick**, a former Gallagher senior vp, has been named senior vp and secretary.
- **Larry Jackson**, a former Gallagher senior vp, has been named senior vp.
- **Brian Billhartz**, a former Gallagher vp, has been named senior vp.

In other brokerage changes:

Bill L. Williamson was named senior vp and account executive in Hobbs Group L.L.C.'s Boston office. Mr. Williamson was formerly a vp for Aon Corp.'s New Business Development Group.

Eric Wurzel has been named partner and executive vp of sales at Travers, O'keefe, an employee benefits and property/casualty consulting and brokerage firm based in New York. Mr. Wurzel previously was vp of sales.

Insurers:

Derek Ratteray has been named senior vp of international casualty for Zurich Global Energy, a unit of Zurich Financial Services Group that specializes in the oil and gas, petrochemical, natural resources mining and power generation industries worldwide. Mr. Ratteray, who formerly was vp and Bermuda casualty branch manager, will be based in Pembroke, Bermuda.

Judith A. Blades has been named senior executive vp of property/casualty operations responsible for all underwriting except reinsurance at The Hartford Financial Services Group Inc. In a related move, **Frederick H. Eppinger** has been named executive vp of property/casualty field and service operations. Ms. Blades previously was executive vp of Hartford's business insurance group. Mr. Eppinger formerly was senior vp of property/casualty strategic marketing.

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Reinsurance:

Donna Mosely has been named senior vp, chief financial officer and chief actuarial officer of ING Re in a shift of these responsibilities to Denver from the reinsurer's Amsterdam, Netherlands, office. Ms. Mosely previously served as vp of financial reporting and control for the global reinsurance company's life and health operations in Denver.

Other suppliers:

Rose Lewis has been promoted to the newly created position of director of claims and service operations for Brokerage Concepts Inc., a King of Prussia, Pa.-based third-party administrator. Ms. Lewis, formerly held the position of managing director of claims.

HMOs/PPOs:

Robert L. Natt has been named executive vp of the New England Region at Oxford Health Plans Inc. In this newly created position, Mr. Natt will oversee a recent acquisition and will focus on Oxford's plans to enhance its provider network and expand its business in Connecticut. Before joining Oxford, Mr. Natt was an independent consultant to the health care industry.

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers.

Please send news of recently promoted, hired or appointed senior-level executives to: Joanne Wojcik, Business Insurance, 777 E. Speer Blvd., Denver, Colo. 80203-4212; releases can be sent by e-mail to jwojcik@crain.com.

Photos should be sent to: Kathy Barnes, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; or submitted by e-mail to kbarnes@crain.com.

TPA listing deadline nears

Business Insurance will publish its online Directory of Third Party Administrators on March 4. That week's issue of *Business Insurance* will include a ranking of the top TPAs and a Spotlight report on Claims Management.

The directory, which will be available on *www.businessinsurance.com,* is published as an editorial service; there is no charge to be included. Eligible companies must simply submit a completed directory questionnaire by the extended deadline of Feb. 22.

To be eligible for the directory, a company must provide claims administration services to self-insured employers on an unbundled basis. TPAs must generate at least $500,000 in gross revenues and must report revenues to be listed in the directory.

If your company meets the criteria but has not received a questionnaire, please contact Assistant Directory Editor Carrie Brittain at 312-649-5313. Questionnaires also can be downloaded from *www.businessinsurance.com.*

Non-U.S. companies facing steep hikes on D&O policies covering U.S. exposures

By CAROLYN ALDRED

Non-U.S. companies with exposure to securities claims in the United States are facing large rate increases and tougher terms and conditions for their directors and officers liability insurance as underwriters reassess their risks.

Brokers note that non-U.S. companies generally are seeing double-digit increases for their D&O coverage, and those exposed to claims in the United States could face hikes of 100% to as high as 300% at renewal, some brokers say.

Many D&O underwriters have experienced large losses over the past year as the number and size of securities-related claims in the United States have increased dramatically, brokers and underwriters note. And the number of non-U.S. companies now exposed in the U.S. market, particularly as a result of U.S. stock exchange listings or American depository receipt filings, has also risen significantly, they say.

"The number of major U.K.- and Irish-based companies listed in the United States increased to 124 last year from 59 in 1995, with a similar upward trend among other European companies," said Joe Fernandez, corporate manager of financial lines management liability for AIG Europe (UK) Ltd. in London.

Meanwhile, the number of securities class-action lawsuits filed in the United States last year soared to 487 after remaining at around 200 for several years, said Mr. Fernandez. And 43 of the suits in 2001 were filed against non-U.S. companies, compared with 12 in the prior year, he noted.

Previously, some underwriters had assumed that non-U.S. companies were better protected from such actions, but they now recognize that a company listed on any U.S. stock exchange, regardless of where the company is based, "has a very severe exposure to class-action claims," he said.

In addition to the increase in claims frequency, the size of settlements also has risen significantly in recent years, underwriters say.

Mr. Fernandez estimates that the average class-action securities claim now is settled for about $20 million, compared with $5 million to $10 million in the mid-1990s.

And some recent claims have resulted in huge settlements, including the $2.83 billion settlement by Cendant Corp. in 1999, which stemmed from a suit charging that the defendants had artificially inflated the company's stock price through an accounting fraud. In 2000, 3Com Corp. settled two securities class actions for $259 million.

See D&O/next page

PHOTO: AFP

Losses from explosion in Nigeria estimated to total $84 million

LAGOS, Nigeria—The Nigerian Insurers Assn. estimates that recent explosions at a military armory in Lagos would result in insured property losses of "several billions of naira."

Prince Omosanya Akinyemi, chairman of the NIA, said that no exact loss figure was yet available for the explosion, which killed more than 1,000 people.

Preliminary investigations put the figure at about 10 billion naira ($83.9 million).

"We will do everything possible to live up to our responsibilities as risk bearers to our clients who have insured with us," he said in a statement.

Sources in London suggested that much of the reinsurance for the loss would be concentrated in Nigeria itself, with a small amount finding its way into the London market via retrocessional coverage.

Ruling raises bar on stress claims

Court stresses action

By SARAH VEYSEY

LONDON—A recent U.K. Court of Appeal ruling will make it more difficult for employees to bring work-related stress claims.

The Feb. 5 ruling stripped two teachers and a factory worker of awards for occupational stress totaling about £200,000 ($283,560). The three workers had not, in the judges' view, made their employers sufficiently aware of the stress they were suffering, nor had they given their employers adequate opportunity to improve the situation before filing a claim.

In their ruling, the three Court of Appeal judges stated that no occupations should be regarded as intrinsically dangerous to employees' mental health. The judges also said employers should be entitled to assume that employees can withstand the normal pressures of a job, unless they have alerted the employer of some particular problem or vulnerability.

Employers that offer confidential counseling and access to treatment are unlikely to be found in breach of a duty of care, the judges said.

Furthermore, if the only reasonable and effective course of action would be to demote or dismiss an employee, an employer does not violate its duty of care in allowing a willing worker to continue his or her job, the judges' ruling states.

The ruling comes at a time when Britain's largest labor organization has reported a huge increase in claims for occupational stress against U.K. employers.

The Trades Union Congress last week reported that new stress claims brought by labor unions on behalf of employees had increased twelvefold in 2000 to 6,428. The data was reported in the TUC's Focus on Services for Injury Victims report.

The huge rise in claims occurred in part because stress has recently become more widely recognized as a cause of illness, a TUC spokesman said.

John Monks, general secretary of the TUC, described the increase in stress claims as "very worrying." He said that management must work with trade unions to combat the growing problem of stress in the workplace.

Report forecasts E.U. pension spending

By EDWIN UNSWORTH

LONDON—Most European Union countries need to better address growing pension problems brought on by demographic changes, according to a recent report.

The report, issued by the European Union's Economic Policy Committee, shows that most E.U. member countries plan to increase government spending by 3% to 5% between now and 2050 to help fund retirement incomes for their rapidly aging populations.

Lower increases of 2% to 3% are expected over the same period in Italy, Luxembourg and Sweden. The countries facing the biggest pension challenges are Spain and Greece, where spending increases of 8% and 12% of GDP, respectively, are projected. Spain's problem stems from significant demographic changes, and Greece's are a result of the government decision to postpone reforms of the state-run pension system, the report says.

The United Kingdom is the only E.U. member that projects a decrease in public pension spending as a percentage of GDP between this year and 2050, said the report, which has been endorsed by the European Commission.

The United Kingdom is considered to be in a better position than the other countries to meet the rising costs of an aging population, according to the report. That stems in part from the U.K. government's approach to its pension system, the report notes. The U.K. state pension is intended to provide minimum retirement income, and "citizens are expected, with the help of government incentives, to ensure that the bulk of their retirement income comes from other sources, in particular private occupational pensions," the report says.

The E.U. report notes that although other member countries are reforming their pension systems, "further reforms may be needed in some member states to ensure the financial sustainability of public pension systems."

World Updates

Syndicates making cash call on investors

Lloyd's of London syndicates are making a $795 million cash call on investors, chiefly to pay losses arising between 1998 and 2001. About half of the total—$395 million—will be used for losses from the 1999 year of account and earlier, according to a Lloyd's statement. Much of the remainder will be used to pay losses from 2000 and later, including those related to the Sept. 11 terrorist attacks in the United States. In November, Lloyd's estimated that the market faced $2.8 billion in net losses related to the attacks. An unspecified portion of the funds will be used to help Lloyd's meet an agreement with U.S. regulators to achieve 100% funding of its U.S. reinsurance trust fund by March 31. Lloyd's was granted a temporary reprieve by regulators from having to fund 100% of the market's gross liabilities after the Sept. 11 attacks (*BI*, Oct. 29, 2001). The syndicates' last cash call, for $1.1 billion, was made last September.

RSA boosts reserves for asbestos claims

Multiline insurer Royal & SunAlliance Insurance Group P.L.C. has boosted its reserves for asbestos and discontinued business liabilities. RSA said last week that it had strengthened asbestos provisions by £371 million ($526.0 million), which would result in a charge of £239 million ($338.9 million) on the company's 2001 results when they are released Feb. 28. RSA also strengthened its provisions for discontinued operations by £145 million ($205.6 million). London-based RSA said that the reserve strengthening, coupled with provisions for its Sept. 11 loss—now estimated at £215 million ($304.8 million)—would mean that its operating result before tax for 2001 would be "around break-even."

Olympus Re capitalized at $500 million

Bermuda startup Olympus Reinsurance Ltd. plans to begin underwriting next week with $500 million in capital. The reinsurer, which will be based in Hamilton, will write property catastrophe and other short-tail coverages. Among Olympus' largest financial backers are Leucadia National Corp. and Gilbert Global Equity Partners. Sheila Nicoll, a former senior vp with Marsh & McLennan Cos. Inc., will be president and chief underwriting officer of Olympus. Ms. Nicoll was mostly recently

See WORLD UPDATES/page 15

D&O: Rates spiking for companies with U.S. risks

Continued from previous page

More recently, on Jan. 22, the U.S. Securities & Exchange Commission announced that the New York-based broker/dealer and investment bank Credit Suisse First Boston Corp. agreed to pay $100 million to settle actions filed by the SEC and NASD Regulation Inc. "for abusive practices relating to the allocation of stock'' in initial public offerings, the SEC said in a statement.

"Loss ratios for D&O accounts involving U.S. business are significantly up," said Nigel Salisbury, manager of professional and financial risk for London-based multiline insurer Royal & SunAlliance Insurance Group P.L.C.

'In an uncertain economy, the number of insolvencies is going to increase, which will result in more litigation against companies, their directors and advisers.'

Nigel Salisbury
Royal & SunAlliance

Rates are going up as a result, he said, estimating that an account with U.S. exposure would likely see increases of 80% or more. The growing number of U.S. securities claims already has caused concern in the D&O market, and "in an uncertain economy, the number of insolvencies is going to increase, which will result in more litigation against companies, their directors and advisers, including lawyers and accountants," he said.

Economic uncertainty, together with increasing corporate governance regulation and shareholder litigation in many European countries, is leading to reduced capacity and higher rates for D&O insurance, particularly for high-risk sectors such as high-tech, biotechnology, telecommunications and energy companies, said Melanie Politi, associate director of the corporate liability unit of Aon Ltd. in London.

She noted that all companies likely will see rate increases for their D&O cover, ranging from just 10% to 15% for a company with a good record and no U.S. exposure, to increases "well in excess of 100%" for many companies that have a U.S. exposure.

Martin Beagley, a director of Willis Group Ltd.'s global financial and executive risks division in London, said that international companies with a U.S. exposure likely would face rate increases of between 50% and 300%.

While capacity of up to $300 million remains available for large companies, underwriters are imposing tougher terms on many clients, brokers note.

In particular, insurers no longer are offering multiyear D&O liability policies, and they have reduced or, in some cases, eliminated extended reporting periods. Some insurers also have brought back coinsurance for securities claims, brokers note, and underwriters have imposed insolvency exclusions for distressed accounts.

D&O buyers also face exclusions for claims from major shareholders and, in some cases, terrorism exclusions for high-risk companies such as airlines, brokers say.

Another type of securities claim is becoming a greater concern for D&O underwriters.

Allegations involving a practice known as "laddering" account for much of billions of dollars in unsettled securities claims, brokers estimate.

In such claims, shareholders charge that preferred customers of investment banks paid excessive fees to the banks in return for allotments of IPO stocks. The preferred investors would also agree to purchase a specified number of stocks on the open market immediately after of the IPO and thus drive up the price of the stock. The banks, as underwriters of the IPO, then benefited by exercising options to issue more shares for themselves at the offering price, the suits allege.

Such claims generally are filed against the offering banks, their directors and officers, and the company making the offering, Ms. Politi said.

"If the laddering claims ultimately are successful, there could be a huge impact on D&O underwriters for financial institutions," said AIG's Mr. Fernandez.

Sulzer Medica agrees to pay $1 billion to claimants

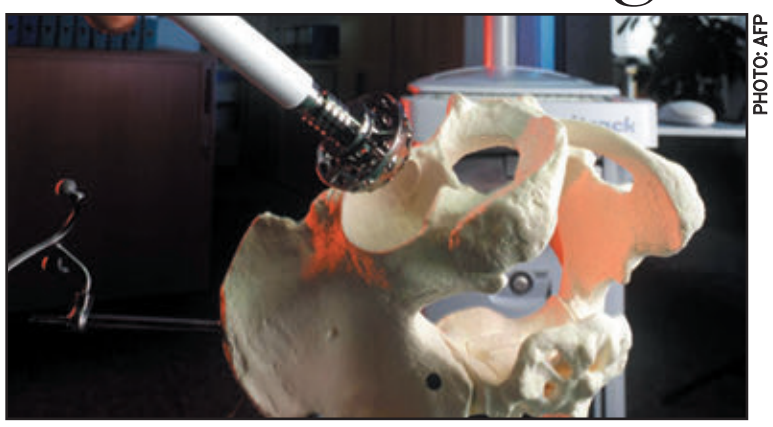

PHOTO: AFP

Switzerland's Sulzer Medica expects insurance to pay part of a $1 billion settlement of claims over defective hip and knee implants.

By SARAH VEYSEY

ZURICH, Switzerland—Swiss medical company Sulzer Medica has reached a $1 billion settlement with thousands of American claimants who say they received defective hip and knee implants from Sulzer Orthopedics Inc., a Sulzer Medica subsidiary in Austin, Texas.

Zurich-based Sulzer announced that a "term sheet for a class-action settlement" had been "signed by all parties." Sulzer Medica Chief Executive Officer Stephan Rietker said in a statement that, under the terms of the settlement, the approximately 4,000 claimants would "quickly receive a considerably larger compensation" than they would have received had the suit gone to court.

Sulzer Medica said it would contribute about $425 million in cash and $300 million in stock toward the settlement. It added that it expected to add proceeds from an insurance policy with Winterthur Swiss Insurance Co. but that it was still in negotiations with Winterthur as to how much money it would receive from the policy.

A Sulzer spokesman said last August that the liability coverage, written to limits of $240 million, had approximately $215 million to $225 million in available limits (*BI*, Aug. 27, 2001).

The proposed settlement has been submitted to U.S. District Court Judge Kathleen O'Malley in Cleveland. A final hearing is slated for May 14.

The claims arose after Sulzer Orthopedics began recalling the hip and knee joints at the end of 2000 because a residue of their oil lubricants prevented the devices from attaching properly.

World Updates

Continued from page 13
executive director of Careers in Insurance, an Internet-based recruitment company in Bermuda.

Hannover Re Group posts nine-month loss

Hannover Re Group reported a loss of 85 million euros ($73.2 million) for the first nine months of 2001, largely as a result of claims from the Sept. 11 terrorist attacks. Gross written premiums for the nine-month period at the Hannover, Germany-based reinsurer totaled 7.3 billion euros ($6.29 billion). Comparable figures for 2000 are not available, as Hannover Re only began reporting quarterly results in 2001. Shortly after the terrorist attacks, Hannover Re estimated that it faced Sept. 11-related losses of 234 million euros ($201.5 million) after tax. Chairman Wilhelm Zeller said, in a statement, "we do not foresee any further charges due to this catastrophe."

Briefly noted

The London-based **Financial Services Authority**, the U.K.'s financial services regulator, said last week that insurers' regulatory costs would rise by about 10% this year. The FSA said the increase stems from its efforts to increase monitoring of the insurance industry....**Ian Agnew**, former chairman of Lloyd's of London company Wellington Underwriting P.L.C., has been appointed nonexecutive director of Equitas Holdings Ltd., the parent company of Equitas Ltd. He was appointed by the Corporation of Lloyd's, which holds a nonequity share of Equitas and can appoint one director to the board of Equitas, the runoff reinsurer for Lloyd's pre-1993 long-tail liabilities. Mr. Agnew replaces Stephen Catlin, chairman of Catlin Underwriting Agencies Ltd., who stepped down from the post in January.

States urged to use hospital bioterror funds wisely

By ED LOVERN

WASHINGTON—The federal government is sending states $125 million to help hospitals prepare for bioterrorism, though state health departments will have the final say on how most of the money will be used by hospitals.

"I think there is worry that states may not spend the money on what hospitals feel they truly need," said James Bentley, senior vp of long-term policy for the American Hospital Assn.

The Health and Human Services Administration is expected to release $1.1 billion to states for bioterrorism preparedness, part of a $2.9 billion allocation authorized by President Bush.

Some $125 million is designated primarily for states to create regional hospital plans for responding to bioterrorism attacks or infectious disease outbreaks.

Although states are obligated to use half of the initial allocation—20% of the $125 million—for developing regional hospital plans, the other half can be used for other hospital preparation needs such as buying pharmaceuticals and upgrading communications equipment, Mr. Bentley said.

Since state health departments are receiving the money, hospitals must rely on state hospital associations to negotiate how the funds will be used.

"There was confusion all along (about) where the money would go," said Calvin Pierson, president of The Assn. of Maryland Hospitals & Health Systems.

Mr. Pierson said he is confident that his group's strong relationship with Maryland's Department of Health and Mental Hygiene will ensure that the $2.3 million the department receives will be spent appropriately.

The remaining $975 million being distributed to states is for unspecified activities to prepare for bioterrorism and other emergencies.

Given states' financial challenges, Mr. Pierson said he worries the funding may end up being used to fill budget gaps.

HHS, however, maintains that safeguards are in place to ensure that all the money is used for disaster readiness.

Ed Lovern is a reporter at Modern Healthcare, a sister publication of Business Insurance.

Symposium on terrorism

Bioterror has huge impact on insurance industry

By MEG FLETCHER

CHICAGO—The handful of anthrax-tainted letters that contaminated a congressional office building, several post offices and two media offices late last year have had a far greater impact on the insurance industry than that small number of incidents would indicate.

"The advent of biological terrorism is spawning unique coverage and legal issues as well as complex adjusting considerations," according to two attorneys who presented a paper on the topic during a recent symposium on the impact of terrorism on insurance claims. The Jan. 31-Feb. 1 meeting in Chicago was sponsored by the Property Loss Research Bureau, an affiliate of the Alliance of American Insurers in Downers Grove, Ill.

There are not yet any cases alleging liability for contamination, said Rebecca G. Casagrande, of Casagrande & Associates P.A. in St. Petersburg, Fla.

We are really "in uncharted waters," said Stephen E. Goldman, an attorney with Robinson & Cole L.L.P. in Hartford, Conn.

Existing legal theories in other types of cases, however, may help indicate whether a policyholder could turn to insurance to cover losses related to an anthrax contamination, he said.

For example, courts differ in their interpretation of when a policyholder's property sustains "direct physical loss or damage." Some courts interpret that common phrase literally and have excluded losses "that are purely economic in nature…including repair and remediation expenses." Other courts, though, have broadly interpreted such loss or damage "to include the effect of any substance that renders insured property useless or otherwise impairs its function," which a court might decide includes anthrax in a facility, the attorneys said.

PHOTO: GETTY

A cleanup crew enters the American Media Inc. headquarters in Boca Raton, Fla., where two employees contracted the anthrax virus.

If anthrax bacteria are considered "a pollutant," coverage issues arise about whether the bacteria were "dispersed, discharged or released in the building" and the "proximate cause" of the contamination, which are terms governing property insurance contracts, the attorneys said.

Finally, potential anthrax coverage cases may turn on whether the anthrax contamination is considered "vandalism," and the extent to which the policyholder purchased coverage to protect against that, Mr. Goldman said.

Before legal issues are resolved, though, immediate challenges for risk managers include decontaminating a worksite and salvaging valuable papers, which may require scanning or cleaning them, Mr. Goldman said. "This is very tricky. The costs can be radically different depending on what your obligations are," he added.

When it comes to remediation of a contaminated site, the difficult questions include "how safe is safe and how clean is clean," he said.

In an effort to prevent coverage disputes arising from anthrax attacks in the future, the Insurance Services Office Inc. in Jersey City, N.J., has filed terrorism exclusions for commercial policies that eliminate coverage for "any incident of terrorism that involves the use, release or escape of pathogenic or poisonous biological or chemical materials…."

Nearly every state—except notably California and New York—has adopted those exclusions for insurers to use in their states (*BI*, Jan. 14).

The issue, however, is complicated by the fact that some forms of anthrax are present in nature and may be able to survive forever, Ms. Casagrande said. But the recent incidents primarily featured an "engineered" form of anthrax, Mr. Goldman said.

Claims: Assessing 9-11 losses

Continued from page 3

served by the insurance community in the wake of this disaster," said Mr. Serio.

Five months after the disaster, though, regulators and insurers face several new challenges.

For example, both insurers and regulators often have to explain to policyholders the types of losses that are—and are not—covered by different types of insurance coverage, even though the answers may not be what policyholders want to hear, Mr. Serio said.

He explained that businesses in the "gray zone" surrounding the disaster site, where businesses experienced decreased sales because authorities closed down street traffic to protect the public from dangerous conditions or to help speed recovery and repair work, may face the biggest challenge in obtaining various coverages.

While some policies cover business interruption losses due to actions by civil authorities, it is currently difficult to document which streets or airports were closed, when and why, said Thomas J. Upman, vp-property claims, for CNA Insurance Cos. in Chicago.

In addition, insurers have received many contingent business interruption claims from property insurance policyholders who had not bought that specialized coverage, he said.

Insurers and regulators are both concerned about preventing fraudulent claims and have taken steps to review questionable ones.

The most common type of fraudulent claim filed in relation to WTC losses involves death claims seeking payouts on life insurance policies for people who are not deceased, Mr. Upman said.

Going forward, the industry and regulators continue to debate the issue of the appropriateness of including terrorism exclusions in policies.

The New York Insurance Department is still negotiating with dozens of insurers to narrow what Mr. Serio considers "overly broad" terrorism exclusions for commercial risks, though nearly every other state—except California—have endorsed exclusions filed by the Insurance Services Office Inc. (*BI*, Jan. 14).

While talks continue, some of the proposed exclusionary language is being amended, Mr. Serio said.

"I think the exercise has been productive."

Mr. Serio, however, said he rejects such exclusions for personal lines risks because reinsurance coverage appears to be available for such risks.

Wal-Mart offers employees health premium option

By JOANNE WOJCIK

BENTONVILLE, Ark.—Wal-Mart Corp. is giving its employees the option of using part of the company's annual contribution to their 401(k) plan benefits to pay for increases in health plan premiums.

In the company's benefits handbook for 2002, employees were told that beginning this month, they can elect one of three uses for one-half of the company's annual contribution. The retail giant contributes an amount equal to 2% of each employee's salary, regardless of whether the employee participates in the company's 401(k) plan.

Under the arrangement described in the handbook, employees can deposit the funds into a 401(k) account, use it "to help offset your healthcare costs" beginning with the employee's April paycheck, or take a cash lump-sum payout.

Under the first two options, the funds will be contributed on a pre-tax basis as part of a Section 125 plan; if employees take the money as cash, it becomes taxable income, a company spokesman said. The other half of the contribution would either go into the employee's 401(k) account or into an individual retirement account-type vehicle.

When it launched its 401(k) in 1997, Bentonville, Ark.-based Wal-Mart decided against making 401(k) plan matching contributions "because it is more consistent with our culture to add the same percentage of wages to each person's account, rather than contribute more to some associates based upon their decision to contribute their own money," the spokesman said.

Employees are eligible to participate in Wal-Mart's 401(k) plan after they work one full year, or at least 1,000 hours. Employees can choose from among 14 investment options, one of which is company stock.

In addition to the 401(k) plan, Wal-Mart employees also receive profit-sharing through an employee stock ownership plan into which the company makes 100% of the contributions. The company also offers a stock purchase plan that lets employees purchase stock through regular payroll deductions. Wal-Mart matches 15% of employee contributions to the stock purchase plan, up to the first $1,800 each year.

PHOTO: GETTY

Wal-Mart is giving employees new options for its contributions to their 401(k) plans, including using funds to defray health plan premiums.

Fire: ISO seeks to revise standard fire policies

Continued from page 1

New York Insurance Superintendent Gregory V. Serio—question, however, whether ISO's proposed campaign could ever eliminate minimum fire protection standards that the majority of states have had in place for at least the last 60 years. Such a move could be seen as diminishing commercial policyholders' protection at a time when they face availability and affordability problems.

"I don't think there is any likelihood that (coverage) is going to change, and I don't think that the department would support that," said Mr. Serio.

However, discussing ISO's proposed legislative campaign "is very helpful, because it has escaped notice among risk managers, until now," said Michael D. Phillipus, vp-external affairs for the Risk & Insurance Management Society Inc.

He plans to ask the New York-based organization's government affairs team to monitor ISO's proposed campaign and track legislative developments nationally so they can be reported to local chapters and members, said Mr. Phillipus, who also is risk manager for Pennzoil-Quaker State Co. in Houston.

His company, however, is not affected because its manuscripted policy does not duplicate the minimum coverage form that often is used in the policies of some smaller companies, he said.

The concept of a standard fire policy had its roots in late 19th century coverage disputes.

'The existence of the standard fire policy in the 30 states simplifies the applicability of terrorism exclusions because of the guaranteed coverage required by the standard fire policy language.'

John Dearie
Edwards & Angell L.L.P.

Various groups—including the predecessor of the National Assn. of Insurance Commissioners—tried over time to resolve the problem by developing uniform policy language. Most current policies and court interpretations are based on the 1943 New York policy form, according to ISO.

The coverage typically protects a policyholder from most direct losses or damage by fire and lightning, as well as removal from premises. according to ISO.

It does not apply to potentially related losses, such as business income or extra expense coverage. In addition, the standard policy excludes war-related risks, but courts have generally interpreted that provision conservatively and ruled that it applies only to conflicts between sovereign nations, not terrorists, ISO said.

Given these limitations, ISO filed two types of terrorism exclusions, depending on whether the state had a standard fire policy law. Regulators in nearly all jurisdictions subsequently approved insurers' use of those forms, except for California, Florida and New York.

"The existence of the standard fire policy in the 30 states simplifies the applicability of terrorism exclusions because of the guaranteed coverage required by the standard fire policy language," said John Dearie, a New York-based insurance attorney with Edwards & Angell L.L.P.

In the jurisdictions without such standard fire policies, though, terrorism exclusion filings do not include coverage for fires following terrorist attacks.

From a consumer's perspective, risk managers in standard fire policy states may seem to have some temporary advantage because of the guaranteed coverage, said Brad Kading, senior vp and director of state relations for the Reinsurance Assn. of America in Washington. Over the long haul, however, having such standardized coverage "limits innovations in the marketplace," which is a disadvantage to risk managers, he said.

In addition, risk managers in states with standard fire policies still have a need for terrorism coverage because they still face the possibility of losses from nonfire hazards, said Don Griffin, assistant vp-business and personal lines for the National Assn. of Independent Insurers in Des Plaines, Ill.

In any case, risk managers need to review their risks and the wording of current policies protecting their companies' property and plug gaps that may exist as insurers and reinsurers try to tighten terms and conditions in renewal policies.

With ISO's development of terrorism exclusions, "all we did was provide a tool to work within the current distressed environment, but it is not the solution," said Ms. Banfield. "The solution is a federal backstop for the insurance industry," she said.

Errors & omissions

Due to a production error, a chart in the Feb. 4 issue on the largest captive managers in Dublin contained incorrect information. A corrected version of the chart appears below.

LARGEST MANAGERS OF DUBLIN CAPTIVES

Ranked by gross premium volume in millions of dollars

Manager	Premium volume 2001	Premium volume 2000	Captives 2001	Captives 2000
Aon Insurance Managers (Dublin) Ltd.	$700.0 0 [1]	$618.0	65	39
Marsh Management Services (Dublin) Ltd.	353.0	308.1	63	51
Eurco Ltd.	266.9	226.9	4	6
FBD International Captive Management Ltd.	253.0	254.0	4	4
Willis Management (Dublin) Ltd.	90.0	NA	16	15

1 Pro forma numbers for 2001 to reflect the merger of Aon Insurance Managers(Dublin) Ltd. and SINSER (Ireland) Ltd.
Source: *BI* survey

Court allows bias lawsuit to proceed

By ROBERTO CENICEROS

SAN FRANCISCO—A federal appellate court in California has ruled that an arbitration clause that last year was upheld by the U.S. Supreme Court violates California law and is invalid.

Last March, the Supreme Court ruled unanimously in *Circuit City Stores Inc. vs. Saint Clair Adams* that the Federal Arbitration Act of 1925 applied to all employment disputes (*BI,* March 26, 2001). The decision overturned a 1999 appeals court ruling that employment arbitration contracts were not enforceable under the FAA.

At issue in the case was whether Circuit City could require an employee to submit a discrimination claim brought under California law to binding arbitration because he had signed a pre-employment agreement to use arbitration in all employment disputes.

After the Supreme Court found in favor of the Richmond, Va.-based electronics retailer, it remanded the case back to the 9th U.S. District Court of Appeals.

The appellate court last Monday unanimously ruled that although the arbitration agreement is valid under federal law, it violates California law because it unfairly favors the employer, according to the ruling.

California law requires a "modicum of bilaterality," and Circuit City's contract did not meet that standard because it forced the employee to arbitrate while the employer could choose either to litigate or arbitrate disputes, according to the ruling. In addition, the agreement limits the damages that employees can recover and forces them to pay half the arbitration costs if they lose, which the court deemed unbalanced.

"Circuit City has devised an arbitration agreement that functions as a thumb on Circuit City's side of the scale should an employment dispute ever rise between the company and one of its employees," wrote Circuit Judge Dorothy W. Nelson.

Circuit City vs. St. Clair Adams, No. 98-15992, 9th U.S. District Court of Appeals.

Asbestos: Alliance seeks reform of claims process

Continued from page 2

The coalition began coming together last spring and had posted its goals and other information on a Web site by mid-summer, and now has about 200 members. But plans to push ahead with legislation fell by the wayside.

"After Sept. 11, Congress was interested in nothing but terrorism for the rest of the year," said John Arlington, assistant vp-federal affairs of the AIA in Washington.

"Now we're back in session, and I think everyone in the private sector is trying to figure out what issues Congress is willing to take up. Right now, Enron is at the top of the list," he said.

"I think we would suggest it is has reached the right time," said Jan Amundson, general counsel for the NAM in Washington.

"When is the right time? Is there only one right time? I think two years ago you couldn't get people's attention. It was too sector specific."

The coalition decided to push ahead "because it just keeps getting worse and worse," said Mr. Arlington.

Mr. Arlington pointed out that some observers "predicted that the number of asbestos lawsuits would begin to decline about 1999 or 2000, and instead of that, they kept increasing." The litigation went up "about 90% in 2000, and I bet they went up another 70% or 80% in 2001," he said.

"There's a growth industry in asbestos lawsuits and so there's a growth industry in asbestos bankruptcies."

"There's an inexhaustible supply of potential claimants if the only requirement is that they have some glimmer of a possible asbestos exposure and an X-ray that a doctor-for-hire says is consistent with some evidence of asbestos exposure," said Mr. Kazan.

He stressed that lung X-rays can't tell the cause of scarring any more than an X-ray of a broken leg can tell what caused the break.

"My view is that it's in everybody's interest to make sure these companies survive, not that I care about the shareholders or the management, but so that they can fulfill their obligations, two years or five years or 10 years from now," said Mr. Kazan.

The National Assn. of Manufacturers' Ms. Amundson called working with members of the trial bar, "a unique opportunity."

"I think we want to make sure that we can work this through," she said.

Ms. Amundson said that the group will follow a flexible schedule as it seeks to have its principles incorporated into legislation.

"We aren't talking about a target date, we want to get something as soon as possible when we have finalized our Hill support."

ADM: Case could open door to self-insured benefits

Continued from page 1

risks through the captive. Meeting that test was virtually impossible, as few employers want their insurance subsidiaries to take on that much unrelated business.

But that obstacle was eased in 1999 when a key Labor Department official said meeting the 50% test no longer would be an absolute prerequisite to winning departmental approval for funding benefits through captives.

Among other things, the department would consider the quality of the primary insurers used by a captive and whether plan participants would benefit through the arrangement.

Following up that pledge of new flexibility, the department in August 2000 approved Herndon, Va.-based Columbia Energy Group's application to use the Vermont branch of its Bermuda-domiciled captive to reinsure its long-term disability benefits program (*BI*, Aug. 21, 2000).

While Columbia Energy, which has since been acquired by NiSource Inc., didn't come close to meeting the 50% test, it did agree, among other things, to sweeten participants' LTD benefits.

Many employers interested in funding benefits through captives are waiting for an expedited review process before deciding whether to proceed.

Henry Saveth
William M. Mercer

While the Labor Department's approval of Columbia Energy's application gave other employers another way to fund benefit risks through their domestic captives, it didn't ease all regulatory obstacles, chiefly a very long DOL review process, which was more than a year in Columbia Energy's case.

But if the department approves ADM's application, other employers wouldn't face such lengthy reviews.

That is because future applicants could take advantage of a special expedited review process in which the department must make a decision within 45 days. To qualify for this fast-track procedure, an applicant has to cite two "substantially similar" exemptions approved by the Labor Department within the past five years.

In fact, many employers interested in funding benefits through captives are waiting for an expedited review process before deciding whether to proceed, said Henry Saveth, an attorney with William M. Mercer Inc. in New York.

Indeed, ADM's proposal is deliberately similar to Columbia Energy's. "We were trying to follow the Columbia model," Mr. Lusk said.

Just as Columbia Energy, in anticipation of the Labor Department ruling, sweetened its LTD benefits package for disabled employees, ADM has substantially boosted basic and supplemental life insurance benefits.

For example, under the company-paid basic life insurance plan for salaried employees, the maximum benefit has been increased to one times base salary, up to $1 million, from one times base salary up to $100,000.

In addition, the supplemental life insurance benefit plan for salaried employees, which is employee-paid, was improved by ADM. The maximum benefit was increased to up to five times salary, with a $2 million cap, from up to four times salary, with a $1 million cap.

Just as Columbia Energy agreed to use top-rated insurers—those with a rating of A or better from A.M. Best Co.—to issue LTD policies, ADM says it also would only contract with insurers with a rating of at least A from Best or the equivalent rating from another rating agency. Minnesota Life, which would be reinsured by the ADM captive, Agrinational, has a Best rating of A++.

ADM, in its application to the Labor Department, said the formula used to calculate premiums by Minnesota Life or any successor insurer would be similar to formulas used by other insurers providing comparable life insurance coverage under similar programs. Columbia Energy had a nearly identical provision, though for LTD coverage rather than life insurance.

Finally, just as Columbia Energy agreed to retain an independent fiduciary—it chose Milliman & Robertson—to determine that all conditions of the exemption were met annually, ADM, in its application, said it also would retain Milliman & Robertson as an independent fiduciary to ensure all conditions of the exemption are met.

Agrinational, the ADM Vermont captive, was licensed in 1987. It generated just over $17 million in net premiums from a wide range of risks in 2000.

ADM's application to the Labor Department was submitted by the law firm of LeBoeuf, Lamb, Greene & MacRae L.L.P. in New York, which also filed the Columbia Energy application.

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CHA INSURANCE COMPANY LIMITED
IN LIQUIDATION
and IN THE MATTER OF THE COMPANIES ACT 1981 and IN THE MATTER OF THE INSURANCE ACT 1978
(Under an Order for Winding-Up the above-named Company, dated 25 September 2001)
NOTICE OF INTENTION TO PAY A DIVIDEND

NOTICE IS HEREBY GIVEN that the Joint Liquidators of CHA Insurance Company Limited - in Liquidation ("the Company") intend to declare a first and final dividend on 1 April 2002, under the provisions of Rule 84 of the Companies (Winding-up) Rules 1982.

All Creditors who have not filed a Proof of Claim against the Company in the liquidation should do so by sending such Proof of Claim to the Joint Liquidators, CHA Insurance Company Limited - in Liquidation, PricewaterhouseCoopers, Dorchester House, 7 Church Street, Hamilton, HM 11, Bermuda on or before 5.00 pm (Bermuda time) 15 March 2002. Failure to file a Proof of Claim on or before 15 March 2002, will result in your claim being excluded from participation in payment of the dividend to be declared.

Proof of Claim forms may be obtained from the Joint Liquidators whose contact details appear below.

PETER C B MITCHELL *Joint Liquidator*
CHA Insurance Company Limited - in Liquidation,
PricewaterhouseCoopers, PO Box HM 1171, Hamilton HMEX, Bermuda
Tel: 441-295-2000. Fax: 441-295-1242.
1 February 2002

LEGAL NOTICES

THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION)
OF DELTA CASUALTY COMPANY) 01 CH 20445

NOTICE OF CLAIM FILING DEADLINE AND PROCEDURES

PLEASE TAKE NOTICE, that on December 4, 2001, the Circuit Court of Cook County, Illinois, entered an Agreed Order of Liquidation With a Finding of Insolvency against Delta Casualty Company ("DELTA"). Nathaniel S. Shapo, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of DELTA ("Liquidator").

TAKE FURTHER NOTICE, that on January 29, 2002, the Circuit Court of Cook County, Illinois, entered an Order Fixing Rights and Liabilities and Providing for the Filing of Claims and the Setting of Claim Filing Deadlines ("Fixing Order"). Pursuant to the Fixing Order, all rights and liabilities of DELTA and its policyholders, creditors and stockholders, and all other persons interested in its property or assets, are fixed as of December 4, 2001, unless otherwise provided in subsequent orders of the Court.

TAKE FURTHER NOTICE, that all persons, companies or entities who have, or may have claims against DELTA, its property or assets, or against a DELTA insured or policyholder, shall have the right to present and file with the Liquidator proper proofs of claim on or before December 4, 2002 at 4:30 p.m. C.D.T.

TAKE FURTHER NOTICE, that any insured under an insurance policy issued by DELTA shall have the right to present and file with the Liquidator a proper proof of claim setting forth a contingent claim on or before December 4, 2002 at 4:30 p.m. C.D.T. No contingent claim shall be allowed for purposes of participating in any distribution of estate assets that may be made at the fourth priority level [215 ILCS 5/205(1)(d)] unless such claim has been liquidated and the insured claimant has presented and filed evidence of payment of such claim to the Liquidator on or before December 4, 2003 at 4:30 p.m. C.D.T. Any contingent claim for which a proper proof of claim is filed on or before December 4, 2002 at 4:30 p.m. C.D.T., but which is not liquidated on or before December 4, 2003 at 4:30 p.m. C.D.T., may be estimated pursuant to 215 ILCS 5/209(4)(b) for purposes of participating in any distribution of estate assets that may be made at the fifth priority level [215 ILCS 5/205(1)(e)] unless otherwise directed by the Court.

TAKE FURTHER NOTICE, that the form and required contents of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, if any, are to be filed with, and may be obtained from, the Liquidator of DELTA, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. A proof of claim shall be deemed "filed" with the Liquidator upon the Liquidator's receipt thereof. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to DELTA upon all filed claims. All proofs of claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR IS SET FORTH ABOVE. NO PERSONS, COMPANIES OR ENTITIES HAVING OR CLAIMING TO HAVE ANY CLAIM AGAINST DELTA, ITS PROPERTY OR ASSETS, OR AGAINST A DELTA INSURED OR POLICYHOLDER, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE PROPERLY FILED WITH THE LIQUIDATOR ON OR BEFORE DECEMBER 4, 2002 AT 4:30 P.M. C.D.T.

Cathleen M. Travis
Special Deputy Receiver

LEGAL NOTICES

Notice to Creditors No. 6899 of 2001

IN THE HIGH COURT OF JUSTICE
CHANCERY DIVISION
COMPANIES COURT
IN THE MATTER OF THE NICHIDO FIRE & MARINE INSURANCE COMPANY LIMITED
AND
IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that by an Order of Mr Justice Jacob dated 25th January, 2002 made in the above matter the Court has directed the sanction of a solvent Scheme of Arrangement ("the Scheme of Arrangement") between the above mentioned company ("the Company") and the Scheme Creditors of the Company.

The Scheme of Arrangement became effective on 29th January, 2002 and as such all Scheme Claims must be received by the Scheme Manager (Axiom Claims Consulting Limited, East India House, 109-117 Middlesex Street, London E1 7JF, England, ref [Paul West]) from all Scheme Creditors by no later than 26th March, 2002 ("the Bar Date"). Scheme Claims notified to the Scheme Manager after the Bar Date will not be admitted against the Company, the Scheme Creditor concerned shall be deemed to have relinquished all of his rights in respect of the Scheme Claim and the Company shall have no further obligations in respect of the Scheme Creditor.

Any further copies of the Scheme of Arrangement, the Explanatory Statement furnished pursuant to section 426 of the Companies Act 1985, and the Claim Form may be obtained by application from the Scheme Manager (Axiom Claims Consulting Limited, East India House, 109-117 Middlesex Street, London E1 7JF, England, ref [Paul West]).

It is requested that all Claim Forms be lodged with Mr Paul West of Axiom Claims Consulting Limited at East India House, 109-117 Middlesex Street, London E1 7JF, England, by the Bar Date.

Dated 29th January, 2002

DLA
3 Noble Street, London, EC2V 7EE, England
Solicitors for the Company

LEGAL NOTICES

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK
In re:
MUNICIPAL GENERAL INSURANCE LIMITED
(Petition of Gareth Howard Hughes, Nigel James Hamilton and Jacqueline Barbara Stephenson)
Case No.: 94-41329 (CB)

PLEASE TAKE NOTICE that on January 25, 2002, the Bankruptcy Court entered an order (the "Order") continuing the Preliminary Injunction Order pursuant to 11 U.S.C. § § 105 and 304(b) originally entered in this case on March 29, 1994. The Order shall remain in effect pending a hearing scheduled for January 24, 2003 at 2:00 p.m. before the Honorable Cornelius Blackshear, in the Alexander Hamilton Custom House, One Bowling Green, New York, New York. Any person wishing to obtain a copy of the Order should contact Theresa D'Agostino at (212) 610-6300.

ALLEN & OVERY
10 East 50th Street
New York, New York 10022
Tel: (212) 610-6300
Fax: (212) 610-6399
Attention: Ken Coleman
Stephen Doody

ACE, XL near deal on WTC

Their cover of Silverstein defined occurrence

By DOUGLAS McLEOD

NEW YORK—ACE Ltd. and XL Capital Ltd. are close to a settlement with World Trade Center leaseholder Silverstein Properties Inc. in which they would pay single occurrence limits totaling $366 million for the WTC's destruction.

Silverstein has argued in litigation with 20 other insurers on its $3.55 billion property program that the Sept. 11 attacks on the twin towers were two occurrences, entitling the company to two full-limit recoveries. Unlike the other insurers, though, ACE and XL specified in coverage binders that they would use a form developed by Willis Group Holdings Ltd. that included a restrictive definition of occurrence.

The Willis form defines occurrence as losses "attributable directly or indirectly to one cause or to one series of similar causes." Lead WTC insurer Swiss Reinsurance Co. and others say they also intended to use the Willis form, but Silverstein argues that they are bound under a Travelers Property/Casualty Corp. form that does not include an occurrence definition.

The expected settlement will benefit both sides, according to Eric M. Roth, a lawyer with Wachtell, Lipton, Rosen & Katz, representing Silverstein. Silverstein will drop its demand for a double recovery from ACE and XL but will receive payments much sooner than it would if the two Bermuda insurers—like other insurers on the program—continued to argue that they are not required to pay until reconstruction of the WTC is underway, Mr. Roth said.

Both insurers participated in high excess layers, with ACE writing $298 million in two layers excess of $1 billion and XL writing a $68 million portion of a layer excess of $3.26 billion.

Mr. Roth also said that the settlement was not motivated by any need on Silverstein's part for cash to make ongoing mortgage and rent payments on the WTC property. Silverstein has received around $150 million in business interruption claim advances from property insurers to cover those costs, he said.

A representative of ACE declined to comment, and XL could not be reached.

A lawyer for Swiss Re, meanwhile, said that the Bermuda insurers' use of the Willis form bolsters other insurers' position that the form governed the entire program.

"It clearly supports our major trial position that this risk was brokered to the market on the basis of the Willis form," said Barry Ostrager, a lawyer with Simpson, Thatcher & Bartlett representing Swiss Re.

Great-West: Plans can't collect third-party payments

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ruled in favor of the Knudsons.

The 9th U.S. Circuit Court of Appeals in 2000 upheld the ruling on the grounds that court-approved third-party payments to plan members are not equitable relief. Therefore, the court said, plans are not authorized under Section 502(a)(3) of the Employee Retirement Income Security Act to recover those payments.

In its 5-4 decision, written by Associate Justice Antonin Scalia, the Supreme Court majority agreed.

The high court's ruling centers on what kind of restitution constitutes equitable relief, which is the only form of relief that section 502(a)(3) authorizes. Under that section, ERISA authorizes civil actions by plan participants or fiduciaries who seek to prevent plan violations and obtain "other appropriate equitable relief."

The high court, relying on a standard it established in its 1993 ruling in *Mertens vs. Hewitt Associates,* distinguished equitable from legal restitution.

Equitable restitution is available when money or property that clearly belongs to a plaintiff can be "traced to particular funds or property in the defendant's possession," the court explained.

In contrast, a plaintiff who cannot show title or the right of possession to "particular property" in a defendant's control still may be able to justify recovering money as compensation "for some benefit the defendant had received from him," the court explained. That is a right to restitution at law, the court said.

Noting that the Hyundai settlement proceeds were not paid directly to the Knudsons, Justice Scalia wrote, "Because (Great-West is) seeking legal relief—the imposition of personal liability on (the Knudsons) for a contractual obligation to pay money—502(a)(3) does not authorize this action."

Benefits experts railed against the majority's reasoning.

"It's a distinction without a difference," said Henry Saveth, an attorney with benefits consultant William M. Mercer Inc. in New York.

Because most employer-sponsored plans contain reimbursement provisions similar to the one in the Earth Systems plan, employers should modify those provisions and their role in third-party litigation by plan participants, attorneys say.

Even if plan participants recover third-party damages directly, suing participants to recover plan costs could be problematic, attorneys note. In state courts, judges might rule that ERISA pre-empts such litigation, they said.

A federal court lawsuit against participants also might be fruitless, because the court could rule that even the proceeds that plan participants recover directly from third parties do not fit the Supreme Court's definition of equitable relief, attorneys said.

The ruling 'confirms the limited scope of equitable relief' plan participants can recover under ERISA.

Nancy G. Ross
McDermott, Will & Emery

In addition, plaintiffs attorneys likely will use this case as a blueprint to try to shield third-party awards and settlements from health plans in trusts created on plaintiffs' behalf, said attorney Nancy G. Ross, a partner with McDermott, Will & Emery in Chicago.

How courts might treat a plan's lawsuit against a trust is unclear, because Great-West's suit against the Knudson trust was dismissed early in the litigation, and the insurer did not appeal, attorneys said.

To ensure the recovery of their plan costs, plan sponsors now may have to take an active role in participants' lawsuits against third parties, attorneys note.

In the Great-West case, "it's more likely that the courts would have said this kind of action didn't breach ERISA, because the plan wouldn't have had to sue under ERISA for equitable relief," Ms. Ross explained.

But, "it costs more for plans to do that, and that's why plans haven't done that in the past," noted Kathleen Rosenow, an attorney with Watson Wyatt Worldwide's research and information center in Washington. That might prompt employers to either cut benefits or increase premiums for plan participants, she said.

Some employers may not even have that litigation option, however. States with anti-subrogation laws would bar insured plans from pursuing such claims, the SIIA's Mr. Pantos pointed out. Anti-subrogation laws would not bar self-insured plans from suing third parties, because ERISA pre-empts those laws for self-insured plans.

In addition, participating in some third-party claims may not be cost-effective for plan sponsors, Ms. Rosenow said.

If employers do not get involved in third-party suits, they could protect plan assets by refusing to provide benefits until plan participants complete all third-party litigation and use any awards or settlements to cover their medical costs, attorneys said.

That strategy would require employers to modify their plan language, they said.

Another approach—albeit one that offers less certain protection for employers until tested in court—would be requiring employees to sign a reimbursement agreement when they join the plan and every time they file a claim, Mr. Saveth said.

"There's no real good solution for this," Ms. Rosenow said.

The good news for employers is that the ruling "confirms the limited scope of equitable relief" that plan participants can recover under ERISA from fiduciaries, such as plan sponsors, Ms. Ross said.

But Timothy Hauser, an attorney with the U.S. Department of Labor, disagreed. "The court doesn't speak to the relief that's available to participants against fiduciaries," Mr. Hauser said.

The Labor Department and the AARP filed separate court briefs supporting Great-West in hopes the court would clarify the relief plan participants may recover from plan fiduciaries.

Great-West Life & Annuity Insurance Co. et al. vs. Janette Knudson and Eric Knudson, U.S. Supreme Court, Jan. 8; No. 99-1786

California: Employers critical of revamped comp bill

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that they had little chance to shape the legislation, as they were excluded from the governor's negotiations over the bill's contents (*BI*, Jan. 28).

"We got rolled," said Dominic DiMare, a lobbyist for the California Chamber of Commerce in Sacramento.

One of the biggest concerns for employers is that the measure would make annual benefits increases automatic by linking certain benefit payments to an index. Maximum and minimum temporary disability benefits as well as permanent total disability benefits would eventually increase annually in accordance with increases in a state average weekly wage determined by the U.S. Department of Labor.

Because the annual benefits increases will be automatic, labor representatives will have little incentive to negotiate over system improvements that employers consider necessary, said Jill A. Dulich, regional director in Santa Ana, Calif., for Marriott Claims Services, a unit of the hotel management company.

"There is not going to be any interest for those parties to come back to the table," she said.

For their part, supporters of the measure note that 42 states currently index benefits to the average weekly wage and that benefits increases were overdue. The maximum weekly wage for most permanently injured workers, for example, had been frozen in California for 19 years.

Many employers and insurers maintain that it is not the benefit increases they oppose, but a lack of substantial reforms that would help offset some of the increased cost. For example, the measure's opponents say it would not eliminate a problem that occurs when injured workers move from temporary to permanent disability status.

Such reclassifications involve subjective physician decisions, which has led to much litigation, say employers and insurers, which had sought an objective rating standard.

'While they might have language we discussed in the past, much of it is watered down to the point it is ineffective,'

Dominic DeMare
California Chamber of Commerce

Employers also unanimously complain that although the bill's authors paid lip service to the reforms sought by employers, in practice the measure would do little to address their concerns.

"They spent a lot of time saying there are a lot of provisions we asked for," Mr. DeMare said of the bill's backers. "While they might have language we discussed in the past, much of it is watered down to the point it's ineffective."

Mr. DiMare cited as an example a provision in the bill that would subsidize employers for helping injured workers return to work. The measure calls for the state to provide up to $2,500 for workplace modifications, up to $1,200 in wage subsidies for workers performing modified duties, and a premium rebate paid over two years, with the amount depending on the size of an employer's workforce.

But these provisions would not take effect until 2004, and implementation would require legislators to appropriate funding from the state's general fund. That may never happen, Mr. DeMare said.

Employers and insurers are pleased with one part of the bill, though.

A.B. 749 would partially eliminate the presumption that a worker's treating physician is correct, said Mark Webb, vp-state affairs in Sacramento for the American Insurance Assn. The measure would eliminate the treating physician's presumption, except in cases in which an employee designates a doctor prior to an accident.

The presumption has been problematic for employers and insurers, because it effectively eliminates second opinions for treatment purposes as well as in court disputes, observers say.

The new measure also simplifies employers' ability to extend their control of injured workers' medical treatment. Currently, California employers can retain control of treatment for 30 days, and they can extend that period to 90 days, 180 days or one year, depending on the medical treatment options they provide. But because the current requirements to extend treatment beyond 30 days are so complex, it often is impractical for employers to do so, said Willie Washington, legislative director for the Sacramento-based California Manufacturers & Technology Assn.

Although the new measure would eliminate the one-year extension, it would make it much easier for employers to extend control to 90 or 180 days, Mr. Washington noted.

Among numerous other benefit changes, the bill:

- Increases the maximum weekly temporary disability and permanent total disability benefits to $602 from $490 for injuries occurring on or after Jan. 1, 2003. It would further increase them to $728 for injuries occurring after Jan. 1, 2004, and to $840 for injuries occurring on or after Jan. 1, 2005. Then, starting in 2006, the amounts will rise in accordance with the percentage increase in the state average weekly wage.
- Increases the minimum permanent total disability benefits to $126 per week from $112 per week.
- Increases the maximum weekly permanent partial disability benefit—which is currently between $140 and $230 per week—to $230 in 2006 for all partial disability ratings under 70%, and $270 for those above 70%.
- Increases death benefits, effective Jan. 1, 2006, to $250,000, $290,000 or $320,000—from $125,000, $145,000 or $160,000—depending on the number of surviving dependents.

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Issue of February 11

Enron: Legislators agree on need for plan reforms

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company stock 90 days after they are vested.

In addition, Senate Health, Education, Labor and Pensions Committee Chairman Edward Kennedy, D-Mass., is preparing legislation, like that proposed by the administration, that would allow employees to sell company-contributed stock three years after joining a 401(k) plan.

Enron's 401(k) plan participants were especially battered by the collapse of the Houston-based company. That is because Enron only matched employees' salary deferrals in company stock and barred employees from trading those shares until age 50. In addition, even though participants had about 20 investment options to choose from, many directed all or much of their own salary deferrals into purchasing Enron stock.

For example, Thomas O. Padgett, a 59-year-old Enron chemist, said he directed all his salary deferrals into Enron stock because he was a loyal employee and, as he told Rep. Boehner's committee last week, "Top management of the company constantly encouraged us to invest in Enron stock."

As a result, plan participants were highly vulnerable to huge losses when Enron stock—which once traded at $90 a share—first began to slip last year and ultimately became nearly worthless after Enron restated financial results to report massive losses instead of profits.

Mr. Padgett's 401(k) account, valued at more than $615,000 in December 2000, now is worth less than $15,000, virtually eliminating the nest egg he and his wife were counting on to retire this year and perhaps start a small farm or ranch for disabled or terminally ill children.

"Now all that is gone and our children may need to take care of us," Mr. Padgett said.

Mr. Padgett doubts he will be able to recover his losses from Enron, but he urged legislators to take action to prevent future 401(k) plan disasters.

The first direction legislators appeared to be going in—placing a limit of perhaps 10% to 20% on the percentage of company stock that can be held in 401(k) accounts—has picked up little support and is strongly opposed by the administration and key members of Congress.

'Employees should have the right to diversify their deferrals, but the match is a company gift, and the company should be able to decide' when employees can sell those shares.

Michael Pikelny
Hartmarx Corp.

Employees "earned it, they sacrificed to save it; and they should have the right to decide how to invest it," said Labor Secretary Elaine Chao.

"How can we deny employees the right to invest in their company?" asked Rep. Boehner.

Rep. Sam Johnson, R-Texas, said constituents in his district are not "excited about Congress placing limits on their investments."

In opposition to percentage caps, he cited the example of a Texas Instruments Corp. employee who invested 100% of his savings plan contributions in TI stock and became very wealthy. "This is a country of free enterprise," said Rep. Johnson, who chairs the Employer-Employee Relations subcommittee.

By contrast, there is broad congressional support, as well as endorsement from the administration, for placing a limit on the number of years employers can require 401(k) plan participants to hold company-contributed stock before trading the shares.

None of Rep. Boehner's committee members opposed such a limit, with only Rep. Miller supporting a limit below the three years advocated by the administration. While Rep. Miller said a three-year limit was too long, Rep. Boehner said the purpose of such limits—attracting and retaining employees—would be lost.

"I don't want to throw out the baby with the bath water," he said.

Some benefit managers oppose such short-time restrictions on how long employers can require employees to hold company stock contributed as a matching contribution.

"I don't think there should be the same degree of regulation for matches as for salary deferrals. Employees should have the right to diversify their deferrals, but the match is a company gift, and the company should be able to decide" when employees can sell those shares, said Michael Pikelny, corporate actuary and benefits consultant at Hartmarx Corp. in Chicago. Hartmarx employees have to wait until age 55 before they can sell Hartmarx shares the company contributed as a match.

Legislators also strongly supported giving employees advance notice—at least 30 days—before companies can "lock down" their 401(k) plans and bar trading activity. This frequently occurs when companies change plan administrators. In the case of Enron, the company changed plan administrators, moving from Northern Trust to Hewitt Associates L.L.C. because of dissatisfaction with Northern Trust, said Mikie Rath, Enron's benefit manager, adding that Enron cut fees by about $700,000 through the switch to Hewitt.

Employers already typically provide lengthy advance notices, and a new mandate would have little impact, benefit experts say.

"Employers are very upfront about this," said Marilyn Scalia, a principal at Unifi Network in Fort Lee, N.J., a Mellon Financial Corp. unit.

"All of our clients give plenty of warning, and a 30-day requirement would not require them to do anything differently," concurred Nell Hennessy, a senior vp in the Washington office of Aon Consulting.

In addition, Republicans and Democrats alike endorsed employers making professional investment advice available to 401(k) participants.

Rep. John Tierney, D-Mass., underscored the importance of such advice, noting that Cindy Olson, Enron's executive vp-human resources and community relations, sold several million dollars of Enron stock after a professional investment adviser she sought out said she was too emotionally involved with the stock and should sell. Mr. Padgett, by contrast, didn't get any advice and, as a result, had virtually all of his retirement savings tied up in Enron stock.

RRG: Airlines plan to cover war risks

Continued from page 1

quarter of this year.

Since Sept. 11, the government has directly insured air carriers' third-party liability war risk exposure excess of the $50 million limit available in the commercial market. While aviation insurers previously had provided up to a $1.5 billion limit—for years at no additional premium—the terrorist attacks triggered a marketwide cancellation of war risk covers on seven days' notice. Insurers then sold back the coverage at vastly higher premiums with a $50 million sublimit for third-party war risks.

The reduced limits fell far short, though, of the $500 million minimum coverage that air carriers are required to maintain by their bank lenders and aircraft leasing companies, and Congress had to authorize the federal insurance program to avert a commercial aviation shutdown.

The near-grounding of commercial aircraft on such short notice "opened the eyes" of airlines to their vulnerability to insurance market shifts, and it was a prime reason for developing Equitime, according to Scott Russell, a Marsh managing director in Minneapolis and head of the broker's U.S. airline practice.

"The problem was the lack of stability and predictability," Mr. Russell said. "That's as much the motivation as any economic matters are."

ATA member airlines approached Marsh in late September to discuss possible solutions to the war risk liability problem, and the RRG concept has developed over the months since.

Equitime—an aviation term for the point in a flight at which the risk of turning back exceeds the risk of continuing—will be capitalized in a private placement of stock to prospective members. Marsh and airline industry officials declined to say how much they plan to raise, but "this does require a significant amount of capital commitment for the airlines, as well as significant premiums," Mr. Russell said.

Membership in the RRG will be open to U.S. airlines and "critical subcontractors," such as ground handlers, refuelers, caterers and airport security companies, Mr. Russell said.

The facility will not be open to airports "right now," in part because the exposures of airports—such as retail and food outlets—extend beyond those the government deems critical to airline operations, he said.

Most members of the ATA and the Washington-based Regional Airline Assn. are expected to become members of the RRG. The ATA's nearly two dozen members include the major U.S. airlines as well as air freight companies such as FedEx Corp. and United Parcel Service of America Inc. The RAA represents 50 regional airlines.

Equitime will offer war risk liability limits of at least $1 billion and possibly up to $1.5 billion, depending on the extent of reinsurance support provided by the federal government or commercial reinsurers, said Jerry Frick, a Marsh managing director and head of its global aviation practice.

Marsh officials declined to comment on Equitime's probable retention, but an aviation source said it would initially amount to $300 million.

As Equitime's capital and surplus grows, it will gradually increase its retention, reducing the Federal Aviation Administration's role as reinsurer.

"It's designed to provide an exit strategy for the FAA," Mr. Russell noted.

The RRG will also seek commercial reinsurance support, though the extent of commercial reinsurers' involvement will depend on the terms they're willing to offer, Mr. Frick said.

One aviation industry source said the cost of Equitime's coverage will be "significantly less" than that of the coverage currently available.

Since the Sept. 11 attacks, aviation insurers have charged $1.25 per passenger per enplanement—each time a passenger boards an aircraft—for war risk coverage with the $50 million third-party liability sublimit. The federal excess insurance has cost $7.50 per aircraft departure, translating to a total cost to the airlines of roughly $1.33 per passenger per enplanement, Mr. Russell said. Insurance costs for U.S. airlines are four-and-a-half to five times higher today than they were a year ago, he said.

Marsh officials said they could not compare Equitime's probable rates to the current alternatives, though, in part because of significant differences in the coverage Equitime will offer.

The RRG's policies, for example, will provide at least 30 days'—and possibly as much as 60 days'—notice of cancellation to policyholders, a response to the jolting seven-day notice the airlines received after Sept. 11, according to Mr. Frick.

"That's a major deal for the airlines," he said. "A vehicle like Equitime offers some forward stability that may or may not be available from the commercial market."

FTR [Week of 2/4-2/8]

This roundup of news from the previous week is generated by *BI*'s daily news reporting. To get breaking news as it occurs, log on to *www.businessinsurance.com*, or sign up online for free *BI* Daily News by e-mail.

Former Chubb managers join OneBeacon unit

A team of former Chubb Specialty Insurance managers is joining Boston-based OneBeacon Insurance Group to start a new directors and officers liability and professional liability underwriting unit. The new unit, OneBeacon Professional Partners, will underwrite public and private company D&O coverage and medical malpractice liability coverage, in addition to other professional liability lines,

OneBeacon said in a statement. Limits and other coverage details were not disclosed. Joining OneBeacon Professional from Chubb Specialty are: Matt Dolan and Tracy Hoffman, former health care underwriting managers; Randy Oates, former communications manager; Mark Rosen, a retired claims manager; and Josh Stein, former reinsurance specialist. The team will be based in Simsbury, Conn., and will report to Larry Haefner, managing director of OneBeacon's specialty business.

Berkshire to post $1 billion 4Q loss

Berkshire Hathaway Inc. will record a fourth-quarter pretax underwriting loss of about $1.27 billion stemming from its General Reinsurance Corp. operations. Overall, Berkshire Hathaway's insurance and reinsurance operations will post a total underwriting loss of about $1 billion for the quarter, as a result of profits at other Berkshire insurance operations, the Omaha, Neb.-based company reported last week. About $570 million of the fourth-quarter loss stems from underreserving for 2000 and prior years in Berkshire Hathaway's North American reinsurance operations, the company said. The losses also include an increase of $170 million to its third-quarter estimate of losses from the destruction of the World Trade Center, and an additional $100 million related to other losses reported during the first three-quarters of 2001. Coverages for failed Enron Corp. produced another $46 million in estimated losses.

Insurers agree to pay Enron surety claims

Units of Chubb Corp. and American International Group Inc. have paid $251.8 million in surety losses to investors in a revenue bond issue used to prepay Enron Corp. for future natural gas deliveries to four West Coast utilities. Chubb's Federal Insurance Co. and AIG's American Home Assurance Co. have each paid 50% of the loss to investors in the 1999 gas supply revenue bond issue by Lincoln, Neb.-based American Public Energy Agency, an energy acquisition agency. Chubb and other surety insurers continue to battle JPMorgan Chase Bank over $1.36 billion in claims on bonds covering separate Enron deals with a Jersey, Channel Islands, trading partner.

Budget proposal calls for FSA rollovers

Employees could carry over from one year to the next up to $500 of an unused health care flexible spending account balance, under the Bush administration's new budget proposal. As part of its federal budget for fiscal 2003, the administration also proposed that employees should be able to take the unused balance—also up to $500—as taxable cash or roll it over into a 401(k) plan or medical savings account. The proposed change would effectively overturn an Internal Revenue Service regulation known as "use it or lose it," which requires employees to forfeit any FSA balance that remains at the end of a given year. The Bush administration also proposed as part of its budget that all employers be allowed to offer tax-favored medical savings accounts. Current law allows only employers with 50 or fewer employees to offer MSAs.

W.R. Berkley boosts loss reserves

W.R. Berkley Corp. is posting a fourth-quarter aftertax increase of $34 million in loss reserves for its discontinued alternative markets reinsurance business and a $21 million boost to treaty reinsurance loss reserves. The increase to reinsurance treaty reserves was primarily needed for contracts that were not renewed and are no longer in effect, the Greenwich, Conn.-based insurer said. William R. Berkley, chairman and chief executive officer, said in a statement that it is "important to recognize the reality of the unprofitable treaty reinsurance market over the past several years. We experienced an unexpected level of reinsurance claim activity in the fourth quarter" and adjusted reserves accordingly.

House panel considers class-action reform

Opponents of a class-action reform bill raised the specter of the Enron Corp. debacle as the House Judiciary Committee heard testimony on the measure last week. In discussing the Class Action Fairness Act of 2001, Judiciary Chairman James Sensenbrenner, R-Wis., said that the reforms in the bill—such as allowing some class actions to be moved to federal court and subjecting certain settlement agreements to heightened judicial scrutiny—would have no impact on the rights of people suing Enron. But the panel's ranking minority member, Rep. John Conyers, D-Mich., retorted that "maybe, maybe not" the bill would apply in the case of Enron. Congress should be trying "to create more corporate responsibility, not less," he said. The bill is supported by numerous business and insurer groups. An earlier version of the measure won House approval in the last Congress but failed to move through the Senate before the November 2000 elections.

Spencer sets up Sept. 11 scholarship

The Spencer Educational Foundation Inc. is seeking donations for its September 11 Memorial Scholarship. The scholarship, established to honor those who died in the terrorist attacks, will be awarded annually to an exceptional student in risk management or insurance. The Spencer Foundation, which is affiliated with the New York-based Risk & Insurance Management Society Inc., hopes to raise at least $100,000 for the scholarship.

Humana profits up 30%, but revenues dip slightly

Humana Inc.'s net income increased 30.1% in 2001 to $117.2 million. Revenues at the managed care company, however, decreased 3.8% to $10.19 billion for the year. A spokesman for Louisville, Ky.-based Humana attributed the results in part to a process of "of divesting those parts of our business that were not contributing to profitability." These included workers compensation business that had been part of an acquisition and certain Medicare health maintenance organization operations in markets where government reimbursement rates were lower than Humana's costs, he said.

Chubb's profits fall 84% in 2001

Losses from the Sept. 11 terrorist attacks and the collapse of Enron Corp. contributed to an 84.4% drop in Chubb Corp.'s net income, which fell to $111.5 million in 2001. Warren, N.J.-based Chubb's net premiums written increased, however, rising nearly 10.0% to $6.96 billion.

Chubb's results included $420 million in aftertax costs related to the terrorist attacks, as well as a $143 million fourth-quarter aftertax charge from surety bond losses related to Enron. "We believe the long-awaited hard market has arrived, and it is evident not only in improved rates but also in better terms and conditions and the ability to be more selective in assuming risks," Dean R. O'Hare, Chubb's chairman and chief executive officer, said in a statement.

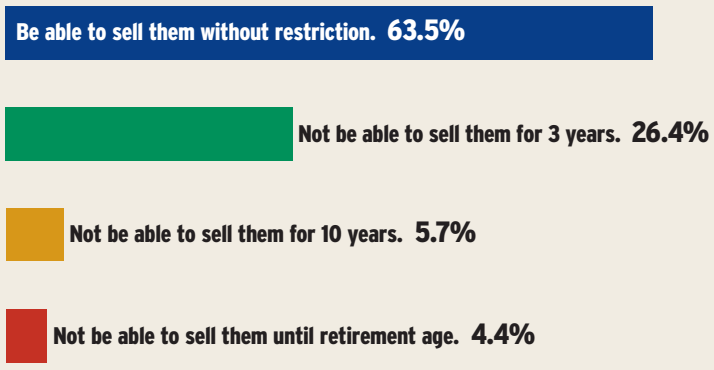
Briefly noted

In its first financial statement since becoming a publicly held company, Indianapolis-based health insurer **Anthem Inc.** reported a 51% rise in profits, to $342.2 million, for 2001.

Operating revenues increased 18% to $10.1 billion, buoyed by a 19% increase in premium volume to $9.2 billion, the company said....Prescription benefit manager **Express Scripts Inc.** has agreed to purchase National Prescription Administrators Inc., an East Hanover, N.J.-based PBM, for $515 million in cash and stock. The purchase will add $2.1 billion in revenue to St. Louis-based Express Scripts and will boost its membership to more than 50 million, according to Express Scripts, one of the country's largest PBMs. The deal is expected to close by April....The New York Senate has passed a bill that would require health insurers to cover **prescription contraceptives for all women**. The bill, S. 6265, also mandates coverage for osteoporosis testing and expands coverage for early testing for breast and cervical cancer. A similar bill passed the Assembly last week, and a conference committee will now meet to reconcile the two measures....Some reinsurers are ceasing to underwrite compulsory insurance lines in Israel, following a recent **Israeli regulatory requirement**. The Israeli insurance supervisor, Tsippi Samet, recently ordered reinsurers backing compulsory coverages in the country to present bank guarantees rated AA or higher, Standard & Poor's in London reported. S&P said that the rule would not immediately affect Israeli insurers' financial strength but would force them to take higher retentions. Compulsory lines in Israel include professional liability, workers compensation and automobile liability....The Bermuda Insurance Institute has named Michael Butt, a director of Hamilton, Bermuda-based XL Capital Ltd., the 2001 **Bermuda Market Leader of the Year**. Robert Clements, chairman of Arch Capital Ltd., has been awarded the Lifetime Achievement Award by the BII. The awards will be presented at a dinner in Bermuda on March 2.

Online Poll [2/4 - 2/8]

Regarding employer matching contributions to 401(k) plans made in company stock, do you believe employees should:



Take part in our weekly poll at *www.businessinsurance.com*

BI Stock Index [2-4 - 2-8]

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

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

BI Stock Index	Dow Jones	S&P 500
2259.25	9744.24	1096.22

Largest gains

PacifiCare Health Systems	12.80
Ohio Casualty Corp.	8.17
St. Paul Cos.	5.28
Seibels Bruce Group	5.13
United Fire & Casualty	4.74

Largest gains

Gainsco Inc.	-39.53
Mutual Risk Mgt. Ltd.	-30.66
Meadowbrook Ins. Group	-24.72
Fremont General Corp.	-17.95
ESG Re Ltd.	-15.36

Weekly change by market segment

Brokers	0.57
Insurers/Reinsurers	-1.75
Managed Care Organizations	1.25

Source: CNET Investor (investor.cnet.com)

See gold *in bales of straw*

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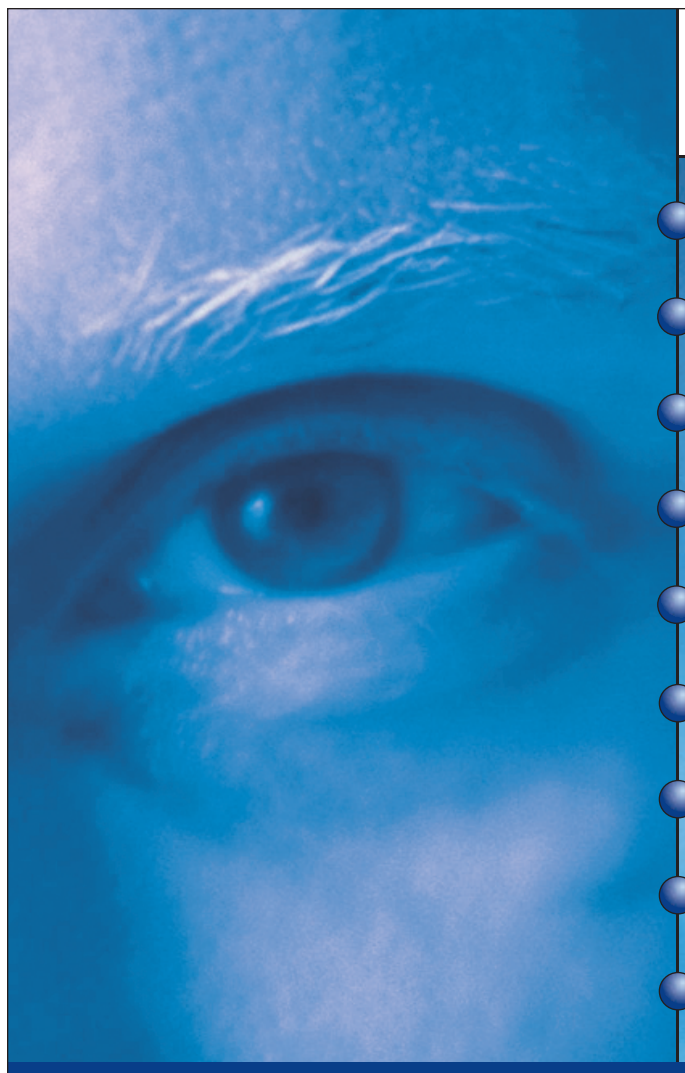

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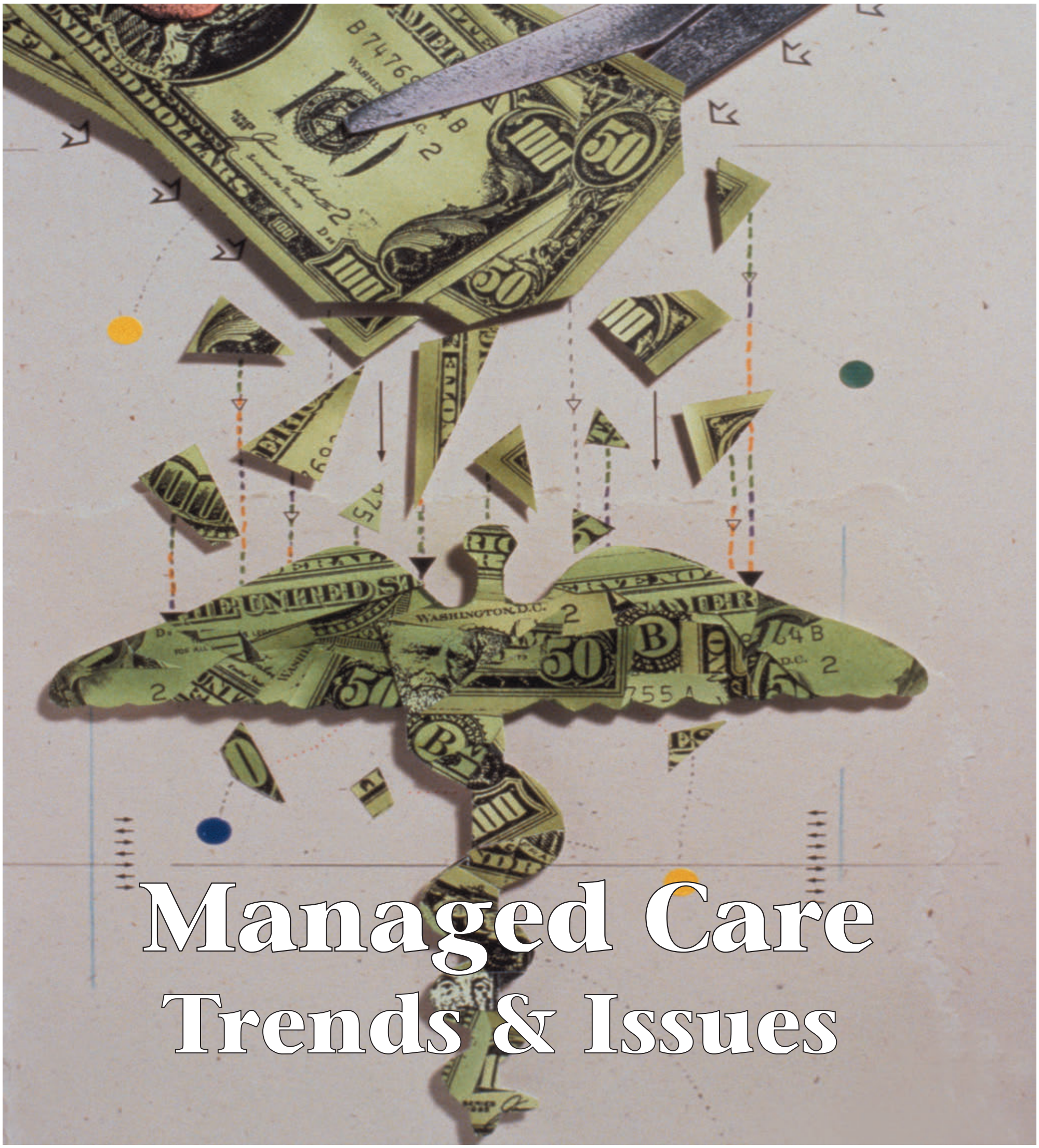
February 11, 2002



Managed Care Trends & Issues

Business Insurance®

Special Take-Out Section

Benefits Management

February 11, 2002

Inside

Managing chronic health conditions

Employers' interest is growing in disease management programs to help control the costs of their employees' chronic health care problems. **Page T4**

BI's list of largest case managers

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Paying more for quality

Two initiatives are trying to cut employers' long-term health care costs by offering financial incentives for quality care in the short term. **Page T10**

List of largest prescription benefit managers

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Consumer-driven options growing

Large health insurers are offering consumer-driven health plan products, increasing employers' choices for controlling costs. **Page T14**

Taking cost control to another level

More HMOs offering tiered health plan options

By JUDY GREENWALD

In response to rising health care costs, a growing number of health maintenance organizations are introducing so-called "network-within-a-network" plans that give enrollees financial incentives to use lower-cost hospitals and providers.

Managed care firms that have already launched such tiered plans include Santa Ana, Calif.-based PacifiCare Health Systems Inc.; Waltham, Mass.-based Tufts Health Plan; and Boston-based Blue Cross & Blue Shield of Massachusetts. And many more are expected to follow suit in coming months.

The move to the tiered system represents a major change in the HMO industry, where for many years the trend has been toward broader and more encompassing networks. The shift among HMOs also to an extent reflects the influence of the increasingly popular consumer-driven approach to health care.

Driving the change is the ongoing double-digit medical cost inflation. Under the tiered approach, employees become more keenly aware of the variability of health care costs, because they must pay more out of their own pockets if they use certain hospitals, say proponents of the model. It also shifts costs away from employers and may have an impact on higher-cost providers, if they lose business as employees seek more services through providers that are part of an HMO's lower-cost network.

Initially, the main criterion for inclusion in these networks is expected to be price, although the

See HMOs/page T7

Strategies changing

Employers shifting drug cost burden

By SALLY ROBERTS

As prescription drug costs continue to skyrocket, employers are taking steps to shift more of the costs on to employees and to make their health plan participants more aware of how costly prescription drugs can be.

Three-tiered prescription drug co-payment plans, which encourage the use of generic equivalents and less expensive brand-name drugs, are the current plan design of choice among employers, pharmacy benefits experts say.

And some employers are trying to further cut their costs by adding a fourth or even fifth tier to their prescription benefit programs, although consultants generally are wary about such moves, as they can add significant complexity to an employer's program.

Employers also are moving to percentage coinsurance arrangements rather than flat-dollar co-pays for high-cost drugs. And they are beginning to explore so-called consumer-driven health plan models, in which employees pay for drugs out of their own spending accounts.

Pharmacy experts note that in addition to shifting the costs on to employees, better pharmacy management and education are key ingredients to cost savings.

Overall, prescription drug costs are projected to increase by 14% to 19% on average for the 2002 plan year, according to consultants and prescription benefit managers. While some note that the large number of blockbuster drugs scheduled to come off patent protection in the next year will help slow cost increases, they predict costs will continue to hover in the double-digit range for the near future.

This is partly due, they say, to technological advances in new drug therapies, an aging population that is using more prescription drugs, and an estimated $3 billion yearly advertising campaign by drug manufacturers.

"We have not shifted enough of the cost over to membership to make a difference in the overall

See DRUGS/page T11

Employer interest in disease management growing

Programs seek to reduce costs associated with chronic medical conditions

By ROBERTO CENICEROS

Fewer than one in 10 employers currently use disease management programs, but the popularity of disease management is likely to grow significantly as employers look for new ways to hold down rapidly rising health costs.

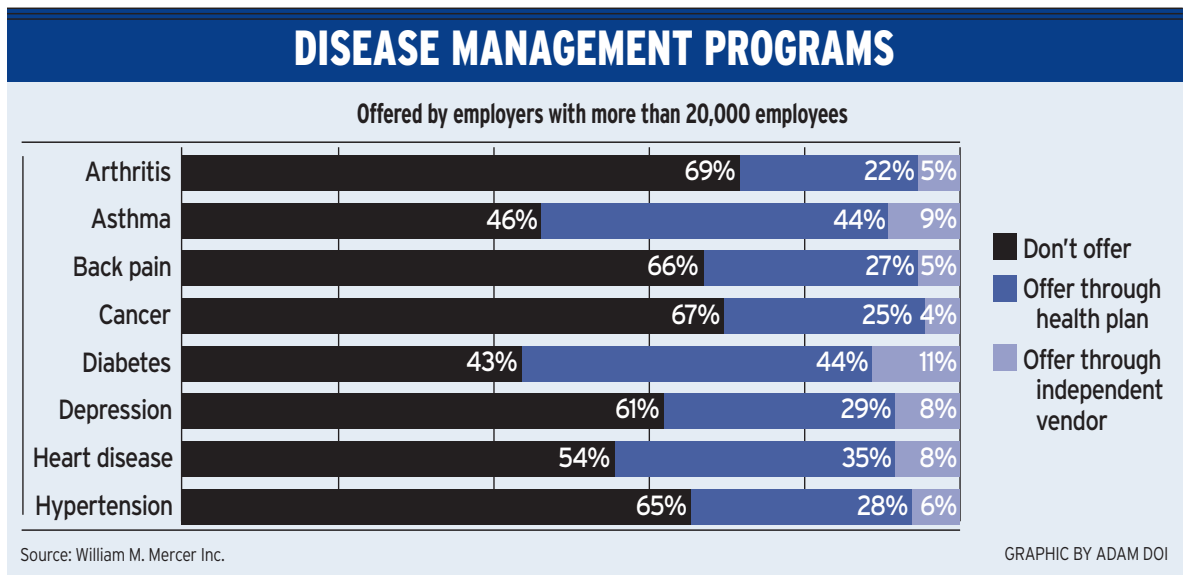
Employers increasingly are

interested in disease management programs to help employees deal with various chronic conditions that are driving up health care costs and holding down productivity, health care experts say. Among other goals, the programs seek to educate patients to help them adhere to treatment plans that are often neglected, to improve doctor/patient understanding of specific health conditions and to prevent costly complications. By encouraging proper maintenance of the conditions, the programs aim to reduce costs that can be incurred when a condition worsens, such as those for hospitalization.

Meanwhile, disease management vendors are evolving, broadening their offerings to meet employers' need for a wider range of services. Vendors say they are becoming better able to identify employees who might benefit from disease management, and that they now can reach larger portions of an employer's entire population by addressing multiple chronic diseases rather than just one. Ongoing consolidation among vendors has helped fuel the trend of companies dealing with multiple conditions.

"There is very strong interest in disease management by employers," said Peter V. Lee, president and chief executive officer of the Pacific Business Group on Health, a large employer purchasing coalition that is based in San Francisco. Because of that growing demand, the PBGH will work with six health plans to test the efficacy of their disease management programs, Mr. Lee said.

It's not enough to know that a vendor has a successful program, Mr. Lee noted. Employers also want to know what percentage of their eligible employees are actually utilizing the program, he said.



Return on investment

Consultants and vendors say that employers should expect to see a two-to-one return on investment, in the form of cost savings, from disease management.

Proponents of disease management say the approach can help improve upon an industry-accepted standard that says 50% of people suffering from chronic diseases do not comply with their treatment plans. That lack of compliance is thought to cost the U.S. health care system between $50 billion and $100 billion every year, and disease management firms say they could substantially reduce those costs by keeping people who suffer from chronic conditions on track with their treatment.

Currently, most disease management programs focus on asthma, diabetes and coronary conditions. But there is growing potential to address other problems, such a chronic back pain and arthritis, said Debra Gold, a principal with William M. Mercer Inc. in Chicago.

Programs typically involve assessing members' health status and educating patients and their doctors about the accepted standards of care and outcomes for specific conditions. Participants also receive additional personal guidance, and they have access to toll-free telephone hot lines staffed by clinicians, who can answer questions and help members manage their conditions between doctor visits. Nurses and dietitians also play a role, focusing on practices such as medication compliance and weight monitoring.

A program offered by Intracorp, like other disease management programs, also offers case management coordination when a participant suffers an acute episode, said Christopher M. Coloian, vp-care management for Intracorp, a medical management and return-to-work service provider in Philadelphia.

"It's a positive benefit vs. some traditional medical management strategies, which were just considered enhanced ways to say no" to physicians' treatment recommendations, Mr. Coloian said of disease management.

The number of employers using disease management programs is expected to grow because plan design changes and managed care only go so far in controlling costs, according to disease management proponents.

Although it is not a "silver bullet" for reducing health care costs, disease management can be an important component of an employer's cost-containment efforts, said Stephanie Pronk, a senior consultant with Watson Wyatt Worldwide in Minneapolis.

And disease management is particularly important now, because health care costs are rising at a time when people's overall health, by some measurements, is declining, Ms. Pronk said. During past periods of health cost inflation, employers did not face a similar decline in health.

For example, the incidence of obesity increased 61% from 1990 to 2000, while diabetes rose 49% during the same period, Ms. Pronk said.

"It's a pretty scary situation and creates a sense of urgency to improve health," she added. Consequently, more employers realize they need to give employees tools that help them address their health.

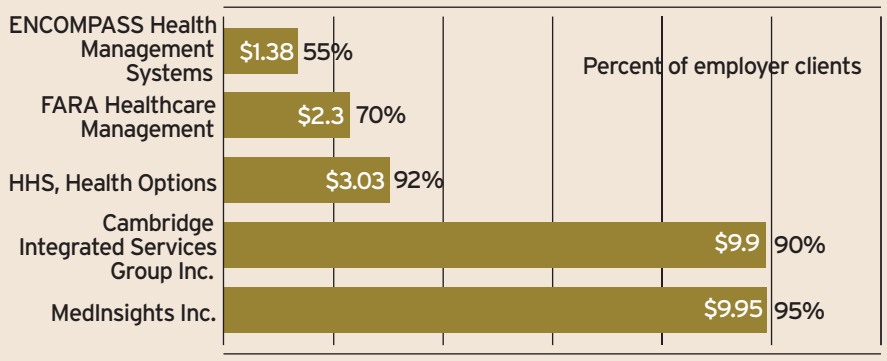
A changing industry

The disease management industry, which is not quite 10 years old, has undergone significant change over its brief history.

See CHRONIC/page T7

TOP EMPLOYER SERVICE SPECIALIST[1]

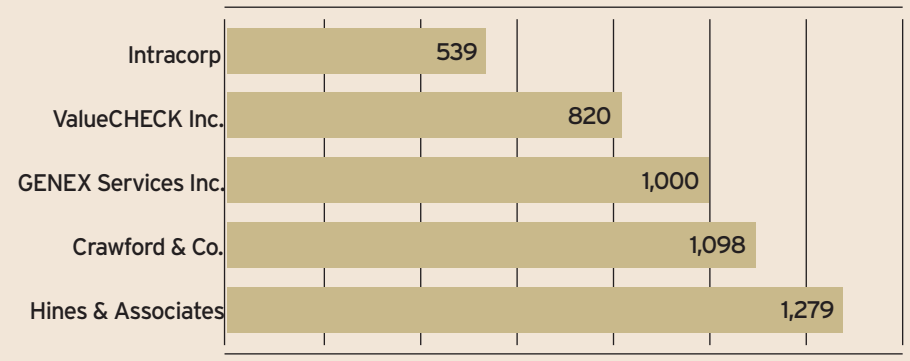
Ranked by case management revenues directly to employers in 2001[1] in millions of dollars



1 Firms that derive 100% from specialized case management services are not included.
Source: *BI* survey

TOP SERVICE PROVIDERS BY CLIENTS

Ranked by number of employer clients in 2001



GRAPHIC BY ADAM DOI

Top case management providers

Ranked by 2001 gross revenues from case management services [1] (in millions)

Company Address	Phone/Fax/Web site	Parent	Case management revenue	Total employees	Certified case managers	Total cases managed
Intracorp 1601 Chestnut St., TL09J Philadelphia, Pa. 19192	215-761-7100 215-761-5538 *www.intracorp.com*	NA	$351.0	3,462	582	1,769,862
Concentra Managed Care Services Inc. 130 Second Ave. Waltham, Mass. 02451	781-290-5350 Fax: 781-890-1535 *www.concentra.com*	Concentra Inc.	$200.0 [2]	4,000	850	165,000
CorVel Corp. 2010 Main St., Suite 1020 Irvine, Calif. 92614	949-851-1473 Fax: 949-851-1469 *www.corvel.com*	NA	$130.0	3,200	300	50,000
GENEX Services Inc. 440 E. Swedesford Road, Suite 3050 Wayne, Pa. 19087	610-964-5100 Fax: 610-964-1919 *www.genexservices.com*	UnumProvident Corp.	$125.0 [2]	1,500	750	175,000
Crawford & Co. 5620 Glenridge Drive,N.E. Atlanta, Ga. 30342	404-256-0830 Fax: 404-847-4025 *www.crawfordandcompany.com*	NA	$67.8	505	NA	105,898
Private Healthcare Systems Inc. 1100 Winter St. Waltham, Mass. 02451	800-253-4417 Fax: 781-895-6848 *www.phcs.com*	NA	$25.1	62	6	2,686,897
CareAdvantage Inc. 485-C Route 1 S. Iselin, N.J. 08830	732-602-7000 Fax: 732-602-7027 *www.careadvantage.com*	NA	$18.0	47	10	2,300,000
Cambridge Integrated Services Group Inc. 4B Cedar Brook Drive Cranbury, N.J. 08512	800-662-1170 Fax: 609-860-7887 *www.cambridgeintegrated.com*	Aon Corp.	$11.0 [2]	99	43	12,996
MedInsights Inc. 4360 Chamblee- Dunwoody Road, Suite 500 Atlanta, Ga. 30341	770-457-2400 Fax: 770-457-1500 *www.medinsights.com*	GAB Robins North America Inc.	$10.5	135	88	13,850
American Health Holding Inc. 921 Eastwind Drive, Suite 104 Westerville, Ohio 43081	614-818-3222 Fax: 614-818-3223 *www.americanhealthholding.com*	NA	$10.0	37	NA	4,374

1 Firms that derive 100% of case management revenues from insurer/managed care clients or from specialized case management services are not included. 2 Estimated
Source: *BI* survey

HMOs: Tiered systems offer range of choices, costs

Continued from page T3

concept likely will evolve to reflect efficiency and quality as well, say observers. Indeed, one buyer representative says that quality must be part of the equation if large employers are going to take an interest in the approach.

Some observers caution, though, that the tiered systems may not work in certain markets where a dominant hospital is unwilling to cooperate.

Under PacifiCare's Select Hospitals plan, which so far is available only in California, enrollees who use certain facilities have their benefits paid in full, while those who use other hospitals in PacifiCare's network must make daily copayments of $100, $250 or $400, depending on the plan the employer selects. There is a comparable deductible plan for primary care and specialist physicians.

About 2,500 members representing about 10 groups are currently participating in the program, which was introduced late last year, said Mike Chiarodit, PacifiCare's vp of product development.

Under the Tufts Choice Co-Payment plan, employees pay $350 per admission to a community hospital vs. $600 if they choose to go to an academic medical center. The program also imposes different cost levels for outpatient surgery and providers, said Jon Kingsdale, senior vp, planning and development for Tufts.

Tufts' program, which was launched for large employers in January, now has about 2,000 to 3,000 members. A program for employers with 50 or fewer employees will be introduced in April, Mr. Kingsdale said. But, he added, "We actually do not expect it to grow very large," he said. "There is not a big appetite here for small networks."

Blue Cross of Massachusetts' HMO Blue Preference plan, which also was introduced in January with similar provisions, has about 2,000 members, said Marketing Vp Alan Rosenberg.

Other HMOs have similar plans in mind: San Francisco-based Blue Shield of California has said that on April 1 it will launch a "network choice" program for its small and midsize commercial groups. And in July, Woodland Hills, Calif.-based Health Net Inc. plans to introduce a tiered plan for its commercial members, initially in California. Health Net, which expects a 10% to 20% shift in members to the plan the first year, has already introduced a similar program for its Medicare enrollees in three markets.

In addition, Philadelphia-based CIGNA Corp. is developing tiered products, which it plans to have

See HMOs/page T10

Chronic: Interest in plans growing

Continued from page T4

Early on, vendors typically specialized in only one or two conditions, said Robert E. Stone, executive vp and founder of Nashville, Tenn.-based disease management program vendor American Healthways Inc. American Healthways, for example, at first dealt exclusively with diabetes. But now, like many vendors, the company handles several conditions, said Mr. Stone, who also is president-elect of the Disease Management Assn. of America in Washington.

As vendors have grown and acquired other disease management companies, they have obtained the resources and expertise to address multiple diseases. That breadth of expertise has made disease management more appealing to employers, Ms. Gold said, because an employer can offer a disease management program to a broader section of its employee population without having to deal with several vendors.

Vendors' expansion has also produced better results for patients, Ms. Gold said. People with health problems often have multiple conditions, and having only one company working them helps pinpoint which treatments are producing the best results, she said.

Using a single vendor can also streamline the delivery of information to patients.

"People have multiple diseases," Ms. Gold said. "You don't want them getting one call from a diabetes nurse and another call from their arthritis nurse."

The predictive modeling used by vendors also is improving, observers say. The models rely on employee health care assessments and other information, such as claims data and clinical data, to identify employees who are at a high risk of developing certain conditions.

HMOs: Tiered approach seeks to hold down costs

Continued from page T7
available next year, said a spokeswoman. Minneapolis-based UnitedHealth Group has "a number of pilots, all built around the concept of consumer-driven health care products," a spokeswoman said. And Hartford, Conn.-based Aetna Inc. is considering the concept as well, an Aetna spokeswoman confirmed.

"I think everybody will look at it and probably offer some type of an option," said Rich Sinni, senior vp with Aon Consulting in New York.

All this represents a significant change from the trend among HMOs in recent years toward broader networks.

"For many, many years, the employer has judged an HMO plan by how broad its network is. So, the HMO market has responded by trying to provide as broad a network as possible, as many hospitals as possible and as many doctors as possible, which, by definition, creates a mix of expensive and inexpensive, and good and bad providers," said Kirby Bosley, a health care practice leader with William M. Mercer Inc. in Los Angeles.

"With the advent of a managed care backlash and hospital systems dropping capitated contracts and flexing their muscles and insisting on getting more money, the HMO costs have gone up faster even than (preferred provider organization) costs the past few years," Ms. Bosley said. Having the differentiated products "gives the employer the opportunity to say to employees, 'If you want an expensive hospital stay, you're welcome to it, but you have to pay more,' " she said.

"We still believe in a broad-access network," said Mr. Rosenberg of BC/BS of Massachusetts. But "we are trying to give our members and our employers choice."

"From the plan's perspective, it's quite simple," said Mr. Sinni. "They're going to satisfy the employers' demand to keep costs down, and what they're going to do is reward the hospitals they have the strongest relationship with" by sending them more business, he said.

With the tiered approach, employees still have options, "but it becomes more of a financial decision for them," said Richard Hemmerich, regional practice leader for Willis North America Inc. in Philadelphia. "I think it's going to lead to a lot of soul-searching," said Mr. Sinni.

Some consultants say that, at least initially, these differentiated products will appeal more to small employers than to large companies.

'I think employers are very interested in tiered products if the plans can marry cost information with quality information.'

Peter V. Lee
Pacific Business Group on Health

Brad Kimler, a consultant in the Waltham, Mass., office of Hewitt Associates L.L.C., said early adoption of these programs will be more prevalent in the small and midsized markets. Because they have fewer contracted plans, smaller companies have fewer concerns about uniformity of benefits or standardization, he said. But, "I think the appeal is there across all market segments," he added.

Some observers say that, at first, the primary criterion for inclusion in these elite networks will likely be price, although such factors as quality and efficiency will eventually be incorporated.

Ted Chien, managing consultant with Watson Wyatt Worldwide in Minneapolis, said he hopes quality will be introduced along with price, "rather than just pure cost first and quality second."

It is going to be a "real issue" whether plans should wait until the tiered programs can be done in a "more sophisticated" way that also incorporates factors such as quality, said Paul B. Ginsburg, president of the Center for Studying Health System Change, a policy research organization in Washington. "But probably the market works against waiting" because of the degree of employer interest in the programs, he added.

However, Peter V. Lee, president and chief executive officer of the Pacific Business Group on Health, a San Francisco-based employer purchasing group, said that ensuring quality is a vital part of the equation.

"I think employers are very interested in tiered products if the plans can marry cost information with quality information," and many large employers are unlikely to take the first steps toward using such plans without that quality information, Mr. Lee said.

Meanwhile, Cora Tellez, president of Health Net's health plan division, said that the company is seeking regulatory approval to distribute to members hospital data on morbidity and mortality rates that is reported to state agencies.

There could be barriers to the programs' success in certain markets, some observers warn. Bob Gold of Chicago-based B. Gold Consulting said some providers "are so strong they can say, 'Gee, I don't care if I'm charging you more than the guy down the street. I don't want to have any barriers to someone coming into my institution. And if you don't play by my rules, I'm not going to play at all in your plan.'"

Health Net's Ms. Tellez agreed this sort of provider clout has been a hindrance.

"In several of our plans, we have hospital systems that so dominate that, in effect, they have a monopoly power, in which case the tiering concept is less of a tool," she said, noting competition is a crucial element of the approach. In these cases "you have to use other strategies" to reduce costs and premiums, she said.

Plans making an investment in quality

Financial incentives seek to encourage provider adoption of standards

By MICHAEL PRINCE

Some employers are taking an unusual approach to rising costs—they're agreeing to pay more.

In several programs started in recent months, employers and health plans have begun paying doctors and hospitals more money if they meet well-recognized health care quality standards.

While the programs involve relatively few employers, proponents of these initiatives believe they represent an important step in increasing health care quality. Beyond ensuring better care for employees, participating employers expect that paying more in the short term will eventually save them money in the future.

Using financial incentives "is the next step in the evolution of managed care," said Maureen Cotter, global director of group benefits and health care consulting at Watson Wyatt Worldwide in Detroit.

"It's a godsend; it's a very favorable development," said Dr. Arnold Milstein, national health care thought leader at William M. Mercer Inc. in San Francisco.

In one of the programs, which started in New York last October, five employers—IBM Corp., PepsiCo Inc., Verizon Communications, Xerox Corp. and Empire Blue Cross & Blue Shield—have agreed to make higher payments to hospitals that undertake certain quality improvements.

Starting last month, hospitals can receive an additional 4% for services paid by Empire, which is participating both as an employer and a health plan. The bonus is paid only for those employers' members insured by Empire's HMO if hospitals meet two safety standards—implementing a computerized physician-order entry system and staffing their intensive care units with physicians trained in critical care medicine.

These two standards were chosen because evidence shows they help reduce medical errors, and The Leapfrog Group, an employer coalition formed to improve health care quality, recommends that hospitals adopt them. Hospitals that implement the systems will earn a 3% bonus in 2003 and a 2% bonus in 2004.

The idea is to reward those hospitals that have already implemented these systems and encourage others to take the step, said Dr. Michael Stocker, chief executive officer of Empire in New York.

The 4% figure was chosen because studies indicate that employers will save that amount by implementing these programs, he said. The payments, estimated to total $2 million over three years, won't pay for the entire installation of the computer systems, but it's a start, Dr. Stocker said.

In addition, the move establishes the precedent of paying more for quality.

"It's a way of making a statement and starting a conversation," Dr. Stocker said.

The program "has created a new interest and new dialogue," said Bruce Taylor, director of employee benefit policy and plans at Verizon in White Plains, N.Y.

Driving employer interest in this idea are two studies from the Washington-based Institute of Medicine detailing the huge numbers of patients who die each year from medical errors as well as the need to change physicians' incentives, Mr. Taylor said. Improving quality will save employers money while making employees healthier.

"No one has to lose on this deal. Everyone can be a winner," Mr. Taylor said.

Another program announced last month by the Walnut Creek, Calif.-based Integrated Healthcare Assn., a group of health plans and providers, brings together six leading health plans in California—serving more than 8 million members—that have all agreed to pay physician groups more if they meet quality standards.

Under the program, called Pay for Performance, bonuses will range from 4% to 10% per plan, but all six health plans have agreed on one set of standards (*BI*, Jan. 21).

Health care experts say this represents a critical step forward. In the past, health plans set different standards for doctor groups to meet, creating a hodge-podge of requirements. With one set of standards, physicians are more likely to work toward meeting them.

"Up until now, providers would say, 'Each of you health plans want something different from us,' " Ms. Cotter said.

Unlike the New York program, the California initiative covers every employer in the six participating HMO plans. Also, there is no time limit in the California plan, whereas the New York program is scheduled to last for only three years, said Dr. Milstein, who helped create both plans.

Employers have turned to financial incentives because managed care no longer controls costs, said Gregg Lehman, president and CEO of the National Business Coalition on Health in Washington. "Employers are taking a longer-term strategy on employee health," he said.

Increasingly, employers realize that higher quality will help control costs in the long term, said Joseph Marlowe, senior vp at Aon Consulting in Philadelphia. "Some employers have to be prepared to spend money in the short term in order to improve quality in the longer term," he said.

While employers and health plans have used various incentives in the past to change physician behavior to improve quality, financial incentives are a relatively new and growing development.

"Money is what will get people's attention," Mr. Marlowe said.

The Leapfrog Group is creating several financial incentive models that employers can adopt, said Suzanne Delbanco, The Leapfrog Group's executive director in Washington.

"You need to align incentives in the marketplace correctly," she said. "It's definitely a trend right now."

The key to these programs is giving employers and providers information that they can trust and that draws them to the program, said Mr. Lehman. Employers need information that the money spent in incentives will result in long-term savings. Meanwhile, providers need information to make sure the standards used truly measure quality.

The NBCH is working on its own

See QUALITY/next page

Drugs: Tiered copayments catching on

Continued from page T3

drug trend," said Kevin Destefino, a senior pharmacy consultant in the Phoenix office of Watson Wyatt Worldwide. "If members share more of the cost, they will think twice about getting prescriptions filled that they don't need."

Consultants also say that the more employees share in the cost, the more likely they are to choose a generic drug if one is available.

That concept underlies the three-tiered prescription drug plans.

Employers are relying heavily on three-tiered drug formularies, said Mike Deskin, president of the Pharmacy Benefit Management Institute Inc., a Tempe, Ariz.-based research and education firm. "It took a little while, but employers are now jumping into that with both feet."

These programs typically offer patients a choice among three drug categories—a generic drug, the preferred brand in the plan's formulary and any nonpreferred brand—with the more expensive drugs involving higher copays.

According to the PBMI's most recent prescription drug survey report, the use of a three-tier plan design has increased to 35% of employers in 2000 from 6% in 1998.

'If members share more of the cost, they will think twice about getting prescriptions filled that they don't need.'

Kevin Destefino
Watson Wyatt Worldwide

Not only does a three-tiered program provide the incentive to use cheaper generic drugs by offering lower copays, it also does not adversely affect an employer's entire membership, consultants point out.

"As opposed to increasing copays across the board year after year, installing a three-tiered benefit only affects a portion of the population that happens to be on what will become a preferred drug," said Connie Perry, Midwest practice leader for prescription drugs at Aon Consulting Worldwide in Chicago.

"Some employers like the fact that it doesn't affect the entire membership," she said.

Recently, some employers have been looking at adding more tiers to their programs, hoping to generate even greater cost savings, consultants say.

"There are a number of employers looking at implementing four- and five-tiered plans," said Nick Vasilopoulos, the managed pharmacy group leader for William M. Mercer Inc. in New York.

He noted that although there is no set definition as to what drugs are categorized in the additional tiers, he has seen some employers put high-cost injectable drugs as well as lifestyle drugs—such as the sexual dysfunction drug Viagra—

See DRUGS/page T13

Quality: Incentive put on savings

Continued from previous page

model for providing financial incentives to improve quality, Mr. Lehman said. The hope is that member coalitions will adopt the model after its release this year.

The Chicago Business Group on Health is also working on a plan, said Executive Director Larry Boress. The employer group is looking into paying more money to physician groups that adopt a diabetes-treatment program developed by the Institute of Health Care Improvement, a Boston-based nonprofit group that promotes health care quality.

Physicians have a disincentive to incorporate higher-quality standards because these programs are costly and won't provide additional revenue, Mr. Boress explained.

A financial incentive helps eliminate this barrier. "If we don't make it profitable to make practitioners to do the right thing…then they won't be motivated to do so," he said.

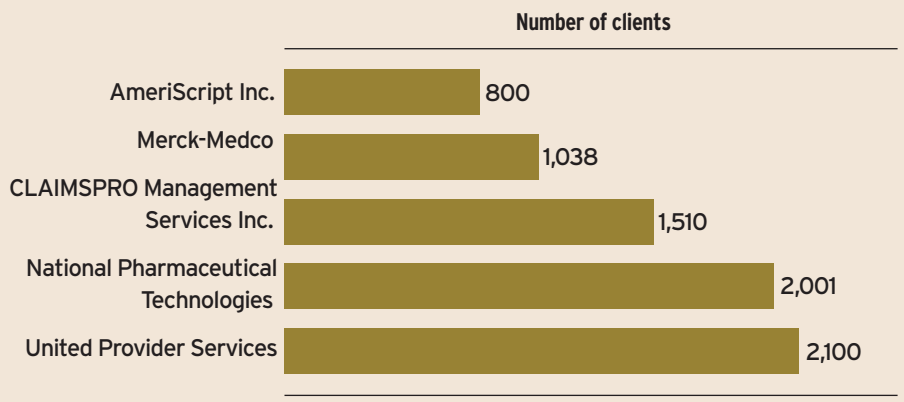
The coalition approach is especially effective because groups of employers can exert greater pressure than one can acting alone. "This is too big an issue for an employer to tackle individually," Ms. Cotter said.

While it may be years before it's known what impact these financial incentives have on quality, linking money and quality is a big start, Mr. Lehman said. "If markets do not do something" that pushes the envelope, "they are doomed to fail," he said.

Perhaps the biggest achievement is just doing something, Verizon's Mr. Taylor said. With costs rising so dramatically, employers must do more than complain, he said. Now it's time for employers to experiment, even if success is not guaranteed.

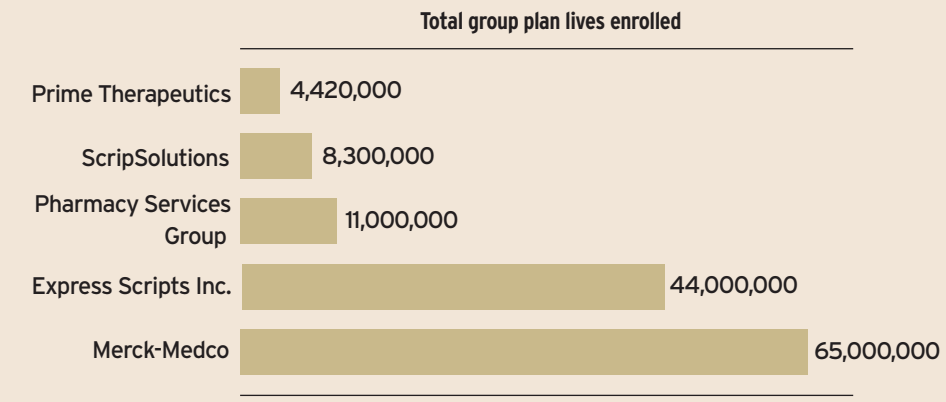
"Rather than reject any one initiative, try something," Mr. Taylor urged employers. "We can't let the perfect get in the way of the good."

TOP PBMs BY EMPLOYER CLIENTS



Source: BI survey

TOP PBMs BY TOTAL COVERED LIVES



GRAPHIC BY ADAM DOI

Top prescription benefit managers

Ranked by 2001 PBM revenues (in millions)

Company Address	Phone/Fax/Web site	Parent	PBM revenues	Total staff	Total clients	Covered lives
Merck-Medco 100 Parsons Pond Drive Franklin Lakes, N.J. 07417	201-269-3400 Fax: 201-269-1109 *www.merckmedco.com*	Merck Co.	$30,000	16,000	1,782	65,000,000
AdvancePCS 5215 N. O'Connor Blvd., Suite 1600 Irving, Texas 75039	469-420-6000 Fax: 469-420-6169 *www.advanceparadigm.com*	NA	$12,200 [1]	5,000	NA	NA
Express Scripts Inc. 13900 Riverport Drive Maryland Heights, Mo. 62025	800-281-0712 Fax: 314-702-7059 *www.express-scripts.com*	NA	$9,250	NA	NA	44,000,000 [2]
Caremark Rx Inc. 2211 Sanders Road Northbrook, Ill. 60062	847-559-4700 Fax: 847-559-3694 *www.caremark.com*	NA	$5,600	4,000	1,200	NA
RxAmerica 369 Billy Mitchell Road Salt Lake City, Utah 84116	800-770-8014 Fax: 801-961-6009 *www.rxamerica.com*	Longs Drug Stores	$534	121	289	2,161,754
ScripSolutions 100 Clearbrook Road Elmsford, N.Y. 10523	888-818-3939 Fax: 914-460-1660 *www.scripsolutions.com*	MIM Corp.	$405	400	NA	8,300,000
CLAIMSPRO Management Services Inc. 24370 Northwestern Highway, Suite 200 Southfield, Mich. 48075	248-352-2852 Fax: 248-352-7475 *www.claimspro.com*	PharmaCare	$373	75	1,600	1,270,000
United Provider Services 5125 Davis Blvd. Fort Worth, Texas 76180	817-281-8820 Fax: 817-427-5213 *www.upsrx.com*	CVS Corp./ PharmaCare	$180	70	2,200	650,000
The Inteq Group Inc. 5445 La Sierra Drive, Suite 400 Dallas, Texas 75231	800-324-7799 Fax: 214-739-7979 *www.inteqrx.com*	NA	$140	55	700	1,300,000
National Pharmaceutical Technologies 14301 First National Bank, Suite 200 Omaha, Neb. 68154	402-964-9030 Fax: 402-964-9004 *www.pti-nps.com*	Pharmaceutical Technologies Inc.	$100	30	2,100	1,200,000

1 Estimated 2 *BI* estimate
Source: *BI* survey

Drugs: Seeking ways to reduce plan costs

Continued from page T11

into a new, separate tier.

But as the number of tiers increase, so does the complexity of the program. And that can be confusing to plan members, consultants warn.

"There's a lot of discussion as to whether to add a fourth or fifth tier, and I'm not necessarily a big fan of that," Watson Wyatt's Mr. Destefino said. There is a great deal of added complexity in creating new tier formularies and in explaining that to members, he said.

Many employers also are now implementing percent coinsurance arrangements on the upper tiers rather than using flat dollar copays

'You don't need to give the world Rolls-Royces when people can drive around perfectly fine in Chryslers.'

Ed Feaver
Prescription Solutions

across their programs. Under such a program, rather than a $25 copay, a member might pay 30% of the total cost of the higher-priced drug.

"We believe a good plan design keeps a flat fee for generic drugs and a coinsurance model on the second and third tier that has more brand name products that are more expensive," said Aon's Ms. Perry, noting that many of her clients are moving in this direction.

And for those employers that are frustrated by conventional health care solutions, the so-called consumer driven health plan model may be an answer.

"We've seen a lot of employers discuss it, and many are considering it for 2003," said Tom Lerche, senior health and welfare consultant at Aon Consulting in Chicago. These models offer a "fundamentally different pharmacy benefit," he said. Unlike copay-based models, consumer-driven plans show employees exactly how much drugs cost, as employees have to pay for them through health care spending accounts. "In the limited number of cases we've seen, that has significantly impacted employees use of generics," he said. "If employees think they are spending their own money, they will almost always choose generics if they are available," he said.

Experts note that in addition to cost-shifting, employers need to improve management of their pharmacy benefits to ensure that the right patients are using the right drugs.

Employers need a strong formulary that ensures that members use the least costly drug that still will produce a given outcome, and that a prior authorization system is available to provide prompt approval for drugs deemed medically necessary, said Ed Feaver, president of Prescription Solutions, a Costa Mesa, Calif.-based PBM.

"If you want to get your arms around these costs, someone will have to say, 'You need this and you don't need that. Or if you need this and want that, it will cost a lot,'" Mr. Feaver said.

While he noted that if a need is demonstrated, a patient should be able to obtain a nonformulary drug, not all members with the same condition will require the same drug.

Technology is going to continue to produce better and more expensive drugs that treat chronic conditions, Mr. Feaver said. Employers need to define which patients need which drugs.

"You don't need to give the world Rolls Royces when people can drive around perfectly fine in Chryslers," he said.

Jeffrey W. Pettegrew, vp-risk management and insurance services for Westaff Inc. in Walnut Creek, Calif., said that in addition to exploring the idea of a multitiered pharmacy plan, he is exploring the use of Web technology to control drug utilization.

"The nature, strength, dosage and quantity of drugs within different therapeutic classes are so diverse that it's essential there be some mechanism to compare various generic options and name-brand options," Mr. Pettegrew said. He noted that a Web-based information system also would help educate employees in understanding the risks involved with taking a variety of different drugs. In many instances, "it's highly dangerous if drugs are mixed," he said.

Consultants say more education also is needed to ensure that employees fully understand drug costs.

Employers need to "communicate (to employees) the hidden economic aspects beyond the copay," said Bob Kordella, vp-PBM operations for Eckerd Health Services in Pittsburgh. Employers, for instance, can use explanation of benefits statements to show that while an employee paid $10 for a drug, the employer paid an additional $95.

"It's a low-tech, but highly effective tool to raise the sensitivity of the value of the pharmacy benefit," Mr. Kordella said. It also perhaps is the first step on the road to a more restrictive approach, he said.

"You can't go to a (consumer-driven) plan overnight without making members aware of the economic issues at stake," he said.

Large health insurers entering market with products of their own

Employers' consumer-driven plan choices growing

By MICHAEL PRINCE

As demand for consumer-driven health plans grows, supply is growing to meet it.

In the past few months, some of the largest U.S. health insurers have introduced their own consumer-driven health plans, directly competing with the existing startup companies that have pioneered the field. With other large health plans also set to introduce their own plans, the competition is heating up to enroll employers in this new health care concept.

Until recently, the consumer-driven field had been the domain of specialized startups, such as Minneapolis-based Definity Health Corp. and HealthMarket Inc. of Norwalk, Conn. All that changed in September 2001, however, when Aetna Inc. launched HealthFund, its consumer-driven plan. Since then, Humana Inc. has rolled out its own product, and other large health insurers, such as CIGNA Corp., will introduce plans shortly.

This new landscape has increased competition while turning what was once viewed as an unusual product into a more mainstream one (*BI*, Dec. 10, 2001).

"When innovation is adopted by big players, it means it's an innovation with big market appeal," said Regina Herzlinger, a professor at the Harvard Business School in Boston and author of a book on consumer-driven health care.

"The employers are demanding to look at something like this," said John Erb, senior manager at Deloitte & Touche in Miami.

While the large health insurers say they have rolled out the plans to meet employers' demand, Mr. Erb said the moves also are designed to keep employers from leaving their existing plans for a startup's consumer-driven plan.

Shopping for care

The goal of a consumer-driven plan is to turn health care users into health care consumers. The plans hope to compel members to purchase health care services in much the same way they buy other products and services—by looking at price and quality.

Most of the products follow a similar format, using an employer-provided spending fund, often $500 or $1,000, from which the employee pays for ordinary health care services. When that money is exhausted, the employee is responsible for the entire amount of bills up to an additional $1,000 or $2,000, depending on the plan. Services above this are handled through a preferred provider network with a low copayment for services in the network and generally 80% coverage for out-of-network services. Any money left in the account generally can be rolled over to the following year.

The idea behind the spending account is that consumers are, in essence, spending their own money, so they will try to maximize the value of their health care services.

"If there are real differences in price and quality, we have to make the participants choose based on these differences and not the health plans," said Brad Kimler, principal with Hewitt Associates L.L.C. in Boston.

The goal is to satisfy employees' request for more choice and employers' need to control costs.

"There is a strong belief in the industry that consumers need to be in the center of the health care industry," said Kate Quinn, senior vp of new products at CIGNA HealthCare in Bloomfield, Conn. She said that CIGNA will soon launch its own consumer-driven health care product.

Employers' choices

Benefit managers that have adopted a consumer-driven approach agree that large health insurers' reputations will get them attention as vendors of consumer-driven plans. But the name recognition won't guarantee a sale.

Don Broecker, director of employee benefits for Charter Communications Inc. in St. Louis, added Definity's plan to Charter's current health plan offerings this year because "they had a real track record already with this," he said. So far, 6% of the company's 17,000 employees have enrolled in the consumer-driven model, more than Charter had projected, he said.

"Brand-name recognition is important," he said, but that has limits. The name will get employers looking at the product, but a final choice will be made on the plan's ability to meet employers' needs.

Employers thinking of adding a consumer-driven plan will look beyond a plan's name and examine its mechanics to make certain it contains all the elements necessary to create a true consumer experience for its employees, said Peter Hayes, health care benefits strategist at Hannaford Bros. Co., a supermarket chain based in Scarborough, Maine.

"Sophisticated buyers are going to look under the hood and look at whether they are doing something significantly different," he said.

Once an employer decides to add a consumer-driven plan, it will "find the best provider," regardless of the plans it currently has, said John McKelvey, vp-human resources at Radnor Holdings Corp. in Phoenix. In fact, he is so pleased with Lumenos Inc. that he has no intention of switching to any large insurer's offerings, he said.

Alexandria, Va.-based Lumenos, a direct competitor of Definity, contracts with seven large employers and more than 150 small employers.

Mr. Hayes is impressed with Definity's ability so far to present cost and quality data to help employees make informed choices about health care providers. This information, he said, is more important than the spending account for creating consumers.

He also doubts whether the large health insurers are willing to provide price and quality information to consumers—a key part of the consumer-driven concept. Large plans in the past have been hesitant to provide this information, he said, as it often angers providers in their networks.

"I just don't think the major plans will do it," he said.

> **'Sophisticated buyers are going to look under the hood and look at whether they are doing something significantly different.'**
>
> *Peter Hayes*
> *Hannaford Bros. Co.*

Mr. Hayes said the startup plans, however, are better suited to deliver this critical piece of the consumer-driven model because they lack the investment in provider networks.

Competition heats up

The prospect of large health plans entering their turf has not fazed the startups. In many ways, the companies say, it has boosted the profile of the consumer-driven model with employers, brokers and consultants.

"We welcome competition from the large guys as it validates the concept," said Doug Kronenberg, chief strategy officer at Lumenos.

"The scary thing is when you are out there alone," said Steve Wiggins, chairman and chief executive officer of HealthMarket, a 2-year-old company that offers a fully funded consumer-driven plan.

"It suggests we are on to something here," noted Chris Delaney, chief marketing officer at Definity in Minneapolis. Definity has contracted with 24 large and midsize employers in the past 18 months for its consumer-driven plan for self-funded employers.

But others are less sanguine. Mr. Erb said, "I would be a little nervous if I were Definity right now."

Mr. Delaney counters, however, that Definity's head start in administering these plans gives it an advantage. Also, he said, an employer would not automatically choose the large insurer's consumer-driven option just because it currently offers its plans. Instead, employers select plans based on which one best matches their needs. "You don't find many employers that believe in one-stop shopping," he said.

The large insurers have publicly shied away from saying their size and clout will overwhelm the smaller startups. Rather, they say that with this field wide open, more than one plan can succeed.

"There is plenty of space in the marketplace," said Russ Fisher, senior vp at Aetna in Hartford, Conn.

Also, the insurers all say that consumer-driven plans are not suited for every employer.

"It's an option that meets certain consumer needs and employer needs," said Ms. Quinn.

Differences in how the plans are marketed also determine how the competition lines up. For example, Humana's plan, Coverage First, which was introduced in November, and Aetna's, are for self-funded employers. These would compete against Definity and Lumenos, which market to those employers, but not HealthMarket, a fully insured product.

"We probably won't compete for years with the big carriers," Mr. Wiggins said.

Also, Humana is marketing Coverage First solely in conjunction with a panel of other more traditional health plans, and only as a total replacement for an employer's health plans, said Dr. Jack Lord, senior vp and chief innovation officer at Humana Inc. in Louisville, Ky. On the other hand, Aetna and the startups offer their consumer-driven plans as an additional option to existing plans.

One concern the large insurers are addressing is how to make sure members of the new plans don't just come from the insurer's old plans. They acknowledge this is a concern but insist the overall effect will be to take members from a competitor's health plan.

"We certainly look at this as a growth strategy," Ms. Quinn said.

Despite the now widespread availability of these plans, the insurers contend the idea is still in its infancy. Few employers have adopted the concept and the growth will be steady but not overwhelming in the next few years, Aetna's Mr. Fisher said.

"We're at the early stage of determining what the demand is," he said.

Two directories to be available online

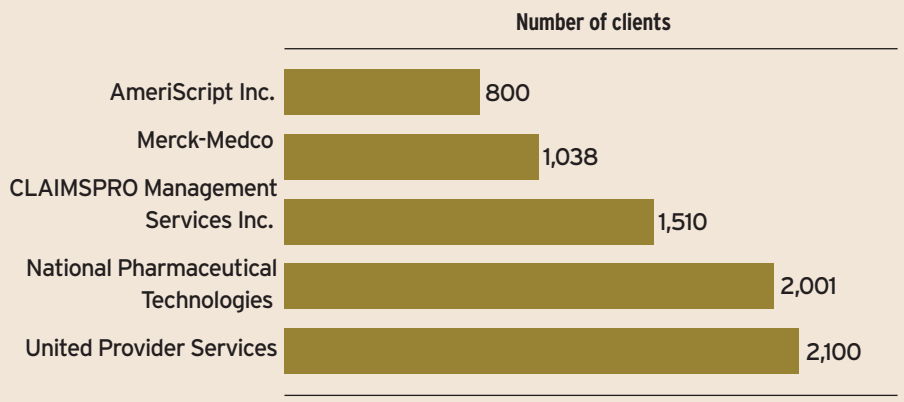
The directories of Prescription Benefit Managers and Case Management Providers will soon be available online in the directories area of *www.businessinsurance.com*.

The Prescription Benefit Managers directory will be searchable by company name, state, PBM revenues, corporate and institutional employer clients, total group health plan lives and services provided. The PBM clients' section specifies the total number of clients, as well as the number of employer/group plans that contracted directly with the PBM in 2000.

The Case Management Providers directory will be searchable by company name, state, case management revenues, total staff members, number of cases managed and specific case management services.

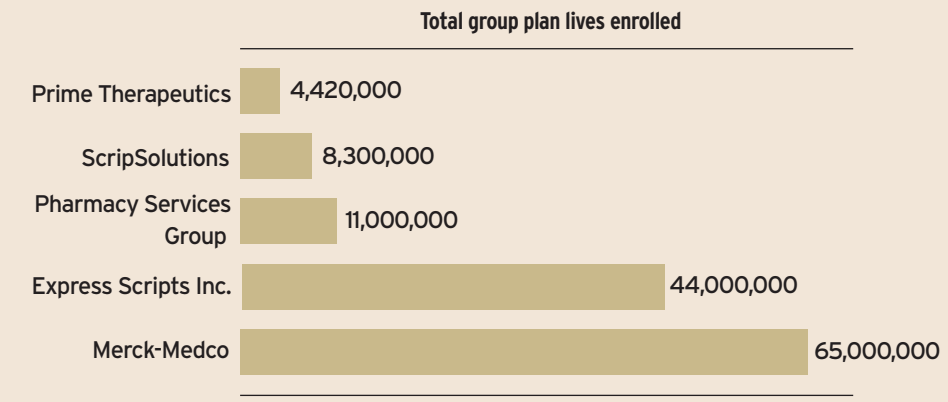
All *BI* directories will soon be online, with information from 2001 listings. As the directories are updated throughout the year, in conjunction with special issues the new 2002 directories also will be posted online. For a limited time, all visitors to the Web site will have access to the online directories. Soon, however, free access to this and other advanced features of businessinsurance.com will be restricted to paid subscribers.

TOP PBMs BY EMPLOYER CLIENTS



Source: BI survey

TOP PBMs BY TOTAL COVERED LIVES



GRAPHIC BY ADAM DOI

Top prescription benefit managers

Ranked by 2001 PBM revenues (in millions)

Company Address	Phone/Fax/Web site	Parent	PBM revenues	Total staff	Total clients	Covered lives
Merck-Medco 100 Parsons Pond Drive Franklin Lakes, N.J. 07417	201-269-3400 Fax: 201-269-1109 *www.merckmedco.com*	Merck Co.	$30,000	16,000	1,782	65,000,000
AdvancePCS 5215 N. O'Connor Blvd., Suite 1600 Irving, Texas 75039	469-420-6000 Fax: 469-420-6169 *www.advanceparadigm.com*	NA	$12,200 [1]	5,000	NA	NA
Express Scripts Inc. 13900 Riverport Drive Maryland Heights, Mo. 62025	800-281-0712 Fax: 314-702-7059 *www.express-scripts.com*	NA	$9,250	NA	NA	44,000,000 [2]
Caremark Rx Inc. 2211 Sanders Road Northbrook, Ill. 60062	847-559-4700 Fax: 847-559-3694 *www.caremark.com*	NA	$5,600	4,000	1,200	NA
RxAmerica 369 Billy Mitchell Road Salt Lake City, Utah 84116	800-770-8014 Fax: 801-961-6009 *www.rxamerica.com*	Longs Drug Stores	$534	121	289	2,161,754
ScripSolutions 100 Clearbrook Road Elmsford, N.Y. 10523	888-818-3939 Fax: 914-460-1660 *www.scripsolutions.com*	MIM Corp.	$405	400	NA	8,300,000
CLAIMSPRO Management Services Inc. 24370 Northwestern Highway, Suite 200 Southfield, Mich. 48075	248-352-2852 Fax: 248-352-7475 *www.claimspro.com*	PharmaCare	$373	75	1,600	1,270,000
United Provider Services 5125 Davis Blvd. Fort Worth, Texas 76180	817-281-8820 Fax: 817-427-5213 *www.upsrx.com*	CVS Corp./ PharmaCare	$180	70	2,200	650,000
The Inteq Group Inc. 5445 La Sierra Drive, Suite 400 Dallas, Texas 75231	800-324-7799 Fax: 214-739-7979 *www.inteqrx.com*	NA	$140	55	700	1,300,000
National Pharmaceutical Technologies 14301 First National Bank, Suite 200 Omaha, Neb. 68154	402-964-9030 Fax: 402-964-9004 *www.pti-nps.com*	Pharmaceutical Technologies Inc.	$100	30	2,100	1,200,000

1 Estimated 2 *BI* estimate
Source: *BI* survey