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Business Insurance

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\$5

Class action bill passes Senate

Expected approval in House would give tort reformers rare victory

By MARK A. HOFMANN

WASHINGTON—The U.S. Senate's 72-26 vote in favor of the Class Action Fairness Act last week could ease the way for additional federal tort reforms, say tort reform advocates.

The bipartisan bill, which, among other things, would permit the removal of certain class actions involving defendants and plaintiffs from different states to federal court from state court, is expected to face little difficulty in the House of Representatives, which had approved earlier versions of the bill.

Senate supporters of the bill were able to block a handful of amendments that would have provided carve-outs for particular types of class ac-

Long-sought tort reforms

The Class Action Fairness Act, S.5, would:

- Allow state court suits seeking \$5 million or more to move to federal court
- Let federal judges decline to hear cases involving many out-of-state class members
- Require greater scrutiny of settlements offering goods or services to plaintiffs
- Ban settlements resulting in a net loss for class members
- Ban settlements giving plaintiffs larger awards on basis of proximity to court

tions, including wage and hour disputes, or that would have changed the procedural provisions of the underlying bill. House supporters had warned that they would support the Senate bill only if it remained unamended.

The bill passed by the Senate, S.5, is designed to cut back on so-called forum-shopping, under which plaintiffs attorneys seek the most plaintiff-friendly state courts in which to file what amount to national class actions.

Under the bill, the amount of money at stake must exceed \$5 million before a case can be moved to federal from state courts. In addition, more than one-third of the proposed plaintiff class must be citizens from states other than the

See **CLASS ACTION**/page 38

AARP lawsuit delays final EEOC ruling on retiree health plans

By JERRY GEISEL

PHILADELPHIA—Employers are going to have to wait longer—perhaps a lot longer—to find out if a longstanding legal threat to retiree health care plans is gone.

Earlier this month, the Equal Employment Opportunity Commission, agreed, as part of legal proceedings brought before a U.S. District Court judge in Philadelphia, agreed not to publish for 60 days a final rule that would exempt retiree health care plans from the Age Discrimination in Employment Act.

Responding to a complaint filed by the AARP, Judge Anita Brody agreed to hear oral arguments next month on the legality of the rule, which the EEOC had been expected to send to the Federal Register some time this month. The rule would have gone into effect upon publication.

The AARP litigation ensures

that the question of whether employers with retiree health care plans can be sued for age discrimination if they don't offer the same level of coverage or spend the same amount on health care benefits for Medicare-eligible retirees as they do for other retirees won't be resolved any time soon.

"It means continued uncertainty," said John Piro, an attorney with Hewitt Associates Inc. in Norwalk, Conn.

"This issue has been around a long time, and it now looks like it will continue to be around even longer," added Henry Saveth, an attorney with Mercer Human Resource Consulting in New York.

Indeed, the issue emerged four and one-half years ago, when a federal appeals court ruled that retiree health care plans are subject to ADEA. To prevent a charge of age discrimination, employers, under ADEA rules, either would

See **EEOC**/page 38

Broker earmarks \$50 million

Aon sets aside settlement funds

By SALLY ROBERTS

CHICAGO—Aon Corp. for the first time last week acknowledged that it will likely pay millions of dollars to settle yet-to-be filed charges by New York Attorney General Eliot Spitzer and other state attorneys general investigating broker compensation practices.

In announcing its 2004 financial results last week, Aon said it is setting aside \$50 million for potential settlements that could result from investigations by the attorneys general of New York and other states.

Although Aon has not been charged with any wrongdoing to date, it has been a target of investigations by Mr. Spitzer and others.

The brokerage previously has acknowledged that some employees failed to follow Aon's code of conduct, but it said that an internal review found no evidence that it solicited fictitious quotes, engaged in bid rigging or violated antitrust laws by tying reinsurance to retail placements (*BI*, Dec. 13, 2004).

Aon's news of the \$50 million settlement reserve comes on the heels of the announcement late last month that Marsh & McLennan Cos. Inc. agreed to pay \$850 million to settle fraud and bid-rigging charges brought by Mr. Spitzer (*BI*, Feb. 7).

Observers say that, with Marsh's settlement now complete, the focus of the investigation has likely turned to Aon. And although Aon's much smaller settlement reserve may be a reflection of less egregious charges to come, it likely represents just a portion of what the Chicago-based brokerage will ultimately pay to various state investigators and private litigants, they say.

In a conference call to investors last week, Aon Chairman and Chief Executive Officer Patrick G. Ryan acknowledged, for the first time, that the brokerage was in settlement talks.

"We continue to cooperate with the investigations by the attorney general and insurance department

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Late News

Property cat losses hit record in 2004: PCS

Catastrophes caused a record \$27.3 billion in insured property damage in the United States in 2004, according to the Insurance Services Office Inc.'s Property Claim Services unit. The United States last year saw 22 catastrophes, according to PCS, which defines such events as those that cause \$25 million or more in insured property losses and affect a significant number of policyholders and insurers. The 2004 total surpassed the \$26.5 billion record set in 2001, which included property losses caused by the Sept. 11 terrorist attacks.



PHOTO: GETTY

GM is cutting Walgreens from its prescription network.

GM dropping Walgreens from drug network

General Motors Corp. said it is dropping Walgreen Co. from its network of prescription drug providers out of concern that the drugstore chain would not service GM employees in response to the automaker's requirement that maintenance drugs be filled via mail order. Walgreens announced last month that it would no longer participate in the state of Ohio's prescription benefit program because of its mandatory mail-order requirement. Walgreens on Friday said, though, that it did not intend to drop GM and was talking to the company.

Brown & Brown adds wholesaler

Brown & Brown Inc. has agreed to acquire the assets of Hull & Co. Inc., a wholesale broker that generates around \$63.0 million in annual revenues. Hull, which is based in Fort Lauderdale, Fla., has 20 offices in nine states. Terms of the deal were not disclosed. Meanwhile, Brown & Brown reported that its revenues rose

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Spotlight Report

SPECIALTY RISKS



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Offsite 9/11 claim valid

Firm can sue over business interruption, court rules

By DOUGLAS MCLEOD

NEW YORK—An engineering and janitorial services company is entitled to pursue more than \$100 million in business interruption losses stemming from the destruction of the World Trade Center, even though it did not own or lease WTC space, a federal appeals court ruled.

San Francisco-based ABM Industries Inc. had an insurable interest in the WTC complex it serviced and is thus covered under the business interruption section of its property policy, a 2nd U.S. Circuit Court of Appeals panel found last week. The decision partially reversed a lower-court ruling granting summary judgment to ABM's property insurer, Zurich American Insurance Co.

"The 2nd Circuit decision has the potential to be one of those cases that policyholders cite with some regularity," said John Ellison, a lawyer with Anderson, Kill & Olick P.C. in Philadelphia, which represented ABM. "It is one of the more definitive statements, if not the most definitive, on the level of connection you need to have to a piece of property" to claim business inter-

ruption coverage.

A Zurich spokesman said the insurer is considering whether to seek review by the full appeals court but declined to comment further.

ABM, a New York Stock Exchange-listed company with \$2.2 billion in 2003 revenues, employed 800 people at the WTC. It operated



the complex's heating, ventilating and air conditioning systems and serviced public areas under contracts with WTC leaseholder Silverstein Properties Inc. and owner The Port Authority of New York and New Jersey. It also provided services to nearly all WTC tenants under separate contracts.

After the Sept. 11, 2001, terrorist attack, ABM sought coverage for all of its lost WTC income. The company also filed claims for lost income at 34 other lower Manhattan loca-

tions under its policy's "civil authority" provision, contending authorities prevented it from entering the downtown area after the attack.

Zurich countered with a declaratory judgment action, and a federal judge found in the insurer's favor in 2003. The lower court ruled, for example, that ABM had no insurable interest in the WTC complex because it neither "used" nor "controlled" the buildings and thus was not entitled to business interruption coverage.

The appellate panel, however, overturned much of the ruling Wednesday.

The business interruption provision, the appeals court noted, covered "the interest of the insured in all real and personal property including but not limited to property owned, controlled, used, leased or intended for use by the insured."

The WTC complex was vital to ABM's business and therefore was "used" by the company, the court found. "To deny ABM's loss-of-income coverage simply because its income is derived from labor that occurs outside of its own cubicles

See WTC/page 39



PHOTO: UPI NEWSPICTURES

The proposed fiscal 2006 federal budget includes a provision that would increase insurance premiums charged by the U.S. Pension Benefit Guaranty Corp.

Bush budget proposals seek to shore up PBGC

Would OK pension plan overfunding

By JERRY GEISEL

WASHINGTON—A pension reform package proposed by the Bush administration would help to shore up the financial base of the U.S. Pension Benefit Guaranty Corp., but experts say the package may not do enough to stop or slow the continuing exodus of employers from the defined benefit plan system.

The package, contained in the administration's proposed federal budget for fiscal 2006 that was released last week, includes the provisions that the administration first released last month.

Those provisions include significantly increasing the insurance premiums charged by the PBGC, simplifying funding rules and linking how employers are to value the size of their plan liabilities with the demographics of their pension plans, the later of which would boost contributions for employers with older workforces.

Additionally, the package would bar bankrupt companies

with underfunded plans from increasing their plan benefits, while plan participants could not accrue new benefits or take benefits as a lump sum. Companies with junk-bond credit status with severely underfunded plans would face similar restrictions.

Conversely, employers would be given the flexibility to overfund their plans. Under that provision, employers could fund up to 130% of their plan liabilities, a change in law that the administration hopes will enable pension plans to build surpluses and leave them better protected when economic conditions deteriorate and employers are less financially able to contribute to their plans.

The budget package also includes new details not previously disclosed. For example, PBGC guarantees of so-called plant shutdown benefits would be eliminated, and employers eventually could not offer such benefits.

In addition, certain financially

See BUDGET/page 37

Connecticut attorney general proposes electing commissioner

By SALLY ROBERTS

HARTFORD, Conn.—The Connecticut insurance commissioner would become an elected position, and agents and brokers would have to adhere to a code of professional responsibility under an insurance reform package sent to the state's Legislature by Connecticut Attorney General Richard Blumenthal.

Mr. Blumenthal, who has been investigating insurance industry practices since last summer, wants strengthened accountability and transparency in the insurance industry. He recently sued Marsh & McLennan Cos. Inc. and a unit of

ACE Ltd. over alleged violations of the state's consumer protection laws (BI, Jan. 24).

"Tougher rules are necessary but not enough. We need better enforcement. An elected commissioner accountable directly to the people can fight abuses that raise insurance costs for everyone. Stronger legal standards can help stop a culture of concealed kickbacks, where business is steered in exchange for bonuses, not the best deal for consumers," Mr. Blumenthal said in a statement.

In his proposal, Mr. Blumenthal advocates a constitutional amendment that would make the insur-

ance commissioner position an elected office.

The proposed legislation also would require insurance agents and brokers to disclose in writing whether they are acting on behalf of insurers and to detail the terms and amount of any compensation arrangements. Agents and brokers also would be required to disclose the details of all quotes from insurers and the reasons for their recommendations.

The proposal also calls for giving a consumer the option to be a broker's sole source of compensation for any business done on behalf of that consumer.

Inside Business Insurance

Health care treatment differs with ethnicity

When it comes to health care, not all groups of workers receive the same quality of treatment. **Page 4**

Noncompete agreements could burn employers

An employer that poaches an employee from a competitor could find itself with a lawsuit as well as a new staff member. **Page 4**

A bald-faced plea for the sake of the kids

Editorial Director Paul Winston urges readers to join him in an event that supports a good cause. **Page 6**

Once TRIA is gone, what follows?

TRIA won't be around much longer, predicted an expert at the American Bankers Assn.'s annual risk management conference. **Page 22**

D&O insurers pressured by securities class actions

Increasing litigation is taking its toll, said a panel at a PLUS D&O symposium. **Page 28**

Underwriters balk at Aon's fee structure change

Underwriters are resisting Aon Ltd.'s plan to revamp its fee structure by imposing an upfront charge for services to the market. **Page 33**

Online

- The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info about your own event.
- Searchable **directories** provide access to all the listings of industry vendors found in *BI's* Market Sourcebook.
- New **Opinion Poll** for readers: Do you think that elected insurance commissioners represent policyholder interests more effectively than appointed commissioners?

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Health care treatment differs with ethnicity

Employers, insurers striving to end disparities for minority and non-English speaking workers

By JOANNE WOJCIK

When it comes to health care, not all groups of workers receive the same quality of treatment.

An Institute of Medicine report, "Unequal Treatment," found that minorities and non-English speakers have greater difficulty accessing health care services and tend to receive a lower quality of health care—even when they are insured.

Since that 2002 report, employers and health plans have been working on ways to address racial and ethnic disparities in health care. Employers have a vested interest in eliminating such disparities because

they undermine the health of the workforce and inflate employers' already rising health care costs, according to the National Business Group on Health. The NBGH has developed an informational toolkit for its members based on the findings from pilot programs at company-sponsored health fairs.

And the disparity could get even worse, given that racial and ethnic minorities will make up 41% of the nation's workforce by the end of the decade, a NBGH report asserts.

"The purpose of our project was to make employers aware that there is a lot of new evidence that there are a lot of significant differences in

health care and health care needs and circumstances of different

This is the first of two feature articles on racial and ethnic disparities in health care.

Part I addresses differences in medical treatment quality.

Part II will focus on benefit communication.

groups," said Helen Darling, president of the Washington-based employer coalition. The business group has more than 230 members, including some of the largest U.S.-based employers.

"For example, we know from evidence that African-American males are much more likely to suffer from undetected or untreated hypertension and are therefore more likely to have (a) stroke or heart attack," Ms. Darling said, referring to prior research by sources including the coalition and the Institute of Medicine.

"If you know that, and you have a lot of African-American men in

your workforce, it really behooves you to consider quite seriously having onsite programs, especially in a manufacturing facility, and onsite health centers that encourage people to get screened," she said.

Insurers also are addressing the issue in various ways.

A consortium of health plans entered into a collaborative effort with the Agency for Healthcare Research & Quality in mid-December to form the National Health Plan Learning Collaborative to Reduce Disparities and Improve Quality.

The collaborative, which initially will focus on addressing disparities

See **DISPARITY**/page 37

Plan aims to curb fraud

NAIC scrutinizing MEWA regulation

By MEG FLETCHER

Some state regulators are promoting changes designed to curb scams associated with multiple employer welfare arrangements and illegal health insurance plans.

MEWAs can be a useful vehicle for allowing small and mid-size employers—those with up to 100 employees—to provide health insurance to employees. Various illegal and fraudulent MEWAs, however, have scammed employers and victim-

sources noted.

Such scams are particularly troublesome for hospitals and health care providers, according to Fred Nepple, general counsel with the Wisconsin Insurance Department in Madison.

Mr. Nepple, who also chairs the National Assn. of Insurance Commissioners' working group that oversees issues related to ERISA, has prepared a conceptual draft of model legislation designed to help identify fraudulent MEWAs and other health insurance scams.

Health care providers may face financial risk if, for example, they contract with a national provider network that has not carefully screened out

'A fairly low-cost measure will go a long way to prevent MEWA scams.'

*Fred Nepple
Wisconsin Insurance
Department*



ized employees—and health care providers—by failing to pay claims.

Since 1983, the federal Employee Retirement Income Security Act gives the states primary authority to regulate most MEWAs. They provide health insurance plans to multiple employers.

Too often, though, MEWA plans and illegal insurance scams are able to operate without regulatory oversight, regulators complain. They take employers' premiums but fail to pay employees' claims.

Although sham MEWAs prey generally on smaller companies, all employers should be concerned about such fraud because health insurance buyers eventually bear the burden of uncompensated health care through higher premiums, several

a bogus MEWA, said Mr. Nepple.

In one case in Wisconsin, health care providers were required by regulators to deeply discount \$1.3 million in billed fees after the failure of a illegal health plan in which the employees had coverage, he said.

In other cases, providers may be able to collect little or no money for their services, as MEWAs do not participate in any industry guaranty funds. Also, some states and receiverships discourage providers from seeking reimbursement from the employee who received care under a sham plan.

Some hospitals, however, have protected themselves through hold-harmless agreements with networks or are located in states where they can directly bill patients for uncompensated care.

See **MEWA**/page 35

Renewal of TRIA said to hinge on Treasury analysis of market

By MARK A. HOFMANN

WASHINGTON—The House of Representatives is unlikely to move on reauthorization of the Terrorism Risk Insurance Act until the Treasury Department issues a report on the state of the terrorism insurance market, according to a member of the House Financial Services Committee.

Rep. Deborah Pryce, R-Ohio, offered that assessment at a legislative meeting sponsored by the Council of Insurance Agents & Brokers and the Reinsurance Assn. of America in Washington on Thursday. Under TRIA, which provides a federal

backstop to help private insurers pay for future catastrophic terrorism losses, the Treasury Department has until June 30 to issue its report. TRIA is scheduled to expire Dec. 31, and risk managers, insurers, reinsurers, brokers and others have urged that the program be extended for two years early in this congressional session to help prevent possible market disruptions.

Rep. Richard Baker, R-La., chairman of the Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises, told the gathering he has heard the Senate may move soon on TRIA. Rep.

Baker—who has been one of TRIA's staunchest supporters—warned that some members of the House leadership "just don't like" TRIA. He said those members recall their bad experience in providing financial guarantees for the U.S. airline industry in the wake of the Sept. 11, 2001, terrorist attacks on New York and elsewhere.

Rep. Baker said TRIA must strike a balance that would keep the insurance industry functioning after a major terrorist attack but allow the Treasury Department to recoup its advances to the industry when insurers returned to financial health.

Noncompetes could burn employers

As hiring increases, risk of litigation may grow

By JUDY GREENWALD

Employers that poach employees from competitors beware: You may find yourself with a lawsuit as well as a new staff member.

If new hires signed noncompete agreements at their former jobs, their former employees may well be within their rights to sue both the employees and their new employers if those agreements are breached.

Noncompetition agreements, which have become more popular over the past several years, preclude employees from engaging in certain competitive practices, such as soliciting customers or divulging trade secrets, after their employment ends. They are particularly popular in certain industries, including high-tech and entertainment.

One mistake employers sometimes make when they hire a new employee is to take the attitude that noncompetes are "not worth the paper they're printed on," said Robert C. Boisvert, Jr., an attorney with Frederikson & Byron in Minneapolis. "That's what gets a lot of

employers and employees into trouble."

Employers who do not consider noncompetes risk being charged with tortious interference with a contract, unfair business competition and misappropriation of trade secrets, among other charges. The employee can also be charged with breach of contract.

State laws vary in their willingness to enforce noncompete agreements, say observers. While most litigation brought by former employers ultimately does not reach the trial stage, these disputes could be costly both in management time and legal expenses, say observers.

With the economy now apparently improving, disputes over noncompete agreements are likely to arise more frequently.

"When the economy heats up, there's more competition for talent, there's more people who are willing to test the limits, and those who lose their valued employees are more inclined to fight because they have the resources," said Kent A. Yalowitz, an attorney with Arnold

& Porter in New York.

The most critical step to take is to first determine during the initial interviewing process whether a noncompete agreement was signed at the former employer.

Interviewers should undergo "very specific" training and be prepared to spot "red flags" in answer to questions as to whether they are bound by any contractual relationship with their former employers, said Richard Reed, Whitehouse Station, N.J.-based vp and global practice leader for intellectual property and electronic commerce insurance products at Chubb Commercial Insurance, a unit of Chubb Corp.

If the employee says there is no such agreement, "have it attested in writing," said William Henry, vp at the Alexandria, Va.-based brokerage CIMA Cos. Inc. "If the previous employer comes after you, at least you have that protection. You made a good faith effort."

Where a noncompete agreement does exist, have an attorney review it to determine whether it is enforceable.

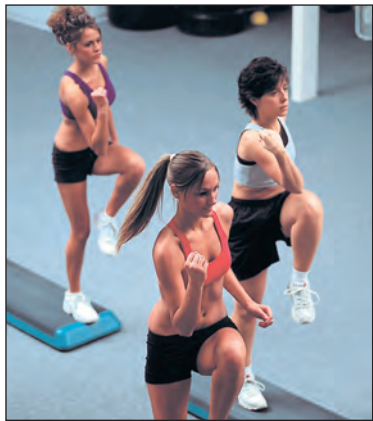
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2005 Employee Healthcare Conference

Financial incentives provide impetus for employees to improve health

By GLORIA GONZALEZ

NEW YORK—Employers are increasingly using financial incentives to encourage employees to take steps to improve their health



Some companies provide financial incentives for their employees to exercise.

and participate in wellness programs that could help reduce health care costs.

Incentives ranging from payments for taking an annual physical to prize drawings for employees who take health risk assessments are helping to curb health care cost increases, a panel of benefit managers said.

The benefit managers described their incentive programs to about 350 attendees at the 2005 Employee Healthcare Conference, presented by the Conference Board and sponsored by Towers Perrin HR Services.

Jane Hopkins, director of benefits for Hartford, Conn.-based Aetna Inc., said the company's healthy lifestyles program was designed to reward employees for healthful behavior.

This year, the company introduced financial incentives for employees to take steps to either pre-

vent or identify health conditions that could lead to costly claims in the future. For example, Aetna gives employees \$25 for getting an annual physical, getting a flu shot or a mammogram.

Aetna's program also features a weight management incentive to address the problem of rising diabetes and hypertension claims. The company provides a \$40 incentive for employees to participate in a weight loss program and \$50 for every 50 workouts completed up to 150 workouts per year.

"We said 'let's focus on that because that's going to lead us to other problems,'" Ms. Hopkins said.

An Aetna employee could earn up to \$345 in financial incentives if they pick up all of the financial incentives offered in the healthy lifestyles program, she noted.

In its incentive program, Hamp-

See RETIREE/page 36

Paul Winston Off with his hair for worthy cause

In 2004, I joined thousands of other people around the world who shaved their heads bald to benefit research into curing childhood cancers. Now, almost one year and a dozen haircuts later, I'm planning to do it again.

What does a smooth pate have to do with cancer research? It is central to the annual St. Baldrick's Day celebration, in which men and women volunteers shave their heads in public to raise pledges of financial support for cancer research. The head shaving is intended to display solidarity with kids who have cancer, many of whom lose their hair during chemotherapy treatments.

I decided to join in the 2004 St. Baldrick's Day celebration largely on a whim and only a few weeks before the big day. I had learned of the fundraiser's general mission—in which participants raise money for the National Childhood Cancer

Foundation—in a column in the Chicago Tribune. I was moved by the unusual effort and by the spirit of the shavees, but I assumed—wrongly—that only people whose lives had been touched by cancer would participate.

I didn't decide to take part until a short time later, when I learned in a *Business Insurance* article that St. Baldrick's Day was begun in 2000 by a trio of reinsurance execs in New York who wanted a way to give back some of their good fortune to society. The reinsurance industry also remains one of the event's largest industry contributors. That convinced me to contribute my head of hair and fundraising to this cause.

If one segment of *BI*'s audience was supportive of this effort, perhaps I could help to enlarge its base of support by publicizing the charity to other segments of the industry, as well as the buyer community.

I also realized that being blessed with two healthy children gives me two great reasons to try to help other children who face a less-certain future.

In a few short weeks, I raised nearly \$3,000, thanks to the kindness of four dozen co-workers, bosses, family members, friends and even a couple of risk managers. I was touched by the generosity of these people and their willingness to help on my behalf. Overall, the St. Baldrick's event raised \$3.5 million

in 2004, with approximately 5,000 participants and more than 50,000 donors. To date, it has raised more than \$7 million for this cause and has formed its own foundation to maximize the funds that are provided for research.

Now, in 2005, I have had more than a few weeks to think about whether to again shave my head for St. Baldrick's Day. And, once again, all I had to do was look at my kids to help convince me of the worth of this cause.

To me, abandoning St. Baldrick's after only one year would make as much sense as leaving the barber's chair after only one swipe of the razor across my scalp. Both jobs are far from finished.

So I'll be back in the chair on March 11. I'm sure this announcement is not the St. Valentine's Day gift my wife had in mind, but, thankfully, she thinks bald is beautiful and supports the cause.

If you would

like to donate to St. Baldrick's, benefiting the National Childhood Cancer Foundation's oncology research group, please visit the charity's Web site, www.stbaldricks.org, or call 888-899-BALD. You can make a tax-deductible donation to this research on my behalf, or on behalf of someone else or directly to the foundation.

Or, join me as a shavee! I would be honored to have your company. Toward that end, I have formed the Republic of Winstonia team on the St. Baldrick's Web site. You can join the team and participate with me in Chicago, or at any of the locations around the world (and, for once, Winstonia won't take a dime). Plus, you will receive honorary citizenship in Winstonia and all the benefits that entails. Check the St. Baldrick's Web site to find an event near you—locations can be found from Fairbanks, Alaska, to Hamilton, Bermuda—and sign up to participate.

Together, we can help sponsor this important specialized research. While there are many worthy organizations devoted to battling other forms of cancer, St. Baldrick's Foundation is the only one of its kind focused on raising funds to battle cancer in children.

Editorial Director Paul Winston can be reached at pwinston@businessinsurance.com.



Paul Winston, shaved

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Editorial

Class action lessons learned

WHAT SEEMED LIKE an impossible dream appears likely to become reality in the next few days.

That dream is meaningful class action reform, made possible by the Senate's overwhelming vote in favor of the Class Action Fairness Act last week. The measure now goes to the House, where approval is a virtual given.

There are lessons to be drawn from the successful effort to get class action reform through the Senate. Some are obvious—that a bill that doesn't enjoy bipartisan support goes nowhere. But some lessons might not be.

One is that the Class Action Fairness Act would deal with procedure rather than substantive law. In fact, it is more venue reform than tort re-

form. No one loses his or her right to a day in court; all the act does is specify in which court an action can be heard.

That's a lesson that could be applied to asbestos litigation as well. Rather than replace the current litigation-based system with a new and complex trust fund, look to docket reform instead. As has happened in Ohio and some smaller jurisdictions, lawmakers should require a claimant to meet specific medical criteria before pursuing a suit. Once again, no injured party loses the right to a day in court, but that day cannot arrive until an injury has been proved.

The other lesson is one that tort reform forces have had to learn over and over: don't let the perfect be the enemy of the good. And, to

be sure, the Class Action Fairness Act isn't as comprehensive as some tort reformers would like.

In fact, class action reform approved in the last session by the House went further than the bill that won Senate approval. But reformers have wisely chosen to stick with something that enjoys broad support. A reform can always be improved later—the hard part is getting it enacted.

Proponents of class action reform legislation suffered numerous bitter defeats before but refused to give up. That persistence, plus a good dose of realism about what could be acceptable to lawmakers on both sides of the aisle, proved to be just the right combination that appears likely to turn an impossible dream into a tangible reality.

Don't elect this proposal

CONNECTICUT ATTORNEY General Richard Blumenthal has proposed some interesting reforms to insurance regulation in his home state that could provide better protection for policyholders. Unfortunately, his lead proposal, that the state's insurance commissioner be elected, is not one of them.

The notion that an elected regulator would be more accountable to voters and more likely to act in their interests has little relevance to the brokerage compensation scandal that spurred Mr. Blumenthal's reform drive.

Would-be insurance commissioners seeking to win favor with the man or woman on the street in any state would be more likely to

target auto rates or homeowners coverage issues than commercial insurance compensation as they seek office.

And incumbent commissioners seeking to win additional terms may be tempted to indulge in short-term fixes that lead to long-term problems, such as ordering insurers to pay out invalid claims after a disaster or slashing rates regardless of the actuarial wisdom of such a move.

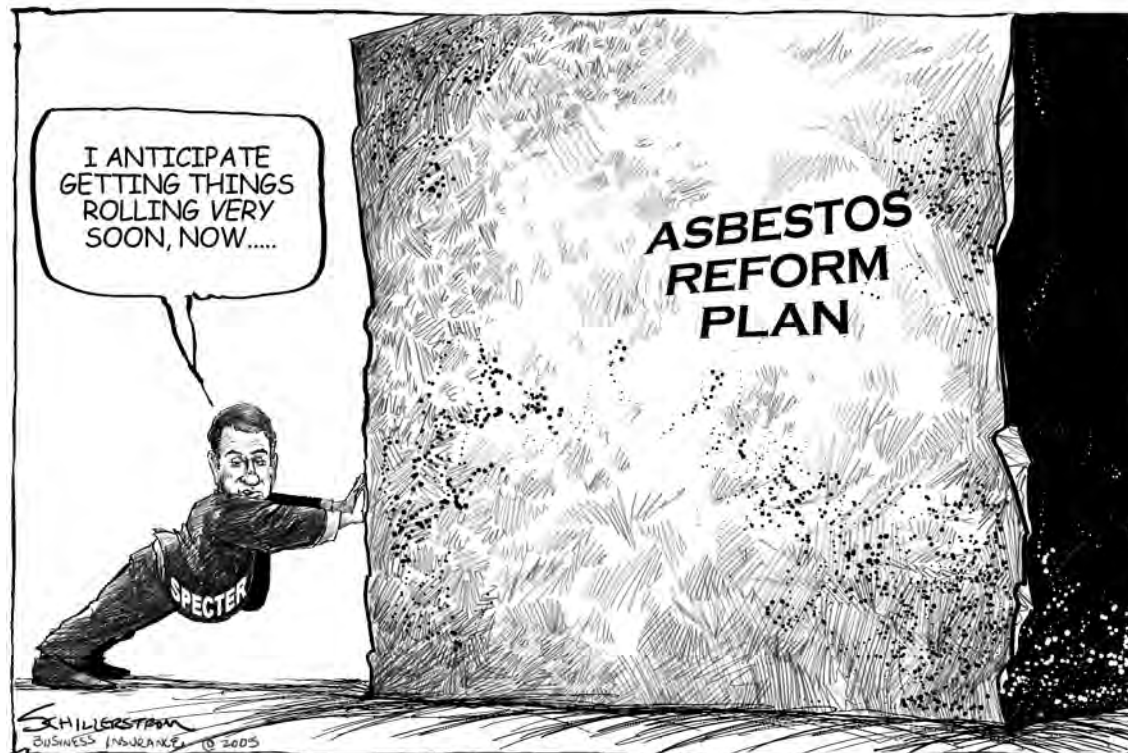
It was the work, and perhaps the future ambitions, of elected officials in certain states that led to the outing of contingent commissions abuses in the first place, but that does not mean every public post needs to be filled through a direct vote.

Other suggestions by Mr. Blu-

menthal are more refreshing, though, such as legislative requirements for brokers and agents to disclose commission arrangements with insurers. Such an approach would be a sensible compromise between permitting contingent commissions to continue and barring them altogether. While we would advocate that contingent commissions should no longer have any part in large commercial placements, the issue is not as clear cut for all lines of business.

Risk managers do not need elected regulators micromanaging their business, but the recent scandals have shown that even the most sophisticated buyers need a heightened level of protection.

Schillerstrom



Letters to the Editor

Buyers need protection through transparency

To the editor: In the Dec. 20, 2004, issue of your publication, a comment was made in an article, "Aussie regulator probes broker pay," supporting the lack of need for increased regulation in the insurance market in Australia. In that article, at least one risk manager suggested that "corporates are big enough to look after themselves....I don't think we need a regulator running around trying to control the market."

It is fair to say that corporations may well be big enough to look after themselves; however, they can do so only based upon the full and frank disclosure of all elements in the purchase of insurance, including their brokers' compensation packages.

While informed corporate risk managers were generally aware of at least some of the contingent commission elements, few risk managers have complete knowledge of all elements of their brokers' compensation packages. So where do you go from here? Many insurance intermediary firms have taken what can only be regarded as an appropriate stance in eliminating at least the contingent commission elements from their compensation packages.

Trust, that time-honored but hopefully not so old-fashioned notion, is and has always been a key element in the placement of insurance. This trust is expected to exist among all parties involved in the insurance procurement process. The results of recent well-publicized investigations have, at a minimum, forced buyers of insurance to reconsider how they go about purchasing this vital commodity. I consider that it would be a brave buyer indeed that considers itself sufficiently informed so as to rely on the existing, largely unregulated, regime. Corporates could well benefit from increased regulation in this area, at least to give them greater confidence that when they believe they know the whole story, this is, in fact, the case.

Clearly, the existing system, supposedly underpinned by self-regulation, has failed demonstrably. Insurance buyers, including corporates, need appropriate legislative intervention, at least, to ensure the new era of full and complete transparency means just that.

Eamonn Cunningham

Vp-Global Risk Management

Westfield Ltd.

Sydney, Australia

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Spotlight Specialty Risks

Spotlight Editor: Roberto Cenicerros



Niche market offers comp coverage for corporate jet crews

Filling guaranteed-cost program holes

By ROBERTO CENICERROS

While most companies with corporate jets likely maintain loss-sensitive workers compensation programs, those that do have guaranteed-cost programs might need to turn to specialty underwriters.

That can happen because insurers that offer guaranteed-cost workers compensation policies sometimes decline accounts that own corporate jets and hire staff pilots, several aviation specialists say. Reinsurers may restrict coverage for corporate aviation crews, so the workers comp insurers follow their reinsurers' lead, sources say.

Specialty aviation underwriters, on the other hand, write only aviation-related workers comp coverage. They don't cover all employees working for a company that is not in the aviation business, explained Rick Weinkauff, vp and director of aviation in Denver for Brown & Brown Inc.

Therefore, to purchase workers compensation coverage for pilots flying corporate jets, some employers with guaranteed-cost programs form separate holding companies that employ their aviation staff. Employers can then turn to admitted market specialty products to insure just the segregated workers comp aviation risks, while their standard policies cover their other workers.

In other cases, corporate jet crews work for the same entity as other company employees. Yet, in a divided risk exposure arrangement, the employer's workers compensation insurer might carve out the corporation's aviation-related risks from the policy covering all other employees, explained Bill Welbourn, executive vp in New York for United States Aviation Underwriters Inc.

In those situations, employers can also purchase specialty policies just for the carved-out aviation risks, Mr. Welbourn said.

In some cases, a workers comp insurer that normally rejects aviation business may include it in a program to accommodate a large client

purchasing a guaranteed-cost program for its entire operation, Mr. Welbourn said.

But employers with guaranteed-cost programs often can face a "very very difficult market," Mr. Weinkauff said.

In contrast, employers with loss-sensitive workers comp programs and large deductibles usually don't encounter difficulty finding market competition for their incidental aviation risks. In those cases, insurers usually include coverage for flight crews along with the insurance provided for all other employees.

Workers compensation insurers sometimes carve out a corporation's aviation-related risks from the policies that cover all other employees.

Many of the Fortune 2000 corporations that ACE USA's risk management division insures have incidental aircraft exposures, such as a couple of corporate jets or helicopters, their pilots and ground crew, noted Keith Mattheessen, vp-Houston branch manager for ACE USA's risk management division.

ACE's risk management division has no problem including those exposures among the workers compensation coverage it provides its clients for all of their employees. But those clients usually have loss-sensitive programs with deductibles ranging from \$250,000 to \$25 million per accident, Mr. Mattheessen said.

ACE, though, might give additional underwriting scrutiny to a potential customer with aircraft by looking at issues such as how many employees work or fly aboard each aircraft, Mr. Mattheessen said.

Caesars Entertainment Inc. in Las Vegas owns four aircraft and last year chartered 900 flights. The company maintains a "massive workers

See AVIATION/page 14

Contests' popularity increases demand for prize indemnity cover

Odds are, though, not all promotions can find insurance

By GLORIA GONZALEZ

Watching this year's Super Bowl was nerve wracking for Lowery Robinson, president and chief executive officer of Duluth, Ga.-based Marketing Etc., a managing general agent that develops sports promotions and facilitates insurance coverage for them.

He spent the entire game rooting against the occurrence of several events—a return of the opening kickoff for a touchdown, a safety and a fourth-quarter field goal of 50 yards or more—because any of those events would have won a substantial prize paid for by one of his insurers.

"We had so many promotions during that game, it was really frightening to watch," he said.

Mr. Robinson ended up having a better game than did the Philadel-

phia Eagles, though, because none of those events occurred, which meant his underwriters did not have to pay out in any of the prize competitions they insured. The Eagles lost to the New England Patriots by a score of 24-21.

Consumer product companies often gain more exposure by holding a contest than buying advertisements or being a corporate sponsor of an event.

The demand for prize indemnity insurance has increased in recent years due to the growing popularity of sales promotions and contests. Consumer product companies have

learned that they can often gain more exposure by holding a contest than purchasing advertisements or being a corporate sponsor of an event, observers say.

"If someone does win a prize at one of these events, it really gives them a lot of publicity," said Jacqueline Fellrath, vp, manager of prize indemnity for AIG Programs, a division of American International Group Inc. unit Lexington Insurance Co. in Boston.

To gain that increased exposure, though, the contest sponsor must offer a prize of noteworthy value, which exposes it to significant risk. Purchasing prize indemnity insurance allows companies to transfer that risk.

"The main benefit is they can manage their budget in an effective way and still offer a large prize that

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Specialty risk group grows on past success
page 16

Niche product development challenging
page 18

Prizes: Contests' popularity increasing demand for cover

Continued from page 10

will gain the maximum attention from the fans," Mr. Robinson said. "Once they pay the premiums, they can manage their budget from that point on, regardless of the outcome."

Prize indemnity policies can be written for both statistical and nonstatistical risks. Statistical risks refer to contests in which the mathemat-

ical probability of loss can be calculated. An example of this type of risk would be a game of chance, such as a scratch-off contest.

Nonstatistical risks refer to contests for which the probability of loss can not be mathematically determined. These types of risks are based on skill games, usually contingent on sporting results, such as a golfer making a hole in one or a

basketball player sinking a half-court shot.

Although the purchase of prize indemnity insurance is increasing, only a handful of insurers offer the coverage. Historically, prize indemnity has been a Lloyd's of London play, but U.S. insurers such as AIG, Warren, N.J.-based Chubb Corp. and Woburn, Mass.-based ASU International also write the coverage.

Generally speaking, there is a greater appetite in the London market for risks for which the probability of loss can be determined mathematically, said Richard Gaunt, contingency underwriter in the specialty division of London-based Markel International Ltd. While Markel does write the nonstatistical risks, it tends to focus on statistical risks, Mr. Gaunt said. "We prefer the business based on mathematical analysis," he said. "It's less volatile. We don't particularly go for risks contingent upon sporting results where the probability of loss is very high"

"The capacity for mathematical games remains very strong," agreed Scott Brady, the New York-based director of the contingency products group of Aon Corp. "You know precisely what your loss probability is."

"Instant-win" contests are considered the most difficult to insure because they are not dependent on intervening steps, such as collecting a number of game pieces, that would minimize the possibility of a loss, said Mark Barry, senior vp of global marketing for ASU International, a unit of Houston-based HCC Insurance Holdings Inc. "You're probably not going to see underwriters clamoring to write that kind of program," he said.

Insurers are also reluctant to write risks in which the probability of a claim is high, Mr. Gaunt said. For example, a contest based on a professional golfer holing out a shot would be difficult to place, he said. "I'm not sure that would be insurable right now," Mr. Gaunt said. "I think it gets to the point where it can't be insured."

Mr. Brady said, though, that he believes a prize can be insured as long as the outcome of the contest is not guaranteed. "If there's a chance they won't be winning that money, it's generally insurable" he said.

Paradoxically, while prize indemnity payouts can help increase awareness of this specialty coverage, Mr. Brady said, insurers actually root against contestants because their wins can mean large losses for the underwriters.

Cost considerations

As in all kinds of insurance, the cost of coverage depends on a number of factors, especially the probability of loss.

Another key factor involves the implementation of the rules of the game. For example, will a contestant participating in a half-court basketball shot know about his or her participation ahead of time? If the person knows in advance, the sponsor would have to pay more for the insurance, because the person likely will have practiced before the contest, Mr. Brady said.

Event security is another important issue in determining whether an insurer will write a risk and how

much premium will be charged, observers note. For contests with potentially large payouts, insurers will either monitor the contest—in person or via videotape—or insist that an independent risk adjuster oversee the contest, to ensure that any insured contest is won legitimately.

Insurance premiums for a \$1 million prize could range anywhere between 1% and 20% of the prize value, depending on these variables, observers say. And minimum premiums often apply. AIG Programs, for example, would not consider writing a policy for less than a \$500 premium, Ms. Fellrath noted.

Prize sponsors usually purchase coverage for prizes valued at \$1 million or more, but prizes below \$100,000 also can be insured, observers say. Capacity is usually available for large prizes, although brokers often have to seek coverage in multiple markets and clients sometimes pay a capacity premium.

"If they're keeping it under \$1 million, there's usually not a problem," Mr. Robinson said.

AIG Programs will generally write up to \$1 million but will consider higher risks based on certain characteristics, such as whether the participant has one shot or multiple shots to win the prize, Ms. Fellrath said. "Terms and conditions can be changed if we are comfortable with the underwriting of the particular risk," she said.

As with other types of insurance policies, there are exclusions featured in prize indemnity policies designed to make it difficult to trigger coverage. Aon's Mr. Brady cited an example in which a beverage company sponsored a promotion for a half-court basketball shot worth \$1 million. The young fan who participated in the contest made the shot. However, the policy excluded people who played high school basketball, and the insurer denied coverage. The sponsor ultimately decided to pay the young fan himself. "It was out of their pocket, so the insurance didn't work," Mr. Brady said.

PHOTO: ZUMA PRESS



Skill games, such as professional football, present nonstatistical indemnity risks, where the probability of loss cannot be determined mathematically, and generally are harder to insure in the commercial market.

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Hole-in-one contests are popular but hard to insure if skilled golfers play.



Some employers with corporate aviation risks have found workers comp coverage hard to land.

Aviation: Comp cover for corporate jet crews

Continued from page 10

compensation" deductible, so its insurers do not scrutinize its aviation workers any more than they do other employees, said Lance Ewing, Caesars' vp-risk management.

Regardless, Caesars' risk management measures ensure that its pilots abide by federal requirements for physical and eye exams. It also purchases additional life and accident policies for its flight crews because workers comp death benefits are negligible in some states, Mr. Ewing said.

Some employers, though, form separate legal entities for their air

crews and insure them through captives, Mr. Ewing added.

Still other employers, those with guaranteed-cost programs, turn to state markets of last resort when insurers want to exclude their flight employees, sources say. But some of those markets insure workers comp aviation risks only when they write an entire corporate entity, Mr. Weinkauff said.

United States Aircraft Insurance Group is among the few specialty insurers writing workers comp coverage for corporate flight staff when they are carved out of employers' standard policies. It is a pool with

several insurer members, including General Reinsurance Corp., Hartford Fire Insurance Co. and Liberty Mutual Insurance Co.

USAU, the entity that Mr. Welbourn works for, underwrites risks submitted to USAIG and carries out all other insurance administration functions such as claims handling. USAU is a joint underwriting authority working on behalf of the pool, Mr. Welbourn said.

In addition to a wide variety of workers comp programs, such as those for cargo companies and offshore helicopter operations, USAIG provides other aviation-related cov-

erages such as airport liability policies, manufacturers' liability and satellite risks.

But with few workers comp markets writing coverage for corporate flight crews for employers with guaranteed-cost programs, aviation brokers approached American International Group Inc. to consider providing the coverage, said Steve Blakey, president of AIG Aviation Inc.

In August, New York-based AIG announced its aviation unit would offer such a specialty workers comp policy. AIG is targeting two market segments: crop duster operators, such as those to which the insurer already sells liability and hull coverage; and small to midsize corporate flight departments with three or fewer aircraft, Mr. Blakey said.

AIG announced this month that it is expanding the coverage to include risks associated with fixed-based operators at private, community, or city-owned airports. Fixed based operators provide services and amenities such as hangar space, fueling and maintenance for corporate and personal aircraft (see story, page 26).

Some guaranteed-cost insurers that carve out workers comp coverage for flight crews also exclude workers comp coverage for any employee who flies aboard the corporate aircraft whether or not he or she is a flight crew member, sources say. AIG will not provide coverage in those instances, Mr. Blakey said.

But USAIG will, Mr. Welbourn said. Buying coverage for those situations, though, is expensive because of the risk concentration factor, sources say.

"Where the primary workers comp carrier doesn't want any of the aviation exposure, that does get costly, because we have the possibility of not two or three but nine or 12 employees aboard one aircraft," Mr. Welbourn said.

It is difficult to say just how expensive it is to insure such "peak exposures," because USAIG often needs to make separate reinsurance arrangements for each such risk, Mr. Welbourn said. So until it markets each specific account, the insurer can't say what the pricing will be, he explained.

In contrast to insuring small corporate flight crews under guaranteed-cost programs, large, commercial airline clients tend to maintain multimillion-dollar deductibles and can find competition for their accounts, the aviation experts say.

The overwhelming concern for insuring airline accounts stems from the concentration of employees that are likely to be aboard a large jetliner in an accident, ACE's Mr. Mattheessen said. In addition, airline companies continue to be viewed as a terrorism target and travel overall could be affected adversely by terrorism, Mr. Mattheessen added.

"So you have to underwrite not only the underwriting risk but also the financial risk involved," Mr. Mattheessen said. Otherwise, ACE prices the risk by looking at issues such as loss history, the number of flights an airline might undertake and their safety practices, he said.

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Specialty risk group is building on past success

North American Contingency Assn. grows from social event to annual conference

By MICHAEL BRADFORD

History has proved that small gatherings of insurance professionals can grow to become influential organizations in the marketplace.

Consider the crowd at Edward Lloyd's coffeehouse in London in 1688, for example. What began there has blossomed into the world's most recognizable insurance marketplace, Lloyd's of London, which, coincidentally, now is

housed in a gleaming tower that some liken to a giant coffee percolator.

Or, how about the National Insurance Buyers Assn.? Created in 1950, its name was changed to the American Society of Insurance Management five years later. Twenty years further on, in 1975, it was renamed yet again. Today, as the Risk & Insurance Management Society Inc., it has grown from a small group of insurance

buyers to a 4,800-member group that is the voice of risk management.

So, if history truly repeats itself, could the fledgling North American Contingency Assn. swell to become a specialty-coverage behemoth, hosting conferences with thousands of attendees and mind-numbing three-hour educational sessions?

Probably not. But they intend to serve their market with the same

zeal as the big guys.

"We're not a very large market segment to begin with," said Aaron Ma, an account executive with Entertainment Brokers International in Los Angeles. NACA's annual conference, held in one form or another since 1998, "is one of the few chances people from around the world come together" to discuss matters of importance to the specialty insurance market, he noted.

"It's very difficult to get all these minds together at once," said Mr. Ma, who serves as NACA's secretary. "But when you do, it's really good."

NACA was established in 1998 by a few contingency insurance professionals who wanted to have an annual gathering to play some golf, get their hands around a few cocktails and share ideas. Fewer than 40 attendees made it to Dallas for that meeting. Attendance at the 1999 meeting in Toronto swelled to 65.

The following year, NACA added an educational component to the conference, while, as its Web site points out, "maintaining the ever-important social aspect of the event." Attendance grew. In 2001, the annual meeting was held on Cape Cod, Mass., and the response told organizers that they were on to something.

"We started to see it really come

NACA's conference 'is one of the few chances people from around the world come together' to discuss matters of importance to the specialty insurance market.

Aaron Ma
Entertainment Brokers
International

together," said Scott La Croix, NACA's president and director of underwriting at Insured Creativity Specialty Brokers Ltd. in Winnipeg, Manitoba. "We were really organized and getting good attendance."

Encouraged, NACA's organizers decided to bring more formality to the group by making it a nonprofit organization. "Whereas it was mostly social, now it's an educational conference as well as a great opportunity for brokers to network with the insurance market," said Mr. La Croix.

Attendees, who numbered around 100 at last year's meeting in Las Vegas, now include adjusters, accountants, attorneys and others with ties to the insurance market and the brokers and underwriters who traditionally have come to the meeting. While there's a larger educational component to the meeting these days, a click on the conference link at the group's Web site, www.nacaonline.com, proves that the social aspect of the conference has most assuredly been kept sacred.

NACA's membership is made up of about 45 corporate members, each of which is permitted to name up to 10 of its employees as individual members.

Everyone who's anyone in the contingency insurance market is at the conference, said Steve Perlini, NACA's vp and an assistant vp at ASU International Inc., a managing

Continued on next page



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Product development requires appetite for risk

Despite careful planning and development, some specialty coverages still fail

By RUPAL PAREKH

From inception to launch, developing specialty products in the insurance business is a multi-faceted process that requires extensive research, marketplace savvy, and most of all, the willingness to take a chance.

Ideas for new coverages are born within as well as outside of insurance companies. Some insurers appoint formal product development teams, others rely on cus-

tomers and brokers to identify coverage gaps, others glean ideas from competitors and some specialty programs emerge out of new legislation.

The time it takes to convert a concept into an insurance product, and ultimately introduce it into the marketplace, varies and can take anywhere from one month to a year. And even after much forethought is poured into new policies, specialty products sometimes still flop.

Product development in the insurance industry is in many ways similar to product development in other industries. "The steps you go through are almost identical to any manufacturing process," according to Teri Taylor, product development leader at Kansas City, Mo.-based GE Insurance Solutions Inc.

Insurance product development does, however, present some challenges that are not necessarily common in other industries due to the

"the intangibility of insurance," said Tom Brown, vp-product management at Hartford, Conn.-based Hartford Financial Services Group.

Idea generation

"We have a full-blown formal process that really starts by listening to the customers," Mr. Brown said.

Hartford has established two separate teams of employees dedicated to product development—one for mid-to-large segment business, and

another for small businesses—that work on creating new policies in the general liability, property and marine lines, among others. In the mid-to-large segment, which Mr. Brown oversees, six employees are devoted to product development.

"The first step is idea generation," said Mr. Brown. "The customers know what they need, they know what they are missing, so that's where all the best ideas come from."

Hartford's recent revamping of its ocean cargo policy, for example, was demanded by the insurer's customers. In addition to coverage for damaged and refused shipments, and protection for perishable goods, the revised policy includes a technology component allowing customers and agents to access

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Chris Brisbee trusts this officer's ability to apprehend a hidden perpetrator with the help of a FLIR Scout hand-held infrared imaging device. He's also secure in knowing his agency won a bid to provide directors & officers liability coverage for FLIR, but only if a certain insurer was involved.

"RLI had already provided an excess layer for FLIR Systems' D&O coverage," Brisbee said. "Our willingness to bring RLI to the forefront for the coverage is what differentiated us from the competition."

RLI earned the respect of Woodruff-Sawyer. "I've dealt with RLI for about eight years," Brisbee continued, "specifically with Blake Rea, and I've always been impressed by his integrity — vital for this kind of coverage. Integrity works hand in hand with his respect for us and for our customer. Blake goes the extra mile to understand what everyone's needs are and he maintains an open line of communication. It's no wonder that my company's relationship with RLI is one built on great mutual respect."

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'The first step is idea generation. The customers know what they need, they know what they are missing, so that's where all the best ideas come from.'

Tom Brown
Hartford Financial Services Group

ocean cargo certification forms online.

Specialists in various industry groups, such as financial services, construction, and the educational field have also been appointed by Hartford to look out for new coverage needs and bring back ideas to the product development team.

Hartford is also developing other strategies to spawn products. Later this year it will begin using "virtual networks" to generate ideas, Mr. Brown said, in which a combination of producers, brokers, agents, clients and other experts will participate in meetings via the Internet to explore new product possibilities.

"Product development can be the 'geeky' side of insurance," Mr. Brown said, "but we try to make it fun."

At GE Insurance Solutions, new product ideas are sparked in several ways. The company regularly conducts market research, keeps close tabs on products being introduced by competitors and uses statistics from its claims department to pin-

Continued on next page

Continued from previous page
point new opportunities.

In addition, "We do active idea generation within the company," said GE's Ms. Taylor. Employees are encouraged to brainstorm ideas and are invited to play creative games that may yield concepts for new specialty products. Using these methods, GE has a consistent supply of ideas, which are then entered into an "idea repository" for possible new products, she said.

"We have over 200 ideas in the repository currently," said Michele Weigand, global new product introduction leader at GE Insurance Solutions. From time to time, GE will go back and review the ideas in the repository. "As market conditions change, an idea that wasn't a good idea before is suddenly a good idea," Ms. Weigand said.

Developing the concept

Once an idea is chosen, it must pass a series of "toll gates" before entering GE's book of business. The first toll gate involves garnering a team of employees from different departments, such as marketing and actuarial, to help build the product. The next is referred to as "the heavy lifting period," during which underwriting and a financial analysis of the new coverage is completed. Toll gate number three is where the policy forms are drafted and the product is launched in the market, and the final toll gate is a post-launch incubation period of one year during which the product is monitored and audits and risk reviews are conducted.

The length of the product development process differs depending on the complexity and novelty of the coverage. "Our shortest launch has been about 60 days," Ms. Taylor said, while the longest has been close to a year.

Legislative changes also create a need for new coverages.

When the federal Support Anti-Terrorism by Fostering Act began being enforced in late 2003, Boston-based Lexington Insurance Co., the excess and surplus lines unit of American International Group Inc., was quick to respond with a new set of related coverages.

"There was legislation put forth by Congress to encourage technology companies to develop anti-terror technology," said William Mihalke, assistant vp and director of product development, and Lexington developed insurance "to help the market meet its needs."

Within months Lexington unveiled the SAFETY Act Homeland Protector program, which offers product and professional liability insurance with limits of up to \$25 million to technology companies deployed by the U.S. Department of Homeland Security to defend against, or recover from, acts of terrorism.

"The insurance was framed within the context of the act," Mr. Mihalke said.

Whether a product is introduced on admitted or nonadmitted paper usually depends upon the industry for which the insurance product is created, and the nature of the competition already existing for that particular business class.

"If all of your competition is writ-

ing on an admitted basis, you will not succeed on a nonadmitted ba-

'If there is one key to having a successful product launch, it is to listen to what the customer needs.'

*Paul Springman
Markel Corp.*

sis," said Chris McGovern, a vp and head of the national specialty program unit of Hunt Valley, Md.-based All Risks Ltd., a national wholesale broker and managing general agent.

Shifting business from the stan-

dard to the surplus lines market is also difficult, Mr. McGovern pointed out.

When an agent pitched a specialty program for Masonic lodge insurance to GE, the insurer felt comfortable enough to issue the product on an admitted basis from the outset. Although the product has only been on the market for one year, GE is already planning to add additional lines of business to the program after it exceeded company expectations. The program provides general liability and property coverage to more than 4,200 Masonic associations and resulted in \$10 million in gross written premium.

Unless companies have a strong client base and loss history, in softer phases of the market cycle, "issuing

carriers and reinsurers that provide capital support on the back side are typically very leery of coming into the market" for new products, Mr. McGovern said.

Market opportunities

The good news for 2005 is that existing specialty insurance programs will likely see better take-up rates, as specialty risks are more appealing to insurers and brokers during a soft market, observers say.

"If there is one key to having a successful product launch, it is to listen to what the customer needs," said Paul Springman, executive vp of Richmond, Va.-based Markel Corp., which tailors insurance poli-

cies for everything from horse farms to martial arts schools.

Mr. Springman, who is also a former president of the Kansas City, Mo.-based National Assn. of Professional Surplus Lines Offices Ltd., stressed that "Insurance products cannot develop in a vacuum."

However, "If the take-up rate isn't very good, you have to ask yourself why, and then go back and try to remedy that," Hartford's Mr. Brown said. And, if problems with the product do not show signs of improvement after some time, insurers should not feel compelled to hold on to them.

"We have pulled products before and we'll probably do that in the future," he said, "because not every product is destined for glory."



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ABA Insurance Risk Management Annual Conference

Experts ponder what happens after TRIA expires

By MICHAEL BRADFORD

ST. PETERSBURG, Fla.—Property owners relying on the terrorism insurance coverage that insurers are required to offer under the Terrorism Risk Insurance Act had better start thinking about an alternative to the government-mandated coverage because it won't be around for much longer, a terrorism insurance expert contends.

"It is unlikely the government will remain involved in the terrorism insurance market," said

William E. Wise, vp specialty products with ACE USA in Philadelphia. Insurers are required to make the coverage available through this year, but ACE is betting that beyond that date the TRIA coverage will no longer be a solution to property owners' terrorism exposures, he said.

"Our government affairs office has told us to make all plans, move full speed ahead, TRIA will not be renewed," Mr. Wise said. He made his remarks during a panel discussion at the American Bankers



'Our government affairs office has told us to make all plans, move full speed ahead, TRIA will not be renewed.'

William E. Wise
ACE USA

Assn.'s Insurance Risk Management Annual Conference in St. Petersburg, Fla., last week.

Buyers need to make some quick decisions about their terrorism exposures, Mr. Wise suggested. He said many need to educate themselves on the risk and what can be covered.

Even if TRIA were to be extended, "most don't understand its value anyway," Mr. Wise said. "I can't tell you the amount of conversations I've had this year with potential buyers" who didn't understand that TRIA coverage does not apply to acts of domestic terrorism even though the exclusion is clearly stated in the act, he said.

"It's a very complex act to understand," Mr. Wise acknowledged, but "you, as a buyer, need to know what you're covered for."

ACE is issuing conditional endorsements on property policies that have coverage periods extending into 2006 and that require the insurer to return partial premiums to policyholders after Dec. 31 if the act is not extended, said Mr. Wise. "ACE will exclude terrorism on all property-related risks going forward if TRIA is not extended," he added.

The insurer does have, though, a "stand-alone terrorism unit in place and that will remain," Mr. Wise said. "We will not impose any conditional endorsements on the stand-alone terrorism unit, and we are formulating a supplement right now, as we speak," to cover terrorist attacks involving biological and chemical weapons, he said. Losses from events involving nuclear weapons will not be covered by the supplement.

Anne K. Anderson, practice leader in the national property practice at brokerage Palmer & Cay Inc. in New York, said most insurers have not revealed how they will react to an expiration of TRIA. Speaking as a panelist at the ABA meeting, she said, "Unfortunately, it's going to be a wait-and-see kind of approach."

"It's really quite shocking and amazing that this kind of snuck up on everybody at the end of the year," Ms. Anderson said. "The first couple of weeks of the year...there really wasn't any kind of response from the market."

Ms. Anderson said the insurance market now finds itself "right back where we were three years ago, with an inconsistent approach by the market to a major coverage issue, especially for financial institution buyers."

She said property owners should be aware that most insurers will act as ACE has done and add to policies "some type of conditional notice that gives them the ability to add a terrorism exclusion at Dec. 31" regardless of whether the policy actually expires after that date "if TRIA in fact does expire. If you have multiple carriers on your property program, you will have variations on these endorsements, and you will have potential nonconcurrences of coverage throughout your program.

See TRIA/next page

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ABA Insurance Risk Management Annual Conference

D&O suits increasingly seek to tap personal funds

By MICHAEL BRADFORD

ST. PETERSBURG, Fla.—Recently announced directors and officers liability settlements that require outside directors to contribute their own funds may signal the start of a new aggressive litigation strategy, a panel of experts suggests.

In two recent cases, directors of Enron Corp. and WorldCom Inc. agreed to fund class action securities settlements partly with their own money. In the Enron case, 10 outside directors contributed \$13 million of their personal funds. The same number of directors agreed to give up \$18 million in the WorldCom settlement; however, that settlement later unraveled after other defendants in the case objected to some details in the settlement agreement (BI, Feb. 7).

"These settlements, obviously, have sparked tremendous debate and concern over whether these are going to be trends moving forward with securities-transaction litigation," said Jill M. Levy, an associate with the New York-based law firm of Boundas, Skarzynski, Walsh & Black L.L.C. Ms. Levy was speaking during a panel discussion at the American Bankers Assn.'s Insurance Risk Management Conference in St. Petersburg, Fla., earlier this month.

It is too soon to judge whether a trend to seek payments from directors' personal assets is underway,

said Joseph Caruso, senior vp with American International Group Inc. in New York. But, he said, it is possible that a new aggressiveness by institutional investor plaintiffs and the proposed settlements by directors at Enron and WorldCom could lead to further "personal liability in these types of class actions."

Ms. Levy said that there is an emergence of "institutional plaintiffs" such as pension funds in D&O suits, which "historically have taken much more of a back seat and over the past several years have

'These settlements, obviously, have sparked tremendous debate and concern over whether these are going to be trends moving forward with securities-transaction litigation.'

Jill M. Levy
Boundas, Skarzynski,
Walsh & Black L.L.C.

shown an interest in becoming significantly more aggressive."

Some institutional investors are "taking lead plaintiff roles and attempting to not only hold directors and officers personally liable in incidents of fraud but also are looking to effect corporate governance changes," she said.

Evan J. Rosenberg, senior vp with Chubb Corp. in Warren, N.J., and a panelist in the discussion, said that "there's a much larger political agenda that's going on" with regard to institutional investors and state

attorneys general who are pursuing directors and officers.

"There's a whole new level of that type of litigation, the aggressiveness, because there are other things that people want to achieve" in bringing the suits, said Mr. Rosenberg, referring to the political ambitions of some of the attorneys general who are involved in litigation against companies and their directors and officers.

But despite the added aggressiveness of plaintiffs and prosecutors

See D&O/next page

TRIA: What will follow?

Continued from previous page

Something to look forward to."

As for a post-TRIA terrorism insurance market, Mr. Wise said there are several options.

A facility such as Pool Reinsurance Co. Ltd., which handles terrorism risks in the United Kingdom, is one way to go, he said. "There's a lot we can learn from them," Mr. Wise said. But, he added, "I don't know how that one is going to fly," if a similar pool concept to cover terrorism risks is introduced in the United States.

As for the private market, Mr. Wise asked, "Are we going to be able to absorb the entire terrorism insurance marketplace?"

"There's a play here for the capital markets, quite possibly," he said. But buyers should understand that insurance products from that source could be quite different from what they are used to, he said, with insurers and capital markets defining the word "underwrite" in ways that are "very far apart."

Now is the time to have a backup terrorism insurance plan in mind, he advised risk managers, because "you are going to be asked the questions: 'What are you doing about TRIA? What are you doing about terrorism protection this year? If it expires, what is your fall-back plan?'"



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D&O: Suits try to tap personal funds

Continued from previous page and the proposed Enron and WorldCom settlements, courts do offer protection for the personal assets of outside directors in securities litigation, Ms. Levy said.

'What we have to put a lid on is severity. So far, nothing is working.'

*Evan J. Rosenberg
Chubb Corp.*

In a recent settlement reached by McKesson Corp. in a securities class action, the outside directors were dismissed from the case and the fraud charges against them dropped, she said. "So I think that when there is a lack of evidence of some type of egregious fraud, we can at least have some level of comfort that these institutional plaintiffs are not going to aggressively seek individual contributions in those circumstances," Ms. Levy said.

But despite some successful defenses, D&O claims are increasing in severity.

In an attempt to curb losses, insurers are pushing policyholders for

more information to help them underwrite the exposures, the panelists said.

There has to be a way to "stem the trends" of multimillion-dollar D&O awards, said Mr. Rosenberg. While the frequency of D&O claims is unlikely to change, "what we have to put a lid on is severity," he said. "So far, nothing is working."

"For us, the underwriting process" means "getting as much information as we can, getting access to the right individuals within the organization who are making decisions" and can answer sometimes pointed financial questions, said Mr. Caruso of AIG.

Roberta M. Nebel, senior vp and director of insurance management at Lehman Bros. in New York and moderator of the discussion, said that many risk managers "are baffled by the underwriting process" and accompanying requests for information that don't seem relevant.

It would be helpful, Ms. Nebel said, if risk managers knew why insurers needed some of the information they request. "I think if we understood the process better and the process was a little more streamlined, it would be helpful to us," she said.

ABA Insurance Risk Management Annual Conference

Industry pressures lead S&P to revise P/C earnings outlook

By MICHAEL BRADFORD

ST. PETERSBURG, Fla.—Commercial insurance rates are softening so fast that Standard & Poor's Corp. has changed one of its projections on insurer performance for this year.

The ratings service in December 2004 projected that, because of rate increases, insurers' earnings in 2005 would be as good as or better than last year's results, said Jason A. Jones, an associate director with S&P in New York.

But the way things have gone lately, that isn't likely, Mr. Jones said during the American Bankers Assn.'s Insurance Risk Management Conference in St. Petersburg, Fla., last week.

"The turndown in rates is now fast enough that we believe the combined ratio in '05 will increase over '04," he said.

The increase will be small, "but still a move in the wrong direction," Mr. Jones said. "And we also believe that premiums will remain more or less flat."

Commercial property/casualty

prices have fallen about 7% in the current quarter, so far, compared with the same period last year, he said.

The softening is occurring at a time of increased competition among property/casualty insurers, some of it coming from new mar-

tinuing investigations by New York Attorney General Eliot Spitzer and others.

"There is such heightened scrutiny of this industry that the practices that were acceptable in the past are coming into question for the first time," Mr. Jones said.



'There is such heightened scrutiny of this industry that the practices that were acceptable in the past are coming into question for the first time.'

*Jason A. Jones
Standard & Poor's Corp.*

ket entrants, according to Mr. Jones.

He went on to say that S&P continues to hold the negative outlook on the property/casualty insurance market that it set last October mainly because of a few industry pressures, one of which is the con-

"Some of them may involve genuine wrongdoing, but many of them involve gray areas where regulators and attorneys general may tighten the reins a bit."

With regard to investigations into commission dealings between

Continued on next page

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Continued from previous page

brokers and insurers, Mr. Jones pointed out that the New York attorney general is not the only one issuing subpoenas. Regulators and attorneys general in many other states are following Mr. Spitzer's lead, he said.

"Nearly every company I cover as an analyst has been subpoenaed. At this point, they're a dime a dozen."

S&P is attempting to determine if there are unique features to the subpoenas, which generally focus

'Nearly every company I cover as an analyst has been subpoenaed. At this point, they're a dime a dozen.'

*Jason A. Jones
Standard & Poor's Corp.*

on suspicions of bid rigging or wrongdoing as part of service agreements between insurers and brokers, Mr. Jones said.

"Unfortunately at this point, it's very difficult to tell," because the subpoenas have all been filed recently rather than as part of ongoing investigation, he said.

Finite reinsurance transactions also are drawing some legal scrutiny, Mr. Jones said. "The opacity of finite contracts tends to draw attention," he said.

Thanks partly to finite reinsur-

ance contracts involving Enron Corp., "there is some concern that something is being hidden here" within such deals, said Mr. Jones.

While it is possible that some finite reinsurance is being written for less-than-legitimate reasons, the majority of contracts are genuine, he said. "It's just a matter of people in the market understanding what finite reinsurance does. And, unfortunately, it's very complex," he said.

It is too early to tell how Marsh Inc.'s agreement to pay \$850 million and apologize to its clients will affect the marketplace, Mr. Jones said last week. "Certainly, it could remove some of the uncertainty," he said.

But, given the "downward pricing trends and the uncertainty of the investigations," S&P's negative industry outlook will remain for the time being, Mr. Jones said.

The property/casualty market also suffers from what Mr. Jones called "inertia in Congress."

The Terrorism Risk Insurance Act is scheduled to expire at the end of this year, and "there is nothing on the table to replace it," he said.

There is, though, the possibility that Congress could make some moves regarding tort reform this year, which would be a positive development for insurers, according to Mr. Jones.

If some type of federal class action reform is passed, it could potentially be the most beneficial re-

form Congress could pass for insurers, Mr. Jones suggested.

"The primary effect there would be to take cases that are in state jurisdictions and put them under federal jurisdiction," he said.

State courts generally have been more willing than federal courts to make large judgments, he said. And

moving class actions to federal jurisdictions could put a halt to frequent venue shopping by plaintiffs looking for favorable juries, Mr. Jones said.

"With everything going up to the federal system, it should reduce the number of mass tort class actions," he said.

Meetings offer chance to rap

ST. PETERSBURG, Fla.—Some who attended the American Bankers Assn.'s Insurance Risk Management Annual Conference & Meetings had a brush with celebrity at one of the conference hotels.

Apparently en route to a Super Bowl benefit he had planned in Jacksonville, Fla., last weekend, rap and hip-hop artist Snoop Dogg was seen in the halls of the Don Cesar Beach Resort, the overflow hotel for guests at the conference.

The entertainer was not spotted, however, in any of the ABA sessions, which covered emerging issues in risk management, the directors and officers liability

insurance market, handling fidelity bond claims and other topics the rapper was unlikely to consider necessary for his appearance at the game.

The conference, which was held Jan. 30-Feb. 2 at the Renaissance Vinoy Resort & Golf Club in St. Petersburg, Fla., drew record attendance with about 550 attendees.

The next conference is scheduled to be held at the Hyatt Grand Champions Resort & Spa in Indian Wells, Calif., Jan. 29-Feb. 1, 2006.

More information is available from the ABA by visiting its Web site at www.aba.com or by telephoning 800-226-5377.

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AIG Aviation expands specialty comp offering

NEW YORK—AIG Aviation Inc., a subsidiary of American International Group Inc., has expanded its specialty workers compensation program to include



fixed-base operators, which are service centers providing catering service, fueling, hangar space, maintenance and ramp service for corporate and personal aircraft. It covers private, community, municipal and city-owned FBOs.

The program is an expansion of the company's small and middle-market corporate flight department workers compensation program. In addition to FBOs, the program covers aerial applicators.

The limits for workers compensation are statutory, and the employers liability limit is \$1 million.

For more information, contact Kevin Shinn, underwriter in the Atlanta office, at 404-249-1829 or at kevin.shinn@aig.com.

Best enhances directory of attorneys, adjusters

OLDWICK, N.J.—A.M. Best Co. Inc. has enhanced the 2005 edition of "Best's Directory of Recommended Insurance Attorneys and Adjusters" by adding three categories to the Expert Service Provider section, which allows users to search for professional experts in various fields.

The 2005 edition of the directory now features listings for third-party administrators, electrical contracting experts and solar energy experts. The directory contains listings for 5,300 law firms and 2,600 adjusting offices and has 46 professional expert categories.

The directory also features a digest of insurance laws for all states and Canadian provinces and the names of legal and claims officials, insurance company groups and fleets, among other information. It is available in print and online.

For more information, contact the Oldwick, N.J.-based Best at 908-439-2200, ext. 5742, or visit www.ambest.com/legal.

The Hartford expands water well coverage

HARTFORD, Conn.—The Hartford Financial Services Group Inc. has enhanced its WellGuard program, which protects companies that provide ground water to businesses, farms and homes.

The program has been expanded

to insure the manufacturers and suppliers of products for the well drilling industry. It also covers well drillers, pump installers, core drilling and test boring contractors and engineers and plumbing contractors supporting drilling operations.

Another addition is the supplemental property insurance coverage endorsement, which covers business personal property in transit or at unspecified locations. The endorsement provides higher limits for the theft of employee tools, now set at \$50,000. A sublimit is available for the coverage of stolen tools for each employee at \$5,000.

The WellGuard program is underwritten by The Hartford Financial Services Group Inc. and administered through Portsmouth, N.H.-based Willis Programs Practice. The available limits are \$1 million per occurrence and \$2 million aggregate. The available umbrella limit is up to \$15 million.

For more information, e-mail the Hartford, Conn.-based company at waterwelldrilling@thehartford.com or visit its Web site at www.thehartford.com.

Liberty Mutual offers online absence tool

BOSTON—Liberty Mutual Group has introduced LibertyOne View, a new database that intends to help benefit managers and risk managers better control the costs of employee absences.

The Boston-based company's online tool allows benefit and risk managers to capture, track and analyze disability, workers compensation and Family and Medical Leave Act coverages.

Claims information can be analyzed by type of benefit, diagnosis, employee age, gender, job type, location and tenure.

To obtain more information, contact Helen Sidney, marketing director, integrated disability management, at 617-654-4935.

AIG offers A&H products for smaller employers

NEW YORK—AIG Small Business and AIG Domestic Accident & Health divisions together are offering a line of accident and health insurance products for employers with 250 or fewer lives.

The accident and health offering includes voluntary accident coverage, basic accident coverage, special risk accident coverage, business travel coverage and vision care. The limits available for business travel accident coverage

are \$1 million principal sum and \$10 million aggregate; for special risk, \$1 million principal sum and \$1 million aggregate; for basic and voluntary accidental death or



dismemberment, \$1 million principal sum.

For more information, contact Thomas Dassow, vp-AIG Small Business A&H in Jersey City, N.J., at 908-679-3574 or at tom.dassow@aig.com.

million, and coverage is available in all states, excluding Arkansas, California, Louisiana, Minnesota, Nebraska, Texas and Wyoming.

To learn more, contact Lori Kee, program manager, at 301-961-9835 or visit Schinnerer's Web site at www.schinnerer.com.

Professional liability cover for care administrators

ANNANDALE, Va.—The Lighthouse Cos., a program underwriting company, has developed a personal professional liability policy for health care administrators.

The VitalCare policy offers a layer of protection above the employer's medical professional liability policy. It is written for the personal protection of the administrator and provides coverage in cases such as being named as a defendant in a negligence claim covered by the employer's medical professional liability policy.

The policy is underwritten and issued by the Chubb Group of Insurance Cos. The coverage extends up to \$1 million per claim and per policy year.

For more information, visit the Web site of the Annandale, Va.-based Lighthouse Cos. at www.lighthousecompanies.com.

HIP of New York offers consumer-driven plan

NEW YORK—HIP Health Plan of New York has introduced a consumer-driven health plan for employers.

The program, myFund, includes a health reimbursement account which includes funds set aside by employers to reimburse employees for qualified medical expenses. All unused funds in the HRA can be rolled over at the end of the year.

The HRA is paired with a high-deductible health plan, and the company offers the HIP Select Exclusive Provider Organization or Preferred Provider Organization choices.

For more information, contact the New York-based company at 800-447-8632 or visit HIP's Web site at www.hipusa.com.

We'd like to report on new risk management and employee benefit products and services offered by your company. Send information about your new offerings to: Carrie A. Peinado, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; telephone: 312-649-5313; fax: 312-649-7801; e-mail: cpeinado@businessinsurance.com.

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Schinnerer adds to D&O program

CHEVY CHASE—Victor O. Schinnerer & Co. has added stand-alone fiduciary coverage to its Not-for-Profit D&O program portfolio, which intends to protect against fiduciary risks such as Employee Retirement Income Security Act lawsuits.

The Chevy Chase, Md.-based company's policy offers fiduciary coverage for any employee acting as a fiduciary on behalf of his or her organization. Employees acting as a fiduciary may include directors, officers and human resource personnel. The program is intended for not-for-profit organizations, including agricultural cooperatives, civic organizations, cultural centers, museums, historical societies and water authorities, among others.

The available limits are up to \$2

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'Decision support tools' aid employees in making informed choices in consumer-driven health plans

By RUPAL PAREKH

As companies increasingly incorporate consumer-driven options into their health plan offerings, the responsibility of making major health care decisions is shifting from the employer and onto the employee. To foster informed choices, employers and health plans are making available a host of "decision support tools" that have the ability to gauge the cost and quality of care.

According to a survey by Deloitte Consulting L.L.P. of 350 benefit managers released last month, 72% of the employers surveyed will place more emphasis on consumerism for their employee health programs in 2005. Eighty-five percent of those surveyed have either improved or will focus on improving communication with employees about their health care.

"The need for communication tools is driven by change," said Cathy Tripp, national practice leader for health and welfare technology at Watson Wyatt Worldwide in Minneapolis. "When employers are disrupting the health care plans of all their employees, they feel the obligation to explain that," said Ms.

Tripp, who has helped numerous companies design and implement consumer-driven plans.

In contrast to managed care, which limits employee involvement, consumerism requires workers to control their own use of and payment for health care services. Consumer-driven plans, consequently, are more challenging for workers to decipher, benefit managers say.

"It's a brand-new concept and it's a brand-new approach, so it usually takes a couple of times before people understand consumer-driven health plans," said Janice Pushaw, director of global benefits strategy at Benton Harbor, Mich.-based Whirlpool Corp.

Before the January 2004 unveiling of its consumer-driven plan—which is offered by Minneapolis-based Definity Health, a unit of UnitedHealth Group Inc.—Whirlpool spent several months preparing its employees for the changes to their health care benefits. As a result, the plan saw an initial participation rate of 40% among its workers, and one year later, enrollment has grown to 55% of employees.

"One thing we know for sure is

that the sooner you start the communication about the CDHPs, the higher your enrollment will be," Ms. Tripp said.

Help is on the way

According to Helen Darling, president of the Washington-based National Business Group on Health, there are three broad types of decision support that companies can offer to make workers better consumers of their own health care.

The most common form is "decision support at the once-a-year open enrollment," said Ms. Darling. "Almost everybody has it, and it's all online," she noted.

Whether built by health plan providers or purchased from technology providers off the shelf, these tools outline the various consumer-driven options available to employees and calculate cost-of-care comparisons. Setup fees for such tools range between \$20,000 and \$200,000 for midsize to large companies, consultants say, but once such tools are in place, their maintenance fees are nominal. While some employers choose to offer these tools solely before annual enrollment, others maintain them on-

line throughout the year, they note.

Louisville, Ky.-based health insurer Humana Inc. in November updated its Compare Hospital tool—which compares the costs for certain medical procedures at up to five different hospitals—to include an out-of-pocket expenses estimator for inpatient procedures. The new "consumer-focused enhancement" allows employees to obtain hospital-specific information concerning complication rates, lengths of stay and mortality rates, Humana said.

Beth Bierbower, Humana's vp of product innovation, noted that detailed cost-of-care information has not been available to employees in the past, mostly because the health care was employer-subsidized. "It's the third-party payer system that's really kept the lid on transparency," she said.

But the rise in the popularity of consumerist health care models is spurring some changes.

"Consumers are now ready for this information," Ms. Bierbower said. "I absolutely think you're going to see more and more of this information being offered to the consumer."

Cypress, Calif.-based PacifiCare

Health System's consumer-driven, or "self-directed," health plan was inaugurated in July 2003 and has an enrollment of more than 5,000 employer groups.

"As we started to roll out the self-directed health plan, one of the concerns employers had was that employees would be responsible for making decisions without knowing how much services cost," said Jeff Adams, PacifiCare's director of product development.

With the help of Waltham, Mass.-based Integrated Health Care Information Services Inc., a consultant and online solutions provider for the health care industry, PacifiCare in January unveiled the HealthCare Cost Estimator, an online tool that supplies cost information for 200 of the most common diseases, conditions and medical procedures.

IHCIS captures about three million records of claims data from health plans around the country and aggregates and averages them, so that members can obtain "a really accurate number for what care will cost if they are in network with PacifiCare or out," Mr. Adams said. "I think it's a real eye-opener for

See CDHP/next page

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PLUS 2005 D&O Liability & Insurance Issues Symposium

D&O insurers pressured by securities class actions

By RUPAL PAREKH

NEW YORK—Securities class action lawsuits are increasing in both frequency and severity, ensnaring a growing number of directors and officers, and placing more pressure on D&O insurance companies.

With a total of 212 securities class actions filed last year, corporate litigation was more active in 2004 year than in most years. The average rate of annual filings since the Private Securities Litigation Reform Act of

1995 was passed is 190 a year; and that rate has not done much in the way of helping the current backlog of hundreds of unresolved cases, according to a panel of D&O law experts.

"These are big numbers, and they're the tip of the iceberg," Tower C. Snow, a partner in the Palo Alto, Calif. office of law firm Clifford Chance USA L.L.P., said while speaking at the Professional Liability Underwriting Society's 2005 D&O Liability & Insurance Issues

Symposium held in New York earlier this month.

Mr. Snow moderated a panel discussion titled "Current Developments Shaping the Securities Litigation Landscape."

A total of 15 multibillion-dollar securities cases were filed in 2004, two of them suing for more than \$100 billion, according to a report by Menlo Park, Calif.-based Cornerstone Research and Stanford Law School in Stanford, Calif.

The top three industry sectors with the largest numbers of securities filings in 2004 were consumer noncyclical—such as food and beverage, agricultural and pharmaceutical companies—technology and communications. The three industries with the least liability expo-

sures last year were industrial, basic materials and utilities.

Auditors were named in 4% of cases, while stock underwriters were named in 1% of all cases filed last year.

William S. Lerach, a partner at Lerach Coughlin Stoia Gellar Rudman & Robbins L.L.P. in San Diego, identified several trends in securities litigation that the D&O community should expect in 2005.

One such trend is the rise in institutional investors filing individual nonclass actions as companion suits to class actions—even when the claims are practically identical to those brought in the class action.

Blockbuster class action cases such as those involving WorldCom Inc., Enron Corp., and AOL/Time

Warner have all been followed by multimillion-dollar private actions, and the Marsh & McLennan Cos. Inc. bid-rigging scandal will be no different, predicted Mr. Lerach. Despite the \$850 million settlement MMC reached with New York Attorney General Eliot Spitzer this month, "I guarantee there are going to be private actions there," he said.

The D&O market in 2005 should also expect to see the continuation of plaintiffs surmounting the safe harbor provisions of the Private Securities Litigation Reform Act of 1995 in order to bring corporate class action cases, Mr. Lerach said. The law is not shielding companies from liability, as 67% of all cases filed last year allege false forward-

See **SECURITIES**/page 30

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CDHP: Decision support tools

Continued from previous page

people," he said.

According to U.N. Amighi, regional director for IHCS, interest in informational health tools is growing fast. "Everybody's asking for the tools, more and more," he said.

Other avenues

Another avenue of decision support toward which employers are guiding their employees in consumer-driven plans is general health information about specific diseases, conditions and prescription drugs.

"Maybe two-thirds of large employers do that, and soon all will," said Ms. Darling.

Web sites that fall under this category are WebMD, which provides online education services for physicians and consumers, or Hartford, Conn.-based Aetna Inc.'s IntelliHealth site, which features consumer health information supplied by Harvard Medical School in

Boston, she said.

State governments are even jumping on the bandwagon, by way of legislation that requires the public disclosure of health statistics, to help consumers make more informed health care choices. To date, four states—Florida, Illinois, Missouri and Pennsylvania—have passed hospital infection reporting laws requiring that hospital-acquired infection rates be made available to the public each year.

In addition, the office of New York State Attorney General Eliot Spitzer has surveyed more than 1,000 pharmacies across the state to create a public Web site that lists and compares prices for the 50 most commonly prescribed drugs.

Beyond general health information, providing "direct, individualized decision support" is yet another form of assistance that employers can use to help make employees more informed consumers, said Ms. Darling. Offered by only a small percentage of providers, these tools provide employees with personalized feedback from medical professionals based upon each individual's medical history.

"We're using live interaction to customize solutions for our customers' health care," said Robert Corrigan, director of group health product management for Downers Grove, Ill.-based First Health Group Corp., which was recently acquired by Bethesda, Md.-based Coventry Health Care Inc.

First Health is making a push to offer what it calls "engagement-driven," rather than consumer-driven, health care, Mr. Corrigan said.

"On the Web, we have a lot of tools available like everyone else," he said. "But what we try to do on the Web is to find a way for members to interact with us."

For example, members can enter a live chat room to ask member services representatives health care questions. Also, Mr. Corrigan said, "we are the only health plan I know of that allows members to e-mail

our medical directors directly." And "we respond to 94% of our e-mails within 24 hours, and not with an automated response but with a real answer," he said.

Yet "the problem with some of the online tools is that we can't get everybody to use them," Mr. Corrigan said. "The phone for us has been magic." First Health offers live representatives to speak with employees about claims and referrals 24 hours a day or to connect members with nurses, with an average wait time of just six seconds.

And the trend toward the use of online health care resources shows no sign of slowing.

In a survey by New York-based MetLife Inc. last month of more than 1,500 human resources and benefits managers from a broad range of industries, 47% of the companies reported that they provided benefits information and enrollment options online for their employees in 2004, up from 38% in 2003.

Looking ahead, the employers said they expect continued growth in that area. Among the companies that currently lack online tools, 36% said they plan to add such capabilities to their benefits offerings over the next 18 months.

Watson Wyatt's Ms. Tripp predicts that as consumer-driven health plans gain ground over time, online health care tools will evolve to become more sophisticated—with the capability to perform advanced functions such as calculating the compounding effect of year-over-year benefit decisions.

Ms. Tripp pointed out, though, that "just because the tool's there, doesn't mean they're going to use it."

The most successful approach for both employers and employees, she said, is to use a combination of means to promote workers' understanding of their health care. "We think that using good communications, tied with Web tools, will drive participation in the consumer-driven plans," she said.

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Securities: Pressure on D&O insurers

Continued from page 28
looking statements.

Still another trend will see settlement amounts swell to even larger numbers, with suits seeking damages upwards of \$100 million becoming commonplace, Mr. Lerach said.

Going forward, there will be a strong effort on the part of shareholders and regulators to hold accountable directors and officers who have been engaging in misleading practices, "despite whatever insurance they have," according to Max W. Berger, a partner in New York law firm Bernstein Litowitz Berger & Grossmann L.L.P.

In turn, "I think we're going to be seeing expanding primary liability," Mr. Lerach predicted, with more directors, investment advisers and accountants being held legally responsible for corporate fraud in the future.

Jeffrey B. Rudman, a partner at Wilmer Cutler Pickering Hale & Dorr L.L.P. in Boston, added that the prospect of outside directors and officers being forced to make personal contributions to settlements—above and beyond insurance payments—"is terrifying people."

Mr. Rudman said that a growing body of people is saying "I really don't want to be a director anymore"—a trend that could seriously affect corporate structure in the United States.

The increasingly challenging securities litigation landscape for D&O insurers means that "the policies are going to be larger," Mr. Berger said.

Whether or not insurers will respond to meet the expanding D&O coverage needs of corporations and their executives remains to be seen.

But, there are some proactive steps currently being taken by regulators in the hopes of curtailing claims and litigation, the panel said.

More emphasis is being placed on corporate governance, for example, as the majority of securities class action settlements now contain clauses requiring mandatory compliance and ethics programs to be instated at companies, that can potentially prevent fraud-related litigation.

In addition, Joan E. McKown, chief counsel, Division of Enforcement, at the U.S. Securities and Exchange Commission in Washington, said that the SEC this year will adopt a new "risk-based investigation" initiative to protect companies and their insurers from securities litigation.

As part of the initiative, the federal agency will conduct probes earlier to "try to find out where problems might be," identify "potential liability" and then help resolve these issues before they can become a full-blown securities class action suit, Ms. McKown said.

PLUS D&O Liability & Insurance Issues Symposium

Most D&O rates fall despite increase in securities lawsuits

By RUPAL PAREKH

Despite a surge in new securities class action lawsuits and larger-than-ever claims, rates for directors and officers insurance in 2004 declined across nearly all sectors of the market.

Based on a study by New York-based consultant Advisen Ltd.—the results of which were first presented at the Professional Liability Underwriting Society's 2005 D&O Liability & Insurance Issues Symposium held in New York earlier this month—new filings increased by 17% over 2003.

The average cost of securities class action settlements jumped from around \$25 million to nearly \$33 million in the last year, and it has more than doubled in the past four years, from about \$15 million in 2000, Advisen said.

Heightened securities litigation activity did not prevent D&O prices in every industry sector from falling between 2003 to 2004, though. Decreases in median premium per \$1 million limits ranged from under 5% to more than 50% in 2004, according to the study.

Of the nine industries Advisen analyzed, building and construction materials experienced the smallest decrease, while telecommunications saw the largest decline in premium in 2004.

Financial services, technology, energy, health care, pharmaceutical and biotechnology, retail and utilities were the remaining industries.

Large public companies with revenues over \$1 billion enjoyed D&O rate decreases far larger than did smaller private companies with under \$100 million in revenues in 2004, Advisen found.

The study also said that pricing decreases varied by layer; primary rates fell moderately, low-layer excess rates were close to 2003 levels, and pricing in upper layers plummeted. D&O prices in some high excess layers in 2004 stood at less than half of what they were in 2003, Advisen said.

D&O continues to be a challenging line of business for insurers, due to poor returns and rising demand. By Advisen's estimates, 2004 will close with a combined ratio of 101.7% for D&O business and will generate a 10% return on allocated surplus.

Overall, insurers providing coverage in the primary and low excess layers will perform better for the year than will companies insuring high excess layers, Advisen predicted.

In addition to escalating claims severity and plunging rates, Advisen cited other discouraging trends for players in the D&O market.

Rapid property/casualty surplus growth is fueling competition and contributing to rate deterioration, Advisen said. New entrants in the market boosted capacity to record levels last year, from nearly \$350 billion in 2003 up to almost \$370 billion in surplus in 2004.

Advisen also estimates that the D&O sector is presently underinsured by more than \$1.25 billion.

The study, "The D&O Market in 2004," was based on the data from D&O programs at more than 15,000 companies in the United States.

Copies of the study are available free of charge to Advisen members, or for \$250 to nonmembers. For more information, call 212-897-4800.

Over 1,200 attend conference

NEW YORK—More than 1,200 people attended the 2005 D&O Liability and Insurance Issues Symposium, held Feb. 2-3 in New York.

Sponsored by the Minneapolis, Minn.-based Professional Liability Underwriting Society, the symposium

drew directors and officers liability specialists—including insurers, brokers and lawyers—

from all over the United States and abroad.

Sessions centered upon pressing issues and critical changes affecting the D&O marketplace, such as the uptick in frequency and severity of securities fraud litigation, current trends in the handling of complex D&O claims and the first-ever session offering a client's perspective on D&O liability.

In addition, PLUS this year will expand its event to the West Coast, where the PLUS D&O West Symposium will be held in San Francisco in September.

For more information, contact PLUS at 800-845-0778 or visit www.plusweb.org.



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Commentary

Are Spitzer's eyes on the top prize?

I ended my Jan. 3 column, which was basically an exercise in insurance-related science fiction, with a reference to the election of President Eliot Spitzer in 2008. As tag lines go, it was meant as a joke, albeit of the darkest possible kind for some in the insurance industry.

Mr. Spitzer, after all, has not announced any intention to run for president. As a matter of fact, he's still got more than 18 months before he will face the voters of New York—provided that he wins his party's gubernatorial nomination—as the Democratic candidate for governor of the Empire State. After that, it's still a couple of years until the next presidential election.

And if that were not daunting enough, a lot of bigger names in the Democratic Party appear to be in the process of positioning themselves for a 2008 run. For example, Massachusetts Sen. John Kerry hasn't ruled out a second shot at the White House, and his erstwhile running mate, former North Carolina Sen. John Edwards, has already been spotted in New Hampshire.

But a couple of things that have transpired of late may indicate that a 2008 Eliot Spitzer run for the White House is not totally out of the question.

One of those was Mr. Spitzer's Jan. 31 address to the National Press Club. During his speech, he made several comparisons between himself and Teddy Roosevelt as he spoke of busting cartels. Teddy Roosevelt became governor of New York in 1898, served two years and found himself vp of the United States after the election of 1900. Less than a year later, an assassin's bullet killed President William McKinley, and, by doing so, transformed Vp Theodore Roosevelt into President Theodore Roosevelt.

Now Mr. Spitzer didn't say that he wanted to be president, but politicians generally don't go out of their way to compare themselves with towering historic figures without a reason. But, with all due respect to the New York attorney general, Mr. Spitzer hasn't amassed quite the resume Teddy Roosevelt had before he reached the governor's mansion. President Roosevelt was, after all, a renowned author, federal administrator and war hero by the time of his gubernatorial election.

Still, many of those listening to Mr. Spitzer at that Press Club

luncheon couldn't help but wonder if the gaze he fixed on the audience wasn't really directed about three blocks due west on a certain white mansion. There can be no doubt that Mr. Spitzer is already a national figure, a state attorney general whose fame eclipses that of many governors and members of Congress.

Another indication that a Spitzer bid may not be categorically out of the question can be found on Mr. Spitzer's own campaign Web site, www.spitzer2006.com. In the Discussion section, supporters debate the pros and cons of a Spitzer presidential bid in 2008. Some of the participants counsel patience, urging that Mr. Spitzer

put off any run for the White House until 2012 or even 2016.

But there's also enthusiasm for a bid, the sooner, the better. One posting offers tips on how a 2008 Spitzer campaign could use the Internet and e-mails more effectively than did the Kerry campaign. Another goes so far as to suggest a running mate for Mr. Spitzer:

"I think President Eliot Spitzer and Vp (Barack) Obama are just what this country needs. They are far more qualified (than) the current imposters in the White House. Too bad we have to wait four more years." Barack Obama is the new senator for Illinois, who has disavowed any 2008 presidential ambitions.

The Spitzer Web site simply provides a forum for those supporters who believe the attorney general ought to be considering what happens after the governor's mansion even before he gets there. What's intriguing about it, though, is that some of the postings date from almost immediately after last November's election, indicating that some voters had been thinking about him even before the Kerry defeat.

I personally think that a 2008 Spitzer run is a long shot right now, although something farther up the way is a definite possibility if he becomes New York's next governor. Still, I'm old enough to remember that at this time in 1973, a Jimmy Carter presidential bid seemed like nothing more than a joke, and a not particularly funny one, either. For many in the insurance industry, Mr. Spitzer's plans may provide little to laugh about, either.

Senior Editor Mark A. Hofmann can be reached at mhofmann@businessinsurance.com.



Mark A. Hofmann

Britney spears her insurers in suit over tour cancellation coverage

NEW YORK—Insurers have wrongly denied a \$9.8 million event cancellation claim filed by Britney Spears after a knee injury forced her to cancel a concert tour last year, the pop star contends.

In a lawsuit filed in a New York state court, Ms. Spears contends that insurers should have known about an earlier injury to her knee that underwriters say should have been disclosed when the 2004 event cancellation policy was written.

The insurers also should not be permitted to deny the claim based on her participation in a video shoot where she sustained the knee injury that led to the cancellation the 2004 Onyx Hotel Tour, which was to have included concerts in Canada, the United States and Europe, the suit says.

The eight insurers named in the suit had issued cancellation coverage for the tour that would pay \$380,000 per show, subject to a \$760,000 aggregate deductible and total indemnity limits of \$26.7 million, court papers say. The premium

charged for the coverage was \$1.3 million.

However, the insurers denied coverage, saying that Ms. Spears failed to disclose a 1999 knee injury on a medical questionnaire when she purchased the coverage.

Ms. Spears contends in the lawsuit that some of the same insurers had provided similar coverage for her tours in 2000 and 2002 and that she disclosed the knee injury to insurers when she purchased those policies.

The pop star also contends that the insurers cannot deny coverage based on their assertion that, in light of earlier knee injuries, it was imprudent for Ms. Spears to have participated in a 2004 video shoot in which she injured her knee and required surgery. It was the second time in 2004 that she had injured the knee.

The insurers named in the suit are Liberty Syndicate Management Ltd., QBE International Insurance Ltd., Markel International Ltd., Beazley Furlong Ltd., Talbot Underwriting Ltd., Great Lakes Reinsur-

ance UK (PLC), and SR International Business Insurance Co. Ltd., which are all based in London, and Paris-based AXA Corporate Solutions.

A spokesman for Liberty, which along with AXA wrote the largest share of the risk, refused to comment. An AXA spokesman could not be reached for comment.

—By Roberto Cenicerio



A knee injury led pop singer Britney Spears to cancel a tour.

PHOTO: PHOTOGRAPHERS SHOWCASE

Crisis management deadline nears

Business Insurance will publish its online Directory of Crisis Management Consultants in conjunction with the March 21 issue. That issue will include a Spotlight report on terrorism and crisis management.

The directory is published as an editorial service and there is no charge to be included. Companies simply submit a completed ques-

tionnaire by the extended deadline of Feb. 25.

Business Insurance describes crisis management consulting as providing services to companies in areas including potential risk from natural disasters, terrorism and political risk, business interruption, workplace violence or labor stoppage, litigation and product tampering or

recall. Companies must provide services on an unbundled basis directly to corporate or institutional clients.

If your company provides these services but has not received a questionnaire, please request one by contacting Directory Editor Kevin P. Edison at 312-649-5279 or kedison@businessinsurance.com.

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International

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Underwriters resisting Aon fee structure change

By CAROLYN ALDRED

LONDON—Underwriters are resisting Aon Ltd.'s plans to revamp its fee structure in London by imposing an upfront charge on insurers for services it says it provides to the market.

All fees involved in the placement and administration of insurance coverage should be paid directly by policyholders, the underwriters say.

Regardless of disclosure arrangements, any payment by insurers to brokers could be construed as a conflict of interest, they say.

The London-based unit of Aon Corp. announced in December that it planned to change its compensation system for specialty business placed in London so that it received a fixed and transparent fee for services such as policy issuance and claims handling (*BI*, Dec. 27, 2004).

That decision came in the wake of New York Attorney General Eliot Spitzer's investigation into insurance industry compensation practices, including alleged abuses of contingent



Fee structure changes

- Levy a fee on insurers for services performed for underwriters.
- Estimated fees would be 2.5-3.5% of premium. Maximum amount £200,000 to £500,000 depending on type of business written.

commission arrangements. Mr. Spitzer earlier this month agreed a \$850 million settlement with Aon rival Marsh & McLennan Cos. Inc. over charges that the New York-based broker had engaged in bid rigging and client steering in attempts to obtain higher contingent commissions (*BI*, Feb. 7).

Although Aon has not been charged with any wrongdoing, the Chicago-based broker has set aside \$50 million for potential settle-

ments (see story page 1). The broker announced shortly after Mr. Spitzer filed suit against Marsh that it would stop accepting contingent commissions. Aon reported that contingent commissions represented about 1.6% of its revenues in the first nine months of 2004.

Aon's proposed charges to underwriters would replace the previous system whereby Aon deducted a percentage of the gross premium charged by underwriters to pay for the administrative services provided by the broker.

Under the proposed system, Aon would levy a fee on insurers for services that the broker provides to the underwriters. Aon estimates that the fees will range between 2.5% and 3.75% of the premium up to a maximum of between £200,000 to £500,000, depending on the type of business written.

The model would be limited to Aon's specialty division in London, said Jonathan Palmer Brown, a director of Aon who heads the specialty risk division. Aon Ltd.'s specialty division places business such

as aviation, marine, energy, property/casualty, terrorism and professional risks in the London insurance market. The unit has premium volume of between \$5 billion and \$6 billion a year.

The model is appropriate for the London market where brokers traditionally have performed services for underwriters that in other markets are undertaken by insurers, he said.

"Lloyd's brokers often act as the back-office administrator for underwriters, and if we are doing these services for them, we should be adequately paid for them," Mr. Palmer Brown said.

The arrangement would also give underwriters a direct interest in making the placement process more efficient, he said.

For example, underwriters may be more willing to implement technological changes if they thought it would reduce placement costs, he said.

Insurers in London "are totally at one with Aon on transparency. We feel very strongly that transparency

See AON Ltd./ page 35

World Updates

U.K. pension deficits fall in 2003

The pension funding deficits of the 350 largest publicly listed companies in the United Kingdom fell to £71 billion (\$136.04 billion) in 2004, down 2.7% compared with 2003, according to estimates by Mercer Human Resource Consulting in London. According to Mercer's estimates, which are based on an analysis of financial reports, the assets of FTSE350 companies' pension funds rose by about £33 billion (\$63.23 billion) during 2004, but liabilities increased by about the same amount.

ZFS estimates tsunami losses

Zurich Financial Services Group said it expects claims of about \$65 million after tax and net of reinsurance from the Indian Ocean tsunami that struck Dec. 26, 2004. In addition, Zurich said it had increased its estimate for losses from the four hurricanes that struck the Caribbean and the United States last year to \$520 million after tax and net of reinsurance, up from a previous estimate of \$400 million. The Zurich, Switzerland-based insurer said the tsunami claims and increased hurricane estimates will reduce its profits for the fourth quarter of 2004 by \$185 million.

U.K. sets levies for pension protection

The U.K. government has announced a flat-fee levy for its Pension Protection Fund to be paid by employers operating defined benefit pension plans. The PPF, which is slated for introduction in April, is loosely modeled on the U.S. Pension Benefit Guaranty Corp. The initial annual levies for the PPF are: £15 (\$28) for every active member or pensioner in a defined benefit plan, and £5 (\$9) for every member who has deferred his or her pension.

Briefly noted

The number of **pirate attacks** on ships fell to 325 in 2004 from 445 in 2003, according to the ICC International Maritime Bureau. The International Maritime Bureau's piracy reporting center in Kuala Lumpur, Malaysia, reported that 30 crew members were murdered in pirate attacks in 2004, up from 21 in 2003....**Allianz A.G. Holding** said its losses from the Dec. 26, 2004, South Asian tsunami will be about 22 million euros (\$28.2 million). The Munich, Germany-based insurer said most of the losses were from property business, with some marine, auto, life, engineering and personal accident policies also affected.

Gay manager wins harassment suit

First award issued under new law

By CAROLYN ALDRED

LONDON—A manager who was taunted about being gay by senior colleagues has been awarded £35,345 (\$65,667) in the first successful case to be brought under new employment legislation.

The Employment Tribunal award was the first handed down since the Employment Equality (Sexual Orientation) Act went into effect in December 2003.

The case is likely to increase awareness among employees of their ability to sue if discriminated against because of their sexual orientation, noted Anthony Fincham, a partner with London law firm CMS Cameron McKenna.

It also will make employers ensure that they have sufficient policies in place to prevent such discrimination, he noted.

Rob Whitfield, who earned £54,000 (\$100,326) a year as a manager for Brentwood, England-based waste management company Cleanaway Ltd., was mocked by senior staff at the company for a period of five months about his sexual orientation.

He was nicknamed Sebastian after a gay character in a popular U.K. television series and was called "dear," "queer" and "queen." Despite having received complaints from homosexual staff in the past, the company did not stop the taunts.

"This case emphasizes that derogatory language referring to an employee's sex, race, sexual

orientation or disability cannot be dismissed as mere 'office banter.' Such language infringes the employee's rights, damages workplace morale and can lead to discrimination claims," according to a client brief issued by Cameron McKenna.

"Employers must take measures to encourage good practice and to reduce the risk of such claims. Staff handbooks and the behavior of senior staff should make it clear to employees that derogatory language is unacceptable," it stated, adding that "any use of derogatory language or other discriminatory behavior must be dealt with promptly and effectively, whether or not the person who is the subject of the discrimination makes a complaint."

Vivienne Gay, the chairman of the Employment Tribunal, ruled that Cleanaway's human resources department had failed to ensure that senior managers understood that derogatory references to sexual orientation were unacceptable.

"It takes a while for employees and employers to become aware of new legislation. This case will raise the profile of sexual orientation crimes and should encourage more companies to introduce best practice to follow from implementing the policies," said Alan Wardle, director of public affairs for Stonewall, a London based gay- and lesbian-rights group.

Australian rule targets conflicts of interest

By ELIZABETH FRY

SYDNEY, Australia—With Australian regulators working to wrap up their investigations into brokerage compensation arrangements, brokers, insurers and other financial services companies in Australia already are dealing with a new duty to address potential conflicts of interest.

A new rule, PS 181, which took effect Jan. 1, states that all licensed providers of financial services must "take steps to identify the conflicts of interest relating to their business, assess and evaluate those conflicts, and decide upon and implement an appropriate response to those conflicts."

PS 181, which was issued in August 2004 by the Australian Securities and Investment Commission, also sets out comprehensive expectations about how financial services companies can fulfill their obligation to manage potential conflicts of interest.

Although Australia's Financial Services Reform Act 2001 requires licensed financial services companies to manage conflicts of interest, that law was primarily concerned with protecting retail clients, which includes only a few types of personal lines insurance, observers say. Commercial coverages are considered "wholesale" products for the purposes of financial services regulation.

Under the 2001 law, "there are less prescribed disclosure obligations in relation to the wholesale market—and that is across the board," said Darren Williams, Melbourne-based director of regulatory compliance for ASIC.

By introducing specific rules for managing conflicts of interest—applying to all financial services licensees—ASIC has effectively ensured that companies in the wholesale sector, such as commercial brokers and insurers, are subject to the same explicit obligations as those in the retail sector, Mr. Williams said.

He also said that it was important to note that disclosure was only one aspect of the new duty.

"Licensees must take steps to identify the conflicts of interest relating to their business, assess and evaluate those conflicts and then decide upon and implement an appropriate response. Appropriate responses include implementing internal controls and disclosure.

"However, there will be some cases where the conflict cannot be adequately managed by those means, and in those cases, the licensee must avoid it or refrain from providing the affected financial service," he said.

Companies that fail to comply with the rule may face enforcement actions from ASIC.

"If brokers don't comply, action will be taken....It will become part of our compliance-monitoring regime, and we will treat noncompliance with that obligation in the same way we would treat other obligations and the actions we take will depend on the nature of the contravention," Mr. Williams said.

According to PS 181, the underlying principle of the new conflict-of-interest duty is to "ensure that the quality of (a licensee's) financial services is not significantly compromised by conflicts of interest." Such a compromise would occur "if the

See AUSSIE/page 35

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AND IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that the Scheme Company intends to apply to the High Court of Justice of England and Wales, Chancery Division, Companies Court, at the Royal Courts of Justice, Strand, London WC2R 2LL, on 24 February 2005 at 10.30am, for an Order to convene a meeting of creditors of the Scheme Company in relation to the Scheme Business (the "Scheme Meeting"). The purpose of the Scheme Meeting will be to consider and, if thought fit, to approve (with or without modification) a solvent scheme of arrangement to be proposed by the Scheme Company in relation to the Scheme Business pursuant to Section 425 of the Companies Act 1985 (the "Solvent Scheme").

The creditors under the proposed Solvent Scheme ("Scheme Creditors") will be insurance, reinsurance and retrocession creditors of the Scheme Company, in respect of books of marine and aviation pool business and non-marine pool business underwritten by The Orion Insurance Company Limited incorporated in England and Wales with company number 256100 (now known as OIC Run-Off Limited (subject to a scheme of arrangement)) in the London Market in the 1950's and 1960's in the names of Sphere Insurance Company Limited and/or The Drake Insurance Company Limited whereby the Orion Insurance Company Limited also appeared as an insurer on the relevant underwriting stamps alongside either or both of Sphere and Drake ("Scheme Business").

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The Scheme Company is of the opinion that the rights of its Scheme Creditors are so similar as to make it possible for them to consult together with a view to their common interests. Accordingly, the Scheme Company has concluded that there is only one class of Scheme Creditors and it is therefore proposed that only one meeting of Scheme Creditors be convened for the purposes of considering and, if the Scheme Creditors think fit, approving the Solvent Scheme.

Further information may be obtained by contacting either Paul West, Colin Horwood or John Farrow of Axiom Consulting Limited at Lloyd's Chambers, 1 Portsoken Street, London E1 8DF; telephone +44 (0)20 7767 2700 or by email at paul.west@axiomcc.com, colin.horwood@axiomcc.com or john.farrow@axiomcc.com

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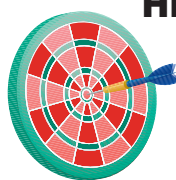
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Aon Ltd.: Fee structure

Continued from page 33

is the only way forward," said Bill Kendall, head of underwriting and claims at the Lloyd's Market Association, which represents underwriters in London.

However, "at the end of the day, it's the client who pays all the costs and the broker works entirely as the agent of the insured. We believe that if the insured chooses, on advice of the broker, to utilize the London market and the special qualities it provides, then all the costs associated with doing so should be agreed in an arrangement between the broker and the client," said Mr. Kendall.

"We accept that because of the way the London market is structured, with many insurers having no back offices or branch offices, we take a lower net premium than a conventional insurer," he added.

The Aon proposal could also compromise brokers and underwriters, Mr. Kendall said.

"If the broker tries to work for two principals, there is an inevitable conflict of interest," he said.

Mr. Palmer Brown, however, said "when we are performing administrative services undertaken on behalf of the insurer, it is something that does not fall under the law of agency."

Both Mr. Palmer Brown and Mr.

Kendall said that they were optimistic that a solution can be found.

Risk manager Reiner Siebert, head of insurance for Virgin Group P.L.C., said that costs associated with the servicing of specific business should be charged to the client rather than the insurer.

"We want to have absolute clarity on the terms of the business we are paying for. We should know what we are paying for and be given some choice and control over the services we want," he said.

Mr. Siebert also has concerns about conflicts of interest and believes that these can be reduced with more upfront fees.

Meanwhile, Lloyd's Chief Executive Officer, Nick Prettejohn, last week called for U.K. regulators to take a tougher approach to broker disclosure.

The Financial Services Authority should change its proposed Conduct of Business regime for brokers from the current approach of "disclosure on request" to mandatory disclosure, Mr. Prettejohn said.

"That way, the conflict of interest issue is dealt with, and we have an unyielding spotlight to shine on the economics of our business," according to the transcript of a speech Mr. Prettejohn gave to the Insurance Institute of London.

Aussie: Conflicts of interest

Continued from page 33

service is of materially lesser quality than the licensee would have been likely to provide if they were not subject to the relevant conflict of interest," ASIC states.

PS 181 requires companies to determine, on an ongoing basis, what processes and procedures they need to ensure they maintain adequate management of conflicts of interest. Such policies must be documented, and companies must keep records showing what they have done to monitor compliance.

In addition, companies must disclose potential conflicts to clients in a way that is "timely, prominent, specific and meaningful," PS 181 states. Disclosures also must occur before or when the financial service is provided and must give clients a reasonable time for assessment.

With regard to remuneration, PS 181 states that "if a provider pays a higher rate of commission to a financial adviser for achieving certain volumes of sales, we would expect disclosure to be part of how the licensee manages that conflict."

Syd Levett, general manager group insurance and risk for Melbourne-based packaging company AMCOR Ltd., said that he welcomed the new rule.

"The advantage of this is that it takes away the constant dispute over what remuneration information should be provided—it's now obligatory, so that's a plus. Up until now, we might demand that information from brokers, but what they provided didn't tell the whole story—they could reveal just the front, and not the bulk commissions," Mr. Levett said.

Noel Pettersen, chief executive

officer of the Sydney-based National Insurance Brokers Assn., said that brokers need to be able to demonstrate to ASIC that they have in place an effective strategy for managing possible conflicts of interest.

"The government is insisting that this be done properly, and if it is not, it will do more to make sure it is done. I think brokers certainly will take this seriously and at the very least will provide to wholesale clients the same information they currently provide to retail clients."

Mr. Pettersen added that NIBA has issued guidelines and is holding seminars around Australia to help members meet the new requirements.

In the wake of the brokerage compensation scandal in the United States, ASIC in December announced that it planned to investigate brokers' remuneration practices to determine whether they are acting in the best interests of their clients (BI, Dec. 20, 2004). The regulator is due to report on its findings in March.

Commenting on that probe, the Risk Management Institution of Australasia said: "Our view is that an insurance transaction is a three-way partnership between insurer, broker and risk manager and that all relevant information needs to be disclosed to each of the parties involved. Without that, there can be no establishment of a trust relationship."

RIMA, which was formed last year through the combination of the Assn. of Risk & Insurance Managers of Australasia Ltd. and the Australasian Institute of Risk Management.

The text of PS 181 is available at www.asic.gov.au.

MEWA: Fraud rules

Continued from page 4

compensated care, hospital representatives said.

Due diligence urged

Mr. Nepple's proposed regulation would impose rules on "persons and licensees who may become aware of, or be asked to assist" illegal MEWAs or other illegal health insurers, according to the proposal.

Such parties could include health insurers, stop-loss insurers, producers and third-party administrators, as well as employee leasing arrangements, preferred provider organizations and professional employer organizations, the proposal states.

Specifically, the model regulation calls for such entities to "carry out appropriate due diligence" by using "reasonably appropriate" measures to establish that a health benefit plan—or its proponent—is not engaged in unauthorized health insurance. For example, a soliciting agent or broker would be required to establish that any insurer that is represented as providing coverage is licensed in the relevant state, the

coverage is fully insured by the licensed insurer and that the insurer has issued the policy.

The draft model anticipates listing—but does not yet specify—detailed measures that an agent or broker should use to make such determinations. Such measures could, however, include contacting the insurance department by telephone or e-mail to inquire about an insurer's status or requiring submission of a policy for the agent or broker to review.

The proposed regulation also requires establishment of supervisory procedures and controls, such as audits, as well as education and training requirements.

Depending upon the violation, a party subject to the regulation could face license revocation and financial penalties.

"I'm fairly confident that a fairly low-cost measure will go a long way to prevent MEWA scams," Mr. Nepple said of his proposal.

A hearing on the proposal is tentatively scheduled for 10:00 a.m. March 13 at the NAIC's quarterly meeting to be held March 12-15 in Salt Lake City.

Opinions mixed

Mr. Nepple's proposal is drawing mixed reviews from insurance industry representatives and observers.

One supporter of requiring due diligence on the part of industry companies is the receiver involved with mopping up the 2002 receivership of American Benefit Plans, which marketed what purported to be an ERISA health plan called "United Employers Voluntary Benefit Assn." The Austin, Texas-based receivership faced a total of 6,164 unpaid claims totaling \$12.3 million, although it was able to make a 20% distribution in December 2004, said Special Deputy Receiver Bob Loiseau.

Naples, Fla.-based NCH Healthcare Systems, which has 3,500 workers, had a total of \$285,458 in approved claims for uncompensated care filed with the Austin, Texas, receivership. In light of that experience, NCH's Chief Financial Officer James Warnken said he endorses the concept of brokers and other licensees being required to perform due diligence before selling an insurance policy.

"Just as important as 'buyer beware' is the fact that (employers) are being led to believe they are buying insurance and they are not," he said.

"This is a bad situation for all involved," said Linda Garrett, an outside attorney for Greenville Hospital System in Greenville, S.C. It filed a total of \$75,991 approved claims for uncompensated services with the receivership.

America's Health Insurance Plans, a Washington-based health insurance and managed care trade association, agrees with the objectives of the draft, though its members are still reviewing it, a spokesman said.

Several groups, however, raised questions about the proposal.

"The reason we are concerned is that the leftover headache of MEWAs gives ammunition to the opponents of Association Health

Plans," which include the NAIC, said Edwina Rogers, vp-health policy for The ERISA Industry Group Washington, which represents more than 100 member companies, each of which have at least 25,000 employees.

Jamie Amaral, national director of health research and development in Washington for the National Federation of Independent Business, wondered why the NAIC was raising the issue now since states' have made it unattractive to establish MEWAs because of "excessively high" actuarial and solvency requirements. She also expressed "skepticism" about the NAIC's ability to adequately scrutinize all types of insurance arrangements and said that MEWAs have been inappropriately vilified.

Bob Lindgren, president of the Los Angeles-based Printing Industries Benefit Trust, said he was "puzzled" by the NAIC's draft proposal, but said that it appears that they could impose such requirements within the limits of federal law. That entity, which has 35,000 covered lives and \$90 million in annual premium, has been operating as a MEWA since 1982. It is one of six MEWAs licensed by the state of California, said Mr. Lindgren, who is president of the California Assn. of Small Employer Health Plans.

Fred Hunt, president of the Society of Professional Benefit Administrators in Chevy Chase, Md., expressed concerns about the proposal. "If they try to do it honestly, it's unworkable," he said. Only industry participants with enough information to render a legal opinion should be held responsible. "Otherwise, it is totalitarian tattling," he said.

The model regulation is available online at www.naic.org/government_relations/health_policy/erisa_wg.htm. There is a Feb. 21 deadline for persons to register to speak at the hearing or submit written comments. For details, contact Jennifer Cook at jcook@naic.org or call 202-624-3541.

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2005 Employee Healthcare Conference

Medicare subsidy helps companies cut retiree costs

By GLORIA GONZALEZ

NEW YORK—Several employers are attempting to curtail the rising costs of their retiree medical programs by eliminating subsidized coverage for some future retirees and incorporating new Medicare prescription drug expenses subsidies in their retiree health care plans.

The benefit managers of JohnsonDiversey Inc. and Kraft Foods Inc. described their efforts to overhaul their programs during a session on retiree medical coverage at the 2005 Employee Healthcare Conference, presented by the Conference Board and sponsored by Towers Perrin HR Services.

The need to revamp the retiree medical program became clear after

the 2002 merger that combined Johnson Wax Professional with DiverseyLever, said Todd Blazei, director of the global benefits programs for the Sturtevant, Wis.-based company.

The two companies featured vastly different benefit programs because of divergent corporate cultures, he said. JWP, which Mr. Blazei described as a "paternalistic company," had a comprehensive benefits program that included a retiree medical plan of which the company paid between 60% and 70% of the premiums for employees who worked until at least age 50 and had 10 years of service.

DiverseyLever, on the other hand, believed financial security in retirement was a personal responsibility with limited employer sup-

port, he said. It offered an access-only retiree medical program for employees at least 55 years of age and with 10 years of service at retirement, with the retirees responsible for paying the premiums.

When developing the company's new strategy, the key question for the benefits team was "how can we get to one program, make it affordable and not have everybody leave on the Johnson side?" Mr. Blazei said. "We decided to provide a program that was definitely more of a shared program, but we did make a decision that retiree medical was a benefit we wanted to provide."

The company developed a defined contribution plan where employees would earn a company subsidy to be placed in a retiree medical savings account, he said. Employee contributions up to \$1,000 per year are matched on a two-to-one basis, but the employee can save up to \$5,000 per year in the account. The company's matching account is forfeitable if the employee leaves the company prior to retirement eligibility, he said.

JWP employees with age plus service as of Jan. 1, 2004, of more than 60 remained eligible for subsidized retiree premiums, but the subsidy will be reduced to 50% over a seven-year period.

The remaining JWP employees would receive a transition credit equal to \$2,000 times the number

of years of service as of Jan. 1, 2004. This money would be placed in accounts with employer matching amounts and these employees would pay full-cost premiums at retirement, he said.

New hires and DiverseyLever employees earn matching amounts for their contributions going forward, but there was no transition credit for the DiverseyLever employees.

Mr. Blazei said announcing the plan was a little tough because older DiverseyLever employees would not receive subsidized medical retiree premiums like their JWP counterparts, but he noted that the DiverseyLever employees would have paid full premiums under their old plan. "The DiverseyLever group in essence is getting a new benefit," he said.

Northfield, Ill.-based Kraft currently has about 38,000 retirees enrolled in its retiree medical program, and about half of them make no monthly contribution to the coverage, said Martha Killius Pechnyo, senior director-benefits. The other half either pay a flat-dollar amount or a percentage of the costs based on years of service. She said the rapid cost increases for retirees who pay a percentage of the premiums might be getting to the point that some would drop coverage.

"Affordability is a big issue for both Kraft and our current and fu-

ture retirees," she said.

The company decided to eliminate subsidized retiree medical coverage for nonunion employees hired after Jan. 1, 2004 and moved to a coinsurance design in its health plans wherever possible. At the same time, the company increased its 401(k) match—now 75 cents on the dollar—for all employees to help them save more money for retirement expenses, she said.

Both companies plan to utilize the new prescription drug benefit, called Part D, included in the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The law says that employers that offer Medicare-eligible retirees prescription drug benefits that are at least actuarially equivalent to Part D will be eligible for a 28% tax-free federal subsidy of drug costs between \$250 and \$5,000 per beneficiary.

JohnsonDiversey plans to use the subsidy payments to lower premium costs to retirees or reduce its total expenditures, Mr. Blazei said. "All our programs currently have pretty rich prescription drug programs," he said. "That's probably why they are as expensive as they are. One of the challenges from my standpoint is to continue to develop lower-cost options, probably do more coordinating with Medicare Part D and look for options that can be cheaper."

350 attend health care conference

NEW YORK—About 350 people attended the 2005 Employee Healthcare Conference, presented by the Conference Board and sponsored by Towers Perrin HR Services.

The theme of the conference, which was held Feb. 2-4 in New York, was "Resolving the Healthcare Dilemma: Managing Costs and Talent in a Tough Business

Environment."

The event featured sessions that included consumer-driven health plans, models for care management and disease management, retiree medical programs and legislative issues related to health care.

Plans for next year's Employee Healthcare Conference have not been finalized.

Retiree: Curtailing coverage

Continued from page 6

ton, N.H.-based Fisher Scientific International takes \$25 off an employee's monthly health insurance premium contribution if the employee agrees to wear a seat belt or helmet while driving or bicycling, agrees not to drink and drive, and agrees not to smoke, said James McGrail, director of corporate benefits.

"It's all done on the honor system...but if they do have a claim and it's determined that they violated their agreement with us, they are subject to denial or reduction of benefits," he said.

Fisher also instituted an opt-out credit of \$50 for people who could certify that they obtained health care coverage elsewhere, which helped save the company money because the percentage of people waiving coverage increased from 10% to 13%. "We only gave the credit to people who certified they had coverage elsewhere," he said. "We don't want people opting out for the cash and then be left holding the bag if they have a health care issue."

These efforts, as part of the company's overall cost containment strategy, helped hold 2004 health care cost increases to 7.5%, down from 9.5% in 2003 and below industry trends, he noted.

Employers are also encouraging employees to understand their health status and what conditions

they are vulnerable to by offering financial incentives for completing health risk assessments.

For example, London-based GlaxoSmithKline introduced a \$100 incentive for its U.S. employees to take a health risk assessment, said Michelle Killian, the Philadelphia-based director of benefits planning and design for GlaxoSmithKline.

Atlanta-based Delta Air Lines

Fisher Scientific International instituted an opt-out credit of \$50 for people who could certify that they obtained coverage elsewhere. The percentage of people waiving coverage increased from 10% to 13%.

wanted to offer an incentive to its employees to encourage them to take health risk assessments, but could not offer a \$100 incentive given by other major companies due to its ongoing financial difficulties, said Lynn Zonakis, director of health strategy and resources. Instead, the company ran a contest in which five employees who completed the health risk assessment won free medical coverage. Other prizes in the program included free hotel

stays for completing the health risk assessment, an incentive that appealed to Delta's employee population, she said.

The total cost of Delta's incentive program was \$18,509 compared with the \$638,400 it would have had to pay if a standard \$100 incentive had been given to the 6,384 Delta employees—11% of its active workforce—who completed the health risk assessment. The program was so successful that the company plans to implement quarterly contests, she said.

Fisher Scientific offered free lunch coupons for some employees who completed the health risk assessment, but no other financial incentives for completing them, Mr. McGrail said. "An incentive definitely helps, but we weren't willing to spend any more money on it," he said. "But if you do an incentive, people will come."

But employers need to make sure employees move beyond simply taking the health risk assessment, Ms. Killian said. "It really didn't matter to us, quite frankly, that the employee took the health risk assessment and put it in the drawer and did nothing with it and got \$100 back," she said. "What mattered to us is that they took the health risk assessment and demonstrated positive actions toward mitigating the risks that were identified."

Noncompete: State enforcement varies

Continued from page 4

forceable, said Randall P. Sutton, an attorney with Salem, Ore.-based Saalfeld Griggs P.C.

"The states really vary on whether an agreement is enforceable," he said. In California, for instance, say observers, noncompete agreements are generally not enforceable except under limited circumstances, while other states that are more willing to recognize them.

Then a decision has to be made as to how to proceed. The employer has to make an assessment "between what the legal risk is and what the business opportunity is. It's a balancing act," said Mr. Reed.

Employers should also make sure that if applicants have any trade secrets in their possession, they "promise that they're not going to use that information, and make it really clear that you're not going to ask for that information," said Mr. Sutton.

And be sure the applicant understands what a trade secret is, said Kimberly Cauthorn, Houston-based director of the financial advisory services practices at Kroll Inc., a unit of Marsh & McLennan Cos. Inc. "You have to ask them things like 'Did you bring a Rolodex with you? Did you bring your active database with you?'" said Ms. Cauthorn.

"You'd be amazed how many people don't realize" that these could be covered by a noncompete agreement.

Mr. Sutton also suggested applicants sign an affidavit acknowledging that if they do pass on trade secrets, they are subject to termination, "to put some teeth into it." Supervisors should also be warned about employees disclosing confidential information, and employees should be told that if such a request is made, a person in authority should be informed.

Also, "make sure your motives are pure," said Mr. Sutton. "If it looks like you're hiring the person away to hurt the other employer, basically to hurt your competition, rather than to help yourself, that can result in liability," he said.

"You might look at how many other employees of the competition the company has hired, because the competitor might not take action if it's just one or two, but if you're taking a whole department of employees away, it's more likely you're going to get sued," he said.

Employers should also avoid encouraging employees to solicit their former employers' customers before they have left their old job, said Mr. Sutton.

Budget: Shoring up PBGC

Continued from page 3

weak employers—those with at least 500 participants in a pension plan, with unsecured debt and whose credit lacks an investment grade rating—would face a new \$700-per-participant “loading charge” contribution to their plans. This charge would be amortized over seven years.

Benefit experts agree that the package, if enacted, would greatly improve the financial condition of the PBGC, which now has a record deficit of \$23.3 billion with the prospect of more massive losses that eventually could outstrip its

ability to pay benefits to participants in the plans the agency has taken over.

“On the positive side, the administration has put forth a package that should take care of the PBGC deficit through a combination of higher premiums and provisions that should reduce the size of future claims,” said Douglas J. Elliott, president of the Center on Federal Financial Institutions, a Washington-based public policy institute that focuses on the federal government’s insurance programs.

Others concur that provisions in the package, most notably eliminat-

ing the ability of financially weak employers to increase benefits, would reduce the PBGC’s exposure to big losses, reducing the need for future premium increases.

In the case of financially distressed firms, “I agree that, at some point, you have to stop benefit increases and accruals,” said Ethan Kra, chief actuary for Mercer Human Resource Consulting in New York.

Experts say, though, that the package lacks incentives to stop the continuing erosion of defined benefit plans. In the last 20 years, the number of plans insured by the PBGC has declined by about 75% to

just under 30,000. While many exiting the system have been small companies, more recently even the nation’s biggest employers, including IBM Corp.; NCR Corp.; and Sears, Roebuck & Co., have decided to phase out their pension plans.

“Overall, I don’t see much to encourage employers to stay in the system,” said Steve Mirante, a managing consultant in the Teaneck, N.J., office of Watson Wyatt Worldwide.

One change in law—not in the proposed package—that would provide such an incentive, some say, would be to allow employers to take, without paying taxes or incurring other financial penalties, surplus assets out of their plans and use the money to pay for other benefit programs.

“Unless they provide a methodology to enable employers to access excess funds, few would want to put in extra money in good times,” said Mr. Kra.

“It would be very helpful if those extra funds could be deployed for other employee benefit purposes,” said Scott Macey, a senior vp with Aon Consulting in Somerset, N.J.

Additionally, some say the methodology that employers would have to use in valuing plan liabilities could be a disincentive for companies to maintain plans. Under the proposal, employers would value liabilities using interest rates on corporate bonds of varying maturities. For example, plans that include mainly older workers and retirees would use rates from shorter-term bonds to reflect that benefit payments would be made in the near term.

The actual interest rate to be used would be based on bond rates averaged over 90 business days. By contrast, under current law, the interest rate used to value plan liabilities is based on the four-year weighted average of yields on long-term corporate bonds.

Because interest rates can sharply spike up or down over short periods of time, the administration’s proposal would introduce more volatil-

The administration's pension reform package would:

- Raise base PBGC premium to \$30 per participant from \$19; give PBGC board flexibility to raise premiums for underfunded plans as necessary
- Measure plan liabilities with corporate bond interest rates
- Require funding shortfalls to be amortized over seven years
- Bar financially distressed companies with underfunded plans from boosting benefits or providing benefits as a lump sum
- Eliminate plant shutdown benefits
- Eliminate funding credits for making extra pension plan contributions
- Allow employers to fund up to 130% of plan liabilities
- Recognize the legality of cash balance plans but set stiff conditions on plan conversions

ity into establishing the amount of the contributions employers would have to make to their plans, noted Steve Kerstein, managing director of Towers Perrin’s global retirement practice in Stamford, Conn.

“There is no tempering of volatility,” said Mr. Kra, contrasting the proposal’s interest rate methodology to the smoothing effect of current law, under which the interest rate to be used is based on corporate bond yields averaged over four years.

Credits could encourage small employers to offer cover

Administration seeking HSA tax break

By JERRY GEISEL

WASHINGTON—The Bush administration is asking Congress to pass legislation—first outlined by President Bush last year—that would give small employers tax credits to partially offset contributions they made to employees’ health savings accounts.

Under the proposal, contained in the administration’s proposed 2006 federal budget, employers with 100 or fewer employees would be eligible for a refundable tax credit for contributions they make to employees’ HSAs. The credit would apply to the first \$500 in contributions an employer makes to each employee’s HSA for family coverage, while a maximum tax credit of \$200 per worker would be provided for individual coverage.

In support of the small employer HSA tax break, the administration notes that more than 9

million people working for small employers lack health insurance.

“Providing an incentive for sponsoring high-deductible coverage along with HSA accounts would encourage employers to offer coverage and contribute toward the health care of their employees,” the administration said.

Additionally, HSAs, which under law must be linked to high-deductible health insurance plans, may encourage more careful use of health care services than more-traditional plans, the administration said.

Other changes related to employee benefits proposed by the administration in its budget include:

- Allowing employers to provide tax-free reimbursement of employees’ adoption-related expenses, regardless of income. Under current law, the tax break begins to phase out for employees making just under \$160,000.
- Allowing spouses of benefi-

ciaries to use a health insurance federal tax credit available under a 2002 law, even after the primary beneficiary no longer is eligible for the tax credit.

Under that law, individuals who lose their jobs due to foreign competition or if they are between the ages of 55 and 64 and are receiving pension benefits from the Pension Benefit Guaranty Corp., are eligible for a 65% refundable tax credit to offset the cost of premiums they pay for a qualified health insurance plan, such as COBRA coverage or coverage through a state high-risk pool.

Eligibility for that tax break ends when the beneficiary turns 65 and becomes eligible for Medicare. At that time, the tax break also ends for the spouse, even if he or she is not yet eligible for Medicare.

Under the administration’s plan, the tax break would stay in place in such situations, as long as the spouse is at least age 55.

Disparity: Reaching minorities

Continued from page 4

in health care for people with diabetes, includes Aetna Inc., CIGNA Corp., Harvard Pilgrim Health Care, HealthPartners, Highmark Inc., Kaiser Permanente, Molina Healthcare, UnitedHealth Group and WellPoint Inc.

Data gathering

The first order of business for the collaborative is to collect as much data as possible to determine the extent of the problem and identify where to concentrate quality improvement efforts.

But that’s no easy task, given the reticence by many organizations to collect information on race and ethnicity out for fear of appearing discriminatory or insensitive, according to Dr. Andrea Gelzer, vp of clinical affairs at CIGNA in Hartford, Conn.

“Data gathering has been a real barrier,” she said. “There’s just not enough data on ethnicity. And so we’ve been trying to find a rational way to go about doing that.”

Among the data-collection methods being used are “geocoding,” in which plan members from a specific geographic area are counted to determine race, and surname analysis, which can be used to determine ethnicity, she said.

Once these groups are isolated, the plans will use Health Plan Employer Data and Information Set, or HEDIS, measures to determine whether they are receiving appropriate treatment, Dr. Gelzer said.

After a survey found that nearly half of the members of America’s Health Insurance Plans were not collecting data on race and ethnicity, the industry trade group launched a series of workshops last month to address concerns by health plan executives about collecting such data.

Those who attend any of AHIP’s four regional workshops will receive toolkits containing information on how to collect such data legally and with sensitivity, according to David Nerenz, senior staff investigator in the Center for Health Services Re-

search at the Henry Ford Health System in Detroit. Mr. Nerenz is coordinating the workshops.

“The workshop and toolkit are divided into sections like legal and regulatory issues, examples of how data can be collected, how to analyze HEDIS or other similar quality measures to identify possible disparities, and provide examples of demonstration projects involving health plans dealing with these issues,” he explained.

Health plans that already have enough data to determine the special needs of certain populations are developing health education programs designed to improve the health of those groups.

For example, Aetna Pharmacy Management, a division of Hartford, Conn.-based Aetna Inc., earlier this month began distributing Spanish-language diabetes care education materials and tools, including blood glucose monitors.

Because of genetic differences, Hispanics are twice as likely as Cau-

casians to suffer from diabetes, said Michael Arizpe, pharmacy director in Aetna’s clinical programs area in San Antonio.

To increase awareness of the availability of the Spanish-language diabetes kits, Aetna issued a news release in Spanish, distributing it on a Hispanic public relations wire where it would be seen by journalists at Spanish-language newspapers, television and radio stations.

In addition to printed materials, a video and other visual materials are included in the diabetes kit to help Spanish-speaking members who are not literate in their native language to understand it, Mr. Arizpe said.

Barriers to access

Language is not the only barrier, though, to good-quality health care, experts point out.

“Their beliefs and customs may prevent them from doing what their doctor asks them to do,” said Beth Remus, president of Remus & Associates Inc., a health care consultant in Chicago. For example, in Hispanic culture, pregnant women don’t seek prenatal care because pregnancy is

not considered a condition that would normally require a doctor’s care, she said.

“It takes understanding how that culture sees medicine and treatment,” Ms. Remus said.

While the stigma associated with seeking psychiatric counseling has been steadily diminishing in the American culture, it has yet to fade among Hispanics, according to John L. Webb Jr., vp of business development at Cameron & Associates, a minority-owned employee assistance program and managed behavioral health care provider in Atlanta.

But Hispanic workers are often willing to seek financial or legal services from EAPs, particularly if counselors speak their language, he said.

To meet the growing demand for multilingual/multicultural EAP services, Cameron & Associates has been recruiting providers to reflect the composition of the population being served.

“For example, in rural parts of Georgia, the poultry industry employs a lot of Spanish-speaking people. So we know to have in place providers who are Spanish-speaking,” Mr. Webb said.

Timeline of legal wrangling over ADEA, retiree benefits

August 2000: The 3rd U.S. Circuit Court of Appeals rules the Age Discrimination in Employment Act applies to retiree health care plans. The ruling, involving retiree health care plans provided by Erie County, Pa., exposes to litigation mainstream employer programs that offer smaller benefits to Medicare-eligible retirees than to younger retirees.

October 2000: The Equal Employment Opportunity Commission adopts the Erie County ruling in its compliance manual.

April 2001: A federal district court rules that Erie County's retiree health care plan violates ADEA because Medicare-eligible retirees receive "lesser" benefits than younger retirees.

July 2001: The EEOC suspends enforcement of the Erie County ruling and says it will review its earlier policy.

August 2001: The EEOC formally withdraws enforcement of Erie County ruling and pledges to develop new rules that do not discourage employers from offering retiree health care plans.

April 2002: Erie County settles litigation by paying \$305,000 to retirees and their lawyers. Prior to settlement approval, Erie cuts younger retirees' benefits to put them more in line with Medicare-eligible retirees.

April 2004: EEOC proposes final rules to exempt retiree health plans from ADEA. Rules make clear that employers can—without violating ADEA—alter, reduce or terminate coverage when retirees become eligible for Medicare.

February 2005: EEOC agrees to delay publication of final rule for 60 days. A federal district court agrees to hear oral arguments next month on a complaint filed by AARP challenging the rule.

EEOC: Erie County resolution delayed

Continued from page 1

have to spend the same amount of money on health care for Medicare-eligible retirees as they do for younger retirees or offer the same coverage to the two groups.

The practical effect of that ruling in the so-called Erie County case was huge. Virtually all plans would be in violation, because employers typically provide richer benefits to younger retirees than to older retirees who are eligible for Medicare benefits.

While the 3rd U.S. Circuit Court of Appeals ruling was a bombshell, its impact was short-lived. Within a year of the ruling, the EEOC, the federal agency that enforces age discrimination law, reversed its policy, saying that it would no longer enforce the ruling.

Last year, the EEOC proposed a final rule that would exempt retiree health care plans from the ADEA, an action that would allow employers with retiree health care plans to continue to offer different levels of benefits to the two groups.

Publication of the final rule had been expected to put an end to the controversy and ensuring that long-standing employer plan designs could continue without fear of legal challenge.

But the AARP, fearful that employers would begin axing coverage to Medicare-eligible retirees, filed suit to block the EEOC rule perma-

nently.

In its complaint, the AARP says the EEOC lacks the legal authority to issue an ADEA retiree health care plan exemption.

"Congress has not delegated to the EEOC any rulemaking authority in the substantive field of health care policy, nor does the EEOC possess any expertise to weigh factors relevant to the challenged exemption, or to accurately predict the consequences of the exemption itself," the complaint says.

If the final EEOC rule is published, AARP members "will suffer irreparable harm" because employers throughout the country will reduce or eliminate health care to older retirees, the AARP complaint adds.

But others say if the AARP prevails, it is retirees who will be hurt. At a time of rising costs, employers will reduce the coverage provided to younger retirees or eliminate coverage for the two groups rather than upgrade coverage for Medicare-eligible retirees, benefit consultants say.

"If anything, you will see cutbacks for younger retirees or the elimination of coverage. Employers aren't going to do anything" that would increase their retiree health care obligations, said Cara Jareb, director of retiree medical consulting for Watson Wyatt Worldwide in Washington.

Aon: \$50 million for settlements

Continued from page 1

in the state of New York and with the investigations by other states as well," Mr. Ryan said. "We have not yet reached settlements with any of these jurisdictions. However, our discussions have progressed to the point where we felt it was appropriate to put up a liability reserve, which we have at this point set at \$50 million. We picked this amount based on all the facts and circumstances today and after thorough discussions with our accounting and legal advisers."

A spokesman for Mr. Spitzer's office declined to comment specifically about Aon, but he referred to Mr. Spitzer's comments the day the Marsh settlement was announced, in which the attorney general suggested there would be more settlements and more guilty pleas to come (BI, Feb. 7).

Industry observers say that Aon's \$50 million reserve is a conservative amount and that the figure will most likely rise once settlements are reached. Still, they don't expect the figure to be as high as the \$850 million Marsh agreed to pay last month.

According to Donald Light, a senior analyst with Celent Communications in San Francisco, "It's not so much the number as it is the message. And the message is, 'We're going to have to pay some money to Spitzer and other states' attorneys general and maybe even the odd insurance department along the way.'"

"The other part of the message is a qualitative message, and that is, 'We're not going to get as bad of a haircut as Marsh got,'" Mr. Light said.

Indeed, "the big unknown is the basis and foundation" of any settlement, said Timothy J. Cunningham, a partner with brokerage consulting firm OPTIS Partners L.L.C. in Chicago. "On a relative basis, (the \$50 million) is smaller than Marsh's \$850 million, so one could reasonably conclude that...whatever problems or issues that might have existed are fairly minor," he said.

Whether the eventual charges are minor in comparison to the fraud and bid-rigging charges against

Marsh, observers agree that Aon's ultimate settlement will likely be larger than its \$50 million reserve.

"My take is it's conservative, in that it's a provision that comes ahead of actually being charged," said John Ward, a Cincinnati-based insurance industry analyst.

But Ken Adams, a partner in the Washington office of Dickstein Shapiro Morin & Oshinsky L.L.P., said the amount is likely to be Aon's best estimate. "It would be surprising if they deliberately underestimated it," he said, noting that such an action could expose them to shareholder lawsuits. "It's just too



'Our discussions have progressed to the point where we thought it was appropriate to put up a liability reserve, which we have at this point set at \$50 million.'

Patrick G. Ryan
Aon Corp.

risky of a thing to do," he said.

"I think they probably believe in good faith that they may be able to resolve with Eliot Spitzer and other attorneys general for \$50 million, but that doesn't address what I think will be the larger cost to Aon, which is resolving the civil claims of their customers," Mr. Adams said.

Last July, a circuit court judge in Cook County, Ill., granted class action status to a 1999 lawsuit against Aon alleging that the brokerage breached its fiduciary duty by taking contingent commissions from insurers without disclosing them to policyholders (BI, Aug. 2, 2004).

The brokerage faces a number of similar suits, as well as several securities class actions and suits filed under the Employee Retirement Income Security Act, all relating to broker compensation practices, according to U.S. Securities and Exchange Commission filings.

Aon's \$50 million settlement provision was just one factor leading to a 12.1% drop in its fourth-quarter 2004 earnings to \$189 million, the brokerage said last week. Contingent commission revenue

fell to \$15 million in the quarter, a 71.2% drop compared with the same period in 2003, reflecting its decision to terminate the arrangements late last year. Aon reported \$1.84 billion in insurance brokerage and consulting revenues in the fourth quarter, a 1.3% rise over the same period in 2003.

For the full year, Aon reported a 3.1% increase in revenues from its insurance brokerage and consulting segments, to \$6.99 billion. Total revenue, which includes revenues from its insurance underwriting unit and other corporate income, rose 4.7%, to \$10.2 billion. Net in-

come rose 4.1%, to \$654.0 million.

In 2004, Aon collected \$132 million in contingent commission revenue, compared to \$169 million in 2003, it said.

In the conference call to analysts, Mr. Ryan noted that while revenue growth was "disappointing," the brokerage continues to gain new clients, including Prudential P.L.C. in the United Kingdom. Mr. Ryan also noted that Aon has been chosen as the broker of record to place the insurance coverage for the construction of the Freedom Tower on the site of the former World Trade Center in New York.

Also during the conference call, Mr. Ryan said Aon is "getting closer to the end of the process" of selecting a new CEO.

"I think the (selection) committee and I personally are feeling quite good about the quality of people interested in the position and feel good about the fact that we will have a few high-quality people from which to make a final decision," said Mr. Ryan, who announced last fall that he will step down as CEO once his replacement has been found.

Class action: Bill passes Senate

Continued from page 1

state in which the action was originally filed before a case can be considered for removal to federal court. Also under the bill, a federal judge could, at his or her discretion, decline to exercise jurisdiction in a class action in which more than one-third but less than two-thirds of the members of the proposed plaintiff class and primary defendants are citizens of the state in which the action was originally filed, provided that the judge consider a half-dozen specific criteria for doing so.

The bill also would subject to greater judicial scrutiny so-called coupon settlements—in which class

members receive coupons for a defendant's goods or services in lieu of cash awards while the plaintiffs attorneys receive cash. The bill also would ban settlements in which class members suffer a net monetary loss.

Long-sought victory

Supporters stressed that their victory, while sweet, was the culmination of an extremely long and arduous process.

"It was a massive effort on the part of the business community generally," said Francis D. Bouchard, senior vp and director-federal affairs for Zurich Financial Ser-

vices Group in Washington. "It took man-hours, it took time—six years at least—and it took money. And these are the level of resources it takes to beat the trial bar in the U.S. Senate today."

"It showed something that our mothers taught us—that's that persistence pays," said Victor Schwartz, general counsel of the American Tort Reform Assn. in Washington. "This took almost seven years and was almost given up on at times, but persistence led to change," he said.

"Sometimes business cannot get everything it wants, but it can obtain some substantial benefits by

See CLASS ACTION/next page

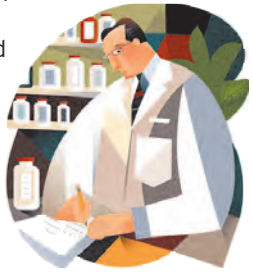
Late News

Continued from page 1

17.4% to \$646.9 million in 2004, while net income rose 16.8% to \$128.8 million. The Daytona Beach, Fla.-based broker attributed the gains in part to 19 acquisitions amounting to \$102.0 million in annualized revenue in 2003.

Reimportation bill introduced in Senate

A bill introduced in the Senate last week would allow licensed U.S. pharmacies and drug wholesalers that register with the U.S. Food and Drug Administration to reimport prescription drugs from Canada and other countries. S. 109, co-sponsored by 29 senators, also calls for the creation of a monitoring program, financed by fees on importers and exporters, to allow the FDA to ensure the safety of reimported drugs. Meanwhile, Vermont passed a bill directing the governor to join the I-Save-Rx program, which makes



prescription drugs from Europe and Canada available to residents in several states.

More reserve boosts set for 2004, S&P says

U.S. property/casualty insurers bolstered their prior-year reserves for a sixth consecutive year in 2004, according to a report by Standard & Poor's Corp. In "Dark Clouds Linger as U.S. Property/Casualty Insurers' Loss Reserves for Old Business Upped Again," S&P estimates that an additional \$13 billion will be placed in prior-year reserves in 2004. The report says that S&P's outlook on the U.S. commercial lines property/casualty industry remains negative because of continuing concerns about reserves, pricing discipline and the investigations into industry business practices.

W.R. Grace hid effects of asbestos: Grand jury

W.R. Grace & Co. and seven current and former Grace executives have been indicted by a federal grand jury on charges they concealed information about the health effects of the firm's asbestos mining operations and knowingly endangered the residents of Libby, Mont., as far back as the 1970s. The defendants also are accused of



Bill Mercer, the U.S. attorney for Montana, announces charges against W.R. Grace & Co.

obstructing the government's cleanup efforts. According to the indictment, about 1,200 Libby-area residents are suffering from some kind of asbestos-related abnormality. Grace, which filed for bankruptcy protection last year, denies any criminal wrongdoing.

CNA returns to profit after 2003 loss

CNA Financial Corp. reported \$441 million in net income for 2004, compared with a \$1.43 billion loss in 2003, when the insurer made \$2.00 billion in reserve strengthening and other charges. Net premiums written by the Chicago-based insurer's property/casualty operations

increased 5.7% in 2004 to \$6.97 billion, while CNA reported a 100.5% combined ratio for the year, compared with 135.6% in 2003. In a statement, CNA Chairman and Chief Executive Officer Stephen W. Lilienthal said, "After shedding noncore businesses and strengthening our balance sheet in 2003, our focus has turned to controlled, orderly execution."

Former XL exec Lusardi joins White Mountains

Robert R. Lusardi has joined White Mountains Insurance Group Ltd. as executive vp and managing director after seven years with XL Capital Ltd. Mr. Lusardi, who served as chief financial officer of Hamilton, Bermuda-based XL and later as chief executive officer of its financial products and services segment, is joining White Mountains in Hanover, N.H.

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Online Poll

[2/7-2/11]

Do you agree with New York Attorney General Eliot Spitzer's charge that the insurance industry is "rife" with corruption in every line of coverage?



Yes 43.0%

No 50.5%

Not sure 6.5%

Class action: Senate passes bill

Continued from previous page

dealing with reasonable Democrats," Mr. Schwartz said.

"It was a long-time-in-coming victory," said Melissa Shelk, vp-federal affairs for the American Insurance Assn. "I think it illustrates that developing a proposal that can get bipartisan support is important."

"This is a process victory—substantive law wasn't changed under this bill. It was the process that was changed under this bill," said Mr. Bouchard.

The New York-based Risk & Insurance Management Society Inc. issued a statement saying that it "applauds the Senate's passage of the Class Action Fairness Act. This legislation represents a critical step toward reforming our nation's legal system and is a major achievement for RIMS' legislative agenda. Class action reform is long overdue and vital to the continued recovery of the American economy."

Mr. Schwartz said the Senate's action could have a positive impact

on the outlook for the Lawsuit Abuse Reduction Act, a House measure that would, among other things, require judges to sanction lawyers who bring frivolous lawsuits.

The Senate has said that "it's inappropriate to have litigation tourism," said Mr. Schwartz, referring to forum shopping. "The Class Action Fairness Act stopped litigation tourism for class actions but not for individual lawsuits," he said. He noted that the majority of asbestos, pharmaceutical and automobile liability suits are individual actions rather than class actions.

Mr. Schwartz also pointed out that, on the matter of class action reform, "the business community hung together, unlike (on) product liability and other areas, where they split."

"It should serve as a framework for future reforms and give hope to businesses and consumers across the country who have been saddled by the extraordinary costs of our

American tort system," Carl Parks, senior vp-government affairs for the Property Casualty Insurers Assn. of America in Washington, said in a statement issued shortly after the vote.

Lawrence Fineran, vp-regulatory and competition policy for the National Assn. of Manufacturers in Washington, said that the bill's effect on other tort measures might be indirect. The measure will have a direct impact, he said, "only to the extent that it demonstrates what bipartisan cooperation can do."

An opponent of the bill does not expect it to have a wide impact on other tort issues, such as medical malpractice liability reform.

"I don't think the medical malpractice bill will go through," said Frank Clemente, director-Public Citizen's Congress Watch, a Washington-based consumer group. He noted that medical malpractice liability reform does not have "the same firepower" that the class action effort had behind it.

WTC: Suit

Continued from page 3

and offices artificially excludes service providers when the (insurance) contract itself does not limit coverage in such a manner," the court wrote.

The lower court wrongly concluded that ABM must have a legal interest in the WTC property to claim coverage when New York law requires only that it have an insurable interest, the appeals panel added.

New York statutes define insurable interest as "any lawful or substantial economic interest in the safety or preservation of a property from loss, destruction or pecuniary damage." ABM's interest in the WTC met that definition, the court found.

The court remanded certain other coverage issues for further hearings in the lower court, including whether ABM's civil authority claims actually arose from official actions or from the company's own decisions.

BI Stock Index

[2/7 - 2/11]

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  **2522.66** **4.62**

Dow Jones  **10796.01** **0.75**

S&P 500  **1205.30** **0.19**

Largest gains

Aon Corp.	12.08%
AIG	8.29%
CIGNA Corp.	7.79%
Brown & Brown	7.14%
Transatlantic Holdings	5.98%

Largest losses

EMC Insurance Group Inc.	-9.02%
United HealthGroup	-4.38%
WellPoint Health Networks	-3.92%
Humana Inc.	-3.55%
Clark Inc.	-3.54%

Weekly change by market segment

Brokers	2.51%
Insurers/Reinsurers	0.73%
Managed Care Organizations	-0.23%

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

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