

**Civil actions filed over Chicago club deaths/ 4**

**Insurers not buried by big storm claims/ 4**

# Business Insurance

www.businessinsurance.com

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\$4

## Most buyers find offers of coverage too pricey, too limited Few buying TRIA cover

By **MARK A. HOFMANN**

**WASHINGTON**—Many U.S. risk managers are finding that the terrorism coverage insurers must, under federal law, make available to them by today is an offer they definitely can refuse.

In fact, only about a quarter of the clients offered the coverage mandated by the Terrorism Risk Insurance Act are buying it. The drawback to the coverage offers, they say, is not solely its cost but a combination of factors, including the limited breadth of the coverage

available.

TRIA requires insurers to offer terrorism coverage as an option on all lines of commercial property/casualty insurance they write as a prerequisite to participation in a government-backed cost-sharing program to help cover insured losses from future acts of terrorism. Under the act, which President Bush signed into law on Nov. 26, 2002, insurers had 90 days from enactment—or until today—to offer the coverage to their policyholders. Although the law applies to all lines, its overwhelming focus is on guar-

anteeing the availability of property terrorism coverage. But the law doesn't tell insurers how much to charge.

TRIA requires only an offer of coverage for "certified" terrorism attacks—those foreign-backed attacks certified as eligible for government cost-sharing by the secretary of the U.S. Treasury. That leaves losses from "noncertified" attacks, such as those caused by domestic terrorist acts, outside the act's scope. Of course, the law also doesn't require commercial clients to buy the coverage, and evidence so far indicates

that clients are not exactly rushing to do so.

"What we have seen as the general response to TRIA offers has been underwhelming, for the simple reason that those insureds who needed terror coverage to satisfy loan agreements had already purchased it last year," said Alexandra Glickman, managing director and practice leader of Gallagher Real Estate & Hospitality Services, a unit of Arthur J. Gallagher & Co. in Los Angeles. "The TRIA coverage is not as broad because of the exclusion for

See TRIA/page 18

### Late News

#### Trump looking for new property insurer

Casino owner and property developer Donald Trump says he is looking for a replacement for American International Group



Mr. Trump

Inc. as the insurer for his \$5 billion property portfolio. Mr. Trump said that despite general property market rate hikes over the past two years, other

insurers are now offering better rates than AIG. "We are seeing a lot of people wanting our business," he said. AIG said Mr. Trump's move is related to the insurer's refusal to participate in a bond issue. "Donald Trump has threatened not to renew AIG insurance policies on Trump properties because AIG declined to buy Trump junk bonds in connection with a debt offering," an AIG spokesman said. Mr. Trump said his decision was not related to the debt offering.

#### California court ruling favors the disabled

California's Supreme Court has strengthened employees' ability to sue employers in pending cases alleging discrimination based on physical disability. The court, in *Francisco Colmenares vs. Braemar Country Club Inc.*, unanimously held that the California's Fair Employment and Housing Act requires a plaintiff suing for bias to demonstrate a physical disability by showing a "limitation" upon a major life activity, the court's opinion states. In contrast, the federal Americans with Disabilities Act requires plaintiffs to show a "substantial limitation" on a major life activity.

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## Insurers can be liable for malpractice: 2nd Circuit Decisions on treatment at risk

By **JERRY GEISEL**

**NEW YORK**—A recent federal appeals court decision weakens health plans' federal immunity to malpractice claims brought under state law.

The case, *Cicio vs. Vytra Healthcare*, involves a cancer patient, Carmine Cicio, who sought a course of treatment that his insurer ruled was experimental and thus not covered by his plan. Later, the insurer approved a different course of treatment from the one recommended by Mr. Cicio's doctor, which it continued to deny until he died.

Mr. Cicio's widow, Bonnie Cicio, then sued the insurer, Vytra Health-

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# HIGH ALERT

## Businesses on guard for terror risk

### Employee, facility safety top concerns

By **SALLY ROBERTS** and **MICHAEL BRADFORD**

The recently heightened threat of a terrorist attack against the United States is causing concern among risk managers, who are taking steps to secure their buildings and to protect their employees and the public at large.

Earlier this month, Homeland Security Secretary Tom Ridge raised the government's five-step color-coded terrorism alert system to orange, indicating a "high risk" for a terrorist attack.

Since its inception in March 2002, the terrorism alert system has remained at the yellow, or "elevated," level, with two exceptions—around the first anniversary of the Sept. 11, 2001, terrorist attacks and now. On both occasions, the alert was raised one level, to orange.

Secretary Ridge said earlier this month that officials believed that the greatest chance of a terrorist attack taking place was during the hajj—the time of the annual Muslim pilgrimage to the holy city of Mecca, Saudi Arabia. Although the hajj ended Feb. 13, the terror alert

remained at the orange level as of late last week.

Preparing for another possible terrorist attack has been a priority for many risk managers since the attacks on the World Trade Center and Pentagon buildings more than a year ago. The recently heightened alert, though, is triggering even more concern over a potential attack—particularly over an attack of

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### Benefits Management Take-out

## HEALTH CARE COST CONTROL



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## Docs' price-fixing suit allowed to proceed

Physicians in Kentucky and Ohio can proceed with their price-fixing lawsuit against four local health insurers, a circuit court judge has ruled. The suit, *The Academy of Medicine of Cincinnati et al. vs. Aetna Healthcare Inc. et al.*, charges



that Aetna, Anthem Blue Cross & Blue Shield, Humana Inc. and United HealthCare Inc. acted in combination and collusion to reduce the reimbursement rates paid to physicians practicing medicine in northern Kentucky and the greater Cincinnati metropolitan area.

## CalPERS to offer credit service

The California Public Employees' Retirement System plans to enter the credit enhancement business, lending its AAA rating to lower-rated municipalities' bonds. The venture, which would involve working with a "strategic partner," is expected to generate \$3.5 million in fee income in the first year and, eventually, as much as \$17.5 million, CalPERS said. The plan approved by the CalPERS investment committee would involve a maximum commitment of the lesser of \$5 billion or 5% of CalPERS assets, which now total \$133 billion. CalPERS would issue letters of credit to municipalities across the nation that have investment grade ratings of at least A-1 or A+.

## AIG funds boost Euclidian capacity

Euclidian Group P.L.C. has received a capital boost of £50 million (\$80.7 million) from American International Group Inc. to support underwriting on Lloyd's of London syndicate 1243. The move brings the syndicate's capacity to £350 million (\$565.1 million) for 2003. The new capacity will be used to increase writings in several areas, including marine reinsurance and international property treaty business, as well as to expand into new lines, including aviation and space reinsurance and U.S. property treaty business, Euclidian said.

# Bankruptcy judge restricts asbestos suits against USG

By DAVE LENCKUS

**WILMINGTON, Del.**—Asbestos liability plaintiffs with fear-of-cancer claims against bankrupt USG Corp. suffered a major legal setback last Wednesday when the company's bankruptcy court judge ruled he would consider claims only from claimants who are suffering or have died from asbestos-related illnesses.

Under the order by U.S. Bankruptcy Court Judge Alfred M. Wolin, the court will consider claims by only those plaintiffs with mesothelioma, lung cancer and other cancers. Those claims alone could make USG insolvent, the judge noted.

"By focusing on those claimants who have indisputably been damaged, the court need not, at this juncture of the case, delve into the troubled and occasionally metaphysical controversy of the so-called 'unimpaired' class of claimants," wrote Judge Wolin of the U.S. Bankruptcy Court in Delaware.

USG faces claims from 190,000 plaintiffs.

The company had sought an order that would have required it to compensate only claimants who could show that their illnesses were caused by exposure

**'By focusing on those claimants who have indisputably been damaged, the court need not delve into' the controversy of 'unimpaired' claimants.**

Judge Alfred M. Wolin  
U.S. Bankruptcy Court

to chrysotile asbestos, the type USG used in its products. Such an order would have precluded awards to seriously ill claimants with mesothelioma, because USG's products did not cause that form of cancer, USG argued.

Under its plan, USG said, it would have been able to fully

compensate the remaining seriously ill claimants without becoming insolvent.

Judge Wolin ruled, though, that USG could raise defenses against even those plaintiffs who claim they are seriously ill, after the plaintiffs submit 10 categories of information about their illnesses. Under one of the categories, plaintiffs must provide their smoking history.

Several state courts hearing asbestos liability cases have streamlined that litigation by moving claims from physically unimpaired individuals to inactive dockets, where those claims will remain dormant until the claimants develop physical problems allegedly triggered by their exposure to asbestos. Meanwhile, the U.S. Supreme Court is reviewing a case that questions whether fear of cancer alone is enough to justify noneconomic damages in certain asbestos liability cases. In addition, a U.S. Senate bill would require that asbestos claimants meet minimum medical criteria.

## Segal diverted funds to politicians: Prosecutors

Near North Insurance Brokerage Inc. owner Michael Segal improperly diverted hundreds of thousands of dollars from a trust account to make



Mr. Segal

loans, gifts and political contributions to Chicago politicians, federal prosecutors have alleged in a court filing. Details of the filing were reported by Crain's Chicago Business, a sister publication of *Business Insurance*. In documents filed as part of Mr. Segal's upcoming trial in April on federal fraud and racketeering

charges, prosecutors said he maintained a \$5 million to \$7 million deficit for years in a trust fund that insurance brokers are required to hold on policyholders' behalf. The missing funds went toward operating expenses, business expenses "and other personal expenses," prosecutors charged.

## TRENWICK GROUP

### Trenwick posts increased losses

Trenwick Group Ltd. reported a \$386.1 million loss for 2002, compared with a \$154.4 million loss in 2001. The Hamilton, Bermuda-based reinsurer reported gross revenues of \$1.14 billion in 2002, a 10.2% increase over 2001. Trenwick increased its loss reserves by \$223.5 million in 2002. The 2002 results

also include a charge of \$150.2 million related to deferred tax assets and a charge of \$41.7 million related to changes in accounting rules, a Trenwick statement said.

### Hannover Re forecasts growth in profits

The Hannover Re Group expects to report profits of 250 million euros (\$270.4 million) for 2002, significantly higher than the 11.1 million euro (\$10 million) profit it reported in 2001. But its latest 2002 earnings projection fell short of its forecast last November for profits of 300 million euros (\$324.5 million). The reinsurer wrote off 81.7 million euros (\$88.4 million) in equity losses in the fourth quarter of 2002. Hannover Re expects to report 2002 gross written premiums of 12.5 billion euros (\$13.5 billion), a 9% increase over its 2001 volume.

## Briefly noted

**Higher benefit costs** related to pension plans are expected to continue to take a toll on the financial results of Kraft Foods Inc., the Northfield, Ill.-based company warned. Kraft said lower returns on pension assets and higher retiree medical costs slowed profit growth in 2002 and will also reduce its 2003 earnings growth by three percentage points. Kraft said it will maintain its long-term pension asset return assumption at 9.0% but will reduce its discount rate to 6.5% from 7.0%....**XL Weather & Energy Inc.**, formerly Element Re Capital Products Inc., has added three contingent risk experts. The unit of Bermuda-based XL Capital Ltd. said the team, which came from weather risk management company Aquila Inc., will be based at XL Weather & Energy's offices in Stamford, Conn., and Overland Park, Kan.... Standard & Poor's Corp. has placed its BB+ financial strength rating of **Kemper Insurance Cos.** under review with negative implications. S&P cited concerns about the Long Grove, Ill.-based insurer's earnings expectations and capital adequacy, among other factors....**Ohio Mutual Insurance Group** has named James J. Kennedy as chief executive officer. Mr. Kennedy previously was vp of the Preston Insurance Agency in Warwick, R.I. William Booher, interim CEO, will become president. The Bucyrus, Ohio-based property/casualty insurer writes both personal and commercial lines, including inland marine and commercial auto....A.M. Best Co. has downgraded **Medical Liability Mutual Insurance Co.** to B++ from A-. The downgrade reflects the reduction in New York-based MLMI's capital and a deterioration in its operating results, the ratings agency said....Specialty insurer **HCC Insurance Holdings Inc.** reported profits of \$105.8 million for 2002, up 250.3% over its 2001 profits. Gross revenues increased 32%, to \$669.4 million.

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

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Chicago Police Department vehicles in front of the building that houses the E2 nightclub, where 21 people were killed in a Feb. 17 stampede for the exits.

PHOTO: JONATHAN DANIEL/GETTY IMAGES

# Deadly Chicago stampede leads to civil litigation

## Altercation at second-story club leads to 21 deaths

By JOANNE WOJCIK

**CHICAGO**—Lawsuits are mounting against the owners of a nightclub in Chicago where 21 people were killed in a panicked stampede last week.

In addition to at least five individual civil actions filed last week in Cook County Circuit Court are at least two suits seeking class-action status, one of which also charges the city of Chicago with failing to enforce a July 2002 court order closing the club for safety violations.

In the early-morning hours of Feb. 17, 21 people were killed and at least 30 others were seriously injured when patrons fled the E2 nightclub after security guards used pepper spray to quell an altercation on the dance floor. It is estimated that as many as 500 people may have been crammed into the club, located on the second floor of a former warehouse on Chicago's near south side. The building also houses the upscale restaurant Epitome on its first floor; both establishments have been closed since the incident.

So far, none of the suits specifies an amount of damages being sought.

Plaintiff's attorney Robert Phillips said he understands "one or more of the co-defendants have multiple layers of insurance, including umbrella and excess."

"We don't know if it's going to be enough to adequately compensate the families, but it's a significant amount," Mr. Phillips said. The coverage is in the "seven digits," he said, declining to elaborate.

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But reinsurers maintain no binding deal was struck

# Lawsuit contends reinsurers reneged on Reliance claims

By DOUGLAS McLEOD

**KANSAS CITY, Mo.**—An auto warranty company is suing London market insurers for allegedly reneging on a \$10 million settlement covering thousands of warranty contracts insured by defunct Reliance Insurance Co. and reinsured with London insurers, including Lloyd's of London syndicates.

Mechanical Breakdown Protection Inc., a Lee's Summit, Mo., warranty administrator, filed suit in a Kansas City, Mo., federal court this month, charging that the London insurers failed to follow through on a deal to fund claims under Reliance-insured contracts that will remain in force through 2004.

MBPI issued about 35,000 such contracts through auto dealers in Arizona, California and several Midwestern states and has advanced more than \$1.8 million to cover

contractholders' claims. Auto dealers have also incurred large unreimbursed costs for repair work, according to Robert O. Jester, a partner with Ensz & Jester in Kansas City, representing MBPI.

"They just changed the deal," Mr. Jester said of the reinsurer's alleged

**'There never was an agreement to pay \$10 million; they were just exploratory discussions.'**

Michael Payton  
Clyde & Co.

efforts to force down the amount of the settlement.

But the London underwriters assert that there was no formal agreement in place.

"It would be fair to say that the reinsurers are incensed at these alle-

gations," said Michael Payton, senior partner at law firm Clyde & Co. in London, which represents the reinsurers.

The reinsurers had held confidential discussions with MBPI and regulators in Pennsylvania who are overseeing the runoff of Reliance, but they had not entered into a binding agreement, he said.

"There never was an agreement to pay \$10 million; they were just exploratory discussions," Mr. Payton said.

The reinsurance program was led at Lloyd's by syndicate 994, which is managed by Greenwich Insurance Holdings P.L.C., and in the London company market by CNA Re Ltd., a former CNA Financial Corp. unit that is in runoff.

The reinsurers are "considering all options" in their defense of the suit, Mr. Payton said.

Under rules followed by the U.S.

See **LLOYD'S**/page 6

# Economies of scale help trim liability cost of risk: Study

By GAVIN SOUTER

Large companies benefit significantly from economies of scale with regard to covering their liability exposures, according to a study by Marsh Inc.

Policyholders with revenues of \$10 billion or more face an average cost of risk of \$1.68 for each \$1,000 of revenue, whereas for policyholders with revenues of up to \$200 million, the cost of risk is \$18.74 per \$1,000 of revenue. The average cost of risk for all policyholders surveyed is \$2.45 per \$1,000 of revenue, according to Marsh's "Casualty Cost

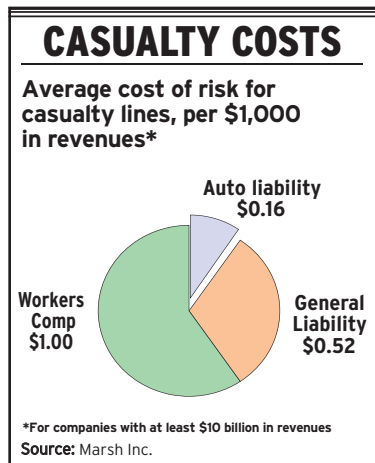
of Risk 2003."

New York-based Marsh based its findings on survey responses from 1,050 policyholders, representing a wide range of total revenues. The cost-of-risk figure includes insurance premiums, retained losses, claims-handling costs and other administrative expenses.

Measured by different comparisons, large companies still enjoyed a significant advantage over smaller companies, but it is less pronounced than the revenue comparison.

For example, the average cost of

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Plows work at clearing snow from Reagan National Airport near Washington, D.C., on Feb. 17 after nearly two feet of snow fell, paralyzing the airport and the D.C. metropolitan area.

PHOTO: REUTERS/BRENDAN McDERMID

# Insurers dodge blizzard of claims

## Big storm produces light losses

By MICHAEL PRINCE

Although last week's winter storm in the Northeast disrupted travel and paralyzed several major metropolitan areas, the deep snows aren't expected to produce insured losses on a par with previous major winter storms.

The storm pounded states from Ohio to North Carolina up to Vermont with strong winds, blowing snow and accumulations of over two feet of snow in some areas. Airports closed, stranding holiday travelers, while schools, businesses and government offices also were shut down.

The Property Claims Services unit of the Insurance Services Office Inc. declared the 16-state President's Day storm a catastrophe, meaning that insured losses are expected to exceed \$25 million.

But, by week's end, major claims had not piled up at insurers, according to a spokeswoman for the Insurance Information Institute Inc. Those claims insurers have received have generally been of small size, she said.

"Virtually nothing significant has occurred," said a spokesman for Warren, N.J.-based insurer Chubb Corp.

State Farm Insurance Co. received 6,271 homeowners claims as of last Friday related to the storm, a spokesman said. They came from a seven-state region where the level of claims attained catastrophe status. That total did not include claims from the New York area and New England, however, where State Farm's claims did not meet catastrophic levels.

The timing of the storm proved fortunate. Because it

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# Lloyd's: Warranty lawsuits filed

Continued from page 4

District Court for the Western District of Missouri, the two sides must submit to mandatory mediation before pursuing the case in court, Mr. Jester said. A mediation hearing will be scheduled after the reinsurers respond to the complaint.

MBPI used Reliance to insure vehicle service contracts it sold through car dealers from April 1994 to October 1998. The contracts run for six to seven years or until certain mileage limits are reached, and as many as 27,000 contracts remain in force, according to Mr. Jester and the complaint.

Reliance acted as a fronting insurer on the warranty program, reinsuring the business in London. After Reliance was ordered liquidated in October 2001, though, its policies covering the MBPI program were terminated effective Nov. 3, 2001, the suit says.

In meetings last year, representatives of MBPI, the reinsurers and Reliance's Pennsylvania liquidator reached an agreement to allow payment of warranty claims arising af-

ter the Reliance policies' termination, according to the suit.

Under the deal, Reliance and the reinsurers would be absolved of further liability in exchange for payment from the reinsurers of \$10 million that would be placed in a trust account to handle the runoff of claims until 2004. MBPI also arranged for a surety company, Kansas City, Mo.-based Traders Insurance Co., to guarantee claim obligations with the backing of the trust account, the suit and Mr. Jester say.

Last month, though—after the surety and other arrangements were in place and after the reinsurers had conducted another claims audit—the reinsurers backed away from the agreement, proposing a smaller, as-yet-unspecified settlement amount and offering payments to "squeaky wheel" claimants, the suit and Mr. Jester charge.

"For outrageous and bad faith reasons," the reinsurers are trying to force claimants to take "significantly less money than they are entitled to receive" by delaying payments

until contractholders lose interest in pursuing their claims, MBPI charges.

"Stated another way, (Lloyd's) proposes to profit from its own dilatory actions and bad faith acts in order to reduce the amount of settlement money it has heretofore agreed to pay," the complaint alleges.

MBPI has so far advanced \$1.8 million to cover contractholders' claims and has incurred other costs in arranging the surety coverage for the runoff, the suit says.

Auto dealers have also been stuck with unreimbursed expenses, Mr. Jester said. One dealer is holding MBPI-approved claims for \$600,000 in repair work it performed, and is carrying the amount as a receivable from MBPI, he said.

"Obviously, he's not a happy person," Mr. Jester noted.

In addition to breach of the settlement agreement, the complaint accuses the reinsurers underwriters of breach of contract, fraudulent misrepresentation and negligent misrepresentation.

## Paul Winston

### Let's get ready to arbitraaaaaate!

I've come up with a new scheme to tap into the billions of dollars generated by our litigation economy.

If my vision becomes a reality, it could not only lower the costs of litigation and liability insurance, but also spawn an entirely new entertainment genre.

My concept: dispute resolution centers with a twist. The twist is that the parties would be able to select from a menu of remedies, including cash, public humiliation and physical challenges. Another wrinkle is that these forums would have spectator seating with full bar service.

I even have a name for this business, thanks to a fellow wordsmith: Extreme Justice.

To parties with a dispute, Extreme Justice would provide a cheap and quick way to resolve disputes and win justice. And with the new penalties at stake, the outcome is sure to be satisfying.

To the public in search of a watering hole with new and exciting entertainment, Extreme Justice will offer a combination of courtroom drama, professional wrestling, demolition derby and reality TV.

I expect these centers to become as ubiquitous as Starbucks or Wal-Marts. In the bargain, I hope to become filthy rich while licensing Extreme Justice franchises and television rights.

A key foundation for my concept is the belief that most of the people now turning to the court system for minor and frivolous disputes are not as interested in obtaining a binding resolution in our formal legal system or gaining a windfall jury award, as they are in having a third party hear their gripe and affirm that they are right or that they were wronged. For these folks, I'm betting that using the dispute resolution services for a reasonable fee will be enough to satisfy their quest for justice.

This has the potential to dramatically lower the cost of litigation—and, in turn, the cost of insurance—while freeing up our courts to hear more serious and complex disputes.

Here's how the Extreme Justice dispute resolution process would work.

The franchise arbitrators would be real lawyers and former judges, who would hear disputes and render decisions on site. Parties with a dispute would schedule a hearing before one of these arbitrators for a flat fee.

Before the proceedings begin, both parties would each indicate which penalties they would be willing to entertain: monetary damages or, in lieu of that, public humiliation or a

physical test, such as eating a quantity of live insects or spending five minutes in a shark tank. The possibilities are endless. Upon a finding that one party was wrong, that person would choose one of the options to satisfy the judgment. For the squeamish or rich, a stiff monetary penalty. For the daring or poor, one of the other options.

This is where the other aspect of Extreme Justice—entertainment—comes into play. This relies on the belief that the public not only has a thirst for bringing lawsuits, but also for watching the drama of these contests unfold. How else to explain our enthrallment with the likes of "The People's Court," "Judge Judy" or other paragons of television

jurisprudence?

Extreme Justice will tap into this obsession, as well as our morbid fascination with witnessing public humiliation, discomfort and ruin. If you have any doubt about this desire, consider the recent media frenzy over Michael Jackson, and such recent television fare as "Fear Factor," "The Chair" and "The Bachelor."

The forum for the proceedings would resemble a courtroom, but the gallery would be separated from the public by thick Plexiglas panels, not unlike at a hockey rink, to keep the public from interfering with the proceedings. Did I mention the full-service bar?

I believe the first Extreme Justice franchises could be profitably established in such judicial hotspots as Los Angeles and Oakland, Calif.; Edwardsville, Ill.; Beaumont, Texas; and New Orleans. All of these locations have a reputation for being particularly conducive to litigation.

From there, I would expect to negotiate a deal whereby Extreme Justice franchises would open in Wal-Mart Stores nationwide. As Wal-Mart is fast becoming one of the country's biggest targets for lawsuits, being named in about 5,000 lawsuits annually, it not only would see this as a revenue-generating opportunity to attract clientele but also a means to reduce its litigation expenses. Of course, some middle-aged male managers might balk at having to greet customers in lingerie to satisfy a public humiliation judgment.

If this scheme takes off, as I am confident it will, look for an Extreme Justice franchise in a strip mall near you soon. I then will move on to my next grand plan: Replacing the U.S. Supreme Court with a Roman coliseum.

Paul Winston can be reached at [pwinston@crain.com](mailto:pwinston@crain.com).



Paul Winston



## Now What?

Retiree health insurance costs are soaring. Administrative pressures are mounting. With so many obstacles, it's tough to move forward. That's why you need NEBCO. As specialists in the retiree medical arena, we work with independent agents to administer a full range of health and life benefit solutions. We can lower your costs, reduce your FASB liability and eliminate your administrative burden. The first step? Contact us today.



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## Editorial

# TRIA already is a success

**N**O ONE DISPUTES THAT enactment of the Terrorism Risk Insurance Act was a victory for risk managers and insurers alike.

The guarantee of a federal backstop for losses arising from certain future terrorist events was rightly viewed as a way to promote economic growth and return some certainty to a very uncertain post-Sept. 11 insurance market. It took more than a year of battle on Capitol Hill—a battle in which risk managers played a major role—to win that guarantee.

With the guarantee, however, came responsibility: insurers that agreed to participate in the backstop program had to offer terrorism coverage to policyholders within 90 days of enactment. That deadline

happens to be today.

But as we report on Page 1, risk manager response hasn't exactly been overwhelming; only about a quarter of those offered terrorism coverage under the law have accepted it so far. And while the eventual number is likely to increase—policyholders have 30 days in which to accept or decline an offer—it also seems likely that considerably less than half of those receiving offers of coverage will accept them.

Does this mean that all the effort expended in winning enactment of TRIA was wasted? Absolutely not. After all, the business of risk managers is just what the name says, managing risk. And managing risk means making decisions, which most definitely include deciding

whether certain coverages are cost effective. Adding terrorism coverage will not make sense for all risk managers, particularly in the midst of the hardest market many remember.

For others, adding terrorism coverage made so much sense that they did not wait for the TRIA-mandated offers and instead bought stand-alone policies that in some cases provide broader coverage than under the required coverage.

TRIA provides a valuable risk management tool whether or not every risk manager uses it. The fact that more risk managers aren't necessarily accepting the terrorism insurance offered under the law is far less important than the fact that they won the right to receive that offer in the face of daunting odds.

# Don't waste opportunity

**I**NSURERS AND BUSINESS groups are applauding the American Bar Assn.'s recent asbestos litigation reform proposals, and rightly so.

With legislation mirroring the ABA proposal already introduced in the Senate, this is clearly a historic opportunity to fix a system that is obviously broken. As industry groups note, it's rare for the legal profession to propose curbs on plaintiffs' ability to file lawsuits. The U.S. Chamber of Commerce called the ABA "a very, very welcome voice adding to a growing chorus calling for a legislative solution."

We couldn't agree more.

The ABA's proposals represent nothing less than an overdue ac-

knowledgment that asbestos litigation has reached a state of absurdity.

Mounting asbestos liabilities are a major problem for businesses and their insurers. Insurers and reinsurers continue to struggle with reserves for future asbestos claims. Even companies only remotely connected to asbestos are facing claims from plaintiffs who show no signs of serious illness. We agree with the ABA that this kind of aggressive litigation ultimately will deprive the truly ill of needed compensation.

That's why standards for filing asbestos claims based on medical criteria make sense. We're not suggesting that individuals injured by exposure to asbestos be barred from

seeking compensation. Rather, we believe that recovery should be restricted to those who are ill. We also agree that the long latency of asbestos-related illnesses gives strong support to the ABA's argument that statutes of limitations should be extended for those who may become seriously ill in the future.

Sen. Don Nickles, R-Okla., has introduced legislation that outlines the ABA's concerns and goes a step further, proposing restrictions on forum shopping by asbestos plaintiffs.

We realize that lawmakers have a lot on their collective plate at the moment, but Congress should not squander this opportunity to enact meaningful asbestos reform.

## Schillerstrom



## Letters to the Editor

### Prosecuting claims fraud harder than detecting it

To the editor: From my perspective as a self-insured, the Feb. 3 article "Self-Insureds Lagging in Detection of Claims Fraud, Little Investigating Done," misses the bigger point.

Outright or suspect fraud is being detected and investigated all the time. Being able to prosecute, much less win, a fraud case is an entirely different matter. Surveillance and most other supporting evidence appear to have little influence on commissions or courts and little bearing on their decisions. There is certainly no guarantee of a favorable outcome. And while some may view a nuisance settlement as a loss, it is often the only sure way to minimize further cost and exit a situation that has already passed the point of diminishing returns.

I often wonder why money is even wasted by states and insurers to advertise that insurance fraud is a crime. Detecting and investigating fraud is the easy part. Being able to do anything about it once detected is where the real problem lies.

**James D. Root**  
St. Petersburg, Fla.

### Job's characterization by BI was a disservice

To the editor: I was disappointed with the unfounded characterization made in the Feb. 17 Between the Lines column regarding my recent decision to serve the higher education community in a new and challenging role with Arthur J. Gallagher & Co.

I feel confident that you hold yourself and your colleagues to a high standard of accuracy in your reporting. That standard was not present in the Between The Lines article "Zebra Changes its Stripes."

The feedback from my prior colleagues at colleges and universities across the nation regarding my decision to seek new challenges has been consistently positive. Many risk managers work diligently for their institutions and struggle against false negative perceptions regarding our profession. Joanne Wojcik has done a disservice to the professionalism of every higher education risk manager by her failure to search out and communicate factual information to substantiate her improper characterization.

Every higher education risk manager is deserving of an apology for this poor performance.

**John E. Watson**  
Executive Director  
Higher Education Practice Group  
Arthur J. Gallagher & Co.  
Glendale, Calif.

*Editor's note: We regret Mr. Watson was not contacted before his job announcement was used to illustrate the phenomenon of risk managers joining brokerages. We apologize if the column implied he was moving to a disreputable profession or company. Between the Lines aims to provide insight and information in a thought-provoking way, but not through unintentional criticism or with inaccurate information.*

# Tort liability needed for its deterrent effect

By Jackson Williams

The business community has embraced a new tactic in its campaign to enact "tort reform."

In recognition of the stake that many Americans have in the stock market, either individually or as pension fund beneficiaries, big business now argues that lawsuits are



destroying the value of investments. They also argue that bankruptcies by companies that used asbestos are throwing Americans out of work.

At first blush, these claims seem alarming. But when you scratch beneath the

surface, all you see is a civil justice system that is working properly.

Nobel Prize-winning economist Joseph Stiglitz co-authored the American Insurance Assn.'s report on "The Impact of Asbestos Liabilities on Workers in Bankrupt Firms." It is undisputed that the massive cost of compensating asbestos injuries has bankrupted around 60 U.S. companies. According to its executive summary, the report is intended to "highlight the fact that payments to any claimants are not free and to illuminate some of the costs imposed on

workers as a result."

The report estimates that each worker at a bankrupt company will lose about \$8,300 of the value of company stock in his or her 401(k) account, amounting to an aggregate loss of \$350 million. It also estimates that some 60,000 jobs will be lost, with each worker losing up to \$50,000 in salary over his or her career, for a total loss of up to \$3 billion.

What benefits to society are gained at these costs? The purpose of tort liability is to require firms to bear the costs of the injuries they cause. This creates an incentive for firms to make and sell only safe products. If the projected injury costs of a product exceed the revenue that product will generate for the firm, the firm will not market the product.

In the case of asbestos, the tort system's incentive effect did not work. Manufacturers mounted a cover-up of asbestos' harmful effects, as shortsighted managers tried to milk the product for additional sales. Eventually the long-latent diseases caught up with the companies, leading to litigation and bankruptcies.

The bankruptcy courts assigned ownership of the asbestos companies' assets to trusts benefiting the injured victims. The company units that produced non-asbestos goods remained in business, their profits plowed into compensation. Company stockholders lost their equity, and the executives who caused these losses were rendered unemployed and, one hopes, unemployable.

In the case of asbestos, the tort system broke down in the sense of *specific deterrence*—it did not deter the managers

from injuring the victims or destroying shareholder value. But it did not fail to provide *general deterrence*—a lesson to all investors and executives of the dangers to themselves in associating with companies that endanger others.

**At first blush, big business' claims that lawsuits are destroying the value of investments and throwing Americans out of work seem alarming. But when you scratch beneath the surface, all you see is a civil justice system that is working properly.**

"Mass torts" like the asbestos disaster remind every executive seeking to acquire a new company to exercise due diligence in ascertaining potential liabilities. They remind managers and stock analysts to track down reports of injured consumers and take them seriously. The stock market will reward safety-conscious companies and punish the negligent ones, reinforcing the deterrent effect.

Implicit in the AIA's release of the asbestos report—but by no means explicit in the authors' commentary—is that these benefits aren't worth the costs to workers or investors.

But let's put the numbers in perspective. What are the costs to society of punishing

sex offenders? According to the Bureau of Justice Statistics' most recent report, there are about 88,000 such offenders serving sentences that average 14 years. Assuming, as did Stiglitz et al., that the value of each one's labor is \$40,000 per year, the cost to society (not counting the costs of the resources used to find and incarcerate them) is \$49 billion. By this standard, asbestos bankruptcies sound like a public safety bargain.

To some, even the costs of punishing sex offenders seemed too high. Roman Catholic bishops made that judgment, and now both citizen juries and the Vatican have repudiated their logic. It's ironic that the insurance industry would promote this rationale in the wake of the pedophile priest scandal.

Even if the costs of asbestos bankruptcies are too high, does the fact that they lower the value of workers' pension funds justify a change in public policy? Many varieties of poor business judgment by company managers lower the value of shares. Does the bankruptcy of Formica Corp. mean that government should bail out shareholders in out-of-style countertop manufacturers? Conversely, perhaps investors in trendy businesses like Internet startups should be bailed out. The whole premise of the report is silly.

Asbestos litigation raises a host of legitimate policy questions. How it affects stock prices is not one of them.

*Jackson Williams is legislative counsel for Public Citizen's Congress Watch in Washington.*

## Text provides instruction on D&O dos and don'ts

"Liability of Corporate Officers and Directors, Seventh Edition"

William E. Knepper and Dan A. Bailey  
Published by Matthew Bender & Co. Inc.  
800-223-1940; www.lexis.com  
\$235

By Dave Lenckus

Considering the huge corporate governance scandals over the last few years, this is as good a time as any for an exhaustive examination of the standard of behavior to which corporate directors and officers should adhere.

In very readable fashion, that is what the authors of "Liability of Corporate Officers and Directors" provide their broad-based



readership. The two-volume effort by insurance attorney Dan A. Bailey and several colleagues at the Arter & Hadden L.L.P. law firm is as much an instruction manual for risk managers and corporate directors and officers on the dos and don'ts of

corporate governance as it is a case law textbook for defense attorneys and lawyers who engage in D&O insurance battles.

The authors do not just lead readers through important court decisions and statutes but also interpret and analyze them—albeit occasionally from the perspective of D&O insurers. They keep the legalese to a minimum and explain the legal

## Book review

jargon with which readers should become familiar.

Unlike the previous hardbound editions, the latest edition is printed in a loose-leaf form so updated material can be added easily. But the breadth of longstanding case law and statutes that the authors analyze is the real value of this work, Mr. Bailey suggests in a forward.

Although some may think new rules are needed to define directors' and officers' conduct in today's business environment, "in almost every instance where D&Os are criticized for perceived wrongdoing today, they failed to comply with basic principles of sound corporate governance and with their simple and long-established fiduciary and statutory duties," Mr. Bailey writes.

The authors set out to detail those duties over 27 chapters and seven appendices.

The 15 chapters in the first volume largely focus on directors' and officers' various duties—including those falling under the business-judgment rule and the duty of obedience to applicable statutes and corporate charters—as well as their various liabilities, including to creditors and other third parties, to employees, during takeovers and mergers and under criminal statutes and the Employee Retirement Income Security Act of 1974.

The first volume also includes a chapter on federal securities laws. That chapter covers the implications of the 2002 Sarbanes-Oxley Act, which regulates a wide variety of director and officer behavior.

The second volume largely focuses on D&O insurance issues, including litigation settlement, insurer claims handling, allocation of coverage between entities and executives, significant insurance policy clauses and provisions and coverage exclusions.

While the authors cover case law and statutes on a wide range of issues, explain the

nuances of how jurisdictions may apply those laws and statutes differently, and even examine the law in some specific jurisdictions, the authors do not cover D&O liability and insurance law on a state-by-state basis.

Overall, though, readers of this work will come away with a clear picture of the D&O liability landscape.

## Guidelines for the submission of Perspectives articles to BI

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

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

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## Investment losses greater than 9/11 claims in several cases, report says

# Falling stock prices challenging insurers

By CAROLYN ALDRED

Falling stock prices are having a more devastating impact on European insurers than are the huge liabilities arising from the World Trade Center tragedy, U.S. corporate scandals and asbestos, according to a new study.

"The stock market slump is now undoubtedly the most significant factor influencing the future of the insurance industry, as insurers strive to maintain solvency levels and balance their assets and liabilities," said Dennis Mahoney, chairman and chief executive officer of Aon Ltd. in London, which commissioned the research by Oxford Metrica.

The study examined the balance sheets, shareholder valuation and



rating agency assessments of the 10 insurers and reinsurers with the largest exposure to insured losses from the World Trade Center disaster during the period between Sept. 10, 2001, and Oct. 31, 2002.

Stock market declines dramatically lowered the shareholder value of all the companies, apart from Berkshire Hathaway Inc., but the study found a marked difference between the impact on companies based in the United States or Bermuda vs. their European counterparts. The European companies have seen much a greater decline in their market capitalization, which is the market price of a company's issued and outstanding common stock, the study shows.

In addition, for most of the companies, including all the European companies, their investment losses related to worldwide stock market declines generally were larger than their underwriting losses stemming from the Sept. 11 attacks, the study shows.

While the companies' market capitalizations still are "fairly substantial," the industry needs a few years of low catastrophe losses and high premium levels to rebuild its capital," said Alan Punter, a managing director of Aon Ltd.

The study shows a distinct split between the scale of market capitalization changes among U.S. and Bermudan companies compared with companies based in Europe.

For example, Berkshire Hathaway's market capital increased 7.8% to \$112 billion from Sept. 10, 2001, to Oct. 31, 2002, while that of Allianz A.G. Holding fell 56.6% to \$27.2 billion during the same period.

The changes reported by other insurers studied were: ACE Ltd.,

See EQUITY/next page

## World Updates

### Employers boost U.K. pension funds

U.K. employers' contributions to pension plans have risen by around 14% during the past year, according to a study by London-based Incomes Data Services. IDS surveyed 339 occupational pension plans and found that, during the past 12 months, employer contributions rose to £6 billion (\$9.59 billion) from £5.3 billion (\$8.47 billion) in the previous year. IDS attributed much of the increase to "special contributions" that companies made to address deficits or, for example, to account for early retirements. IDS also noted that, despite the rise in employers' contributions, nearly 10% of all plans surveyed received no such contribution during the past year.

### Mercer to buy unit of KPMG in Germany

Mercer Human Resource Consulting has agreed to buy KPMG Deutsche Treuhand-Gesellschaft A.G.'s actuarial services division. The transaction, which must be approved by German regulatory authorities, will add about 70 pension consultants to Mercer's German operations. When the transaction is completed, Mercer will have about 180 employees in its German offices, which are in Cologne, Dusseldorf, Frankfurt, Hamburg, Hannover, Munich and Stuttgart. Terms were not disclosed.

### Great-West purchase prompts rating review

Great-West Life Assurance Co. has agreed to purchase Toronto-based Canada Life Financial Corp. The largely cash-and-stock deal is valued at about \$7.3 billion Canadian (\$4.85 billion). Following the announcement, A.M. Best Co. and Standard & Poor's Corp. placed their ratings of Winnipeg, Manitoba-based Great-West under review.

### Briefly noted

Andrew McMellin has been appointed underwriting director and business group leader at Lloyd's of London agency **Catlin Underwriting Agencies Ltd.** Mr. McMellin, who joined Catlin in 1999 as a class underwriter for nonmarine liability business, will oversee the company's professional liabilities business group....French reinsurer **SCOR S.A.** recorded gross written premiums of 5.02 billion euros (\$5.39 billion) for 2002, up 2.6%. SCOR said its retention rate increased to 89%, compared with 84% in 2001. The Paris-based reinsurer said it will announce its 2002 financial results early next month.



PHOTO: GETTY

Waters from the Elbe River flooded the city of Meissen, Germany, in August 2002. Floods ravaged other cities in central Europe last year, causing billions of dollars in insured losses.

## European insurers' reporting big 2002 flood losses

# Flood claims soak results

By CAROLYN ALDRED

Losses stemming from the widespread flooding in Europe last year are continuing to hit insurers.

Munich, Germany-based Allianz A.G. Holding reported last week that it paid out 635 million euros (\$681.6 million) in flood claims as of Jan. 31. Allianz estimates its total flood-related liabilities at 770 million euros (\$826.5 million).

Hanover, Germany-based Hannover Re Group last week said its gross flood loss for 2002 would be 143.2 million euros (\$153.7 million) but would fall to 69.7 million euros (\$74.8 million) after retrocessional reinsurance.

Among other European insurers reporting flood-related losses,

the Austrian insurance association said that the nation's insurers had 400 million euros (\$432 million) in flood losses in 2002. The flooding increased Austrian insurers' total property/casualty losses last year by 11.9%, to 4.44 billion euros (\$4.80 billion), according to the Vienna-based Verband der Versicherungsunternehmen Osterreichs.

Gross premiums for the 79 insurers that make up the VVO increased 6% to 5.76 billion euros (\$6.22 billion). The VVO expects gross premiums to increase by 4.5% in 2003.

Other insurers, including Paris-based AXA Group and the Czech Republic's Ceska Pojistovna, have also reported hundred of millions of euros in expected flood losses.

During the summer of 2002,

heavy rains led to weeks of rising flood waters that caused damage across countries including Austria, Bulgaria, the Czech Republic, Germany, Hungary, Italy, Romania, Slovakia and Spain. While economic losses have been estimated in the tens of billions of dollars, insured claims were expected to be a small fraction of that total.

Zurich-based Swiss Reinsurance Co. estimated last year that insured flood-related claims would exceed \$2 billion.

The flooding was considered one of Europe's costliest natural disasters in recent history. European insurers and reinsurers paid out more than \$5 billion in losses from Lothar, a windstorm that lashed parts of the United Kingdom and Northern Europe in December 1999.



PHOTO: AP/WIDE WORLD

Headquarters of Fiat S.p.A.

## Fiat to sell multiline insurance unit Toro

### Buyers sought

**TURIN, Italy**—Automotive company Fiat S.p.A. plans to sell its multiline insurance arm, Toro Assicurazioni S.p.A., as part of a turnaround plan.

A spokesman for Turin, Italy-based Fiat said that Toro was one of several assets earmarked for sale in a restructuring plan for the troubled auto manufacturer. He declined to provide details about the asking price.

In 2001—the latest year of published annual results—Toro posted net income of 152 million euros (\$163.2 million) and wrote premiums of 5.75 billion euros (\$6.17 billion).

Earlier this month, Gabriele Galateri was named chairman of Toro, replacing Franzo Grande Stevens, who left the post due to "increased professional commitments" within Fiat.

Last year, Toro was thwarted in its attempts to increase its stake in Florence-based insurer La Fondiaria Assicurazioni S.p.A. after the deal hit regulatory snags (BI, Jan. 14, 2002).

—By Sarah Veysey

## Equity: European insurers hit

Continued from previous page

down 2%; XL Capital Ltd., down 3.3%; American International Group Inc., down 3.7%; St. Paul Cos. Inc., down 12.2%; Swiss Reinsurance Co., down 20.6%; Zurich Financial Services Group, down 36.9%; AXA S.A., down 39.8%; and Munich Re, down 48.3%.

That trend has continued over a longer period. The percentage declines in market capitalization between Sept. 10, 2001, and Feb. 18, 2003, are: ACE, down 3.1%; XL, down 4.5%; Berkshire Hathaway, down 7.5%; AIG, down 23.3%; St. Paul, down 22.3%; Swiss Re, down 27.3%; Zurich, down 59.0%; AXA, down 42.8%; Munich Re, down 59.8%; and Allianz, down 65.6%.

The impact of declining stock markets also hit the 10 companies'

investment portfolios. Traditionally, European insurers and reinsurers invest more heavily in equities than do their U.S. and Bermudan counterparts, though Berkshire Hathaway has more than 40% of its investment portfolio in equities, the report noted. ACE, AIG and XL Capital all have less than 5% exposure to equities.

The study notes, the four companies that suffered the biggest monetary declines in their invested equity portfolios—Allianz, Berkshire Hathaway, Munich Re and Swiss Re—are also the same four companies with the largest exposure to Sept. 11 losses. Conversely, the two companies with the lowest exposure to Sept. 11 claims—AIG and AXA—are the only two companies in the study that achieved positive

returns on their equity portfolios during the period studied.

Liabilities stemming from WTC; Enron and other corporate collapses; and long-tail liabilities together with the even-bigger losses caused by declining stock markets worldwide, have created a "nightmare scenario of unprecedented proportions for the industry," according to the study.

Although the insurance market "has survived remarkably well", underwriters now are "determined to underwrite for profit" and are "greatly reducing their reliance on investment income," the study notes.

Free copies of the study can be obtained by calling Sebastian St. John-Clarke at 44-207-505-7201.

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## Commentary

### Med mal reform is bad medicine

Linda McDougal, the Wisconsin woman whose doctor mistakenly performed a double mastectomy on her even though she was cancer-free, has decided to become the poster child against medical malpractice tort reform.

At the risk of sounding like a liberal, I'm with her.

The tort system's fundamental moral purpose is to punish those who harm others, and, where feasible, to force them to pay restitution to their victims. Capping doctors' malpractice liability for noneconomic damages at \$250,000—which is less than one year's salary for most of them—effectively removes the deterrent the tort system is meant to create.

Even the president's Council of Economic Advisors acknowledges that the existing tort system promotes patient safety. The council says that the ability of a patient to file a lawsuit "provides an additional incentive for the physician to follow good medical practice."

According to a March 2000 report by the Institute of Medicine, between 44,000 and 98,000 people die each year, and many more—such as Ms. McDougal—are injured by preventable mistakes. In addition, about 1 million medication errors occur in hospitals each year.

That's not all. The Centers for Disease Control and Prevention estimate that some 2 million hospital patients develop infections that result in another 90,000 deaths each year. To put these figures into perspective, the Journal of the American Medical Assn. estimates that physician negligence causes the equivalent of one jumbo-jet crash every three days!

Yet despite this epidemic of errors, fewer than 2% of the victims of medical malpractice ever sue their doctors, and, when they do, fewer than 10% of the suits make it to a jury. Even then, awards rarely come close to the magnitude of the harm that's been done. In fact, the median payment to a victim of medical malpractice in 2000 was just \$125,000, according to the National Practitioner Data Bank, not \$1 million as reported by Jury Verdict Research, the source that advocates of medical malpractice liability reform cite most often. In fact, verdicts of \$1 million occur in only 4% of medical malpractice cases, and they are usually reduced to a median of \$235,000 upon final judgment.

Why the discrepancy in the figures? Well, as its name suggests,

JVR collects only jury verdict information. The NPDB, on the other hand, includes both verdicts and settlements, and 96% of all med mal cases are settled, generally for smaller amounts than courts typically award.

Contrary to the claims by advocates of tort reform, government data show that med mal awards have increased at a slower pace than health insurance premiums have over the past five years. While NPDB data show that the median medical malpractice payment rose 35% from 1997 to 2001—an average of 8.5% a year—the average premium for single health insurance coverage increased 39% over that time

period, or an average of 9.5% a year.

If there must be a law limiting damages, it should make exceptions for particularly egregious acts of malpractice, such as "accidentally" removing a woman's breasts. And insurers should really underwrite this risk, charging higher premiums or even denying coverage to

doctors who are repeat offenders, just as they do to drivers with poor driving records. According to the NPDB, just 5% of all U.S. doctors are responsible for 54% of all malpractice claims. If a doctor can no longer buy insurance because he has been sued for malpractice numerous times, he or she shouldn't be treating patients.

Does anyone really think that Ms. McDougal's pain and suffering as a result of her permanent disfigurement is worth just \$250,000? And what about that other woman, the one who really did have an aggressive form of cancer, whose lab results were mistaken for Ms. McDougal's? Will her life be shortened because she wasn't immediately treated? And, if so, is her pain and suffering worth only \$250,000, too?

The NIS used the first part of the aphorism "to err is human" as the title of its report on the epidemic of medical errors plaguing this country. Fortunately, it didn't propose as a solution the second part, "to forgive, divine."

No, I think it is appropriate that the threat of losing their livelihood hovers, like the sword of Damocles, over doctors' heads. They are, after all, taking our lives in their hands.

Senior Editor *Joanne Wojcik's* commentary appears periodically and on [www.businessinsurance.com](http://www.businessinsurance.com). She can be reached at [jwojcik@crain.com](mailto:jwojcik@crain.com).



**Joanne Wojcik**

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UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK  
 IN RE PETITION OF DAN YORAM SCHWARZMANN AND MARK CHARLES BATTEN, AS PROVISIONAL LIQUIDATORS OF INDEPENDENT INSURANCE COMPANY LIMITED, DEBTOR IN A FOREIGN PROCEEDING CASE NO. 01-13899 (SMB)

**NOTICE IS HEREBY GIVEN** THAT ON FEBRUARY 13, 2003, THE BANKRUPTCY COURT ENTERED AN ORDER (THE "ORDER") CONTINUING THE PRELIMINARY INJUNCTION ORDER PURSUANT TO 11 U.S.C. §304 ORIGINALLY ENTERED IN THIS CASE ON JULY 31, 2001. THE ORDER SHALL REMAIN IN EFFECT PENDING A HEARING SCHEDULED TO BE HELD ON AUGUST 14, 2003 AT 10:00 A.M. (THE "RETURN DATE") BEFORE THE HONORABLE STUART M. BERNSTEIN, CHIEF UNITED STATES BANKRUPTCY JUDGE, IN THE UNITED STATES BANKRUPTCY COURT LOCATED AT ONE BOWLING GREEN, NEW YORK, NEW YORK. ALL PAPERS SUBMITTED FOR THE PURPOSE OF OPPOSING THE CONTINUATION OF THE ORDER AFTER THE RETURN DATE SHALL BE FILED WITH THE COURT, WITH A COPY TO THE CHAMBERS OF THE HONORABLE STUART M. BERNSTEIN AND SERVED ON COUNSEL FOR THE PETITIONERS LISTED BELOW. SO AS TO BE RECEIVED AT LEAST FOURTEEN (14) DAYS PRIOR TO THE RETURN DATE, ANY PERSON WISHING TO OBTAIN A COPY OF THE ORDER SHOULD CONTACT COUNSEL TO THE PETITIONERS.

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**IN THE HIGH COURT OF JUSTICE**

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**COMPANIES COURT**

No. 861 of 2003

**IN THE MATTER OF**

**LA METROPOLE S.A.**

**AND IN THE MATTER OF THE COMPANIES ACT 1985**

Notice is hereby given that, by an Order dated 14 February 2003 made in the High Court of Justice of England and Wales in the above matter, a meeting (the "Meeting") was ordered to be convened of the Scheme Creditors (as defined in the Scheme of Arrangement hereinafter mentioned) for the above named company (the "Company") for the purpose of considering, and if thought fit, approving with or without modification a scheme of arrangement (the "Scheme of Arrangement") proposed to be made between the Company and its Scheme Creditors. The Meeting will be held at PricewaterhouseCoopers LLP, 2-3 Bloomsbury Square, London, WC1A 2RL, United Kingdom on 7 April 2003 at 11 a.m. at which place and time all the Scheme Creditors are requested to attend. Scheme creditors are creditors in respect of the business of the United Kingdom branch of the Company, which was written between 1983 and 1985 by Travelers Corporation (UK) Limited (an English incorporated company that was placed in voluntary liquidation in 1990) and subsequently transferred to the Company pursuant to section 51C of the Insurance Companies Act 1982.

Scheme Creditors may vote in person (or, if a corporation, by a duly authorised representative) at the Meeting or they may appoint another person, whether a Scheme Creditor or not, as their proxy to attend and vote in their place.

It is requested that forms appointing proxies and voting forms be lodged at PricewaterhouseCoopers LLP, Plumtree Court, London EC4A 4HT, United Kingdom, for the attention of Baljit Goraya (tel: +44 20 7804 5339; fax: +44 20 7212 6316) not later than 10 a.m. on the appointed day of the Meeting. If forms are not so lodged they may be handed to the Chairman at the Meeting or alternatively sent by facsimile, by the same time and date referred to above, provided that if sent by facsimile then the original must also be sent by post (to the person and at the address referred to above), so as to be received no later than four days after the Meeting. Any Scheme Creditor completing and returning a form of proxy only will have the value of its claims determined for voting purposes by the Chairman of the Meeting on the basis of information available to the Company in respect of such claims.

By the said Order, the Court has appointed Dan Yoram Schwarzmann to act as Chairman at the Meeting and has directed the Chairman to report the result of the Meeting to the Court.

A copy of the Scheme of Arrangement, a copy of the statement required to be furnished pursuant to section 426 of the Companies Act 1985, a form of proxy and voting forms may be obtained from Baljit Goraya at the offices of PricewaterhouseCoopers LLP, Plumtree Court, London EC4A 4HT, United Kingdom, during normal business hours on any day (other than a Saturday or Sunday or public holiday) prior to the day appointed for the Meeting.

The Scheme of Arrangement will be subject to subsequent sanction of the Court.

Dated 24 February 2003

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The "side A" coverage is in addition to standard D&O insurance that Arch writes at limits of up to \$25 million. For information, call Thomas Gamble, 212-651-0490.

### RMS releases new U.S. hurricane model

**NEWARK, Calif.**—Risk Management Solutions Inc. has launched the third generation of its U.S. hurricane model, which it says is the first to fully represent the physical processes of the storms.

Among other enhanced features, the model incorporates new research into the phenomenon of

transitioning storms, which exhibit different characteristics from pure hurricanes. Transitioning storms pose particular risks to the Northeastern United States.

RMS' new research will change how companies manage risks related to the storms and how insurers underwrite those risks, Robert Muir-Wood, managing director of global risk modeling at Newark, Calif.-based RMS, said in a statement. More information is available from RMS, 510-505-2500.

### New guide reviews laws for boilers

**WASHINGTON**—A comprehensive, state-by-state guide to boiler and pressure-vessel laws is available from the American Insurance Assn.

The guide, "Boiler and Pressure Vessel Laws and Regulations," also covers several large metropolitan areas, including Chicago, Miami, New Orleans, New York and Seattle.

The book includes information on codes and standards, inspections, repairs and alterations, insurance inspection requirements, among several other topics.

The book is available online at [www.aiadc.org](http://www.aiadc.org). There is no charge for AIA members, and the cost is \$195 for nonmembers.



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## Nightclub: Civil actions filed

Continued from page 4

"Adequacy of limits will be the big issue here, even with coverage in the seven figures, and even if all seven of those figures are nines," said Randy J. Maniloff, an attorney with Christie, Pabarue, Mortensen & Young P.C. in Philadelphia who represents insurers in coverage matters.

Representatives of the club did not return calls seeking information on its insurance coverage.

A suit seeking class-action status filed by the Chicago-based law firm of Loevy & Loevy asks to have all the defendants' assets, including insurance proceeds, put in a common fund to be equitably divided among the victims and their families.

A second class-action suit, filed by Chicago-based Kenneth B. Moll & Associates, seeks similar treatment of defendants' assets and insurance.

All of the suits filed to date name as defendants the club and the restaurant, both of which are owned by Le Mirage Inc., which also is named as a defendant. Other defendants include Dwain Kyles, the president of Le Mirage; Calvin Hollins, Mr. Kyles' business partner; Lesly Benodin, the owner of the building where the club is housed; Lesly Motors Inc., Mr. Benodin's nearby car dealership; and Onesti Entertainment Corp., a Chicago-based coordinator of special events.

Mr. Kyles could not be reached for comment.

Mr. Benodin referred calls to his attorneys, Chicago-based Hardt & Stern, which did not return calls by deadline.

A spokesman for Onesti said that

his company was not providing services that night but apparently was named in the suits because "we did a show there once a long time ago and, unfortunately, I left it up on our Web site." He added that the company has insurance to defend itself but declined to provide details of the coverage.

**'We are also looking at the culpability of the city.'**

*Kenneth B. Moll  
Kenneth B. Moll & Associates*

Mr. Moll's suit also names the city of Chicago, which it charges with failing to enforce a court order issued last July closing the club after numerous safety violations were found by city building inspectors. Among the violations cited was a lack of suitable exits.

"We are also looking at the culpability of the city," Mr. Moll said.

Mr. Phillips said the city might also be named as a defendant in his clients' suit.

Though police had been summoned several times to stop disturbances at the club since the court order was issued, they did not enforce the order, Mr. Moll said.

But Chicago Police Superintendent Terry Hillard explained at a televised press conference last Monday that the Police Department is not notified of such court orders and has no role in enforcing them.

A city Law Department spokeswoman said the city had not yet been served with any of the suits. The spokeswoman added that if the

city were to be sued, it might use the Local Governmental and Governmental Employees Tort Immunity Act as a defense.

But whether the city could claim immunity depends on how the issues could be framed, according to Mr. Phillips. The state law would provide absolute immunity in some situations, regardless of the facts. In others, a court would waive the immunity defense if the city were shown to have displayed "willful and wanton conduct" or "conduct which exhibits reckless and conscious disregard for the safety of others."

Dan Kotin, an attorney at Corboy & Demetrio in Chicago who is not working directly on the case but expects that he will, said the government tort immunity act is "a pretty strong shield" in Illinois. For example, he said, the city cannot be found liable for failure to enact or enforce a law, nor can it be held liable for the issuance or denial of a license or for failure to conduct an inspection properly.

According to reports of statements by Andre Grant, the attorney representing the club's owners, the club continued to operate because the owners thought the court order referred only to a mezzanine level above the second floor of the warehouse in which the club is located. Mr. Grant did not return several phone calls seeking comment.

*Alby Gallun contributed to this story. Mr. Gallun is a reporter at Crain's Chicago Business, a sister publication of Business Insurance.*



PHOTO: REUTERS

**Pedestrians stroll down Wisconsin Avenue in Washington's Georgetown neighborhood, after a Feb. 17 storm dumped nearly two feet of snow on the area.**

## Storm: Deep snows, but only light losses

Continued from page 4

struck over the President's Day holiday, fewer people were at work than usual, which reduced commuting traffic.

In addition, although the snow was widespread and deep, it was also light and fluffy and did not cause as much damage as heavy, wet snow would have, said Rob Meyers, executive vp of loss adjuster GAB Robins North America Inc. in Parsippany, N.J.

Heavy, wet snow is more likely to down power lines, snap trees and destroy roofs, he said. "Light, powdery snow doesn't do a lot of damage."

Even so, many of this storm's commercial losses were from collapsed roofs. For example, a roof caved in under the weight of over two feet of snow at an APR Supply Co. location in Ephrata, Pa., said Scott Weaver, president of the Lebanon, Pa.-based plumbing and heating supply company.

"The steel support was twisted up like a pretzel," he said.

The sinking roof destroyed the sprinkler system, flooding the 20,000-square-foot location and damaging much of the inventory, Mr. Weaver said.

APR Supply is insured by Penn National Insurance Co., which hired contractors to fix the roof and remediate water damage.

In another incident from the storm, one person was killed and four others hospitalized when an awning collapsed on Monday outside the Edison Job Corps Academy in Edison, N.J. The U.S. Department of Labor owns the building and the job center is operated by ResCare, a spokeswoman for the center said.

One of the more-dramatic storm-related losses occurred in Knoxville, Tenn. Heavy rains from the storm triggered a mudslide that hit a

Knoxville apartment complex, pushing four apartments from their foundation and prompting the evacuation of dozens of people. One tenant was seriously injured.

Even if the number of claims grows, though, insured losses will likely pale in comparison with oth-

**'Light, powdery snow doesn't do a lot of damage.'**

*Rob Meyers  
GAB Robins North America*

er winter storms in recent years. In January 1996, for example, four storms caused a total of \$1.82 billion in insured losses in the Northeast, said a spokesman for Jersey City, N.J.-based ISO.

Insured losses from other large winter storms include:

- \$1.75 billion in losses from a winter storm affecting 24 states in March 1993.

- \$800 million in losses from a January 1994 winter storm.

- \$775 million from a January 1999 storm that spanned 26 states.

Although the snow itself is expected to cause relatively light losses, there is continued concern about the damages that could result from flooding as the snow melts, said Mr. Meyers of GAB Robins.

The National Weather Service echoed these concerns.

"At this time, we do not expect a repeat of the disastrous river flooding of late January 1996," Frank Richards, a senior NOAA hydrologist at the NOAA National Weather Service, said in a written statement. "However, where storm drains are now snow-clogged, serious urban flooding could be a problem unless concerted efforts are made to open storm drains."

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February 24, 2003

# Plans: Insurers can be found liable for malpractice

## Continued from page 1

care, and its medical director, charging medical malpractice under New York law. The case was dismissed on the grounds that the pre-emption provisions of the Employee Retirement Income Security Act preclude group health plan enrollees from suing insurers under state law for coverage eligibility decisions. Ms. Cicio appealed the case to the 2nd U.S. Circuit Court of Appeals in New York.

In its ruling, a panel of the 2nd Circuit ruled 2-1 that although ERISA would preclude a pure coverage-eligibility suit, the pre-emption provisions do not apply to so-called "mixed" eligibility-treatment decisions—those that involve both eligibility and treatment options.

**As a result of the court's decision, health insurers will be much more careful in evaluating and deciding on the care recommended by a patient's doctor.**

*David Trueman  
plaintiff's attorney*

The eligibility component of coverage decisions revolves around whether a particular condition is covered. Treatment decisions, however, center on the diagnosis of a patient's condition and, given those symptoms, what is the appropriate medical treatment. These two components often are so intertwined that they cannot be separated, the court said.

"We are not convinced such a distinction can in fact be drawn. In sum, it would be difficult to delve into physicians' minds to examine their decisions, which are frequently executed in very brief time periods and under tremendous pressures, to determine what part of them is medical and what part is administrative," the court said.

The "mere presence" of an administrative component in a health care coverage decision no longer has any significance in determining whether ERISA pre-emption should apply, the court held.

"Nothing in ERISA suggests that Congress intended any displacement of the quintessentially state-

law standards of reasonable medical care as applied to the medical component of a mixed decision," the court ruled.

The case was returned to the trial court to determine whether the treatment was, in fact, experimental and whether the insurer committed malpractice.

David Trueman, an attorney in Mineola, N.Y., who represented the plaintiff, described the ruling as a "victory for patients and justice for everyone."

As a result of the decision, he said, health insurers will be much more careful in evaluating and deciding

on the care recommended by a patient's doctor.

The decision "ensures a more level playing field," assessed Rhonda Orin, a managing partner in the Washington office of Anderson, Kill & Olick P.C., which filed an amicus brief supporting the plaintiff.

Just as a doctor can be held accountable for his or her medical decisions, a health insurer should be held to the same standard, she said. "Everyone has an equal obligation to do the right thing."

But Daly D.E. Temthine, an attorney with the law firm Epstein, Becker & Green in Washington, who rep-

resents managed care plans, said the court ruling fails to take into account fundamental differences in the obligations of a patient's doctor vs. his or her health insurer and its medical director.

The physician should be an advocate for the patient, he said. The role of a health plan medical director, however, is to weigh costs and the likelihood of success of a particular treatment, he said.

In short, Mr. Temthine asserted, the responsibilities of a treating physician and a health insurer are different, and, consequently, they should not be judged by the same

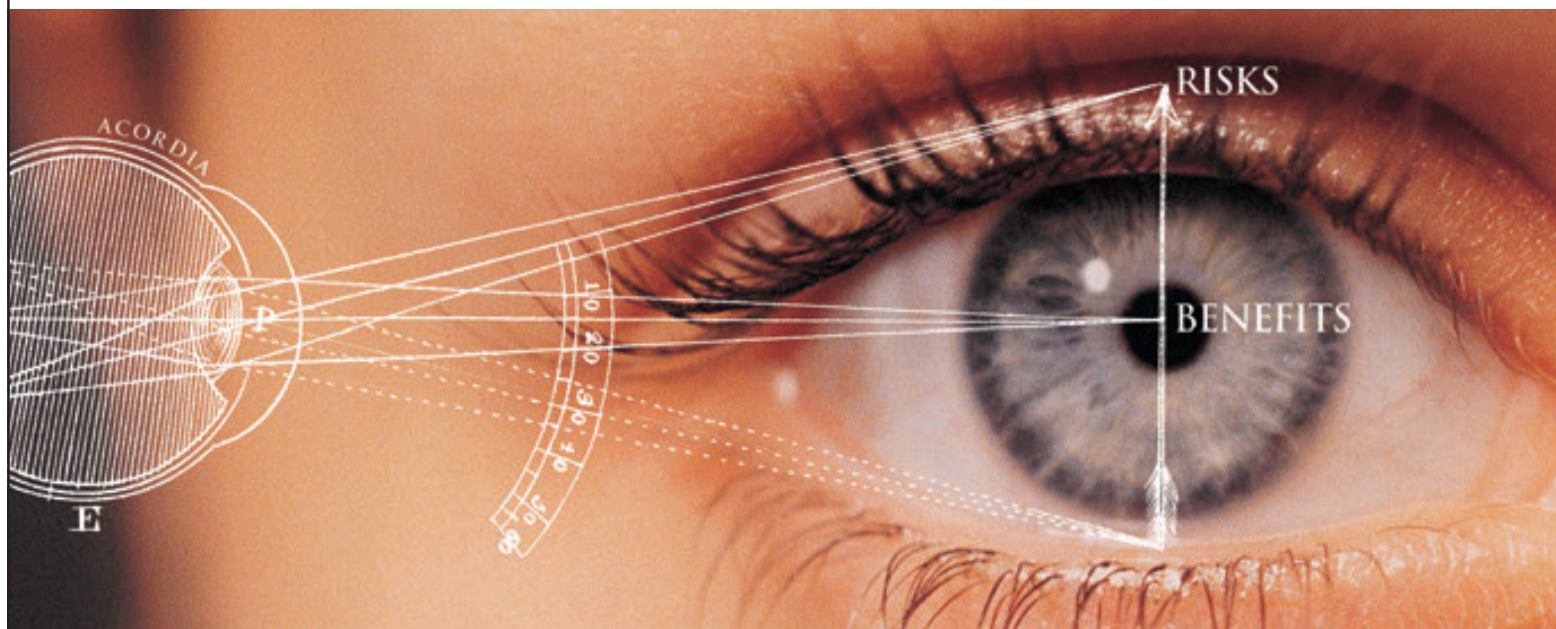
standards.

Others say that the ruling will lead to an increase in third-party review of coverage disputes.

"Medical necessity and experimental treatment disputes will be subject to independent review...this is destined to reduce the level of litigation that might otherwise" follow in the wake of the appeals court decision, said Michael Langan, a principal with Towers Perrin in Valhalla, N.Y.

*Bonnie Cicio vs. Vytra Healthcare et al.; 2nd U.S. Circuit Court of Appeals; No. 01-9248.*

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# TRIA: Most buyers find cover too pricey, too limited

Continued from page 1

noncertified acts. So, as a result, most insureds who had terror coverage in place did a cost/benefit analysis of canceling and replacing it and came to the conclusion that it wasn't a good decision."

"The take-up rate has been pretty paltry; we're looking at probably a 20% to 30% range in terms of take-up. It's kind of puzzling. In most cases, I think, the pricing is reasonable, but just because budgets are so tight and the cost of insurance in general has risen so dramatically in the past 12 to 18 months, there's nothing left in the budget," said Gary Marchitello, managing director-national property practice for Aon Corp. in New York.

Steve Lundin, a senior vp with Marsh Inc. in New York, said that its preliminary analysis showed about an acceptance rate of 25%.

The acceptance rate for large accounts is currently about 15%, said Daniel Rockwell, senior vp-property lines for U.S. insurance operations at Chicago-based CNA Financial Services. He pointed out, though, that this could change because policyholders have 30 days from their receipt of the offer to accept or decline coverage.

Randy Schreitmueller, vp at Johnston, R.I.-based Factory Mutual Insurance Co., which does business as FM Global, said the insurer has

"been quite pleased" with the acceptance rate among its clients. He said the rate is about 70%, which reflects the fact that the insurer's typical customer is a Fortune 1000 manufacturer not located in a central, high-risk city.

"It's pretty much across the board. Based on my experience in speaking with other risk managers, it depends on their industry and their risk appetite. Some are purchasing it somewhat reluctantly. This reluctance is due more to pricing as opposed to coverage," said Lance Ewing, executive director-risk management at Park Place Entertainment Corp. in Las Vegas.

"It goes from the ridiculous to the sublime; we've seen it all over the map. I think that more risk managers are going to their upper management and having lengthy discussions about their true exposures for terrorism and whether the premium justifies the coverage," he said.

"Basically, what we're getting is a letter in the mail with a quote. We've had quotes with zero premium and quotes with over six figures. I think it truly depends on the carrier and the relationships," Mr. Ewing said.

"It's all over the board," agreed Millicent Workman, director-risk management of Mueller Industries in Memphis. "I got a stack of no-

tics, but, with the exception of one company, you couldn't identify

**'Basically, what we're getting is a letter in the mail with a quote. We've had quotes with zero premium and quotes with over six figures. I think it truly depends on the carrier and the relationships.'**

Lance Ewing  
Park Place Entertainment Corp.

which policy it applied to. You're getting notices of policies that you couldn't possibly care whether you have terrorism coverage on or not," such as excess flood coverage, Ms. Workman said.

The Risk & Insurance Management Society Inc. "has been putting pressure on the underwriting community in various ways since the passage of the legislation to influence them to be reasonable in their response to it. I think that the general consensus about it is that they have been reasonable," said Christopher E. Mandel, president of New York-based RIMS.

"I've heard the majority of peo-

ple are, on the one hand, not happy to have to deal with this issue because of the time crunch that surrounds it, but that, in general, the offers they've been getting are considered reasonable, myself included," Mr. Mandel said.

"That's not to say that there are not people out there who are getting prices that make them nauseous," he said, "but, in general, they're managing higher-risk-profile locations."

A Marsh analysis of about 1,500 accounts, representing a wide range of exposures in terms of type and geography, showed that "overall, pricing is between 8% and 10% of the all-risk property premium" Mr. Lundin said.

"When you begin to talk about industries, financial services, municipalities and governments, and also commercial real estate—those three are on the higher side of the averages," he said, noting that the manufacturing and retail risks would be on the lower end. Risks in the East and West are generally seeing higher rates than are those in the South and Midwest, he said.

"If you put aside the major metropolitan areas and what you might consider target risks, generally, the pricing is what you might describe as reasonable," said Aon's Mr. Marchitello. Median pricing has been running at 10% to 20% of

the underlying property premium, though he noted that for high-profile risks, "you could see 100% or more of the underlying premium."

Jill Dalton, managing director and North American property practice leader at Marsh, noted that even a relatively small percent addition is still significant. In addition, she said, even as of late last week, the "level of preparedness on the part of the markets has really varied, so any client who might have multiple carriers on their placement may not have gotten quotes from all of those carriers, and some might not have made a decision yet."

Mueller Industries' Ms. Workman said that she and her managers are going over the offers but haven't decided whether to purchase additional terrorism coverage.

Randy Thurman, director-risk management of Gaylord Entertainment Co. in Nashville, said that while offers varied widely, he has found some "to be very competitive, and we're more than likely inclined to take advantage of the offerings."

"We have purchased freestanding terrorism coverage as of last June and would probably, at least in some cases, cancel that coverage and replace with some that's being offered by our existing carriers," Mr. Thurman said.

# Alert: Risk managers respond to new warnings

Continued from page 1

a biological or chemical nature.

While some risk managers are relying on the policies and procedures put in place after Sept. 11, others are taking additional steps to mitigate their exposures.

Gary A. Baxter, assistant treasurer and director of insurance at Weyerhaeuser Co., for example, is taking steps to keep contaminants out of the air in the company's Federal Way, Wash., headquarters should there be an attack. Mr. Baxter explained that wiring in the building's ventilation system is being changed to allow the system to be shut down from a remote control center. In addition, he said, tarps have been cut to fit over the build-

ing, he said.

Mr. Baxter said that employees are being advised to bring small stores of bottled water and food to the workplace, much as they might prepare for an earthquake.

Storage Technology Corp. is relying on its existing procedures "for what we hope is something that never occurs," said Sherry Pixler, risk manager of the Louisville, Colo.-based data storage company. The heightened alert has elevated the company's awareness and its concern for employees traveling abroad, though, Ms. Pixler said. "We've always looked at that, but we're really looking at it now," she said.

Ms. Pixler said she is making sure,

response services. Although the imposition of the orange alert has not resulted in any new security, mitigation or response plans at the

not instituting any new procedures as a result of the heightened alert.

The orange alert "reinforces the need for us to maintain a constant



**Sherry Pixler of Storage Technology Corp. is seeing that any employee traveling abroad knows the location of the local U.S. embassy and is comfortable about reporting anything that is amiss.**

county, it has created a sense of urgency to get a variety of existing programs formalized, he said.

"It's created a little bit of a stir for us," said Mr. Salen, who is vice chair of the Risk & Insurance Management Society Inc.'s external affairs committee. "It's really helped...to get things finalized and get further along in our efforts to comply with the Homeland Security measures and response mechanisms that the feds and states have put in place since Sept. 11."

One area the county oversees, for example, is the local water treatment facility. Mr. Salen said the county has been working with the facility on ways to prevent as well as respond to a biochemical attack to the water supply.

James E. Crockett, manager of risk and benefits at Denver Water, said his facility is also ensuring the safety and security of its water supply from a potential attack but is

high level of security to protect the system," Mr. Crockett said. Still, he said, the level of security maintained by the facility does not change if the national terrorism alert system goes up or down.

Domino's Pizza L.L.C. also is relying on plans already in place to prepare for any potential attack. Employees, for example, are trained to respond to bioterrorism or other forms of terrorist attacks, said Robert Boik, director-risk management at the Ann Arbor, Mich.-based pizza chain. Existing procedures detail "who does what, who is notified, and what your responsibilities are," Mr. Boik explained.

The response to a bioterrorism incident would resemble actions taken during a product recall, he said.

Though no new measures were implemented when the level of terrorism alert was raised, "we certainly did put ourselves on a higher state of alert," Mr. Boik noted. Em-

ployees throughout the distribution chain "were more cautious," he said. "They kept a sharper lookout, and we sent out internal notices about the possibility of products being altered or contaminated."

Mr. Boik said he plans to have his broker review the chain's response plans to determine whether changes can be made to improve the process.

Mr. Boik said, though, that the government's suggestion to use plastic sheeting and duct tape to seal off areas in case of an attack got very little consideration. "We prefer our employees to breathe while they work," he said.



**Gary A. Baxter of Weyerhaeuser Co. is taking steps to keep contaminants out of the air in his company's Federal Way, Wash., headquarters should there be an attack.**

ing's three air intakes to seal off the building if a cloud of biological agents were to reach the area.

"We also have a bulletin coming out telling employees to look to federal or state authorities for advice" in preparing for terrorist attacks, Mr. Baxter said. "But we are also advising them that they may need to stay in their buildings for two or three days" should something oc-

for example, that any employee traveling abroad is aware of the location of the local U.S. embassy and has been made comfortable about reporting anything that is amiss.

Wayne Salen, director of risk management for Niagara County, New York, said that the heightened alert is a matter of particular concern because the county is a significant provider of emergency re-

## ADVERTISER

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# For the Record

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



PHOTO: REUTERS

## Court upholds denial of cricket match claim

The organizer of a canceled cricket tournament in Canada is unable to recover damages from its insurers, the Commercial Court in London has ruled. The court ruled that the word "necessary" means "practically necessary" rather than "legally necessary" in the context of a contingency market cancellation and

abandonment warranty. In *IMG vs. Marcus Ian Clifford Simmonds et al.*, International Management Group filed a claim on its contingency insurance policy after a cricket tournament in Toronto between India and Pakistan was canceled in 2000. The Sahara Cup, which was organized by IMG, was canceled due to tensions between India and Pakistan over the disputed territory of Kashmir. Prior to the tournament,

though, the Indian Cricket Board informed IMG that the Indian government refused to allow the team to travel to Toronto to take part in the tournament for political reasons. London-based IMG had bought insurance, which was placed at Lloyd's of London, to cover both cancellation and war and political risks.

## Vesta settles D&O claim with Cincinnati

Vesta Insurance Group said it has reached a \$16 million settlement in connection with a 1998 claim under a directors and officers liability policy issued by Cincinnati Insurance Co. Vesta also said that litigation filed in connection with the D&O claim, which included other claims, has been terminated. Cincinnati Insurance Co. had filed the September 1998 lawsuit in federal court in Birmingham, Ala., seeking to rescind its coverage. Cincinnati Insurance Co. said the suit was based on Vesta's restatement of its financial results earlier that year.

## White Mountains posts \$950 million profit

White Mountains Insurance Group

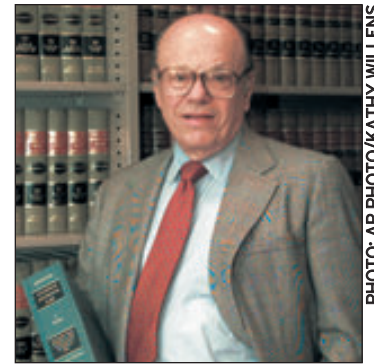
Ltd. reported profits of \$950 million in 2002, compared with a \$302 million loss in 2001. The 2002 profits include \$660 million in deferred income as a result of accounting changes. The insurer's gross revenues rose 29.4% in 2002 to \$4.19 billion.

## First Health profits, revenues grow

Managed care company First Health Group Corp. reported profits of \$132.9 million in 2002, a 29% increase over 2001. Gross revenues at Downers Grove, Ill.-based First Health increased 28% to \$760 million. First Health reported a 41% increase in claims administration revenues to \$237.5 million, primarily due to new business. The company said it also saw significant increases in preferred provider organization revenues, which grew 26% to \$437.8 million in 2002.

## Aviation lawyer Lee Kreindler dies

Noted air crash plaintiffs' attorney Lee S. Kreindler has died of



Mr. Kreindler

PHOTO: AP PHOTO/KATHY WILLENS

complications from a cerebral hemorrhage he suffered in December. Mr. Kreindler, 78, was the senior partner at Kreindler & Kreindler, a New York firm he founded with his father in 1950.

## Briefly noted

Standard & Poor's Corp. has placed its BB+ financial strength rating of **Kemper Insurance Cos.** under review with negative implications. S&P cited concerns about the Long Grove, Ill.-based insurer's earnings expectations and capital adequacy, among other factors.

# Survey: Casualty cost of risk

Continued from page 4

workers compensation risk per \$100 of payroll is \$2.89 for companies with up to \$50 million in payroll, whereas the average cost is \$1.06 per \$100 of payroll for companies with more than \$1 billion in payroll. And the average cost of risk per \$100 of payroll for all companies surveyed is \$1.37, according to the study.

Measured against revenue, workers compensation represents the largest proportion of casualty costs for policyholders, accounting for \$1.52 per \$1,000 of revenue, compared with 65 cents per \$1,000 for general liability and 28 cents per \$1,000 for auto liability.

The differential between the revenue measurement and the payroll measurement occurred because companies do not proportionately increase staff numbers as they grow revenue, explained Timothy P. Brady, a managing director at

Marsh in New York.

The loss-cost findings show that most companies' casualty insurance costs come from traditional areas, such as workers comp, he said.

"The fundamentals of the business remain critically important for successful execution. Terrorism, asbestos and other mass torts have an impact, but at the end of the day workers comp accounted for 62 cents for every primary casualty insurance dollar," he said.

The study also shows up that losses are still the key cost driver for most insurance programs, Mr. Brady said.

A breakout of fixed costs—which include insurance premiums, insurance fees, administrative charges and third-party administrator fees—and variable costs, which include retained losses and claims-handling costs, shows that variable costs are substantially higher.

Workers comp fixed costs were

12% of the total cost and variable costs accounted for 88%; general liability fixed costs were 19% and variable costs were 81%; and auto liability fixed costs were 15% and variable costs were 85%.

The difference in fixed and variable costs should be taken into consideration when policyholders choose their insurers, he said.

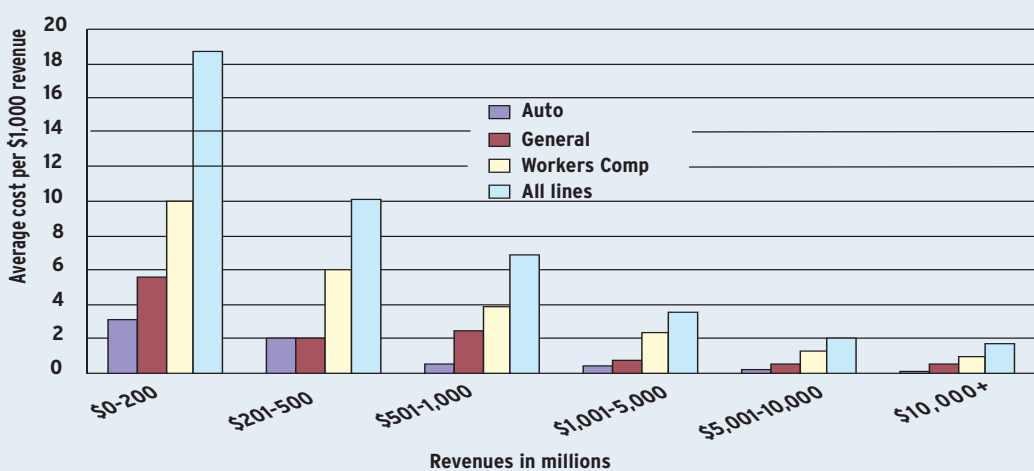
Policyholders may be inclined to select insurers based on the premiums they charge, but their record for agreeing and paying claims could be a better measure, he said.

"If you have \$1,000 in costs with \$800 in variable costs and \$200 in fixed costs, if a carrier can resolve the claims for 10% less, it saves you \$80, but if the fixed costs are 10% cheaper it only saves you \$20," Mr. Brady said.

Copies of the study, "Casualty Cost of Risk 2003" can be obtained by calling 212-345-3393.

## COST OF RISK LOWER FOR LARGER COMPANIES

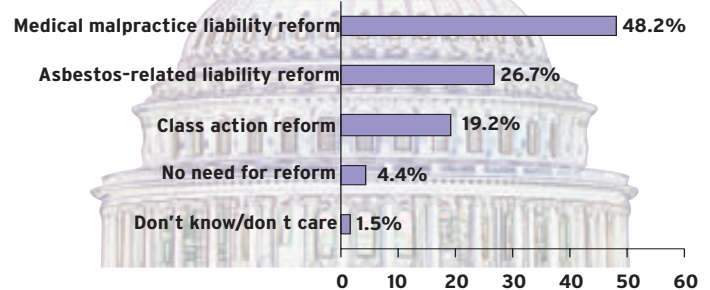
Cost of risk by casualty line and company size



Source: Marsh Inc.

## Online Poll [ 2/17 - 2/21 ]

What do you think should be Congress' top priority?

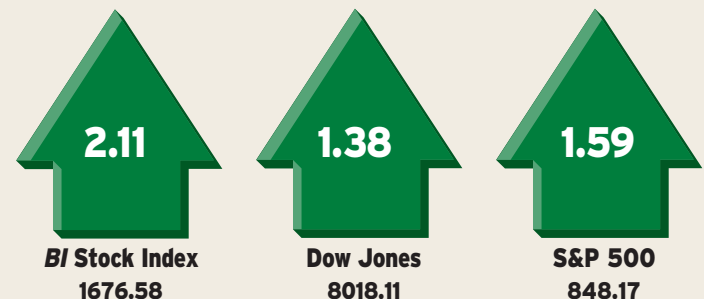


Take part in our weekly poll at [www.businessinsurance.com](http://www.businessinsurance.com)

## BI Stock Index [ 2/17 - 2/21 ]

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

Percentage change of BI Stock Index vs. key indicators



### Largest gains

Unico American Corp.	26.18%
Vesta Insurance	15.08%
SCOR	11.63%
CNA Surety	10.85%
ACE Ltd.	10.31%

### Largest losses

Trenwick Group Ltd.	-22.00%
Gainsco Inc.	-10.00%
Fairfax Financial Holdings	-9.87%
Argonaut Group	-6.92%
PXRE Corp.	-4.66%

### Weekly change by market segment

Brokers	0.23%
Insurers/Reinsurers	1.52%
Managed Care Organizations	1.80%

Source: CNET Investor ([investor.cnet.com](http://investor.cnet.com))

# Business Insurance

Special Take-Out Section

# Benefits Management

February 24, 2003

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# Health Care Cost Control



## Rankings:

- Largest case management providers T4
- Largest prescription benefit managers T8

# Business Insurance

Special Take-Out Section

# Benefits Management

February 24, 2003

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T3

## Disease management value comparisons difficult

By JUDY GREENWALD

While there is general recognition that disease management programs can help improve employees' health and their employers' bottom line, coming up with a meaningful return-on-investment figure is often easier said than done.

Vendors use a variety of standards to measure return on investment, making it difficult to compare the estimates of disease management firms. It is very important, though, for employers to have "apples-to-apples" comparisons, said Dennis White, executive director of the Ann Arbor, Mich.-based South Central Michigan Health Alliance, an employer group.

Further complicating the matter is that the indirect effects of a disease management program—including its impact on absenteeism and productivity—also should be

considered in evaluating the program's effectiveness, but such costs are much more difficult to quantify.

Return on investment is generally expressed as the amount of return per dollar spent on disease management programs. For example, a two-to-one return on investment means the employer's health care costs for factors including hospitalizations and emergency room visits were reduced by \$2 for every dollar spent on the program.

The target figure will vary depending upon the individual program. Overall, though, "I think employers are expecting ROIs in the neighborhood of two-to-one" the first year, and an improvement to perhaps four-to-one in subsequent years, said Joe Marlowe, senior vp with Aon Consulting in Philadelphia.

The lack of standardization in return-on-investment data is one of the issues the disease management industry faces in trying to establish the value of its services.

"Certainly, we think a lot about

**A lack of standardization 'is one of the contributing factors to continuing skepticism about the effectiveness of disease management programs...'**

Bob Stone  
American Healthways Inc.

ROI," said Suzanne Paranjpe, senior vp-development for the Washington-based National Business Coalition on Health.

"The fundamental challenge

right now is ... that there's not a standard methodology that we would have, maybe, in the finance world," Ms. Paranjpe said.

Bob Stone, executive vp of Nashville, Tenn.-based disease management firm American Healthways Inc., said that the lack of standardization "is one of the contributing factors to continuing skepticism about the effectiveness of disease management programs, where the people in the industry can't even come together with a meaningful standardized methodology for evaluating performance."

Such a situation "leaves purchasers, be they employers or health plans, sort of in a position where they have to throw their hands up," he said.

Efforts are underway to develop standards.

Mr. Stone said American Health-

ways, with assistance from Johns Hopkins University and health plan representatives, last week released a document, "Standard Outcome Metrics and Evaluation Methodology for Disease Management Programs," that addresses this issue. The tool, which addresses diabetes, heart disease and respiratory disorders, "provides a standardized floor that, if everybody uses (it), would provide purchasers ... with the ability to effectively evaluate" and compare different plans, Mr. Stone said.

"Hopefully, it will provide at least a foundation" that can be used to drive the industry into uniformity on this issue, he said.

Several other groups are working on developing standard methodologies. They include the Washington-based Disease Management Assn. of America and the NBCH,

See **DISEASE/page T5**

## Inside

### Case managers

The largest case management providers are ranked.

Page T4

### Prescription managers

The largest prescription benefit managers are ranked.

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### Employers battle rising drug costs

Higher prescription drug costs parallel the rise in direct-to-consumer advertising by pharmaceutical companies.

Page T9

### Promoting generics

Blue Cross & Blue Shield of Michigan campaign increases use of generic drugs.

Page T10

## Benefit education, communication needed

By JOANNE WOJCIC

Despite being bombarded with stories about rising health care costs in the media, many employees still don't see how the trend affects them, benefit consultants say.

As a result, the employee response to the increased sharing of health benefit costs has ranged anywhere from outright revolt to reluctant acceptance, employers are finding.

For example, in January, 20,000 employees of General Electric Co. in 23 states went on a two-day strike to protest a \$200 annual increase in their annual health insurance premiums, citing the company's increased profitability.

"Let's face it, GE is a company that made \$16 billion last year," pointed out Charlie Flemming, the president of the Atlanta Labor Council AFL-CIO, during the strike. "It's not like it's going to the poorhouse."

The GE example illustrates the need for employers to increase their communication and education efforts, benefit consultants say.

"The general media articles are not getting through to employees. People are just being bombarded with so much health information, they're tuning it out," observed Jean Schauer, a senior consultant and national health care communications leader at Watson Wyatt Worldwide in Minneapolis.

Often employers also have to combat the negative perceptions their employees have because of senior executives' hefty compensation packages or their company's record profitability, as in the case of GE.

Even though employers are still picking up more than 80% of the tab, on average, "employees generally feel like they are bearing the greatest burden of the cost," Ms. Schauer said. "They always overestimate what they're contributing pretty significantly, and then they really underestimate what their employer is contributing."

Furthermore, she said, "the system is just so broken that we're fighting that battle as well."

To avoid being perceived as adversaries, employers are discovering they must be more open and share information with their employees about the cost of health care and how much they have been contributing on their employees' behalf, said Mike McAllister, a senior communications consultant at Mercer Human Resource Consulting in Washington.

"Employers should be opening their books to employees," Mr. McAllister said. "It's a real compelling story."

If employees were to become aware of just how much health care really is costing their employers and see how much those costs are

See **COST/page T6**

## Provider rankings help cut health costs

By ROBERTO CENICEROS

Some health plans are gauging the efficiency of individual physicians and hospitals, using their findings to downsize their provider networks in an effort to eliminate variability in treatment costs and reduce expenses.

This nascent trend relies on mining "episodes of care" and pharmacy utilization data. The resulting information on the efficiency of individual providers can shed light on which doctors in a given region provide the best quality and most cost-effective treatment, say benefit

consultants and a health plan that is already applying the approach.

Health plans can then use the provider information to offer employers narrower networks that exclude less-efficient providers—those who generate greater treatment costs than their peers, yet do not produce better health care results.

The savings from contracting only with doctors and hospitals that efficiently produce the best-quality results can then be passed on to employers and employees, say proponents of the strategy.

Doctors in such a network may not necessarily charge the lowest

price per individual procedure, said Greger Vigen, a principal in the Los Angeles office of Mercer Human Resource Consulting. But their total cost for treating specific ailments would typically be less than the overall costs generated by many of their peers treating the same illness, Mr. Vigen explained.

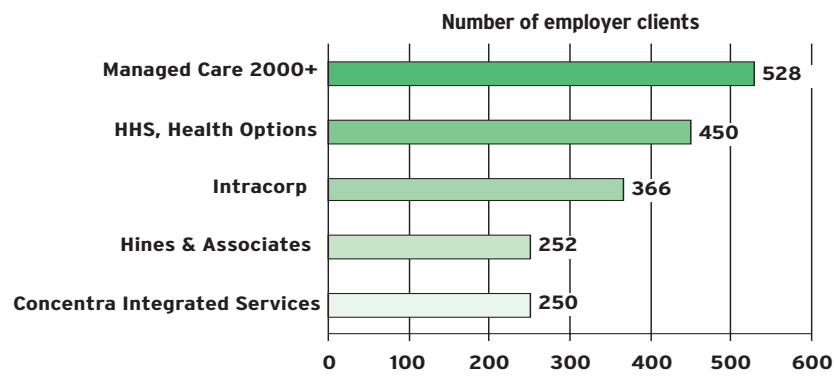
A health plan, therefore, might be willing to compensate such a doctor more than it pays a provider who charges less per procedure or per visit but whose total treatment costs and care results do not compare favorably with the doctor ren-

See **NETWORKS/page T7**



### LARGEST PROVIDERS BY EMPLOYER CLIENTS

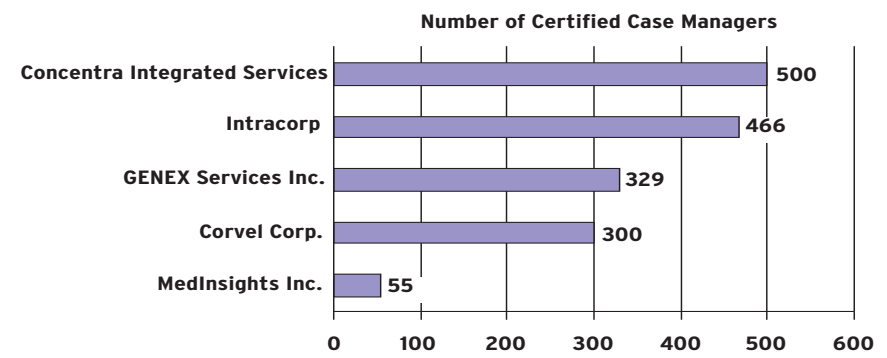
Ranked by number of employer clients in 2002



Source: BI survey

### LARGEST PROVIDERS BY CASE MANAGERS

Ranked by number of staff holding Certified Case Manager designation in 2002



Source: BI survey

# Largest case management providers

Ranked by 2002 gross revenues from case management services <sup>1</sup>

Rank	Company/Address	Telephone/Fax/Web site	Parent	Case management revenues	Total employees assigned to case management	Certified Case Managers	Total cases managed	Principal officer
<b>1</b>	Intracorp 1601 Chestnut St. Philadelphia, Pa. 19192	800-345-1075 Fax: 215-761-5538 <a href="http://www.intracorp.com">www.intracorp.com</a>	CIGNA Corp.	\$496,000,000	3,203	466	1,978,539	Kirk Rothrock, president
<b>2</b>	Concentra Integrated Services 5080 Spectrum Drive, Suite 400W Addison, Texas 75001-4648	800-232-3550 Fax: 972-387-0550 <a href="http://www.concentra.com">www.concentra.com</a>	Concentra Inc.	\$300,000,000	2,130	500	292,806	Dan Thomas, CEO
<b>3</b>	GENEX Services Inc. 440 E. Swedesford Road, Suite 1000 Wayne, Pa. 19087	610-964-5100 Fax: 610-954-1919 <a href="http://www.genexservices.com">www.genexservices.com</a>	UnumProvident Corp.	\$148,000,000	1,170	329	195,000	Peter C. Madeja, president/CEO
<b>4</b>	Corvel Corp. 2010 Main St., Suite 600 Irvine, Calif. 92614	949-851-1473 Fax: 949-851-1469 <a href="http://www.corvel.com">www.corvel.com</a>	NA	\$130,000,000	3,300	300	75,000	Gordon Clemons, CEO
<b>5</b>	Kemper National Services Inc. 1601 S.W. 80 Terrace Plantation, Fla. 33324	954-452-4000 Fax: 954-452-4074 <a href="http://www.kns.kemperinsurance.com">www.kns.kemperinsurance.com</a>	Kemper Insurance Cos.	\$95,000,000	700	34	166,945	David K. Patterson, president/CEO
<b>6</b>	SHPS Healthcare Services 14770 N. 78th Way Scottsdale, Ariz. 85260	800-333-3760 Fax: 480-443-5302 <a href="http://www.shps.net">www.shps.net</a>	NA	\$22,417,537	240	23	142,473	Dave Garner, CEO
<b>7</b>	MedInsights Inc. 4360 Chamblee-Dunwoody Road, Suite 500 Atlanta, Ga. 30341	770-457-2400 Fax: 770-457-1500 <a href="http://www.medinsights.com">www.medinsights.com</a>	GAB Robins North America Inc.	\$12,300,000	128	55	22,609	Jeff Aycock, senior vp
<b>8</b>	Cambridge Integrated Services Group Inc. 4B Cedar Brook Drive Cranbury, N.J. 08512	800-662-1170 Fax: 609-860-7887 <a href="http://www.cambridgeintegrated.com">www.cambridgeintegrated.com</a>	Aon Corp.	\$8,200,000 <sup>2</sup>	90	43	13,795	Tracey Carragher, chairperson
<b>9</b>	Managed Care 2000+ P.O. Box 10040 Tampa, Fla. 33679	813-281-9210 Fax: 813-207-0495 <a href="http://www.managedcare2k.com">www.managedcare2k.com</a>	Corporate Benefit Services of America	\$7,650,748	72	19	2,234	Phil Christianson, CEO
<b>10</b>	ASU Group-Recovery Unlimited 2173 Commons Parkway, P.O. Box 1520 Okemos, Mich. 48805-1520	517-349-9092 Fax: 517-349-1332 <a href="http://www.asugroup.com">www.asugroup.com</a>	ASU Group	\$6,500,000	51	47	2,842	Tara LaRose, executive vp

<sup>1</sup> Companies that derive 100% of case management revenues from specialized case management services are not included. <sup>2</sup> BI estimate.  
Source: BI survey

The full directory of case management providers is available online in the directories area of [www.businessinsurance.com](http://www.businessinsurance.com). The searchable directory allows users to locate case management providers by company name, case management revenues and number of cases managed, among other information. PDF copies of the directory can be purchased by calling the Crain Information Center at 312-649-5476.

# Disease: Calculating a return on investment

Continued from page T3

whose "eValue8" project is now in its sixth year. Forty member companies of Mr. White's South Central Michigan Health Alliance are among the participants in the NBCH project.

A standardized methodology will ultimately emerge, said Chris Coloian, vp-care management at Philadelphia-based Intracorp. "I think that the purchasers of disease management services will drive that, as they have driven it in other areas," he said.

Once the industry does develop a standard methodology, "it will get us looking more at results, rather than haggling over the process," said Debra Gold, a principal with Mercer Human Resource Consulting in Chicago.

But Michael Cousins, director of health informatics at Richmond, Va.-based disease management firm Health Management Corp., cautioned against a "one-size-fits-all" approach. "Some groups or plans are interested in answering a specific question, and one methodology adopted by an industry may not be the one that best answers that question," he said.

Dr. Pamela Hymel, vp of medical services and benefits at El Segundo, Calif.-based Hughes Electronics Corp., said her company has only one insurer, Aetna Inc., which provides ROI data for all Hughes' plans. "Because of that, we feel that they're measuring the same thing across the programs that we put in place and feel more comfortable in looking at ROI within that."

## Looking at data

Meanwhile, employers must carefully analyze the data presented by vendors.

"I think you have to get into the nuts and bolts of their methodology to know if the estimates of savings are going to be realistic," said Bruce Kelley, a senior consultant with Watson Wyatt in Minneapolis.

"Knowing the numbers is not enough," said Mr. Cousins. "It behooves the employers to know precisely how the methodologies work."

Dr. Alan Spiro, head of clinical consulting for Towers Perrin in Boston, said that one approach is to be very careful about assessing the vendor numbers and to understand how they were arrived at. "That may mean having the right expertise to assess it," he said.

Another approach is to have an outside data vendor assess the data, Dr. Spiro said.

One issue in this area involves the statistical concept of "regression to mean," which can skew return-on-investment estimates. For example, if an employee enters a disease management program shortly after heart bypass surgery, his health care costs will tend to decrease the following year, moving him back toward the population average. Employers must beware of vendors who try to claim credit for this in their ROI data, say observers. Some companies will claim return-on-investment figures of eight-to-one or

16-to-one, but, in fact, "it's not happening—that is regression to the mean," said Mercer's Ms. Gold.

Employers can address this issue by looking at the entire population of employees who suffer from a particular chronic condition and then comparing those who do participate in the disease management program with those who do not.

Employers should also assess who enters the disease management programs when looking at return-on-investment data, say observers. Disease management firms that enroll only the highest-risk or sickest individuals will have better-looking re-

turn-on-investment figures than will those who select a broader range of the population.

"Part of the problem with the measurement starts with the fact that there isn't a kind of baseline of who they're measuring, so that means the employers really need to look for vendors who will do population assessments," said Suzanne Mercure, principal with Falls Church, Va.-based Barrington & Chappell, a consulting firm.

## A complete picture

In addition to the hard-dollar

savings related to disease management programs, "there are other sources of return from these programs," said Towers Perrin's Dr. Spiro. "There is the issue of productivity; there is the issue of absenteeism and its related costs and so on." But these factors are usually not included when we talk about return on investment, he said.

Indirect costs are "a very important part of the whole equation," said Aon's Mr. Marlowe. For instance, patients who suffer from cardiac conditions and diabetes often suffer from depression as well,

and "there's an increasing body of evidence now that depression has a particularly heavy impact on worker productivity, both through increasing absenteeism and also reducing employee effectiveness while on the job."

"I think a lot of employers want to look" at indirect costs, but as part of a two-step process that also includes return on investment, said Mercer's Ms. Gold. "I think we'll see something evolve over time to link disease management with disability managers and return to work in terms of trying to integrate health and absence," she said.



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# Cost: Communicating with employees key

Continued from page T3

increasing, it would be easier to enlist their support, he said.

In the mid-1980s, when managed care was introduced, "there was a fair amount of resentment against employers because they weren't sharing that information," yet they were forcing employees to accept changes that made their health care more restricted, Mr. McAllister said.

"The message with managed care was 'compliance,'" said John Moses, a communications consultant at Hewitt Associates Inc. in Bridgewater, N.J.

"With managed care, what we were saying was that managed care was the 'silver bullet,' and it was going to help contain these costs, and you needed to comply with regulations of managed care and then everything would be OK," he said.

But that's not the case today, because there is no perceived panacea.

Today, "instead of asking people to comply, we're asking people to be more responsible," Mr. Moses said. And to convey that message, "we need to help people understand what the situation is. We need to create a line of sight for them as to what's going on nation-

ally with health care costs, what that means to their employer specifically, and then what that means to them."

"They read things in newspapers that health care costs are increasing, but they really don't see how that relates to them," he added.

To assist employers in this endeavor, the Washington Business Group on Health has prepared a communications "toolkit," similar to the lesson-planning books that teachers use. The kit, which is actually a spiral-bound book separated by tabs, contains sample letters, a glossary of health care terms, fre-

quently asked questions, comparison data and other materials. It also provides a timeline for disseminating information to employees so they won't feel overwhelmed.

The communications kit is so comprehensive that employers could opt to simply photocopy the sample letters and fill their names in the blanks, avoiding the need to hire expensive communications specialists and benefit consultants to get their message across.

But regardless of whether they use the WBGH toolkit, develop a program themselves or hire consultants, employers must spread the

word about health care costs if they are ever to gain their employees' acceptance of increased cost shifting or effect changes in future medical spending, benefits experts say.

"The most important thing employers can do is communicate," said Helen Darling, the president of the WBGH.

Communication and education also are integral to the consumer-driven health plan model that is being introduced by many employers nationwide as an alternative to managed care and other higher-cost options, she added.

"If they have a choice (in how their health care dollars are being spent), then, ideally, you want them to know what they need to know in order to make that choice," Ms. Darling said.

But the message must be simple and practical, to help "people understand the role that they will have to play if we're going to keep health care affordable," said Ms. Schauer of Watson Wyatt, who assisted the WBGH in developing its communications toolkit.

**Employees 'read things in newspapers that health care costs are increasing, but they really don't see how that relates to them.'**

*John Moses  
Hewitt Associates Inc.*

"We've been telling employees things like 'Make sure you're using a generic,' and 'Are your doctors prescribing off the drug formulary?', and most employees don't even know what a formulary or a generic is," she said.

The toolkit recognizes this naiveté in health care selection and spending by providing a glossary of terms and a list of "10 simple things people can really do in life to help keep health care costs down," Ms. Schauer said.

The theory is, "if you can only understand these five things or these 10 things, you will help effect change in the cost of health care," she explained. "We want people to have sustained behavioral change. But we know that people are not even on the continuum of effecting change, for the most part."

"I think employers have now run down all of the options they have around plan design and pricing and they've done a lot of tweaking to their designs, and now the only thing that employers really have left is to ask employees to get in the game," Ms. Schauer said.

But she acknowledged that it won't be easy to win employees over, especially in today's economy.

"The GE strike is such a good and interesting current events example that asking them to pay just a couple hundred dollars is unacceptable. But you never heard anybody say, 'Well, we're innovating in this way to help employees use the system more appropriately.' There was nothing in there about what employees should do. It was all about what GE should do for the employees," she said. "That's one of the big shortcomings that we really have to fight against right now."



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February 24, 2003

# Networks: Fewer physicians, more-efficient care

Continued from page T3

dering the more-efficient care, he said.

PacifiCare of California, encouraged by several large employers and Mercer, announced in October that it would offer such a network under a new product called the Value Network Plan.

The Value Network contracts with only about half the number of doctors and hospitals that many other California health plans now include in their networks.

PacifiCare Health Systems, the parent of PacifiCare of California, is now working to introduce similar network plans in Arizona, Colorado, Oregon, Texas and Washington, said Dr. Sam Ho, senior vp and chief medical officer for PacifiCare Health Systems in Cypress, Calif.

Additionally, Mercer is helping several health plans nationwide develop similar "high-performance networks," Mr. Vigen said. So far, the concept mostly is being applied under preferred provider organization plans, but he noted that it also can be applied to other health plan platforms.

**PacifiCare of California says that it expects employers to save between 4% and 8% on their premiums if they contract with the Value Network.**

An employer could design its plan offerings to encourage employees to choose the network with the most-efficient providers, Dr. Ho explained. Employers could do so by offering employees richer benefits or lower costs to select the desired plan over the others.

PacifiCare says, though, that it expects employers to save between 4% and 8% on their premiums if they contract with the Value Network.

Increasingly, people in the benefits industry are discussing plans such as those launched by PacifiCare, said Joe Martingale, national leader of health care strategy for Watson Wyatt Worldwide in New York. But whether many more health plans and employers implement such arrangements will not be known until next year, Mr. Martingale said.

Some observers say the high-performance network concept has a "back to the future" ring, offering a network philosophy similar to the constricted networks health plans

originally offered years ago.

Health maintenance organizations originally reduced costs by limiting networks to the best and most cost-effective doctors, Mr. Martingale pointed out.

But over the last decade, as employees demanded greater access to providers, employers lost sight of HMOs' original strategy of reducing costs by limiting networks to doctors that agreed to work for lower fees, said Sally Welborn, vp of corporate benefits for Wells Fargo & Co. in San Francisco.

Network size, therefore, continued expanding, said Ms. Welborn,

whose company was among the large employers that sought the creation of the Value Network.

But the development of these newer, smaller, provider networks differs from the approach taken in the early days of managed care, Ms. Welborn said. Back then, she said, inclusion in a network rested only on a provider's price and a simple check of his or her professional credentials.

Today, though, the high-performance networks are formed with greater consideration of provider quality and efficiency data that was not available until recently, propo-

nents point out.

The goal is to create networks that reduce variability in provider efficiency and cost. Data often reveal a variation of 40% to 300% in the treatment costs among providers when weighing efficiency and quality data, Mr. Vigen said. Those findings hold true among doctors treating the same illnesses in the same region, he said.

Provider performance can be measured and compared against that of other doctors through the use of episodes-of-care data. Those data result from examining factors such as a physician's charges and

the specific condition he or she is treating.

Additionally, electronic data gleaned when health plan members use their prescription drug cards could provide a more-sophisticated view of a doctor's performance when combined with the episodes-of-care information, Mr. Vigen said.

The drug data help by providing a clearer picture of the specific condition a doctor is treating, Mr. Vigen explained. The type of drug prescribed and its prescribed strength could indicate the type and seriousness of the condition the doctor is treating.

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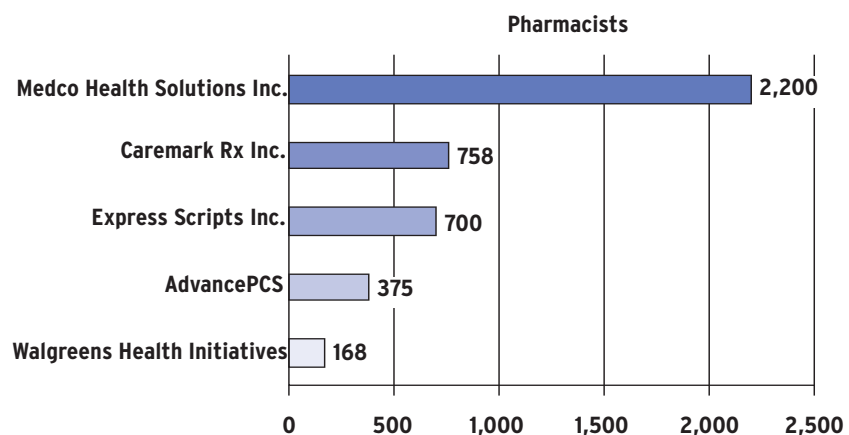
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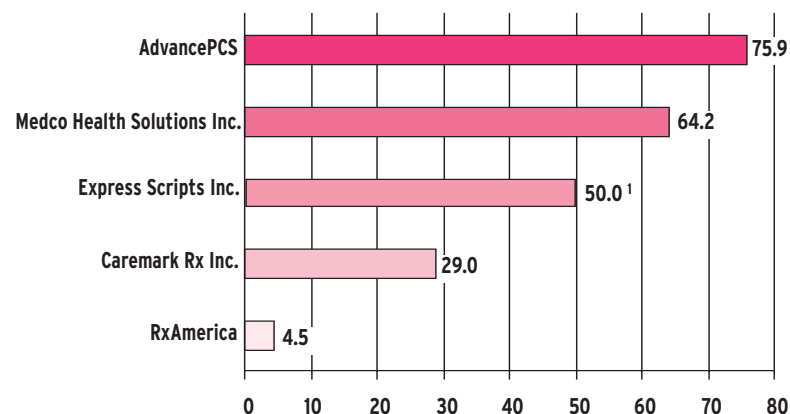
Ranked by number of registered pharmacists on staff



Source: BI survey

## LARGEST PBMS BY COVERED LIVES

Ranked by total group plan lives enrolled



<sup>1</sup> BI estimate  
Source: BI survey

# Largest prescription benefit managers

Ranked by 2002 revenues from unbundled PBM services

Rank	Company/Address	Phone/Fax/Web	Parent	PBM revenues	Total staff	Total clients	Covered lives	Principal officer
<b>1</b>	Medco Health Solutions Inc 100 Parsons Pond Drive Franklin Lakes, N.J. 07417	201-269-3400 Fax: 201-269-1109 <a href="http://www.medcohealth.com">www.medcohealth.com</a>	Merck & Co. Inc.	\$33,000,000,000	14,700	1,680	64,200,000	Richard T. Clark, chairman/president/ CEO
<b>2</b>	AdvancePCS 750 W. John Carpenter Freeway Irving, Texas 75039	469-524-4700 Fax: 469-524-4701 <a href="http://www.advancepcs.com">www.advancepcs.com</a>	-	\$13,100,000,000	6,000	1,000 <sup>1</sup>	75,000,000	David D. Halbert, chairman/CEO
<b>3</b>	Express Scripts Inc. 13900 Riverport Drive Maryland Heights, Mo. 63043	800-281-0712 Fax: 314-702-7059 <a href="http://www.express-scripts.com">www.express-scripts.com</a>	-	\$13,020,000,000	7,000 <sup>1</sup>	NA	50,000,000 <sup>2</sup>	Barrett A. Toan, chairman/CEO
<b>4</b>	Caremark Rx Inc. 2211 Sanders Road, Northbrook, Ill. 60062	847-559-4700 Fax: 847-559-3694 <a href="http://www.caremark.com">www.caremark.com</a>	-	\$6,800,000,000	4,700	1,200	29,000,000	Mac Crawford, chairman/CEO
<b>5</b>	RESTAT Pharmacy Benefit Managers 724 Elm St. West Bend, Wis. 53095	800-926-5858 Fax: 262-808-4260 <a href="http://www.restat.com">www.restat.com</a>	The F. Dohmen Co.	\$699,500,000	97	3,089	2,777,743	Michael W. Clark, president
<b>6</b>	RxAmerica 221 N. Charles Lindbergh Drive Salt Lake City, Utah 84116	801-961-6000 Fax: 801-961-6008 <a href="http://www.rxamerica.com">www.rxamerica.com</a>	Longs Drug Stores Corp.	\$500,000,000	125	300	4,500,000	John Gardynik, president
<b>7</b>	ScripSolutions Inc. 100 Clearbrook Road Elmsford, N.Y. 10523	888-818-3939 Fax: 914-460-1660 <a href="http://www.scripsolutions.com">www.scripsolutions.com</a>	MIM Corp.	\$475,000,000	400 <sup>1</sup>	650	3,500,000	Richard Friedman, CEO
<b>8</b>	National Pharmaceutical Services 14301 First National Bank Parkway, Suite 200 Omaha, Neb. 68154	402-964-9030 Fax: 402-964-9004 <a href="http://www.pti-nps.com">www.pti-nps.com</a>	Pharmaceutical Technologies Inc.	\$150,000,000	35	3,500	1,300,000	Douglas M. Pick, president/CEO
<b>9</b>	Innoviant Inc. 1800 W. Bridge St., P.O. Box 8082 Wausau, Wis. 54402-8082	877-559-2955 Fax: 715-841-5050 <a href="http://www.innoviant.com">www.innoviant.com</a>	WBI Holding Corp.	\$110,000,000	26	184	268,717	Mark Campbell, CEO
<b>10</b>	CBCA Rx <sup>3</sup> 675 Foxon Road, Suite 204 East Haven, Conn. 06513	203-468-8367 Fax: 203-468-8930 <a href="http://www.usi-rx.com">www.usi-rx.com</a>	CBCA Inc.	\$79,000,000	21	167	220,000	James Santella Jr., president-integrated services, CBCA Inc.

<sup>1</sup> Estimated <sup>2</sup> BI estimate <sup>3</sup> Formerly USI Prescription Benefit Co.  
Source: BI survey

The full BI Directory of prescription benefit managers is available online in the directories area of [www.businessinsurance.com](http://www.businessinsurance.com). The searchable directory allows users to locate PBMs by company name, revenues, and number of clients, among other information. PDF copies of the directory can be purchased by calling the Crain Information Center at 312-649-5476.

February 24, 2003

# Employers countering drug ad campaigns

By MICHAEL PRINCE

As drug manufacturers spend more money to advertise their products directly to consumers, employers have increased their own campaigns to slow down employee demand for these expensive drugs.

Drug makers spent an estimated \$3 billion in direct-to-consumer advertising in 2002, up slightly over 2001, according to benefit consultants. This amount is still only a small part of drug manufacturers' overall marketing budgets, but the amount has soared since the U.S. Food and Drug Administration in 1997 first permitted broadcast ads.

While there is no evidence that marketing directly to consumers caused drug spending to rise, the increase in drug spending closely parallels the rise in drug advertising. A report released in November 2001 by the National Institute for Health Care Management in Washington points out that, between 1999 and 2000, sales of the 50 most heavily advertised drugs rose by 32%. This growth, amounting to \$9.9 billion in additional sales, accounted for almost half of the total increase in drug spending from 1999 to 2000.

"We know that people who see ads will go see their doctor," said Dr. Glen Stettin, vp of clinical products at prescription benefit manager Medco Health Solutions Inc. in Franklin Lakes, N.J.

The NIHCM report said "such ads are one element—and perhaps an increasingly important one—in the recent trend to the expanded use of newer prescription drugs and the resultant increased overall spending on pharmaceuticals."

Direct-to-consumer ads have also changed the drug mix by shifting usage toward the higher-priced advertised drugs and away from generics and older, less costly ones, said Kevin DeStefino, national leader, pharmacy benefits consulting at Watson Wyatt Worldwide in Phoenix. "It's definitely one of the influences on the national trend."

One of the reasons for this shift is that drug ads work. In a survey released in November 2001 by the Henry J. Kaiser Family Foundation, 30% of respondents said they spoke to doctors about a drug they saw advertised. Of those people, 44% received the drug from their physician, the survey found.

## Doctors feel pressured

Ads have put doctors in a difficult position, Dr. Stettin said. "They are trying to balance between giving their patient a satisfying experience when their patient comes to see them," he said. "At the same time, they would not want to do something that is unsafe" for patients.

Because of consumers' responses to ads, some physicians may feel compelled to write prescriptions.

"The pressure is enormous," said Dr. Mark Chassin, chairman of the department of health policy at Mount Sinai School of Medicine in New York.

Doctors tend to agree. A survey of 500 doctors released by the FDA in January shows that when a patient

asked for a specific drug, 61% of doctors said they felt some pressure to write the prescription.

The ads also have an impact on costs, the doctor survey shows. Because of direct-to-consumer ads, 86% of doctors said that patients have asked for unnecessary drugs, while 88% said that patients have asked for advertised drugs over less costly treatments.

But the drug ads are not always a negative influence. The ads often help raise awareness of health issues and open a dialogue between the patient and physician about medical conditions and their remedies,

said Sean Brandle, vp at The Segal Co. in New York. "It gets the conversation rolling with the doctor."

Drug makers point to this as a significant benefit of their ad campaigns. A paper published in October 2002 by the Pharmaceutical Research & Manufacturers of America, the drug industry's trade group, states that drug advertising does not promote inappropriate use of prescription drugs and in fact provides valuable education to the public.

"Despite what some critics suggest, there is no evidence that" advertising to consumers encourages "inappropriate prescribing of pre-

scription drugs. Utilization of pharmaceuticals is increasing for a multitude of reasons, including the aging population and the development of new and improved medicines," the report states.

Instead, the report says that consumer advertising provides value to patients "by making them aware of the risks and benefits of new drugs; it empowers patients and enhances the public health; it plays a vital role in addressing a major problem in this country of undertreatment and underdiagnosis of disease."

But not everyone is convinced. The ads do not improve dialogue

between doctors and patients because they lack sufficient data on side effects and who should be taking the drug, Dr. Chassin said.

"They are clearly intended to sell drugs and not to inform," he said.

Mr. DeStefino said the added drug costs resulting from the ads outweigh any increased awareness of health issues.

## Counter measures

Employers, health plans and prescription benefit managers are taking steps to counter the potency of the ads. Generally, the approach has been to educate employees and physicians about alternatives to the advertised drugs and change plan

See DRUGS/next page



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# Drugs: Combating advertising

Continued from previous page

designs to put up financial hurdles to buying the expensive drugs.

"It's really changing the way our benefits are offered," Mr. Brandle said.

Drug plans in recent years have been redesigned so that generic drugs carry a lower copayment. Requiring patients to pay more for expensive drugs puts a hurdle in drug buyers' path, Mr. DeStefino said.

"What allows direct-to-consumer (advertising) to work is that the majority of Americans don't pay for

the stuff," he said. Changing drug plan pricing helps "make consumers aware of what this costs."

More employers have begun requiring doctors to spell out the reasons a patient needs an expensive drug when less expensive options are available, Dr. Stettin said.

In addition, some health plans are promoting generics aggressively (see related story).

Just as important as plan design is the need to educate employees and physicians on the importance of exploring alternatives.

"We need to have counter measures" to ensure consumers are educated, said Dr. Vince Kerr, director of health care management at Ford Motor Co. in Dearborn, Mich.

The goal is to intervene when the treatment is decided. This means educating doctors and patients so that when a decision is made to write a prescription, the most effective drug is selected, he said. This will open up the conversation from just the advertised drug to all options, including nondrug therapies, he said. "Information is power and

can actually trump advertising."

For example, CIGNA HealthCare has put such information online for its members. The goal is to help members have a more wide-ranging discussion with their doctors than just talk about the one advertised drug, said Jon Maesner, vp of pharmacy policy at CIGNA HealthCare in Hartford, Conn.

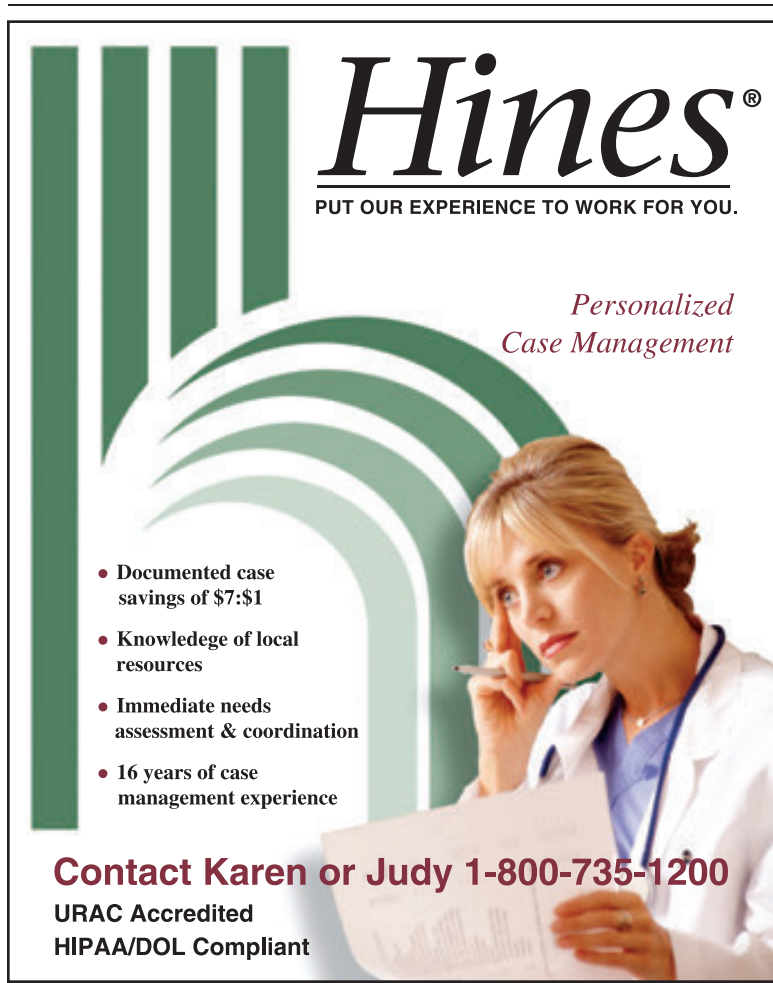
CIGNA's Web site contains information on 10 conditions, such as heartburn, arthritis, asthma and high cholesterol. "All of those conditions are ones where drugs are heavily advertised," he said.

The site offers data on specific drugs, alternative drugs and nondrug therapies, with price compar-

isons. It's all designed so the members "can place the drug in context," Mr. Maesner said, "to help them make the right decision." The site also lists questions about conditions and drug therapies that patients can pose to their doctors.

Medco's Generics First program promotes the use of generic drugs and gives physicians samples to distribute to patients. Medco says the program has significantly pushed up the rate of generic drug usage among the participating doctors.

Ford has worked with Medco and other vendors to provide samples of generic drugs to doctors and "have them on the shelf with the brand names," Dr. Kerr said.



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## Blues boosting use of generics

By JERRY GEISEL

In a David vs. Goliath scenario, Blue Cross & Blue Shield of Michigan launched a modestly funded campaign recently that managed to reverse a steady decline in the use of generic pharmaceuticals in favor of brand-name medications.

While manufacturers of brand-name drugs spend billions each year marketing their products, the Blues fought back with an ad campaign that cost just \$1 million.

Just as the biblical David prevailed against a giant, the Blues have succeeded in changing consumer behavior. Over the last two years, the plan, the largest health insurer in Michigan, has achieved a nearly four percentage point increase in the use of generic drugs, saving tens of millions of dollars for the plan, employers and consumers, Blues executives say.

In those two years, the proportion of prescriptions for plan participants filled with generic drugs rose from about 37% to 41.5%, according to preliminary estimates.

"To have such an increase in such a short amount of time is remarkable," said Atheer Kaddis, the Blues plan's director of clinical pharmacy services in Detroit.

The effort of the Michigan Blues to expand the use of generics was not unique, though its approach—promoting generics as the "unadvertised brand"—may have been.

Health plans around the country have been seeking new ways to encourage the substitution of generics. Pennsylvania's Highmark Blue Cross & Blue Shield has been distributing thousands of free samples of generics to physicians, while Excellus, a health plan in Rochester, N.Y., has been advising physicians how their rate of prescribing generics compares with that of other doctors in their communities.

There is good reason for those efforts; a one-month supply of a brand-name prescription costs, on average, \$72, while a generic equivalent averages \$14. Health plans, employers and enrollees could save enormous sums through greater use of generics. Indeed, the Michigan Blues estimate that raising the rate of dispensing generic drugs by one percentage point saves \$17 million.

But getting enrollees to switch is no easy task. Makers of brand-name drugs spend billions promoting

their products, while the producers of generics often lack the resources to advertise their own products.

Clearly, advertising has produced positive results for the makers of brand-name drugs. Increasingly, consumers ask for brand-name drugs, experts say, even though less costly generics, where they exist, must be chemically equivalent.

And there is another, less tangible but real problem: consumers' perception that generics' quality is not always equal to brand names'.

"There is a certain stigma associated with the word 'generic.' You think of someone trying to save a few pennies at the grocery store," said Kevin DeStefino, national leader, pharmacy benefits consulting with Watson Wyatt Worldwide in Phoenix.

The Michigan Blues, drew, in part, from the success of the makers of brand-name drugs in their efforts to change that perception.

At the heart of the campaign, which began in 2001, was a competition that urged pharmacies to increase the rates at which they dispensed generic drugs. The Blues challenged pharmacies to encourage customers to use generics, and they announced they would track and compare the pharmacies' rates for dispensing generics during fourth-quarter 2001 with their rates for the comparable period in 2000.

The retail chain and independent pharmacy that saw the biggest increase in their rates for dispensing generics would be featured in a \$1 million ad campaign, sponsored by the Blues, to promote generic drugs.

The Blues distributed sample posters and brochures and they produced a campaign slogan, "Generic Drugs—the Unadvertised Brand."

More than 1,000 pharmacies competed. At Grand Value Drugs in Detroit, customers were told when they submitted prescriptions whether generic equivalents were available and what the cost difference between the generic and the brand name drugs would be.

"We wanted to increase the customers' awareness," said Kevin White, Grand Value Drug owner/pharmacist. Grand Value, whose dispensing rate for generics quickly climbed by five percentage points, was the winner of the competition in the independent pharmacy category. Camp Hill, Pa.-based Rite Aid Corp. was the winner in the retail

chain category.

When winners were announced in March 2002, 38% of all prescriptions dispensed to plan members were generic; that represented an increase of one percentage point and a reversal of a four-year decline.

The next part of the campaign was launched in May: running ads for five consecutive weeks in more than 100 Michigan newspapers. The campaign attracted national media attention. And, significantly, through the end of second-quarter 2002, the proportion of prescriptions for Blues' plan enrollees in Michigan that were being filled with generics had increased by nearly two percentage points. By year end, that proportion had risen by about four percentage points.

Other steps the Blues took included development of a Web site that compared prices of the 25 most frequently prescribed brand-name drugs and their generic equivalents.

Eager to share the success of its efforts, the Blues plan last September sponsored a conference in Detroit, which attracted representatives from 50 plans to discuss ways to promote the use of generic drugs.

"I liked the fact that they were willing to share information. The sharing of best practices is something that benefits everyone," said Laura Perry, director of corporate communications at Blue Cross & Blue Shield of Western New York in Buffalo. Ms. Perry attended the Michigan Blues conference.

And the prospects for expanding the use of generic drugs are favorable, experts say.

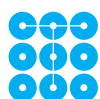
In 2002, the FDA approved 48 generic drug substitutes, up from 17 the year before, said Joel Owerbach, vp of pharmacy clinical services for Excellus in Rochester, N.Y.

With more generics out there, "we want to be sure that people have the best chance of spending the least amount of money on the proper medication," he said.

While brand-name drugs always will command a significant share of the prescription drug market, expanding the use of generic drugs can result in huge savings.

"You really can bend the trend," said Mr. DeStefino, noting that drug cost increases—which in recent years have been in the range of 18% to 20%—could be roughly halved if the dispensing rate for generics were to continue to rise.

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