Successor firms set back on asbestos liability relief/ **3**

U.S. lawmakers warned of cyberterror risks/ **4**

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Audit program stepped up

IRS to scrutinize big pension plans

By JUDY GREENWALD

WASHINGTON—Employers with large pension plans should brace themselves for the possibility of extensive Internal Revenue Service audits of their defined contribution and defined benefit plans.

A two-year, limited pilot program of the IRS to increase its pension audit activity of large plans became permanent last October. There are now six regional employee benefit plan audit teams, each poised to conduct 15 examinations each year of pension plans with 2,500 or more participants.

In the past, IRS audits have been conducted on a "catch-as-catch-can basis," said Fred Rumack, national director of tax and legal services at Mellon Human Resources & Investor Solutions in New York. Now, though, the IRS has teams of experts "looking to resolve issues and find problems, if they exist," said Mr. Rumack.

There are steps, though, that an employer can take to prepare for a possible IRS audit, including conducting its own audit beforehand to identify potential problems, consultants say.

The IRS audits will be conducted by teams of senior IRS personnel

See AUDITS/page 26

Broker didn't inform insurers of form switch

By DOUGLAS McLEOD

NEW YORK—Brokers at Willis Group Holdings Ltd. intended to switch the World Trade Center property program to a Travelers Property/Casualty Corp. form that might define the WTC's destruction as two occurrences but never told London market underwriters before the Sept. 11, 2001, terrorist attacks, a Willis official testified last week.

In the third week of a trial on the $3.55 billion property program, Paul Blackmore, a broker with Willis' London office, confirmed being told around July 12, 2001, that the program might be shifted to the Travelers policy from a Willis form—known as Wilprop—which would treat the loss as a single occurrence and which insurers say governs the program.

Mr. Blackmore testified, though, that he never informed London underwriters of the planned change.

"You agree that at no time after July 12th did you provide any one of those companies or syndicates with a copy of the Travelers form?" asked Barry Ostrager, a lawyer representing Swiss Reinsurance Co., the largest WTC insurer.

See WTC/page 6

Lloyd's names mull changes in liability

By SARAH VEYSEY

LONDON—Groups representing unlimited liability investors in Lloyd's of London are working on a project aimed at giving the Lloyd's names more options to convert to limited liability partnerships from their current status.

If the effort succeeds, it could prompt more names to abandon what was once Lloyd's main means of attracting capital. For much of the Lloyd's market's long history, most of its capital backing came from names—individual investors who were said to be liable "down to their last cufflink."

That situation has changed dramatically over the past decade, though, with massive losses and market reforms transforming Lloyd's capital base. As a result, the number of individual names now stands at just over 2,000, down from a high of 36,000 in 1996. But such names remain a force in the market, contributing about 12.5% of Lloyd's 2004 capacity of £14.9 billion ($26.6 billion), and many have said they have no interest in changing their status.

Proposed tax changes in the United Kingdom may alter their position.

According to the London-based Assn. of Lloyd's Members, a pledge last year by U.K. Chancellor of the Exchequer Gordon Brown that tax changes would be introduced in his 2004 budget, due in April, has made the idea of converting to limited liability more attractive to some names.

Under the unlimited liability system, names enjoy tax benefits related to accounting for losses. But under current tax rules, this advantage is lost when converting to a limited

See LLOYD'S/page 23

Late News

Court clears IBM of illness liability

A Santa Clara County, Calif., jury cleared IBM Corp. from potential liability when it found that two former IBM workers did not suffer systemic chemical poisoning from their work at the company's San Jose plant. Plaintiffs were Alida Hernandez, 73, who was diagnosed with breast cancer, and James Moore, 62, who suffers from non-Hodgkin's lymphoma. Plaintiff attorney Richard Alexander, of Alexander, Hawes & Audet, noted California law provides only a very narrow exception to its workers compensation law. That exception states an employer may be held liable for a worker's injury only if it knows an employee's injury was caused by the job and it fails to inform the employee.

PHOTO: ZUMA PRESS

Union grocery workers in Southern California have been on strike since October.

Supermarkets, union reach pact on strike

Three supermarket chains and a grocery workers union reached a tentative agreement late last week to end a Southern California strike and lockout sparked by disagreements over wages and health benefit cost sharing. The "tentative agreement squarely addresses the challenging health care costs and competitive issues we face," the stores said in a joint statement. The stores and the United Food & Commercial Workers Union, however, refused to provide details of the agreement, which UFCW members will vote on this weekend. But published reports say the agreement calls for a two-tier pay and benefit system, with new hires receiving less-generous offerings than veteran workers.

Mississippi bill would cap noneconomic damages

Tort reform in Mississippi is gaining momentum with the state Senate's approval of a

See LATE NEWS/page 27

International

CATASTROPHE LOSSES RISE

Page 21

Pennsylvania keeps door open on asbestos successor liability

By DOUGLAS McLEOD

PHILADELPHIA—Pennsylvania's highest court has struck down a state asbestos reform law aimed at limiting corporations' successor liability for asbestos claims assumed as a result of mergers and acquisitions.

In ruling that the 2001 statute unconstitutionally denies plaintiffs legal redress, a 4-3 majority of the Pennsylvania Supreme Court reinstated packaging manufacturer Crown Cork & Seal Co. Inc. as a defendant in 376 asbestos cases pending in a Philadelphia state court.

A lower court had earlier cited the 2001 law in dismissing the claims, a small fraction of the roughly 78,000 asbestos cases pending against the company nationwide.

Philadelphia-based Crown Holdings Inc., Crown Cork's parent, expressed disappointment with the ruling and said it is "currently studying the scope and limitations of the decision and available options."

The company also said it "will continue its efforts supporting legislative solutions to asbestos litigation" at state and federal levels.

Texas last year enacted reform legislation similar to Pennsylvania's, limiting companies' liability for asbestos claims assumed in an acquisition to the value of the acquired company's assets. About a third of Crown Cork's pending asbestos claims are in Texas courts, and the company is now seeking dismissal of Texas claims on the basis of the new law, according to Crown Holdings financial reports and a company spokesman.

The Ohio House of Representatives also passed asbestos reform legislation last year that is under consideration in the state Senate, and other states are considering their own reforms as the U.S. Congress prepares to reconsider a national asbestos compensation proposal that failed to win passage last year.

Absent federal legislation, Crown Cork is expecting challenges in each state that adopts reforms, the company spokesman acknowledged.

"Different jurisdictions will review their own laws under their own constitutions," he said. The Pennsylvania ruling represents "one state and one case. Other states are going to have to test it themselves."

Pennsylvania's statute, limiting liability for acquired asbestos liabilities to the fair market value of the acquired company's assets, applied to all asbestos claims, including all claims and lawsuits pending as of

See ASBESTOS/page 26

Senate reform vote falls short

Malpractice bill failure may hurt other measures' chances

By MARK A. HOFMANN

WASHINGTON—The Senate's failure to proceed with limited medical malpractice liability reform last week could muddy the outlook for approval of other tort reform measures.

The medical malpractice vote could be particularly critical given that the Senate is likely to take up, before the summer, a class action reform bill and possibly a measure designed to replace the current litigation-based system for compensating victims of asbestos-related diseases with a no-fault trust fund.

While the chances of Senate approval of a medical malpractice reform bill had never appeared strong, the tabling of the measure still represented a setback for pro-tort reform forces.

That's true even though 62 senators from both parities have indicated that they would vote to end any filibuster against the Class Action Fairness Act, which has already won House approval. Opponents of that proposal have said that they will try to add nongermane amendments, such as the extension of unemployment benefits, to the bill in an attempt to scuttle it.

The outlook for asbestos reform legislation is even murkier, in part because no one knows exactly what bill—if any—will ultimately be brought to the Senate floor.

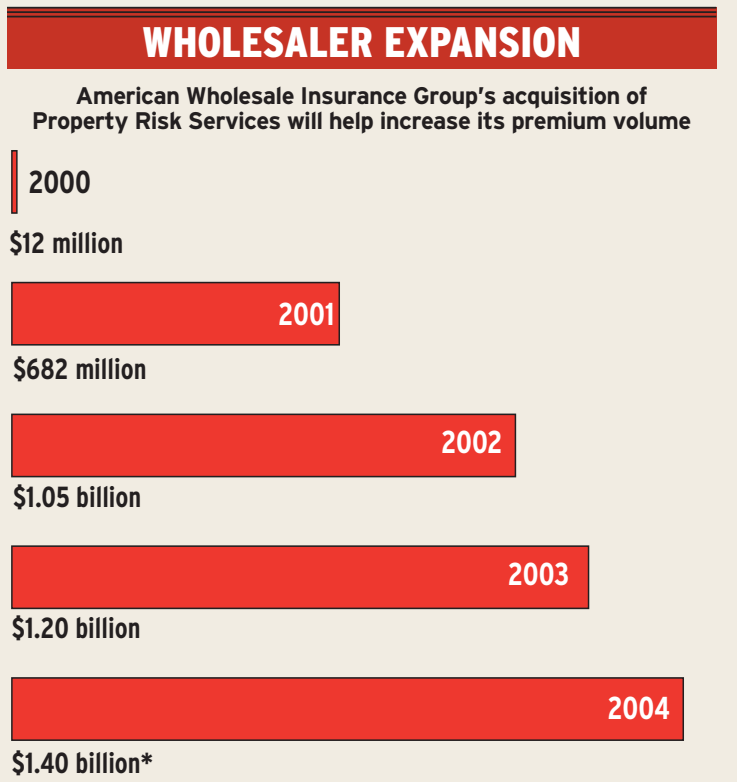
The medical malpractice reform defeat came last week when Senate Majority Leader Bill Frist, R-Tenn., attempted to invoke cloture—which requires 60 votes—to limit debate on S. 2061, the Healthy Mothers and Healthy Babies Access to Care Act. The measure would have provided some relief from liability to obstetrician-gynecologists and other medical professionals involved in childbirth. Among other things, the bill would have capped noneconomic damage awards in covered cases to $250,000.

The cloture measure failed, however, 48-45, with three Republicans voting against cloture and only one Democrat voting in favor. President Bush quickly issued a statement calling the vote that rejected cloture "a blow to America's families" and called again for approval of medical malpractice reform legislation.

Last week's vote marked the second time in a year that the Senate has failed to proceed on medical malpractice reform. An attempt to invoke cloture on a more comprehensive bill failed last summer (*BI*, July 14, 2003). Nevertheless, Sen. Frist has indicated he may bring up medical malpractice reform legislation again before the Senate adjourns.

Regardless of what the Senate leadership decides to do with medical malpractice reform, some civil

See MED MAL/page 26



Wholesalers hope deal spurs growth

By JOANNE WOJCIK

CHARLOTTE, N.C.—American Wholesale Insurance Group Inc., one of the nation's largest wholesalers, is positioning itself for growth after acquiring Property Risk Services L.L.C., a wholesaler that specializes in the large commercial property market.

The deal, sealed last week, will enable American Wholesale, which had been a player in the middle-market property arena, to break into the large property market, providing coverage for risks with annual premiums exceeding $1 million, according to M. Steven DeCarlo, president and chief executive officer of the Charlotte, N.C.-based wholesaler.

"It helps us on large account property. They do big, jumbo deals. We've got a great property facility out west. Now we have a property facility out east," Mr. DeCarlo said. PRS is based in Edison, N.J.

Furthermore, PRS, which will maintain its brand identity and continue to operate autonomously, will now be able to offer additional products and services to the agents and brokers it previously worked with only on large property risks, according to John F. Keegan, president of PRS.

"There will be a lot more cross-selling of products," Mr. Keegan agreed. "The whole thing is about being able to offer retail agents and brokers additional products and services, where before we were just in that large property niche."

The acquisition, which had been a year in the making, will enable PRS to both grow geographically and increase its product offerings to existing clients, said Thomas L. Spinner

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Inside Business Insurance

Cybersecurity fears may prompt probes

Government officials say more-intrusive rules may be needed to protect against terrorist attacks on computer networks. Page 4

Employers can give younger workers less

A ruling finds that providing less-generous benefits for younger workers does not violate the ADEA. Page 4

What's eating your health care budget?

Editor Paul Winston writes that an old but renewable, er, resource could help in cutting some health care costs. Page 6

Reform advocates should focus efforts on states

With tort reforms faltering at the federal level, their best chances may be with the states. Page 8

Maritime safety efforts stuck in doldrums

European marine safety initiatives launched after the Erika oil tanker disaster, above, have yet to be implemented. Page 21

Online

- The **Datebook** lists not only upcoming industry events but an interactive tool also lets sponsors add information on their own meetings and seminars.
- Searchable **directories** of industry vendors enable visitors to research the companies using various criteria.
- New **Opinion Poll** for readers: Do you think prescription drugs manufactured for the Canadian market are as safe as those produced for the U.S. market?

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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U.S. Steel benefits from drug subsidy

By JERRY GEISEL

PITTSBURGH—U.S. Steel Corp. has slashed its future retiree health care obligations by hundreds of millions of dollars as a result of the 2003 federal law that adds a prescription drug benefit to the Medicare program, the nation's largest steel producer disclosed last week.

Pittsburgh-based U.S. Steel estimates that the new law, along with certain other changes the company is making, will reduce its future retiree health care obligations by $450 million.

That whopping reduction in obligations will be the result of several factors, U.S. Steel disclosed in its annual report.

The greatest portion of its savings will result because, U.S. Steel predicts, there will be a significant withdrawal of retired steelworkers from one of its optional prescription drug plans beginning in 2006, as participants in that particular plan seek more affordable coverage in the federal program when it kicks in that year.

That migration should accelerate in future years as the result of a cost cap in a 2003 contract U.S. Steel negotiated with the United Steel Workers union that in 2006 freezes company retiree health care costs at a fixed per capita rate for subsequent years.

"This cost cap is expected to cause increasingly higher premiums charged each year and to accelerate the participant withdrawal rates," U.S. Steel said.

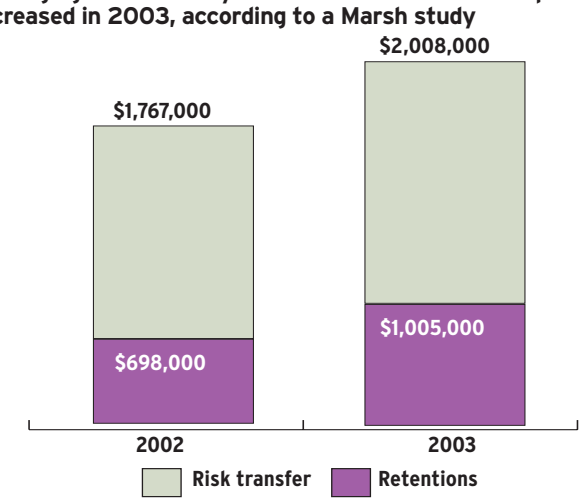
U.S. Steel estimates $70 million of the $450 million in savings will accrue because of a provision in the Medicare law that provides tax-free payments to employers that maintain prescription drug plans that are at least as generous as that which Medicare would provide.

U.S. Steel expects that the drug plan it offers to unionized retired mine workers will qualify for the federal tax break in which the government subsidizes 28% of an employer's drug costs for each beneficiary after a $250 deductible and subject to a $5,000 ceiling.

See STEELMAKER/page 24

RETENTIONS vs. RISK TRANSFER

Average general liability retentions and attachment points increased in 2003, according to a Marsh study



Note: Data submitted by 1,433 entities in 2003, and 1,050 in 2002.
Source: Marsh Inc.

Casualty cost of risk survey

Buyers pay more for less: Marsh

By MEG FLETCHER

Buyers who pay more for less coverage while retaining more risk are becoming a fixture in the primary casualty market, according to the most recent annual study from Marsh Inc.

U.S. businesses overall are spending an average of $2.32 per $1,000 of revenue on insurance-related measures to manage those lines, which include workers compensation, general liability and auto liability risks, according to the New York-based broker.

Measured against revenue, workers comp represents the largest portion, accounting for $1.46 per $1,000 of revenue, compared with 55 cents per $1,000 of revenue for general liability and 31 cents per $1,000 of revenue for auto liability. Although the study is conducted annually, Marsh said direct comparisons with prior years are difficult to make because the sample sizes change.

However, businesses and government entities that provided two years of data for the 129-page "Casualty Cost of Risk 2004" study experienced a "relatively modest" 6.9% increase in the casualty cost of risk.

That single-digit increase might suggest the hard market has ended, the study said. But buyers were paying more for less coverage as well as retaining more risk, said Timothy Brady, managing director in the U.S. casualty practice of Marsh. Essentially, underwriters were winning on all three fronts, while buyers were losing.

"Businesses have elected higher retentions to mitigate higher premium costs," Mr. Brady said.

For example, all survey respondents reported that average

See CASUALTY/page 25

Errors & omissions

• Due to incomplete information supplied by Verdictsearch.com, a Feb. 16 chart of the largest jury verdicts of 2003 misidentified one of the case names. The proper name of the case is *International Paper Co. vs. Affiliated FM Insurance Co., et al.* Affiliated FM, part of what is now FM Global, was among several insurers dismissed from the case in 1996, though the case still bears its name.

U.S. vulnerability to cyberattack studied

By MARK A. HOFMANN

WASHINGTON—The federal government may have to take a more intrusive role in promoting cybersecurity, a senator suggested last week during a hearing on cyberterrorism.

Between 85% and 90% of the nation's electronic data infrastructure is under private-sector control, said Sen. Dianne Feinstein, D-Calif., during a hearing held by the Senate Judiciary Committee's Subcommittee on Terrorism, Technology and Homeland Security. The Bush administration has "embraced a voluntary market-based approach to cybersecurity," Sen. Feinstein said.

But she noted that even former Virginia Gov. James Gilmore—the chairman of the president's recently dissolved Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction—has criticized that approach as inadequate to the threat of cyberterrorism.

"I am concerned that we essentially are unprepared for a cyberattack," she said.

Just how catastrophic such an attack could prove to be, particularly

given the ever-increasing use of wireless technologies, was underscored by Dan Verton, a former intelligence officer and author of "Black Ice: The Invisible Threat of Cyberterrorism."

"The economy right now has multiple Achilles' heels," said Mr. Verton. He said that the spread of wireless technologies has led to "an unprecedented level of vulnerability." Unprotected wireless networks are in use at hospitals, airline baggage checking systems, uranium mining operations, railroad track heating switches and even some security camera systems, among other places, he said.

Mr. Verton spun a hospital-based scenario to illustrate how unprotected wireless networks could help terrorists achieve their goal of spreading panic and confusion. A terrorist could sit in a car in a hospital parking lot and remotely change medical records, he said. By changing blood type information, the terrorist could kill patients by having them receive transfusions of the wrong type blood, Mr. Verton said.

He also said that a future massive power failure, such as the one that

See TERROR/page 25

ADEA for older workers: Court

Ruling allows more generous benefits for those over 40

By JERRY GEISEL

WASHINGTON—Employers can provide less-generous benefits to younger workers than to older workers without violating federal age discrimination law, the Supreme Court has ruled.

In its first ruling on the issue, the high court in a 6-3 decision issued last week said the Age Discrimination in Employment Act permits corporate benefit plans to favor older employees over younger ones.

"It is beyond a reasonable doubt" that the intent of the ADEA was to protect older workers, those 40 and older, wrote Associate Justice David Souter for the majority. If Congress had been concerned about protecting younger employees against older employees, it likely would not have ignored everyone under 40 when drafting the ADEA, Justice Souter said.

The decision on so-called "reverse age discrimination" involved a 1997 collective bargaining agreement between a unit of Falls Church, Va.-based General Dynamics Corp. and the United Auto Workers union. Under the agreement, General Dynamics eliminat-

ed retiree health care coverage to all future retirees except current employees who were then at least 50 years old.

Dennis Cline, a 48-year-old General Dynamics vehicle operator, and other employees under age 50, sued the company.

A U.S. District Court in 2000 dismissed the suit, but in 2002 the 6th U.S. Circuit Court of Appeals reversed the lower court, saying that the ADEA was intended to protect any individual against discrimination based on age, an interpretation of the law the Supreme Court reversed.

The ruling prevents what could have been a slew of litigation against employers, which for decades have designed and offered a wide array of benefit plans that offer more generous benefits to older employees.

Some of those programs include early retirement incentives, in which employers, to encourage older employees to retire and avoid layoffs, give extra benefits, such as additional pension credits, to

See ADEA/page 25

WTC: Form shift not expressed

Continued from page 1

"That's correct," Mr. Blackmore answered.

"It never happened, right?"

"That's correct."

While Mr. Blackmore said he told a Swiss Re underwriter about the policy switch shortly before Swiss Re issued a revised binder later in July, the broker acknowledged that he made no notes reflecting the conversation and that the Swiss Re binder itself did not mention a policy form.

The concept of 'lead insurers and follow form has been introduced by the attorneys....There was never a lead insurer picked prior to 9/11; this is a creation by all you guys.'

Robert F. Strachan
Silverstein Properties Inc.

Lawyers for WTC leaseholder Silverstein Properties Inc. countered by pointing out that a Willis employee had e-mailed portions of the Travelers form to Swiss Re before the revised binder was issued, and that another insurer—Paris-based SCOR S.A.—had acknowledged the Travelers form as the controlling policy in July 2001.

Swiss Re, London underwriters and several other insurers are locked in a battle with Silverstein over which policy controls the program. Insurers argue that they bound coverage on the basis of the Wilprop form, which Willis provided when it marketed the program to underwriters and which a federal appeals court has already ruled would treat the WTC loss as one event.

Silverstein, though, argues that the program was being shifted to the Travelers form and that the insurers either knew that or had waived approval of the policy form. The Travelers form, which contains no occurrence definition, would treat the loss as two events, entitling Silverstein to two $3.55 billion policy limits, the leaseholder maintains.

Mr. Ostrager, who is with Simpson, Thacher & Bartlett in New York, last week introduced deposition testimony in which Silverstein Risk Manager Robert F. Strachan seemed to undercut the leaseholder's contention that Travelers was intended to lead the program under its form.

Asked which primary insurer he considered the lead for claims-handling purposes before Sept. 11, Mr. Strachan replied, "The whole concept of lead insurers and follow form has been introduced by the attorneys here. There was never a lead insurer picked prior to 9/11; this is a creation by all you guys."

Asked about this statement on the witness stand last week, Willis Assistant Vp Timothy Boyd said, "I don't agree with it."

Mr. Boyd e-mailed other Willis brokers on July 12, 2001—days before the program was completed July 17—telling them he "intended to use Travelers and accept form," noted Eric Roth, a lawyer with Wachtell, Lipton, Rosen & Katz in New York representing Silverstein.

Asked if that meant that he intended to use the Travelers form only for Travelers' own participations, Mr. Boyd replied, "The statement was to use the Travelers form as the program policy form."

Mr. Blackmore followed Mr. Boyd on the stand and was questioned over three days last week.

Acknowledging that he received Mr. Boyd's July 12 e-mail, Mr. Blackmore testified he did not tell London or European insurers—including Swiss Re—about the Travelers form before the program's July 17 completion and never told London underwriters of the form switch before the Sept. 11 attacks.

A Willis London office employee e-mailed portions of the Travelers form to Swiss Re on July 23, along with a revised binder that reflected changes a Swiss Re underwriter had sought in its original July 9 placement slip.

Mr. Blackmore also testified that he told Swiss Re underwriter Daniel Bollier between July 17 and July 23 that the program was being shifted to the Travelers form. Questioned by Mr. Ostrager, though, Mr. Blackmore conceded that he had made no notes of the conversation despite having taken detailed notes of other coverage concerns Mr. Bollier had raised earlier.

"You did not write down anywhere in any form that you had discussed with Mr. Bollier that the entire policy form was going to be switched to Travelers?" Mr. Ostrager asked.

"I didn't, but we sent him (the July 23) e-mail with the Travelers form. That is memorialization," Mr. Blackmore replied.

He acknowledged, though, that the e-mail itself—apart from attaching the Travelers form—says nothing about switching forms for the program.

Mr. Ostrager suggested that Willis sent the Travelers wording not because it wanted to shift from the Wilprop form but because Swiss Re wanted changes in the program's electronic data processing coverage and the Travelers form included language that could be adapted for the program.

Lawyers for Silverstein, though, noted that Willis' July 23 e-mail begins, "further to your telephone conversation with Paul Blackmore this morning," supporting Mr. Blackmore's claim that he told Mr. Bollier about the Travelers switch.

They also introduced an internal SCOR e-mail dated July 20 in which a SCOR underwriter discusses the placement and concludes, "Policy form will be Travelers and we will soon have a copy."

Mr. Blackmore is expected to continue his testimony March 1.

Allianz, AXA to pay Deutsche Bank $140 million

Bank settles property claim

By GLORIA GONZALEZ

NEW YORK—Deutsche Bank A.G. has reached an agreement with its insurers in the dispute over the bank's claim on its heavily damaged office tower near the World Trade Center.

John Massopust, a lawyer for Allianz Insurance Co., confirmed that a settlement has been reached with the bank. Under terms of the settlement, Allianz and AXA S.A. would pay Deutsche Bank $140 million for its insurance claim on the property at 130 Liberty St. The bank would then sell the property to the Lower Manhattan Development Corp, which would demolish the building. LMDC would pay $45 million toward the demolition costs, and the insurers would be responsible for any costs above that amount.

The settlement does not address Deutsche Bank's business interruption claims.

John Massopust
Zelle, Hofmann, Voelbel, Mason & Gette

While this settlement resolves the insurance claim on the Liberty Street building, it does not address claims related to other Deutsche Bank properties in the area nor does it address the bank's business interruption claims, said Mr. Massopust, a partner with Minneapolis-based Zelle, Hofmann, Voelbel, Mason & Gette. "There are other parts to the insurance dispute that still have to be resolved," he said.

The bank sued last year to force Allianz and AXA to pay for a total loss of the 40-story building, which the bank said was irreparably contaminated with asbestos and other toxins in the storm of dust and ash that accompanied the WTC's destruction. The two insurers wrote a combined 50% of the $1.7 billion limit on the building. Deutsche Bank also sued the state of New York, charging that the state prevented the bank from containing damage to the gutted building in the weeks after the Sept. 11, 2001, terrorist attacks.

Paul Winston

So would you call them 'moneygrubs'?

U.S. employers, always searching for creative ideas from other nations on how to lower their soaring health care costs, may soon turn to the United Kingdom for new inspiration.

Over the past year, increasing attention has been devoted to several payers in the United States, chiefly state and local governments, that discovered that it was cheaper to buy prescription drugs made by U.S. pharmaceutical companies from Canadian pharmacies rather than from American distributors. Just as drivers on the highway speed up when they notice law enforcement vehicles surpassing the speed limit, private employers are bound to assume that if their local governments can flout the law, it must be OK for them to follow suit.

Paul Winston

But there are other opportunities for savings elsewhere around the globe for interested U.S. employers to emulate. One of them is an old idea made new by the British National Health Service.

The National Health Service recently began prescribing live maggots as a cheap and effective means to treat people with infected wounds. The service sees it as a cost-effective alternative to expensive hospitalization.

Using maggots is an enormously effective method of battling infection and necrosis in wounds that has been around for centuries, experts say, and it is far less costly than modern medications. And by prescribing the maggots for patients in their home, British citizens avoid the unpleasantness of having to stay in the hospital while they are on the mend.

This program is sure to appeal to U.S. employers trying to wiggle out of additional prescription cost increases.

Unlike costly prescription drugs, there are no questions (yet) about brand name vs. generic maggots. Also, they're a renewable resource as long as blowflies continue to, er, blow. And there's no risk of unpleasant side effects (other than unrelenting nightmares), because maggots are all natural.

Sure, some people might be a bit squeamish at first and give serious thought to amputation, but when they consider that the huge savings will enable their employer to ease up on the cost shifting, they're sure to embrace the little buggers.

I'm certain there's an added benefit to some patients in that it is far more entertaining to have wiggling maggots packed in a wound and bandaged up than to apply salves and dressings and take frequent (and costly) antibiotics. It's also a conversation starter when others inquire as to why a patient's arm or leg appears to be moving of its own volition. And those who lack the comfort of pets in their lives will suddenly have dozens of little friends.

Hundreds of U.S. hospitals now have maggots on hand for such purposes, but they're not widely used because of the challenges of devising billing codes for the service and because few patients ask for them by name (yet).

Of course, the U.S. Food and Drug Administration would have to regulate medicinal maggots. This is ironic, given that, until now, its experience with the critters has been limited to keeping them out of the industries it oversees. But regulation is needed to ensure the quality of maggots and to prevent black market maggoteers from trying to supply inferior product.

In addition, we want to avoid U.S. companies importing maggots from Canada or the United Kingdom, putting U.S. bug farmers out of work. People with maggot benefit plans should be able to continue to proudly Buy American when their health is at stake.

Savvy employers also could introduce new financial incentives to their prescription benefit plans. Employees who opt for this cost- and life-saving treatment would get generous full coverage, while the selfish ones who insist on using expensive high-tech treatments would have to pay more out of their own pockets. I imagine a few short-sighted individuals (such as myself) would consider it money well spent.

If maggot benefits take off, a number of medieval treatments are still available that have been displaced by the medical industry's mad rush to develop newer and more costly procedures. Consider blood letting, leeches and the diagnosis of an imbalance of humors.

Britain's National Health Service has shown that medicine does not need to cost an arm or a leg to save an arm or a leg. I predict that, before long, this forward thinking will creep into the strategies of U.S. employers as well.

Paul Winston can be reached at pwinston@businessinsurance.com when he is not busy incorporating his new state-of-the-art maggot ranch.

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Editorial

Look to states for med mal reform

GETTING MEDICAL MALPRACTICE liability reform legislation through the Senate was the longest of three longshot tort reforms this year.

We applaud Senate Majority Leader Bill Frist, R-Tenn., for his effort and pledge to keep pushing for medical malpractice reform legislation as long as this Senate sits. However, we believe the time has come for supporters of malpractice reform to redouble their efforts at the state level.

This shift in focus is needed for several reasons. While we firmly believe that medical malpractice liability—like class action reform and asbestos liability reform, the two other major tort reforms before the Senate—is a national issue that deserves a national answer, we also recognize malpractice liability has traditionally been a matter for state assemblies and courts.

Efforts to federalize what has traditionally been a state issue have led some otherwise pro-business lawmakers to resist federal reform efforts. That was evident in last week's vote, as Sen. Frist failed to keep even all his fellow Republicans in the Senate behind a motion to limit debate on the bill.

Further underscoring the difficulty of passing federal medical malpractice legislation is the fact this was a modest bill—impacting only obstetricians/gynecologists and others involved with women's and babies' health. That field has been hit hard in the current tort system. Yet there wasn't even sufficient Senate support to head off filibusters, let alone pass the bill.

That's the bad news. The good news is state malpractice liability reform efforts often enjoy considerable success. California's 1975 Medical Injury Compensation Reform Act—which limits noneconomic damages in malpractice cases—has become a model for other states. As the record shows, states that have adopted MICRA-style laws have not suffered the kind of medical malpractice crises—such as skyrocketing liability insurance costs and physician exoduses—that their unreformed counterparts have.

We would continue to support any effort to win federal medical malpractice reform legislation. But right now, meaningful reform appears an impossible dream at the federal level, while it perhaps is achievable in the states.

The statehouses now look like the most likely places for reforms to hit their target, and that's where serious reform efforts should concentrate.

More can be done to cut Rx costs

IF THERE EVER was a benefit program in need of cost management, it is prescription drug coverage.

As much as group health care costs have risen over the past few years, the costs of prescription drugs have risen even more, with 15% to 20% annual increases quite common.

In recent months, several purchasers have turned to reimporting prescription drugs from Canada as a means of lowering their staggering costs. Federal regulators, though, have banned reimports and pharmaceutical companies also are looking at ways to curb the practice. As such, it only offers employers the prospect of short-term savings.

However, there still are plenty of other measures employers can take that can have a more lasting impact.

For starters, employers and their benefits advisers have to take a more aggressive stance to ensure that purchasers receive the discounts and rebates that prescription benefit managers are winning from drug manufacturers.

It is the collective buying power of employers that allows PBMs to obtain rebates and discounts, so surely employers should reap the financial benefit of that buying clout. At least one PBM, Medco Health Solutions Inc., has agreed to do just that as part of an arrangement with a Towers Perrin-organized employer coalition. We expect other PBMs will follow, if employers press them.

Employers also have to continue to look at their plan designs.

Too many drug plans still have too small a cost difference between the coverage of brand name products and generics. Given that the efficacy of brand name and generic drugs are equal, giving employees powerful financial incentives to use lower-cost generics is an obvious and effective cost control strategy. In addition to differing reimbursement levels, some employers are temporarily waiving copayments or coinsurance for generics when such alternatives exist.

Similarly, health plans need to do more to educate medical providers that brand name drugs should not automatically be their first choice when it comes to writing prescriptions.

There may also be a role for the government, too, in lowering costs. With the addition of a Medicare drug benefit, the federal government is bound to subject drug makers to the same billing and pricing scrutiny as other federal contractors. That could shed some much-needed light on the imbalance between drug pricing in this country and others, such as Canada.

The federal government also needs to take a look at whether its broad opposition to allowing prescription drugs to be reimported from other countries is appropriate in every case. President Bush last week said he would appoint a panel to study the issue, which is a start.

Unless and until all stakeholders do more to manage the soaring cost of prescription drugs, they will continue to bear the costly consequences of their inaction.

Schillerstrom

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Avoid pitfalls in benchmarking for savings

Accurate data, analyzed properly, can help reduce losses, insurance costs

By George G. Pallis

Many organizations are making greater use of benchmarking in their risk management efforts. Gaining the most from these activities requires a clear understanding of the objectives and a careful consideration of how a benchmarking analysis should be conducted.

Benchmarking helps firms evaluate program costs, market capacity, retentions, deductibles, attachment points, limits, sublimits and coinsurance. In addition, it aids in the examination of coverage scope and exclusions, insurer preferences and service capabilities, risk-financing options, and claim and litigation trends.

Mr. Pallis

With underwriters requiring detailed information, effective benchmarking to identify and control cost drivers can help in negotiating better quotes, terms and conditions.

With underwriters requiring detailed information on clients' losses, exposures and relevant loss control activities, the effective use of benchmarking to identify and control cost drivers can help in negotiating better quotes, terms and conditions. Additionally, a detailed benchmarking report might improve insurers' perception of a firm's risk profile.

When incorrectly performed, though, benchmarking can lead to the wrong conclusions or prevent an organization from obtaining the best results.Here are seven common mistakes that can produce those outcomes:

- Inadequate sample. Many benchmarking data sources can provide breakouts for multiple revenue groupings, industries, locations and other categories. The sample size must be adequate for each of the breakouts to be statistically significant, though. Consider workers compensation, for which rules and regulations vary by state. Relevant data for benchmarking typically must be analyzed by jurisdiction as well as by employee occupation. This requires several segmentations of the data. In addition, workers comp benchmarking efforts typically call for examining frequency and severity, specific business units or operations and individual exposures rather than aggregated risk. Therefore, it is important to know the size of the sample.
- Not finding the right peers. A peer might be an organization with the same scope of operations within a firm's industry group; an employee base in the same occupation, regardless of industry; or claims data with the same loss characteristics.

To identify peers, start with your organization's benchmarking objectives. It's not unusual to select different peers for different benchmarking objectives. In many cases, a firm in the same revenue class might have a different scope of operations. To benchmark auto risk, fleet size often is more meaningful. And payroll may be a better yardstick for workers comp. To illustrate this further, a firm that analyzed its workers comp costs measured itself against one peer and saw no need for change. Yet, because it manufactured two vastly different products, it conducted a second analysis against a separate peer, which helped it pinpoint significant opportunities for savings.

- Limited access to data. Data for use in benchmarking is available from a range of sources. For internal comparisons, firms collect

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their own data.

To benchmark against peers, they often must obtain data from third parties, including insurers, brokers, trade groups and management consultants. Yet these sources may not provide the same access to data. Accessibility to raw data from the central database of a broker or consultant often enables companies to obtain better and more meaningful custom reports on a timely basis. These sources may be especially valuable for loss and insurance program structure information, because they may include information aggregated from multiple insurers.

- Poor data quality. While self-reported data accumulated by third-party sources may be of some value, aggregated data from actual bound programs gathered by insurance brokers and consultants from their client bases usually provides greater assurance of quality and accuracy.
- Outdated data. Significant changes in the insurance marketplace during the past several years may make historical comparisons that draw on data that is two or three years old less valuable. Consequently, knowing the timeliness of the data is extremely important. In addition, the ability to examine data by time period can be very useful.
- Overlooking potentially meaningful trend data. A key aspect of many benchmarking projects involves gathering baseline data relative to an organization's risks and costs. Although the data could encompass a single period, such as one year, compiling data in successive years often yields a clearer picture of a firm's risk profile and the effectiveness of risk control, productivity and process improvement initiatives over time.

Significant changes in the insurance marketplace during the past several years may make historical comparisons that draw on data that is two or three years old less valuable.

- Not using the right measurements. When evaluating benchmarking data or reports from third parties, make sure you use meaningful statistical measurements. Some benchmarking reports cite only minimum, maximum and average (or mean) values, which can be misleading. The median, or median range, can reduce the distortion in means caused by outliers. In addition, benchmarking insurance purchasing trends and program structure often calls for going beyond the categories that may appear on a survey form. Underlying factors in these areas should be explained in the accompanying text or as footnotes to the charts.

Properly used, benchmarking provides firms with a multitude of benefits. It helps evaluate the effectiveness of initiatives designed to generate savings or improve performance. In this respect, it should not be a single exercise but a tool to yield continual improvement.

George G. Pallis is a senior vp at Marsh Inc. in New York.

How to submit an article for *Business Insurance*'s Perspectives

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

The section is intended to be a forum for readers' opinions and 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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- You will receive from us an acceptance or a decline of your article idea.
- If accepted, we will respond with comments and request the full article, which generally should be no more than 800 words in length.
- All articles are to be accompanied by a photograph of the author and a brief biography.
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To submit a Perspective article query or for more information, please send a note to *biweb@crain.com*.

Documenting progress key to rehabilitation

Measuring progress reduces costs, aids return to work efforts

By Marjorie K. Manahan, Mark S. Dakos and Dr. David C. Bachman

The biggest cost driver in workers compensation litigation is the unknown.

As long as the improvement in the physical performance of the injured worker remains undocumented, the medical and legal costs will continue to grow in workers comp. The more subjective the medical provider is in reporting outcomes, the more the plaintiff's legal counsel will be able to successfully challenge the actual benefits the treatment may have provided to the injured worker. A smart plaintiffs attorney will use the lack of objective physical performance outcomes to design a line of questioning through which the injured worker is able to claim successfully that the therapy didn't provide any benefit. Without the documentation of performance gains over the course of treatment, the defense attorney's argument of increased capacity is severely hindered.

The commitment to an established protocol of objectively documenting performance outcomes at regular intervals over the course of treatment ensures that the employer, the insurer and the injured worker receive substantial benefits. Those benefits are:

- Reductions in unnecessary treatment through the accurate determination that the patient has reached a plateau or the preinjury condition (if a post-offer-of-employment test was conducted).
- Reductions in temporary disability expenses through interim measures of physical ability that enable the placement of the worker in modified or alternate work on a safe and dependable basis.
- Reductions in vocational rehabilitation expenses in more serious cases in which the documentation of the residual abilities of the worker may have been underestimated or the potential vocational goal may appear to be questionable.
- Reductions in permanent disability/permanent impairment expenses through accurate documentation of increased physical abilities over the course of time in a treatment program. With a measurement of physical ability at the point of hire, the means to reduce permanent disability expenses through medical apportionment is also achieved.
- Reductions in legal expenses by providing an objective means to resolve cases on an expedited basis.

Additional reductions may come in personnel and recruitment costs; short- and long-term disability insurance premiums; administration expenses; and, of course, workers comp insurance premiums.

In the milieu of the medical and legal community, one party that is

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Ms. Manahan

Mr. Dakos

Dr. Bachman

Document: Measure progress

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often forgotten is the patient. Patients who believe the medical community is not meeting their treatment needs to restore function will seek legal counsel. All patients need feedback to be reassured that a positive goal is being achieved through medical treatment. Monitoring progress through objective measurement provides the patient with the knowledge that the restoration of ability is actually taking place. Patients that are provided only with an "educated guess" of ability are often prone to question the discrepancy between their own perception and the physician's estimate of functional restoration, thus driving them to seek answers through legal channels.

For many clinicians, the challenge of documenting outcomes that are not favorable to the treatment provided to the patient appears to be contradictory. Yet the clinician striving to achieve the best possible outcome will identify negative outcomes and strive to correct the situation to improve results. The failure to recognize a substandard outcome by hiding it only blocks the means to ultimately achieve success.

Although the world has evolved through the advances of the computer, many within the medical and allied health fields fail to recognize the benefits of technology in practice. The necessity of professional judgment is not disputed; however, the documentation of outcomes needs to be objectified in order to eliminate claims of bias. The failure to use objective and unbiased evaluation systems only serves to discredit the practitioner's opinion.

Patients that are provided only with an 'educated guess' of ability are often prone to question the discrepancy between their own perception and the physician's estimate of functional restoration, thus driving them to seek answers through legal channels.

Employers, through their insurers or third-party administrators, must begin to demand greater accountability from the medical or therapeutic treatment provided. Furthermore, interim reports of ability in direct relation to the demands of the employers' jobs must be provided to enhance the return-to-work process. Medical providers, in turn, must be required to use objective measures of function to accurately determine the residual abilities of the patient. The "educated guess" or opinion should be heavily discounted due to its tendency to deliver injured workers to legal representation, as opposed to back to the workplace.

Finally, employers need to take a serious look at the physical demands of their jobs, how they are documented and whether the workforce has been suitably matched to them. Failure to accurately document the functional requirements of the job costs employers billions of dollars every year. By assuming that medical providers should be able to understand the exact nature of the work to be performed by the patient, the professional evaluator faces the errors associated with the aforementioned "educated guess" process. Without accurate documentation of the physical requirements of the job, the word of the patient will be the primary resource upon which the physician will rely for a return-to-work decision.

Only when the employer takes direct responsibility for the control of its workers comp program and demands accountability from all parties to the process will a cost-effective and appropriately controlled program be established.

Marjorie K. Manahan is division manager-workers compensation and loss control for Sara Lee Bakery Group in St. Louis. Mark S. Dakos is chief clinical officer at BTE Technologies Inc. in Greenwood Village, Colo. Dr. David C. Bachman is Pacific area medical director for the U.S. Postal Service in San Francisco.

Terror, war threats demand focus on management of AD&D exposures

By Steve Mueller

The daily realities of terrorist attacks, acts of war and other tragedies have increased the possibility of death and injury to large numbers of employees and have made this potentially catastrophic financial risk a paramount concern for employers. Why, then, do some risk managers believe that the potential catastrophic risk of an accidental death and dismemberment

Mr. Mueller

exposure is being strategically managed simply because a policy is in place?

In a business environment as dynamic as today's, not only must AD&D risks be insured, they must be managed, just like all other potentially catastrophic exposures. Managing this risk requires in-depth knowledge of your company's business travel and 24-hour AD&D exposures, domestically and internationally. As a starting point, risk and benefit managers should consider the following key elements to effectively manage their organizations' business travel and 24-hour accident programs.

Your AD&D risk. Before AD&D risks can be properly managed, they must be thoroughly understood. Hence, it is critical to assess a company's domestic and international business travel and 24-hour AD&D exposures, location by location.

Accumulation issues must also be examined. Many companies are extremely vulnerable to severe losses resulting from a catastrophic event impacting a large concentration of employees. AD&D risks can fluctuate over time, so risk managers must be alert to changing employee circumstances and emerging world events that can impact exposure.

The risk implications of future corporate strategies must also be contemplated. Will future opportunities take employees into new parts of the world or bring significant numbers together in particular locations?

Your current AD&D policy. A risk manager must know how the company's current AD&D program, including business travel and 24-hour accident offerings, measures up.

Many, lured by convenience, have simply tacked AD&D coverage on to the company's group life policy, rather than securing a stand-alone policy. This raises a red flag. Life risks are far more predictable, as life underwriting is data-driven. Underwriting accident coverages, on the other hand, requires tailoring policies to address highly unpredictable exposures. It should be left to underwriters who specialize in AD&D risks.

Risk managers are also advised to check where their current AD&D cover stands on key exposures, particularly acts of war and terrorism. Many insurers do not address these exposures; as a result, many companies are leaving significant threats uninsured. The flexibility an insurer offers is also important. If a company has unique risks, such as employees working in remote or particularly volatile locations, it could require innovative AD&D underwriting.

The current underwriting company's financial strength ratings should be thoroughly vetted. Its prowess in managing the substantial catastrophe risk it takes on its own balance sheet as a result of writing AD&D cover should be weighed. Is the insurer managing its own accumulation exposure and strategically applying reinsurance? Does its reinsurance encompass vital areas such as chemical, biological or nuclear events?

Accidental death and dismemberment risks can fluctuate over time, so risk managers must be alert to changing employee circumstances and emerging world events that can impact exposure.

Your crisis response readiness. A large-scale disaster, such as a terrorist attack, could be devastating for employees and the employer's ongoing operations. Often the life-or-death consequences of a disaster can be mitigated by an intelligent, timely crisis response. Every company should be prepared with detailed plans to respond to various crisis scenarios.

Moreover, they should expect these plans to be supported and indeed enhanced by their AD&D insurer. AD&D underwriters that

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Fruit-picking accident compensable under comp

The compensability of a workers compensation claim basically turns upon whether the employee was acting for the benefit of her employer to any appreciable extent when an accident occurred, according to the Court of Appeals of North Carolina.

Alice McGrady was employed by Olsten Corp. as a certified nursing assistant. As a CNA, Ms. McGrady provided in-house care for patients requiring assistance with daily living. In July 1999, she was serving an elderly woman with limited physical abilities. Ms. McGrady assisted the client with bathing, dressing, personal care, housekeeping and meal preparation. In addition, she drove the client to various places in the community and did her grocery shopping. The client enjoyed fresh fruit, which Ms. McGrady obtained for her from the local farmers' market or at a grocery store.

On July 26, 1999, the client asked Ms. McGrady to take her dog out to the yard. While there, Ms. McGrady noticed her client's pear tree had borne a pear. She tried to climb the tree but realized the pear was too high for her to shake it out. Ms. McGrady fell, breaking her back. She required back surgery but continued to experience pain. Her physician thought it unlikely that Ms. McGrady could return to work, even light duty. She filed a workers comp claim that was denied. Subsequently, the Industrial Commission reversed that decision and awarded her benefits. The employer appealed.

On appeal, Olsten argued that because she was not authorized to climb a tree to obtain a pear for her client, Ms. McGrady's injury did not result from a risk that might have been contemplated by a reasonable person familiar with the situation as incidental to the service when she entered the employment. But, the court said Ms. McGrady's entitlement to workers comp generally was not defeated by her negligence or by evidence that at the time of the injury she was engaged in a foolish, even forbidden, activity. The court was satisfied that her injury arose out of and in the course of her employment because she was required to make meals as well as snacks, and regularly served her client fruit as part of her job. The court affirmed the award of benefits.

McGrady vs. Olsten Corp., Court of Appeals of North Carolina, Aug. 5, 2003 (*BI*/01/F.-$10)

Legal Briefs

Employee thefts count as two occurrences

Employee thefts during two policy periods constituted more than one occurrence for purposes of the per occurrence limit of successive employee dishonesty policies, according to the Court of Appeals of Oregon.

Robben & Sons Heating Inc. purchased commercial multiperil insurance that included coverage for employee dishonesty from Mid-Century Insurance Co. for two policy periods: Oct. 1, 1998, through Sept. 30, 1999; and Oct. 1, 1999, through Sept. 30, 2000. From October 1998 through September 2000, a Robben employee stole Robben's checks and used them to pay herself and others. As a result, more than $50,000 in withdrawals occurred from Robben's account during each policy term. Robben submitted a proof of loss to the insurer, seeking to recover a total of $100,000 under the employee dishonesty coverage in the policy. However, the insurer invoked a coverage limit in the policy of $50,000 on the grounds that the employee's conduct during the two policy periods constituted a single occurrence. The insurer paid Robben $50,000. Robben sued to recover the remainder of its claim. The trial court ruled for the insurer.

On appeal, Robben argued that the insurer made an unequivocal promise to pay for loss or damage that took place in the policy period. Thus, Robben argued the "occurrence" limitation could not stretch across multiple policy periods. The court noted that the insurer expressly provided in the same policy that other coverage limits extended beyond the policy period. "The absence of such a provision with regard to coverage for employee dishonesty," the court said, "suggests that coverage and its limits were applicable only for the policy period designated in the declarations page." Thus, the court said that the fact the insurer paid the coverage limits for one policy period did not relieve it from paying under the coverage limits for the second policy period.

The trial court decision was reversed.

Robben & Sons Heating Inc. vs. Mid-Century Insurance Co., Court of Appeals of Oregon, Aug. 13, 2003 (*BI*/05/F.-$10)

Health plans need not cover contraceptives

At the request of a federal trial court, the Supreme Court of Washington certified that the failure of a group health insurer to provide all forms of U.S. Food and Drug Administration-approved prescription contraception did not violate Washington insurance law.

Shulamit Glaubach and Dawn Merydith had health insurance through Regence Blue Shield. Ms. Glaubach purchased an individual plan; Ms. Merydith's employer provided a group plan. Neither plan provided coverage for all FDA-approved prescription contraception, though Ms. Merydith's did cover oral contraception. Washington state law requires contraceptive coverage in otherwise comprehensive health plans. Both women sued Regence in federal court, seeking damages for historically failing to provide coverage for prescription contraceptives in its group and individual health plans. The federal trial court certified the question to the Supreme Court of Washington on whether the Washington state insurance reform act mandated such coverage.

Ms. Glaubach argued, in part, that because Regence's plan contained a general drug benefit, it must offer all prescription drugs approved by the FDA or else violate Washington law. The court said that, in essence, this reasoning would require every plan to offer every service, which would counter the general flexibility health insurers have to tailor plans to meet different needs and different resources. Furthermore, the court found nothing in the legislative history that indicated the Washington legislature contemplated contraceptive coverage in the insurance reform laws. Thus, the court said that the statutes did not require coverage of prescription contraceptives.

Glaubach vs. Regence Blue Shield, Supreme Court of Washington, July 17, 2003 (*BI*/03/F.-$10)

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

AD&D: Exposures changing

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are committed to this line of business can significantly assist in crisis response and recovery efforts, through the services and relationships they offer to support everything from swift evacuations to employee access to proper medical care. As a result, an insurer's travel assistance and claims management services should be a critical part of the AD&D purchase decision.

The response to claims. AD&D claims can involve tragic human losses and grieving family members. AD&D claims professionals must have the experience and ability to make decisions and interpret contract issues with compassion. They need to achieve the dual objectives of paying claims swiftly and responsibly to family members and helping ease a very difficult process.

AD&D risks must be managed differently from in the past by employing steps similar to those long used to manage other types of catastrophic threats. AD&D risks must be managed strategically. Fortunately, insurers that specialize in AD&D stand ready with the experience, knowledge and resources that risk managers need to comprehensively and proactively manage AD&D risks worldwide.

Steve Mueller is senior vp of sales and marketing at Zurich Accident & Health, a division of Zurich North America in Parsippany, N.J.

Comings & Goings - Buyers

Mr. Pettegrew

Ms. Stevens

Jeffrey W. Pettegrew has been appointed executive director of the Sacramento-base California Self-Insurers' Security Fund, a nonprofit mutual benefit corporation chartered by private self-insured California companies. The fund provides continuation of workers compensation benefits to injured workers of the private self-insured California employers should they file bankruptcy or fail to pay workers comp benefits.

In his newly created position, Mr. Pettegrew is responsible for all of the fund's activities and interests.

Previously, Mr. Pettegrew, who was named Risk Manager of the Year in 1989 by *Business Insurance*, served as vp of risk management and insurance at Walnut Creek, Calif.-based Westaff Inc., an international temporary staffing company. Before that, he served as chief administrative officer of the Contra Costa Municipal Risk Management Insurance Authority.

Mr. Pettegrew holds a master's degree in public administration from California State University, Hayward, and a bachelor of arts degree in communications from Denison University in Granville, Ohio. Mr. Pettegrew also holds the Associate in Risk Management designation.

***

Jonny Johnson has been promoted to senior vp of human resources at Richmond, Va.-based LandAmerica Financial Group Inc., a real estate transaction service provider.

Mr. Johnson will oversee all employee benefits and compensation programs. He reports to Ross Dorneman, executive vp of human resources. Previously, Mr. Johnson served as director of compensation and benefits.

He has a master's degree in human resources and media management and a bachelor's degree in marketing and communications from Virginia Commonwealth University in Richmond.

***

Stacy L. Stevens has been promoted to senior vp of risk management at Lowe Enterprises Inc., a Los Angeles-based real estate management, investment and development firm.

In her newly created position, Ms. Stevens is responsible for all of the risk management programs for Lowe's commercial properties and hospitality units. She also oversees the company's loss control and prevention and claims management programs.

Ms. Stevens previously served as the company's vp of risk management.

Before joining Lowe, she served as an insurance products and services consultant in Bermuda.

Ms. Stevens is a member of the Chartered Property Casualty Underwriters Society, and she is a board member of the Los Angeles chapter of the Risk & Insurance Management Society Inc.

***

Marlene Young-Peel has joined Chicago-based Blackwell Consulting Services as human resources director.

Ms. Young-Peel is responsible for recruiting, personnel, training and development, compensation and benefits and performance and resource management. She reports to Pamela Blackwell, chief operating officer.

Before joining Blackwell, Ms. Young-Peel held various human resource management positions. Most recently, she was a manager of employment and diversity at Exelon Nuclear.

She earned a bachelors degree in marketing with an emphasis in personnel management from Arkansas State University in Jonesboro.

We'd like to report staff changes in your risk management, safety and employee benefits departments. Contact Carrie A. Brittain, Business Insurance, 360 N. Michigan Ave., Chicago, IL 60601; phone: 312-649-5313; fax: 312-649-7801; e-mail: cbrittain@businessinsurance.com.

Medstat makes money by helping companies save

Reducing health care costs prompts big growth for information firm

By ANDREW DIETDERICH

When Ernest Ludy started Ann Arbor, Mich.-based Medstat Group Inc. in 1981, he had $330,000 from friends and business contacts and a simple plan: Cut health care costs for employers.

Twenty-three years later and the mission of the company—now owned by Thomson Corp.—remains unchanged. The difference between then and now? Medstat is bigger.

Analysts estimate Medstat's annual revenue to be about $100 million. A spokesman for Medstat declined to provide figures but confirmed that the estimates were close.

Medstat's client portfolio includes more than 1,400 companies. Medstat employs 700, with about 400 in Ann Arbor. It offers about 30 health care cost-cutting products and services and it's armed with the resources of well-capitalized parent, Stamford, Conn.-based Thomson.

And Medstat continues to land big employers: Wal-Mart Stores Inc. contracted with Medstat in November, New York-based aluminum giant Alcoa Inc. did the same in September. General Motors Corp. renewed its contract in July.

Medstat plans to push three new product lines in 2004: one designed to help midsize companies cut health care costs, one to collect and analyze medical errors for investigative purposes and one to analyze the use of brand-name medications.

"Our information capabilities are designed to try and help industries manage the cost and quality of health care more effectively," said Chief Executive Officer Larry Hagerty. "As economic pressures have grown, it's created great demand for our products and services."

'Our information capabilities are designed to try and help industries manage the cost and quality of health care more effectively.'

Larry Hagerty
Medstat Group Inc.

In mid-2000 however, Medstat's future was uncertain: Thomson announced plans to sell it, saying it didn't fit in with the Thomson Scientific & Healthcare Group. Thomson changed its mind five months later and still owns the company.

"Being for sale creates uncertainty. It wasn't like, 'Isn't this great? We've got this great motivational tool,'" Mr. Hagerty said. "The strength of the organization really shows though because we met all our results during that period and didn't get distracted."

Medstat announced Nov. 3 that it landed a multiyear deal with Wal-Mart to help the retailer cut health care costs for 500,000 employees. Terms were not disclosed.

"We selected Medstat because of its record of success integrating data from large, complex organizations," said Greg Goggans, director of benefits for Wal-Mart. "Their expert team and data-management tools will make it much easier to analyze large amounts of information and to make appropriate decisions. Medstat also provided the best value in terms of consultative service and overall analytic support."

How has Medstat become what it is today?

By sticking to its core business, Mr. Hagerty said, while adapting quickly to always-evolving client needs and technology.

Mr. Ludy started Medstat in 1981 with seed capital supplied by friends and business contacts. He said he took the company public in 1983 with revenue of $500,000 and no earnings.

Mr. Ludy said Medstat targeted employers with more than 10,000 employees. Medstat collected insurance claims from employers and built databases. Employers could then pinpoint if costs were rising because of increased illness, higher doctor fees or medicine costs.

Medstat promised to cut an employer's projected growth in health care costs by half, Mr. Ludy said. If costs were projected to rise 10%, Medstat promised 5%.

Chevron Corp. became Medstat's first customer, at an annual rate of $100,000.

Ford Motor Co.; Sears, Roebuck & Co.; General Electric Co.; Marriott International Inc.; and United Parcel Service Inc. soon followed.

Mr. Ludy said insurance companies then began asking for the same information, with the idea of offering a similar service to companies with fewer than 10,000 employees. Medstat couldn't justify serving the smaller companies, he said, but it could justify serving the insurers.

Mr. Ludy said the company saw another huge potential pool of new clients at the state level, both in the number of employees most states have and in Medicaid programs. By 1988, Medstat had contracts with 25 states.

Between September 1990 and September 1991, Medstat shares rose from $12.50 to $36.50. Revenue had risen to more than $31 million by 1992.

In 1992, Medstat bought the research operations of SysteMetrics, a subsidiary of McGraw-Hill. SysteMetrics had proprietary methods to evaluate medical practices and quality of care along with extensive experience in the management and analysis of large-scale Medicaid and Medicare claims databases. Medstat then set its sights on hospitals and physicians. Mr. Ludy said health care providers could improve their services by having access to Medstat's database. A physician could find out what the average cost was to have an appendix removed in a specific region; a hospital could predict how much would be spent on product lines in specific ZIP codes.

Medstat Systems became The Medstat Group on Feb. 25, 1993, when shareholders approved its merger with Inforum Inc., which had a system that forecast demand for hospital services.

"I expected that at least one of the product lines would have problems," he said. "But that didn't happen. They all grew like crazy."

Medstat continues to grow today and is part of Thomson's Scientific & Healthcare Group, which had 2003 revenue of $760 million, up from $692 million in 2002.

"It's been one of their best divisions," said Vince Valentini, analyst at TD Newcrest. "They've had annual growth of about 10% over the past two years and in an area they continue to have success."

Andrew Dietderich is a reporter for Crain's Detroit Business, a sister publication of Business Insurance.

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• SERVICES •

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EAP directory deadline approaches

Business Insurance will publish its online directories of employee assistance programs and dependent care resource and referral service providers on March 29. That week's issue of *BI* will include rankings of both types of companies, as well as a Benefits Management Take-Out Section on work/life benefits.

The online directories will be available to subscribers on *www.businessinsurance.com* and will be included in *BI*'s 2003/2004 Market Sourcebook, a special printed compilation of all of *BI*'s directories and rankings, which will be published in December.

The EAP directory lists companies that provide EAP services directly to employers on an unbundled basis. To be listed, a company must generate at least $100,000 in gross revenues from EAP services or provide such services in at least three states.

The dependent care directory lists companies that provide resource and referral services on a direct, unbundled basis. To be listed, a company must generate at least $100,000 in gross revenues from such services or provide services in at least three states.

Companies must report gross revenues to be listed. If your company meets the requirements for either directory but has not received a questionnaire, please request one by calling Directory Editor Kevin Edison at 312-649-5279. There is no charge to be listed.

Copies of the questionnaire can also be printed from the *BI* Web site at *www.businessinsurance.com*. Completed questionnaires must be returned by the extended deadline of March 15.

Taking stock

Will it really be different this underwriting cycle?

Market signs, old lines offering cause for cynicism

By Myron M. Picoult

"The Devil's Dictionary," by Ambrose Bierce, defines a cynic as "a blackguard whose faulty vision sees things as they are, not as they ought to be. Hence, the custom among the Scythians of plucking out a cynic's eyes to improve his vision."

After watching the ebbs and flows of the property/casualty business for some 38 years, it is difficult not to be a cynic.

Mr. Picoult

Some industry observers and some insurance company executives argue that the path of the current underwriting cycle will be more tempered than the wild swings of relatively recent past sine curves. If memory serves me right, that line has been uttered in the past just before the inmates began to run the asylum again.

Underwriting cycles are always similar but never identical. As the pricing recovery starts to loose steam, there are always various sound bites that accompany the optimism of some industry observers as to why the cycle going forward would not repeat the mistakes of the past.

The one liners being issued this time around include: "a diversified and well-underwritten book of business"; "a disciplined analytical approach"; "we're focused on a few specific lines of business"; "we are a group of seasoned executives and experienced underwriters"; "we have a culture of accountability"; and finally, "we are a company of specialists, not a company of generalists."

The optimists say that things really *will* be different this time, owing to several factors.

These include the low yield curve, the focus on underwriting, the sharpened purview of the rating agencies, the need for some additional restoration work, the ongoing conservative impact of the Sarbanes-Oxley Act, the fact that there are more financially oriented CEOs in place and that many of the crazies are gone.

The cynics, myself included, point to fourth-quarter 2003 management commentary that the marketplace is changing and that carriers have to adjust.

In fact, many managements have acknowledged the slowdown in price increases on many lines and, in some cases, price decreases. Virtually all claim, however, that they have never been better positioned to deal with these shifting dynamics.

There is relentless pressure on the industry from Wall Street and investors for top- and bottom-line growth. But insurance is a business that has not been able to sustain profitability for any reasonable period of time.

There are the ever-present pressures to enhance shareholder returns and to put excess capital to work. This is also a business that continues to be market-share oriented. Finally, the cost structures of most insurers are out of sync with the real world; the business models must be changed!

I would very much like to embrace the logic behind a more tempered underwriting cycle and, in all fairness, the comments put forth by the optimists should not be perfunctorily ignored.

Ironically, what may ultimately prove to be the cycle's savior is the very fragility of this current underwriting recovery. However, that cuts many ways—aiding those with strong balance sheets and pressuring those with weak ones.

If one digs into the numbers, one will find that it appears that the current pricing recovery is only about two-thirds of the scale of pricing recoveries of the 1975-1978 and 1985-1987 market recovery periods. In addition, I would argue that the industry's balance sheet was much more compromised going into this recovery cycle than has ever been the case before.

Consider, too, that there were many insurance companies with "disabled capital positions" that were unable to take full advantage of the price increases in a timely manner, as they had to spend a considerable amount of time reorganizing and restructuring their operations.

Also, have the pricing gains of the past few years really been sufficient to cover the potholes of the past? For that matter, just look at the adverse development of the business written in the 1998-2000 period.

I also sense that the financial difficulties faced by the reinsurance industry have not been fully recognized by the primary side of the business. For example, reinsurance disputes have grown rapidly, and there appears to be less of an ability to pay by some and a shrunken willingness to pay by others. This all points to the carrying value of reinsurance recoverables. Indeed, the possible looming insolvency of a once-prominent primary insurer (which could prove to be the industry's largest insolvency) is likely to bring more focus to the reinsurance recoverable issue.

This all means that the focus right now should be on the fragility of the industry's current recovery.

Myron M. Picoult is an adviser to Lazard Freres & Co. in New York. He is a past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. An archive of Mr. Picoult's Business Insurance columns can be viewed online at www.businessinsurance.com.

Sliding scale health premiums draw interest

By MARY ELLEN PODMOLIK

As president of Rockwell FirstPoint Contact Corp., Terry Murphy has one of the highest salaries at the 500-employee, Wood Dale, Ill.-based company. But he also pays more for health care.

Mr. Murphy, a former Motorola Inc. executive, hadn't heard of a salary-based health care program until he joined the division of Milwaukee-based Rockwell Automation Inc. three and one-half years ago. But it didn't stop him from taking the job, and now he's a believer in the system.

"It's a very fair and equitable culture," Mr. Murphy said. "If you ask the secretary to carry the same deductible that I do, that appears unfair."

Rockwell uses employee salaries as a basis for figuring maximum out-of-pocket health care costs, so higher-compensated employees pay more for health care. The company is so wedded to the idea that it incorporated it into the consumer-directed coverage it began offering last month.

Under a consumer-directed health care plan, an employer establishes a health savings account for each employee, who decides how to spend the dollars. Once a worker exhausts the account, he or she must pay expenses out of pocket up to a certain sum. After that, the employer's traditional health care plan kicks in.

The goals are to make workers more-savvy health care consumers and shift more cost onto them. A spokeswoman for Alexandria, Va.-based Lumenos Inc., the provider of Rockwell's consumer-directed plan, said Rockwell is its only customer that ties salary brackets to the program.

Maximum out-of-pocket costs are the same for Rockwell's three plans: the consumer-directed plan, a preferred provider organization and a self-insured health maintenance organization. The consistency makes administering the plans easier and avoids steering workers toward a particular plan.

The idea of establishing sliding scales for health care premiums or out-of-pocket costs is at the "chatter" stage, but it's getting louder, said Scott Wayne, a senior consultant in the Chicago office of Mercer Human Resource Consulting L.L.C. "When you've got double-digit increases in health care, (the costs are) just taking so much of employee wages at the lower level that something's got to give," he said.

Chicago-based Bank One Corp. moved to a salary-based system for health insurance premium payments in 2001. The highest-paid executives contribute as much as 80% of the cost of their premiums, while employees in the lowest tier pay 25%.

"It's an important message to send that there are benefits and responsibilities to being an executive," a bank spokesman said. The future of Bank One's program is uncertain, given the bank's pending acquisition by J.P. Morgan Chase & Co. New York-based J.P. Morgan uses a traditional health care plan that isn't tied to salary brackets, a spokeswoman said.

Among those who think the concept merits a closer look is Helen Darling, president of the National Business Group on Health, a Washington-based consortium of 186 large employers nationally that includes Bank One and Rockwell Automation. But she said that human resources managers are concerned about possible administrative hassles and the prospect of asking their higher-paid—and more-affected—superiors to sign off on the idea.

Employers that use the system have worked around administrative hassles. Most move employees between brackets only during annual open enrollment.

All agree that it hasn't affected executive recruitment and retention because health care costs are a relatively small part of a compensation package.

What also helps sell the idea to corporate chieftains is the prospect of stabilizing claims. Lower-paid employees are generally younger and healthier. So, if participation becomes more affordable for them, the risk of health claims is spread across a wider, younger group. In effect, a salary-based plan redistributes health care costs among employees and can reduce the employers' premium costs and employees' contributions by increasing participation.

Northwestern University's PPO was in a death spiral in the late 1980s, the victim of low enrollment and a higher average age of participants. Poor participation led to higher premiums, causing even more lower-paid employees to decline coverage.

In 1989, before the adoption of a sliding scale, 1,100 of 4,600 eligible employees participated in the PPO; another 2,781 were in an HMO. Now, 2,400 of 7,100 employees are in the PPO, and another 3,442 are in an HMO that isn't salary-based, said Thomas Evans, director of benefits for Northwestern in Evanston, Ill. That means 34% are in the PPO now vs. 24% before the sliding scale.

Robert Garcia, director of graduate admissions for the Medill School of Journalism at Northwestern, said he'd be willing to assume more cost. "The difference between my bracket and the one right below me isn't very much. I wouldn't mind (paying a little more). They are good benefits."

Mary Ellen Podmolik is a reporter for Crain's Chicago Business, a sister publication of Business Insurance.

Comings & Goings

Mr. McDade

Mr. Berger

Mr. Abraham

Insurers:

Hamilton, Bermuda-based ACE Ltd. has made several senior-level appointments.

- **Peter Seymour** has been named senior vp-marine for ACE Overseas General, with responsibility for all marine business outside the United States. Previously, Mr. Seymour, who will be based in London, was director of marine underwriting for the ACE European Group.
- **Simon Burton** has been named president of ACE Financial Solutions International. Before his promotion, Mr. Burton was executive vp of ACE FSI. He will be based in Hamilton.
- **Robert Mills** has been named chief financial officer of AGC Holdings Ltd. Before joining AGC, Mr. Mills was CFO for the Americas, regional operating officer for the Americas and global head of fixed-income business control for United Behavioral Systems.
- **Pierre Samson** has been named chief actuary for AGC Holdings and chief underwriting officer of AGC International, unites of ACE Ltd. Previously, Mr. Samson was president and chief executive officer of ACE Global Financial Solutions.

Restaurant Insurance Corp., a Denver-based specialty insurance company, has named **Dan Knise** as executive vp. Before joining RIC, Mr. Knise was president and CEO of Dionis Insurance Holdings.

NJ PURE, a Princeton, N.J.-based medical malpractice insurer, has named **Joseph McDade** as senior underwriter. Previously, Mr. McDade was product development and compliance coordinator for Princeton Insurance Co.

Eric S. Berger has been named executive vp of The Gray Insurance Co., based in New Orleans. Before his promotion, Mr. Berger was the director of the company's government affairs department.

Harleysville Mutual Insurance Co. and Harleysville Group Inc. have named **Michael L. Browne** as CEO and president of Harleysville Mutual and CEO of Harleysville Group. Prior to his appointment as CEO, Mr. Browne was head of the international insurance practice group at the law firm of Reed Smith L.L.P. in Philadelphia.

Reinsurance:

New York-based QBE the Americas has made several senior-level appointments.

- **Jim Lynch** has been named senior vp and chief actuary. Previously, Mr. Lynch was vp and actuary for the company.
- **Pete Maloney** has been named senior vp and corporate counsel. Before joining QBE, Mr. Maloney was with the law firm of Edwards & Angell.
- **Nancy Kelly** has been named senior vp of human resources. Previously, Ms. Kelly was human resources manager.

Pembroke, Bermuda-based IPC Holdings Ltd. has made two senior-level appointments:

- **Peter J.A. Cozens** has been named senior vp of IPC Holdings Ltd. and IPCRe Ltd. Previously, Mr. Cozens was vp of IPCRe Ltd.
- **Stephen F. Fallon** has been named senior vp of IPC Holdings Ltd. Before his promotion, Mr. Fallon was senior vp of IPCRe.

Brokers:

Willis Group Holdings Ltd. has named **James L. Abraham** as president and CEO of the broker's Minneapolis office. Previously, Mr. Abraham was manager of the Minneapolis office.

Robert W. Lampus has been named president of RiskProNet International Inc. Before joining the Menlo Park, Calif., broker network, Mr. Lampus was senior vp and general counsel for Dawson Insurance Inc.

Canada seeing shift to DC pension plans

By GLORIA GONZALEZ

Many Canadian employers are moving from defined benefit pension plans to defined contribution plans as they try to hold down plan costs.

Last month, Montreal-based Air Canada's new equity investor, Trinity Time Investments, proposed a transition from a defined benefit to a defined contribution plan. Under its proposal, employees with 60 or more combined years of age and service would have the option of remaining in the current defined benefit plan. All other employees would move to a defined contribution program while keeping their accrued rights under the defined benefit plan. The change would not affect current Air Canada retirees.

Many other Canadian companies have either proposed or instituted similar changes for new hires, though most are giving all current employees the option to remain in their defined benefit plans, benefit consultants say.

Defined benefit plans account for most of the retirement benefit programs in Canada, but interest in defined contribution plans has increased due to the downturn in the equities markets and its impact on pension funding levels, consultants say. For example, Air Canada's pension plan surplus was about $915 million Canadian ($590.8 million) in 2001, but the plan is now underfunded by about $1.2 billion Canadian ($897.6 million).

Under federal regulations, if a valuation report indicates a pension plan is underfunded, the company must boost its contribution to the plan by making special payments over a five-year period. More Canadian companies have been forced to fund deficits in their defined benefit plans in recent years, which reduces the amount of money available to reinvest in the company, pension experts say.

Defined benefit plans 'took a big hit, and many companies were obliged to start funding at a higher level than they had before.'

Ian McLeod
John Chute & Associates

"The plans took a big hit, and many companies were obliged to start funding at a higher level than they had before," said Ian McLeod, a consultant with Toronto-based John Chute & Associates, a benefits consulting firm.

A survey jointly conducted by Watson Wyatt Worldwide, Mercer Human Resource Consulting and Towers Perrin showed that defined benefit plans in Canada were underfunded by an estimated $225 billion Canadian ($143.28 billion) at the end of 2002. "This represents the amount of money that will have to go into pension plans to pay off that deficit over the course of the next five to 10 years," said Ian Markham, director of pension innovations for Toronto-based Watson Wyatt Canada.

However, Canadian companies are hesitant to put too much money into funding the deficits because they cannot retrieve the money if the markets rebound and the plans become overfunded. Last month, the Supreme Court of Canada reviewed a lower court decision that ordered an employer to distribute its pension surplus.

The decline in the equities markets has encouraged Canadian companies to explore changes to their pension plans, said Greg Hurst, manager, pensions for Vancouver-based Heath Lambert Benefits Consulting Inc. From an employer's standpoint, there are many advantages to shifting to defined contribution plans, including the ability to fix pension costs and eliminate the uncertainty of pension investments. Defined contribution plans also allow employers to shift investment risks to their employees, he noted.

In addition, the regulatory environment for defined contribution plans is less complex than for defined benefits plans, pension experts say. The Ottawa-based Office of the Superintendent of Financial Institutions, which oversees about 1,200 federally registered pension plans, requires defined benefit plan sponsors to pay current service costs and to fund any deficit in the plans. The organization ordered Air Canada to put about $200 million in its plans last year to cover service costs.

"OSFI is doing their best to protect the plan members while not letting the pension plan drag the whole company into real bankruptcy," Mr. Markham said.

Not all companies, though, are eager to make the switch to defined contribution plans, consultants say.

Calgary, Alberta-based TransCanada Pipelines, which had sponsored both a defined benefit and a defined contribution plan, in 2003 terminated its defined contribution plan. "That's fairly rare and pretty

See CANADA/next page

Up 37% over 2002: Munich Re study

Insured catastrophe losses near $16 billion in 2003

Insured losses from natural catastrophes totaled about $15.8 billion in 2003, up 37.4% over 2002, according to a report by Munich Reinsurance Co.

In addition, the 700 natural catastrophe events recorded in 2003 resulted in the loss of 75,000 lives, the Munich, Germany-based reinsurer's report states.

In the United States, wildfires in California in October and November caused insured losses of about $2 billion, while May hailstorms in Texas caused losses of more than $1 billion. In addition, Hurricane Isabel, which raked the East Coast in September, caused losses of about $1.7 billion, the report notes.

PHOTO: REUTERS

Construction equipment in Pusan, South Korea, was among the property destroyed by Typhoon Maemi.

Also in September, Hurricane Fabian became the most severe hurricane ever to hit Bermuda, according to the report, giving rise to losses of $400 million. Another hurricane, Juan, battered large parts of Eastern Canada and cost insurers about $60 million, while losses from Typhoon Maemi in South Korea totaled about $500 million, the report noted.

In France, flooding in the Rhône region led to claims of about $1 billion, the report notes.

Last year also saw 70 loss-producing earthquakes, which cost insurers about $100 million, Munich Re notes.

The report, "TOPICS geo Annual Review: Natural Catastrophes 2003," is available at *www.munichre.com.*

—By Sarah Veysey

E.C. urges action on ship safety

E.U. directive at issue

BRUSSELS, Belgium—Twelve European Union member states have not yet implemented maritime safety legislation that was developed by the European Commission following the Erika oil tanker accident in 1999.

In a statement, the Commission warned the states that they have two months to detail how they intend to implement the legislation.

If they fail to do this, the Commission said it will take further enforcement measures, which could ultimately lead to taking the noncompliant states to the European Court of Justice.

The 12 states that have not implemented the legislation are: Austria, Belgium, Finland, France, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Sweden and the United Kingdom.

Only three states, Denmark, Germany and Spain, have implemented the legislation.

The legislation, E.U. Directive 2002/59, which establishes a community vessel traffic monitoring and information system, was implemented in 2002 to increase the safety of maritime traffic.

The directive consists of a package of measures including the establishment of places of refuge for ships in distress and the installation on ships of voyage data recorders that are similar to those used on aircraft.

The measures were developed to address concerns raised by the Erika, a single hull oil tanker that broke in two off the coast of France in 1999, spilling 3.8 million gallons of oil.

—By Peta Miller

World Updates

Corporate killing law not seen as big catalyst

Many employers in the United Kingdom believe that a corporate killing law would not necessarily improve health and safety management, a survey of 105 U.K. businesses concludes. While 41% thought that a corporate killing law might improve safety standards by moving the issue up the corporate agenda, only 24% said they thought such a law would lead to reviews of health and safety procedures. And more than half the respondents—59%—said they are not convinced that a corporate killing law would improve health and safety in the workplace. The survey was conducted by the London-based law firm of Norton Rose.

JLT revenues, profits increase in 2003

Revenues at Jardine Lloyd Thompson Group P.L.C. rose 10.4% in 2003 to £429.0 million ($767.9 million). JLT said that its revenues from risk and insurance business increased 12.0% to £352.8 million ($631.6 million) in 2003, while employee benefits revenues grew 2.0% to £76.2 million ($136.4 million). The London-based brokerage's pretax profit increased 10.0% to £100.7 million ($180.3 million). JLT Chief Executive Steve McGill said that JLT is looking at potential acquisitions, noting that the brokerage is in exclusive negotiations with London-based Heath Lambert Group P.L.C. about taking over some of that company's Latin American operations.

Portuguese industry stable: Moody's

The outlook for the Portuguese insurance sector is stable, according to a report by Moody's Investors Service Ltd. in London. But while there are opportunities for growth in life and pensions business, these are offset somewhat by sluggish demand for products sensitive to economic growth, such as workers compensation, the rating agency noted.

Swiss Re, university issue catastrophe atlas

Swiss Reinsurance Co. Ltd. and Beijing Normal University have launched a catastrophe atlas for China. The atlas is intended to help insurers and the general public better understand natural catastrophe risk in the country, Swiss Re said. The atlas contains 500 years' worth of data on earthquake, flood, typhoon, snow and hailstorm risks, the Zurich, Switzerland-based reinsurer noted.

Commentary

IRS sends warning to piggish PORCs

It's almost tax time again, and some clients of American Bankers Insurance Group Inc. may be feeling a little queasy.

The Internal Revenue Service has subpoenaed the Miami-based insurer, a unit of Assurant Inc., for the names of clients—auto dealers, retailers and others—who sold ABIG credit insurance to their customers and then had the business ceded to their own captive reinsurers in the Turks & Caicos Islands.

The IRS issued the subpoenas after finding that three companies—all ABIG credit insurance producers—used Turks & Caicos captives to hide more than $2.8 million in taxable income. As many as 300 more ABIG producers may have similar captive arrangements, the tax agency says, though an ABIG spokesman maintains the number "isn't anywhere near 300." ABIG has complied with the subpoenas, the spokesman said.

Douglas McLeod

Whatever the number turns out to be, you can say only one thing about the IRS action: better late than never.

It's been more than a year since the IRS proclaimed certain types of "producer-owned reinsurance companies," or PORCs, to be shams aimed at diverting their owners' taxable earnings. While 1,653 companies have so far complied with a Treasury Department directive to disclose their ownership of PORCs, countless others have not, and the IRS says it has no way of identifying them without access to the records of middlemen such as ABIG.

Hence the subpoenas.

The three ABIG clients the IRS cited are typical of abusive captive reinsurance schemes, according to IRS court filings backing the subpoenas. One of the three—a retailer identified only as Corporation A—sold ABIG credit life, disability and P/C coverages through the early 1990s, taking a 40% sales commission and a retrospective profit commission on the business and reporting the commissions as taxable income.

In 1994, though, Corporation A formed a Turks & Caicos captive with a $100 capital contribution and began reinsuring the ABIG policies. Its sales commission dropped to 20%, and its profit commission was eliminated.

ABIG units, meanwhile, withheld premium to cover claims but paid only $25,944 in losses on $2.4 million in premiums from 1994 to 1996, the agency found.

The effect of the arrangement was to transfer Corporation A's taxable commission income to its offshore captive, where it was purportedly exempt under a part of the Internal Revenue Code that taxes only investment income of insurers with annual net premiums under $1.2 million. Corporation A recovered its money in monthly dividends from the captive, which it claimed were also tax-exempt.

The IRS deemed it a "tax-motivated sham" that did not represent valid reinsurance and had no economic substance. Corporation A capitulated, agreeing to a $1.6 million increase in its taxable income for the years in question, IRS court filings say.

Corporation A may be only the tip of the iceberg. The IRS is now investigating all ABIG credit insurance producers that also owned Turks & Caicos reinsurers. More audits are likely to follow. And, while the IRS has identified ABIG as one of the largest players in the offshore PORC industry, it is not the only player.

Granted, the tax dodges of a given small-business PORC owner may be small potatoes. There are certainly bigger ploys that shelter more money for richer taxpayers.

New York Times reporter David Cay Johnston, for instance, has covered the case of Wall Street investor Peter Kellogg, one of the wealthiest men in America. Mr. Kellogg used a loophole in section 501(c)(15) of the tax code—the same section that spawned many PORCs—to create a Bermuda reinsurer that wrote only a few thousand dollars in premiums a year despite having several hundred million dollars in capital. Section 501(c)(15) conferred tax-exempt status on insurers writing less than $350,000 in annual premiums but neglected to put a limit on their capitalization, letting Mr. Kellogg's massively overcapitalized reinsurer generate hundreds of millions of dollars of tax-free investment income.

The ABIG targets may be smaller, but you can't fault the IRS for trying. No one is obligated to pay more than tax law requires. But tax avoidance has become a spectator sport in the last decade, and a government facing massive deficits can't afford to ignore it.

Companies that engage in bogus reinsurance schemes—and the promoters that facilitate them—deserve a visit from the IRS. Those PORCs aren't kosher.

Senior Editor Douglas McLeod can be reached at dmcleod@business-insurance.com.

Canada: Pension costs rising

Continued from previous page

courageous," Mr. Markham said. TransCanada made the change for several reasons, including the possibility of lawsuits being filed by employees burned by bad investments, a spokesman said. An effort to retain key employees was another reason for the change, he said.

Although the growing popularity of defined contribution plans has been indirectly influenced by a similar U.S. trend, Canadian companies have adopted a more conservative approach toward pension changes than their U.S. and U.K. counterparts, partly because of the barriers to change in Canada, benefit consultants say.

One barrier is that pension rules vary from province to province, making it more difficult for companies that have employees in several provinces to develop a plan that would satisfy the legal requirements of each province, said Fred Vettese, executive vp and chief actuary for Toronto-based Morneau Sobeco. "There's almost no chance that (the provinces) can come together and make things simpler," he said.

Canadian companies that have tried to make the shift have also met strong union opposition, Mr. Hurst said. Union representatives for Air Canada workers have refused to negotiate on a switch to defined contribution plans, arguing that they have already made many concessions to help the company save money. Air Canada and employee representatives recently agreed to a revised schedule that would fund the deficit over a 10-year period, but there have been no further discussions regarding the structure of the plans. "Canada probably has stronger unionization than the United States," Mr. Hurst said.

Among Canadian companies, 'employees want to keep their defined benefit pensions and are willing to pay a little more to do it.'

Paul Purcell
Mercer Human Resource Consulting

Benefit consultants see several pension trends developing for 2004 and beyond. Some companies may begin introducing or increasing employee contributions to their defined benefit plans, predicts Paul Purcell, Canadian retirement practice leader in Mercer's Toronto office. "Employees want to keep their defined benefit pensions and are willing to pay a little more to do it," he said.

A few companies have offered their employees cash instead of a pension, which some employees prefer because they have complete control over how they invest, benefit consultants say. Unlike in the United States, tax rules on registered retirement savings plans in Canada allow individuals to save similar amounts of money on their own as they could under their employers' program, they say.

However, the main trend will be for more Canadian companies to switch to defined contribution plans, consultants say. "The next few years are going to be about plan design," Mr. Purcell said. "Canadian companies have been resigned to a very long and slow phase-out of the defined benefit plan."

Lloyd's: Names mull conversion

Continued from page 1

liability partnership.

A working party—made up of representatives from the four remaining members agents that look after names' interests in the market and the ALM—has submitted a report to the legal department at Lloyd's on the potential attraction of allowing individual names to form limited liability partnerships under the proposed tax changes.

During market consultation on the 2002 Chairman's Strategy Group, which developed various reforms to modernize the Lloyd's market, names successfully campaigned to remove a proposal that would have forced all unlimited liability names to convert to limited liability status by 2005.

The names had argued that converting to limited liability from unlimited liability would rob them of tax advantages.

Although Lloyd's abandoned the conversion mandate, it did cease admitting new unlimited liability names to the market. There currently are 2,048 unlimited liability names, according to statistics from the Lloyd's Members' Services Unit. Unlimited liability names currently underwrite about £1.86 billion ($), or roughly 12.5%, of the market's capacity for 2004, according to Lloyd's.

Chancellor Brown announced in last April's budget that he would introduce measures to give tax relief to names comparable to that received by other sole proprietors in the United Kingdom, such as the self-employed and professionals, who convert to limited liability.

Lord Peter Levene, chairman of Lloyd's, welcomed that promise and said the change would remove a "significant disincentive" to names converting to limited liability status.

Limited liability partnerships were introduced in the United Kingdom in 2001.

Previously, some names had become members of Scottish limited partnerships, a legal structure that allowed them to trade at Lloyd's with limited liability.

The SLP structure was one of the mechanisms introduced following Lloyd's 1996 Reconstruction and Renewal program to allow limited liability underwriting in the market.

At that time, there was no facility under English law for the establishment of limited liability partnerships.

Individuals who join SLPs can invest in Lloyd's on a limited liability basis but benefit from some of the perks of unlimited liability membership.

But according to the working group, U.K. limited liability partnerships might be more advantageous to some names, as they would enable names to have some control over syndicate selection—something that is not available to participants in SLPs.

There is a good deal of interest among names in the limited liability partnership concept, according to John Maudslay of members' agent Hampden Agencies and a member of the working party.

But just how great that interest is in practice will be difficult to gauge until there is feedback from Lloyd's on how limited liability partnerships might be introduced to the market, he noted.

Edward Vale, a consultant at the ALM, said it is hoped that a framework for limited liability partnerships might be established by year end, in time for the 2005 underwriting year.

A spokeswoman for Lloyd's said that the market's legal department had received the working party's report and that Lloyd's would consider any ideas for names to convert to limited liability.

Lloyd's, the ALM and Mr. Maudslay all noted, however, that moves to introduce limited liability partnerships at Lloyd's are still in very early stages.

Few hospitals meeting Leapfrog standards on safety, study shows

Despite an aggressive nationwide campaign to improve patient safety, few hospitals have been able to meet the Leapfrog Group's standards, primarily because of their cost, according to a study released last week by the Center for Studying Health System Change.

Many hospitals reported that employers and health plans in their markets were not providing strong enough financial incentives to meet the standards or participate in the Leapfrog survey, according to the study, which is published in a new HSC issue brief, "Leapfrog Patient-Safety Standards are a Stretch for Most Hospitals."

Many hospitals reported that employers and health plans in their markets were not providing strong enough financial incentives to meet the standards.

"Many factors, including a lack of financial incentives, are hindering hospitals' adoption of the Leapfrog patient-safety practices," said Paul B. Ginsburg, president of HSC, a nonpartisan policy research organization in Washington.

The Leapfrog Group, formed in 2000 by the Business Roundtable, a group of Fortune 500 top executives, has been promoting the implementation of three hospital patient-safety practices: computerized prescriptions, specially trained intensive care unit physicians and volume thresholds for certain high-risk procedures.

The study, which examines hospital patient-safety activities in 12 nationally representative communities from November 2000 through July 2003, can be found on HSC's Web site at *www.hschange.org*.

—By Joanne Wojcik

Lawsuit targets prescription drug laws

Suit seeks drug reimportation

By GLORIA GONZALEZ

WASHINGTON—A Chicago couple has filed suit—with the encouragement of Illinois Gov. Rod Blagojevich's office—in a bid to force the Department of Health and Human Services and the Food and Drug Administration to allow the reimportation of prescription drugs from Canada.

The suit, which seeks class action status, was filed in Washington federal district court on behalf of Ray and Gaylee Andrews. It asserts that the U.S. Food, Drug and Cosmetic Act violates their 5th Amendment right to privacy by denying them freedom to make personal medical decisions. The federal law makes it illegal for anyone other than the original manufacturer to reimport prescription drugs into the United States.

The lawsuit also charges that the law improperly gives legislative authority to the executive branch by letting the Secretary of Health and Human Services decide if and when reimportation should be legal. The 2003 federal Medicare prescription drug law allows the HHS secretary to issue waivers to individuals for drug reimportation, but only if safety standards are met.

In addition, the suit asserts that federal law is enforced in a way that disproportionately affects individuals in nonborder states who do not have the option of driving across the Canadian border to legally buy medications.

"If this lawsuit succeeds, the state of Illinois can go ahead and import prescription drugs from Canada," Gov. Blagojevich said in a statement. "It means Ray and Gaylee Andrews can buy their prescription drugs from Canada and never have to worry about being prosecuted by the FDA for it."

Prescription drugs generally cost 30% to 80% less in Canada due to government-imposed price controls.

Steelmaker: Subsidy helps lower costs

Continued from page 4

Other retiree health care benefit changes U.S. Steel is making that shift more costs to retirees will reduce the Pittsburgh-based employer's future benefit obligations by $136 million.

In all, U.S. Steel now estimates that its retiree health care obligations total approximately $2.7 billion, down from $3.2 billion in 2002.

The massive reduction in U.S. Steel's retiree health care obligations likely is only a precursor of the cost savings other major employers with retiree health care plans are expected to report in the next month as they file their 2003 annual financial statements with the Securities and Exchange Commission.

The magnitude of the savings reported by U.S. Steel highlights how the new prescription law—which the Bush administration now projects will cost the government $500 billion over 10 years—will be a boon not only to Medicare beneficiaries but also to employers as they either cut back on their retiree health care plans or collect the federal subsidies, or combine both strategies.

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ANNOUNCEMENT

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

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

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

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

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

LEGAL NOTICE

IN THE SUPREME COURT OF BERMUDA
COMPANIES (WINDING-UP)
NO. 369 OF 1990
IN THE MATTER OF
FOCUS INSURANCE COMPANY LTD.
IN LIQUIDATION
and IN THE MATTER OF THE COMPANIES ACT 1981 and IN THE MATTER OF THE INSURANCE ACT 1978
(Under an Order for Winding-Up the above-named Company, dated 5 February 1991)
NOTICE OF INTENTION TO PAY A DIVIDEND

A Final Dividend is intended to be declared in the above matter to Creditors whose claims have been agreed in accordance with the Court Order of the Supreme Court of Bermuda made on 18 April 2002, following which a filing deadline of 12 July 2002, was established.

It is anticipated that the Final Dividend will be paid during March 2004.

Creditors requiring further information should contact the Liquidator in writing at the following address:-

Focus Insurance Company Ltd - in Liquidation, PricewaterhouseCoopers, PO Box HM 1171, Hamilton HMEX, BERMUDA (Fax: 441-295-1242)

PETER C B MITCHELL *Liquidator*

Focus Insurance Company Ltd - in Liquidation

16 February 2004

LEGAL NOTICE

NOTICE OF MEETINGS

THE BERMUDA FIRE & MARINE INSURANCE COMPANY LIMITED

(IN LIQUIDATION) (THE "COMPANY")

NOTICE IS HEREBY GIVEN that the Company has applied to the Supreme Court of Bermuda and to the High Court of England and Wales for directions relating to the convening and conduct of meetings (the "Meetings") of the Company's Scheme Creditors ("Scheme Creditors").

The Meetings are proposed to be convened under Section 99 of the Bermudian Companies Act 1981 and Section 425 of the Companies Act 1985 of Great Britain for the purpose of enabling the Scheme Creditors to consider and, if thought appropriate, approve an Amending Scheme of Arrangement (the "Amending Scheme") in respect of the Company and its Scheme Creditors.

Should the Amending Scheme become effective, it will amend and restate the terms of the Scheme of Arrangement presently in force in respect of the Company dated 14 January 1997 (the "Original Scheme").

The Amending Scheme will introduce a mechanism for the closure of the Original Scheme by utilisation of a bar date for submission of claims together with an actuarially based estimation methodology, where appropriate, to evaluate and quantify liabilities (including contingent and future insurance and reinsurance liabilities) notified under the Amending Scheme owed by and to the Company. Such a mechanism will facilitate the making of a substantive and ultimate distribution to Scheme Creditors earlier than would be the case under the Original Scheme.

At these directions hearings (the "Hearings"), the Company will request that the Bermudian Court and English Court convene separate meetings of its:

(i) Protected Scheme Creditors (being Scheme Creditors whose claims are eligible for protection under the applicable provisions of the Policyholders Protection Act 1975 by the Financial Services Compensation Scheme Limited); and

(ii) General Scheme Creditors (being Scheme Creditors in respect of claims which are not Protected Scheme Claims).

Scheme Creditors who wish to attend and make representations in connection with the composition of the Meetings at the Hearings at 2.30pm on 1 April 2004 in the Supreme Court of Bermuda and at 10.30am on 31 March 2004 in the High Court of England and Wales, should contact the Liquidators as soon as possible.

If the Courts give directions to convene the Meetings, the Company will, in due course, make available to all Scheme Creditors copies of the Amending Scheme and Explanatory Statement at the same time as formal notice is given of the Meetings. In the meantime, the latest drafts of those documents, the Liquidators' letter to the Scheme Creditors dated 1 March 2004 notifying Scheme Creditors of the Hearings and a more detailed notice of the Hearings, the Bermudian and English Court applications and draft Court Orders setting out the proposed directions can be downloaded from www.bfmic.bm. Alternatively, hard copies can be obtained from the Liquidators. In the event the Courts give leave to convene the Meetings, we would expect the bar date to be toward the end of September 2004.

J C McKENNA, G H HUGHES and L A JOAQUIN

Address for correspondence:

BFMIC Liquidators, John Stow House, 18 Bevis Marks, London EC3A 7JB, United Kingdom.

Tel: +44 (0) 20 7645 4995. Fax: +44 (0) 870 600 7582.

Clifford Chance LLP, 10 Upper Bank Street, London E14 5JJ, United Kingdom (Ref: PLH/M5020/18)

Appleby Spurling & Kempe, Canons Court, 22 Victoria Street, PO Box HM 1179, Hamilton HM EX, Bermuda (Ref: JF/SD)

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LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re Petition of Board of Directors of LUDGATE INSURANCE COMPANY LIMITED, Debtor in a Foreign Proceeding.	**In a Proceeding Under Section 304 of the Bankruptcy Code** **Case No. 04-B-10590 (RDD)**

NOTICE IS HEREBY GIVEN that, in connection with the Petition filed on January 30, 2004, pursuant to section 304 of the Bankruptcy Code (the "Petition"), with respect to **Ludgate Insurance Company Limited** (the "Company"), the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") has entered a Preliminary Injunction Order dated February 19, 2004 (the "Order"):

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

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

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

The Order shall remain in effect pending determination following a hearing to consider whether the Bankruptcy Court will (i) issue a permanent injunction order, pursuant to Section 304 of the Bankruptcy Code, providing for, among other things, recognition of the Scheme of Arrangement in the United States and/or (ii) continuation of this Order, which hearing is scheduled to be held before the Honorable Robert D. Drain, United States Bankruptcy Judge, United States Bankruptcy Court, One Bowling Green, New York, NY on April 8, 2004 at 10:00 a.m. (the "Return Date"). All papers submitted for the purpose of objecting to the issuance of a permanent injunction order and/or the continuation of the Order after the Return Date shall be filed with the Bankruptcy Court, with a copy to the Chambers of the Honorable Robert D. Drain, and served on Chadbourne & Parke LLP (Attn: Howard Seife, Esq.) so as to be received at least seven (7) days prior to the return date.

Any party-in-interest that has not received a copy of the Petition, supporting papers and/or the Order should contact counsel for the Petitioner at the address below:

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

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Casualty: Rates rise

Continued from page 4

retention levels on general liability policies rose 44% to slightly more than $1 million in 2003 from $698,000 in 2002, according to the study. In addition, the amount of actual coverage purchased dropped an average of 6% because attachment points rose to slightly over $2 million in 2003 from about $1.8 million the year before (see chart).

By line of coverage, policyholders' retentions rose an average of 17.7% in workers comp, 14% in general liability and 12.5% in auto liability, according to the study.

The study was based on responses from 1,433 businesses and governmental entities compiled through November 2003. Each respondent reported at least $500,000 in insurance-related costs, including retentions, for the three primary casualty lines of coverage, Mr. Brady said.

In other findings, "large employers generally enjoy substantial economies of scale in the purchase of insurance the use of other risk mitigation approaches to address their primary casualty exposures," according to a Marsh statement. For example, policyholders with more than $10 billion in revenue have risk costs associated with the casualty programs of $1.38 per $1,000 of revenue, while policyholders with revenue of $200 million or less pay $21.75.

As a result, larger employers "generally enjoy a competitive advantage as respects the casualty insurance component of their overall cost of goods sold," Mr. Brady said.

Losses, however, continue to play the key role in cost of risk.

Among all businesses, an average of 80 cents of every primary casualty dollar goes to pay projected losses and related expenses, the study said.

As a result, "an organization's cost of risk is more affected by how it manages its risk and how the firm is perceived by an insurer than by its size," Mr. Brady said. So, "a small firm that effectively manages its exposures can have a lower cost of risk than a larger company with poor risk management."

Benchmarking is one of the most important tools that businesses can use to help determine how it should allocate its resources to manage risk, Mr. Brady said.

The report provides key benchmarking data for businesses in the 92 pages it devotes to presenting detailed cost of risk data and key loss drivers for 23 Standard Industrial Classification categories, ranging from chemical and pharmaceutical businesses to wholesale and retail trade operations.

To obtain a copy of the study, contact Peggy Sherertz at 212-345-3393.

Terror: U.S. vulnerability

Continued from page 4

struck the Northeast on Aug. 14, 2003, might not be a "self-inflicted wound" but rather a terrorist-instigated failure.

The terrorists could potentially exploit the situation by machine-gunning people milling about the darkened streets and launch attacks against those stranded in subway systems, he said.

Like Sen. Feinstein, Mr. Verton questioned the effectiveness of the Bush administration's market-based approach to cybersecurity.

"The current non-regulation model has not proved itself up to the challenge," he said.

Another witness disagreed. In fact, the chief information security officer for San Jose, Calif.-based eBay told the panel's chairman that the private sector was responding to the threat.

"The private sector has been organizing among itself," eBay's Howard Schmidt told Sen. John Kyl, R-Ariz. For example, the security information officers of major corporations have been meeting and discussing ways to confront the threat, Mr. Schmidt said.

Manufacturers of hardware and software are committed to making systems more secure, he said. He cautioned, though, that doing so will take time.

"We can get things done," he said. But progress will have to be made on a priority basis and recognize economic reality, he said.

Earlier in the hearing, both Sens. Kyl and Feinstein seemed unimpressed with government witnesses' descriptions of federal efforts to stem the tide of cyberattacks.

Sen. Kyl in particular kept questioning Amit Yoran, director of the national cybersecurity division of the Department of Homeland Security about DHS' failure to issue a comprehensive analysis of cyberattack vulnerabilities. Mr. Yoran told Sen. Kyl that the government plans to issue a classified national intelligence estimate on cyberterrorism soon.

ADEA: Protects older workers

Continued from page 3

employees over a certain age.

Other programs that potentially would have been at risk include those in which employers, when converting traditional pension plans to cash balance plans, give older employees an opportunity to choose between the two plans but don't extend that choice to younger workers, said Nancy Ross, a partner with the law firm of McDermott, Will & Emery in Chicago.

"The implications for many benefit designs would have been pretty profound" had not the Supreme Court reversed the lower court ruling, said Neil Grossman, an attorney with Mercer Human Resource Consulting in New York.

With the high court decision, Mr. Grossman said, "it is basically business as usual."

"Long-standing employee benefit practices can continue," said Scott Macey, senior vp at Aon Consulting in Somerset, N.J. Mr. Macey added that most benefit experts had believed that the 6th Circuit decision was inconsistent with the ADEA as widely interpreted and had expected it to be reversed by the Supreme Court.

General Dynamics Land Systems Inc. vs. Cline et al., U.S. Supreme Court, No. 02-1080.

Audits: IRS increasing scrutiny of plans

Continued from page 1

who will be assisted, when appropriate, by various specialists, including actuaries, attorneys and computer auditors, said Thomas Petit, an Austin, Texas-based IRS regional group manager for the program.

Each audit will take from 200 to 300 staff days, as opposed to the more usual five-day audits, said Mr. Petit. "It all depends on the size of the employer, the size of the plan" and the number of plan participants, he said.

The audits will not necessarily include every single plan offered by a plan sponsor and could cover just its major plans. They may also cover single or multiple years.

Peter Breslin, the IRS senior manager for the program in Washington, said that close to 5,000 plans with 2,500 or more plan participants will be the focus of the audits. These account for only 1% of the total number of plans offered nationwide but represent 60% of plan participants and 70% of plan assets, he said. Overall, these large plans represent 73 million participants and $4.9 trillion in assets.

"In the past, we haven't had a lot of activity on this market segment," Mr. Breslin said. "That's why we're conducting this program now."

A complex point system is first used to determine which employers will be subject to audits. Points are assigned based on the number of plan participants, gross assets and contributions to the pension plan, explained Mr. Breslin.

The IRS audits will 'pretty much look at the whole shebang of issues' that affect plans.

Peter Breslin
Internal Revenue Service

"More subjective" issues are then also considered, including whether an employer has been involved in a major merger or acquisition. Referrals from other agencies, such as the Department of Labor and the Securities and Exchange Commission, are considered as well, said Mr. Breslin.

The compliance history of the pension plan is also taken into account. "Have we looked at it before? If so, what was the result; how long as it been?" he said.

The audit will examine both the form of the plan, including whether its language meets the requirements of the law, and whether it operates in accordance with its provisions.

"They pretty much look at the whole shebang of issues" that affect plans, said Mr. Breslin.

Mr. Petit said this includes making sure that every eligible participant is included, that distributions are calculated correctly, that hardship distributions are handled appropriately, that spousal consents are properly documented, and that deductions made on tax returns correspond to contributions made to the plan's trust fund. The audit will also evaluate whether investments are proper and properly accounted for.

"We're going to make sure the laws are complied with" and plan participants protected, said Mr. Petit. "That's why it takes so many hours to conduct these audits," he said, noting that some plans may have as many as 100,000 participants.

The IRS officials acknowledge that, given the size and complexity of these plans, none will be in perfect shape.

"We don't really expect that," said Mr. Breslin. "We know that if you've got 100,000 employees, there could be some errors, and we would just ask the taxpayer to correct those things."

Both IRS officials and benefit consultants note that there are IRS programs currently available under which employers can correct discovered problems with relatively little or no penalty.

Consultants stress, though, that employers are far better off if they find and correct any pension problems themselves rather than wait for the IRS to discover them in an audit.

"The penalties can be substantial" if the IRS discovers the problem, said Dawilla Madsen, a compliance consultant with Milliman & Robertson in West Paterson, N.J.

Employers have to "sort of beat the IRS to the punch," said Joe Walshe, a principal for PricewaterhouseCoopers in Washington.

Employers can conduct their own compliance reviews to determine whether their procedures are in compliance with their plan documents and the law, said Meg Doyle, a principal with Towers Perrin in New York. "And make sure those compliance reviews are conducted in the same manner in which the IRS were to conduct an audit of this detail," she said.

"Obviously, you have to just do the best you can with the information that you have, but employers should ask a lot of questions of their service providers and anyone who provides investment services," said Lynn Dudley, vp and senior counsel with the Washington-based American Benefits Council.

Employers should also examine whether their plans operate in accordance with plan documents, consultants say.

Many times, the documents are very well written and follow regulations "to a tee" but the plan's operations do not conform to them in areas such as eligibility, breaks in service and recognition of service, said Tom Meagher, Somerset, N.J.-based senior vp of Aon Consulting's national tax and ERISA practice.

But Tilda Kaplan, a principal with Mercer Human Resource Consulting in Atlanta, said that as long as employers make sure their plans are administered in accordance with IRS regulations and plan documents, "they shouldn't have to worry about it."

Med mal: Reform outlook cloudy after Senate failure

Continued from page 3

justice reform advocates find last week's defeat worrisome for the broader tort reform agenda.

"Considering that the bill was a much scaled back version, failure to get 60 votes may not bode well for federal tort reform in general," suggested Glenn Lammi, chief counsel-legal studies division of the pro-reform Washington Legal Foundation.

"It certainly points up the need for responsible judicial decision making in liability cases, especially at the state level, and is a reminder that there needs to be more to the legal reform movement than just federal legislative reform," Mr. Lammi said.

"We certainly hope that this does not impact the rest of the litigation reform" agenda, notably class action reform, said a spokeswoman for the Property Casualty Insurers Assn. of America in Washington.

A prominent tort reform opponent said that the legislative defeat ought to make Sen. Frist reconsider any additional forays into tort reform.

"The fact that Sen. Frist brought this bill up at all was frankly a surprise, because it had been defeated so soundly just last year," said Pamela Gilbert, an attorney with Cuneo Waldman & Gilbert L.L.P. in Washington, and a longtime consumer advocate.

"In fact, it was not only defeated soundly again but an additional Republican voted against the bill. That's a big loss, I think, because Sen. Frist was trying very hard to keep his caucus together," she said.

"This recent defeat was a very bad one for the Republican leadership, and it should make Sen. Frost think twice about bringing more controversial and unpopular tort reform measures before the Senate," said Ms. Gilbert. Regarding the class action bill, she pointed out that "62 people support cloture, but many of those 62 have concerns with the bill."

A spokesman for the Assn. of Trial Lawyers of America said, "there's no constituency other than corporate greed for any of these pieces of legislation designed to take away the legal rights of American families. Clearly, there's no sentiment in the Senate to penalize the most seriously injured of medical malpractice. Whether or not that will translate into other areas remains to be seen."

An insurance industry federal affairs official did not foresee the medical malpractice vote having a direct impact on the fate of the class action reform bill.

"I think they're separate issues," said Melissa Shelk, vp-federal affairs for the American Insurance Assn. in Washington.

"The vote on medical malpractice was not unexpected. We know that there will potentially be one or two more votes this year on targeted medical malpractice bills. And I don't expect to see any of them being able to get cloture." In contrast, the class action reform bill already has at least 62 votes for cloture, Ms. Shelk noted.

Despite last week's defeat, the Risk & Insurance Management Society Inc. plans to continue pushing for reform, said Lance J. Ewing, president of New York-based RIMS.

"RIMS is very disappointed in the Senate's failure, once again, to act on medical malpractice reform. Risk managers will continue to advocate for passage of this critical legislation," he said.

RIMS will be holding its annual legislative gathering in Washington March 10-11 and RIMS members will continue to push for tort reform at the meeting, said Mr. Ewing, who is also vp-risk management for Caesars Entertainment Inc. in Las Vegas.

Asbestos: Ruling OKs successor liability

Continued from page 3

the law's 2001 effective date.

Within months of the law's enactment, Crown Cork sought to dismiss 376 cases pending in a Philadelphia court.

The claims—like all of the company's asbestos claims—arose from its 1963 takeover of another packaging company, Mundet Cork Corp., that operated an asbestos insulation contracting division. Although Crown Cork never operated the insulation business itself and sold the division within 90 days of acquiring Mundet, Crown Cork had paid $336 million on the acquired asbestos liabilities through February 2002, court filings say.

A Pennsylvania state court dismissed the 376 Philadelphia claims in 2002, agreeing with Crown Cork that it had paid out many times the value of Mundet's assets, which amounted $55 million adjusted for inflation.

The state Supreme Court reversed that ruling Feb. 20, though, finding the asbestos reform statute violates the state constitution's guarantee of legal redress for injuries, known as the "Remedies Clause."

While the Legislature can bar certain types of legal claims in future suits, it cannot retroactively eliminate claims filed under previously existing law, the majority ruled.

The court also rejected Crown Cork's argument that plaintiffs did not lose their right to redress because they may still recover damages from other defendants named in their suits.

"While a plaintiff may…join the cause of action he has against one defendant with the cause of action he has against another defendant in one lawsuit, the cause of action he asserts against each defendant remains distinct," the majority found.

Three judges on the seven-member panel signed two dissenting opinions arguing that the reform statute is constitutional.

One of the dissents held that plaintiffs' constitutionally protected rights of redress are against the acquired company responsible for asbestos injuries rather than a successor corporation, and that the state Legislature can thus limit the impact of such claims on the successor company.

The Pennsylvania reform law "does not retroactively limit or extinguish the liability because the successor corporation…is not the tortfeasor," the dissenting opinion says.

The justices in the majority, however, responded that "we are as concerned with the heavy toll that asbestos litigation is visiting upon certain (Pennsylvania) corporations as are our respected colleagues in the dissent. Nevertheless, any statutory effort aimed at reformation must not offend the Remedies Clause, if it is to pass constitutional muster."

Ieropoli vs. AC&S Corp. et al; Supreme Court of Pennsylvania, No. 117 EM 2002, J-21-2004.

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comprehensive bill that includes caps on noneconomic damages. S.B. 2783, approved 32-15, would cap noneconomic damages at $250,000 on all tort actions. The bill calls for the elimination of joint-and-several liability, the establishment of a medical malpractice liability review board, caps on punitive damage awards, protections for landowners and "innocent sellers" and other reforms.

CIGNA to let employers customize health plans

CIGNA HealthCare is introducing products that will enable employers to "mix and match" benefit options to create a customized plan for their employees. With "CIGNATURE—Your plan. Your choice," employers can build individualized health plans by selecting options in five key areas: clinical programs, benefit plan design, network size, use of primary care physician and funding type, according to the health insurer. The potential combinations will eliminate the distinctions that once existed among indemnity, HMO, PPO and point-of-service plans, said a CIGNA spokeswoman.

California considers tribal comp exclusion

Legislation introduced late last month would allow California employers to forgo purchasing workers compensation coverage when contracting with self-insured Indian tribes that provide temporary employee staffing services. Tribes across the nation have created temporary staffing or leasing agencies. Some argue that immunity from state regulation lets them provide employers off their reservations with temporary workers covered under tribal workers comp statutes. States increasingly are seeking to regulate or halt the activity.

PHOTO: KRT

Minnesota Gov. Tim Pawlenty testifies regarding the cost of prescription drugs in the United States.

Minnesota panel urges individual coverage law

Individuals—not employers or health plans—should take the lead in reshaping the health care system to ensure universal coverage and better quality health care, asserts a task force assembled by Minnesota Gov. Tim Pawlenty. The task force urges state lawmakers to mandate that everyone buy health insurance, either on their own if they can afford it or with government subsidies if they cannot. Both recommendations were part of a report released last week by the Minnesota Citizens Forum on Health Care Costs, an 18-member citizen panel appointed by the governor in September.

High court lets stand ruling on COBRA error

The Supreme Court declined to review and thus let stand an appeals court decision that the estate of a deceased man whose former employer improperly denied him COBRA coverage while he was alive isn't entitled to recover from the employer medical expenses that were paid by his wife's group health plan. The 2003 ruling by the 8th U.S. Circuit Court of Appeals was the latest twist in a case more than a decade old that resulted in a landmark Supreme Court ruling, *Geissal vs. Moore Medical Corp et al.* That 1998 ruling was the first time the high court ruled on the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Briefly noted

The Supreme Court ruled that the 1998 death of an asthma sufferer who was repeatedly denied permission to change seats to get away from a smoking section of an airplane constituted an "accident" under Article 17 of the **Warsaw Convention**, which governs airline liability. The decision in *Olympic Airways vs. Husain* means that survivors of the victim can pursue a claim against the Greek airline despite the pre-existing nature of the victim's illness. The Supreme Court decision upholds a lower court that awarded the victim's estate $1.4 million....The Arlington, Va.-based **Public Risk Management Assn.** elected Cindy Davis, director of risk management for the University of Colorado at Boulder, as president. PRIMA also elected two risk managers as regional vps on its eight-member board—Sara Stevenson of Marion County, Ore., and Joseph T. Peckham of Broome County, N.Y....Risk management and insurance expert **Nestor R. Roos** died Feb. 20 in Tucson, Ariz. Mr. Roos, 78, a professor emeritus at the University of Arizona, was instrumental in forming the Public Risk Management Assn. He also co-wrote books on governmental risk management, insurance and loss prevention; was the chairman of the Self Insurance Board of Trustees for Pima County, Ariz.; and was a board member and past chair of Arizona Blue Cross & Blue Shield.

Business Insurance staff will be attending an editorial meeting March 1-2, and during that time, there will no daily e-mail alerts or updated news on the magazine's Web site. Both services will resume March 3. To sign up for *BI*'s free daily e-mail alerts, please visit *www.businessinsurance.com.*

Check out BusinessInsurance.com

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

Wholesalers: Firms hope deal spurs growth

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Jr., PRS' chairman.

"We had a two- to three-year plan in the works that included expansion into other geographic territories. It also included expanding our product line. What this does is gives us these two goals immediately," Mr. Spinner said.

In addition, it will give PRS, known primarily for servicing only jumbo property accounts, the ability to compete for middle-market accounts, Mr. Keegan said.

"I think you'll see us servicing our producers with some middle-market business now," he said. "We were a niche player. This should give us a wider breadth."

American Wholesale also plans to exploit PRS' close relationships with insurance buyers, according to Mr. DeCarlo. Traditionally, surplus lines brokers deal directly with retail agents and brokers but rarely have contact with risk managers—the ultimate insurance buyers.

"They're very unusual high-end property guys. Their skill is they are very close to their retail clients and the accounts they work on," he said of PRS.

Industry experts agree that this is a good match.

"I think it's a natural kind of build-out of what it appears American Wholesale is attempting to do. They're adding pieces, and if PRS has that large account property expertise, it's one more arrow in the quiver," said Tim Cunningham, principal of Optis Partners, an industry consultant based in Chicago.

American Wholesale has grown in leaps and bounds since it was formed in 2000 by the merger of MTS Insurance Services L.L.C., New Century Global Inc., Specialty Programs & Facilities Managers Inc. and Americana Financial Services Inc.

Its first-year premium volume totaled just $12 million, but in only three years it has developed into a $1.05 billion company, making it the third-largest wholesaler in the *Business Insurance* 2003 rankings.

The company expects to report 2003 premium volume of $1.2 billion for *BI*'s 2004 rankings, according to Gregg Calistini, chief marketing officer.

PRS also has grown quickly since its founding in 2001. In its first year of operation, it produced $76.6 million in premiums and nearly doubled that in 2002, when its premium volume totaled $151.7 million. Its 2003 premium volume totaled $200 million, according to Mr. Calistini.

Terms of the acquisition were not disclosed, but American Wholesale did reveal that the acquisition is being financed with a revolving line of credit provided by GE Commercial Finance. The credit line is large enough to give the company the wherewithal to complete several other transactions, according to Mr. DeCarlo.

"They created a revolver. What that means is, as we pay our obligation, they will continue to give us money to make more deals," he said. In fact, he said, "we've got a lineup of four deals. And we keep a pipeline of potential acquisitions."

Online Poll

[02/23 - 02/27]

Does your organization have a workplace policy on personal e-mail communications?

Yes	72.84%
No	22.22%
Not sure/ Don't know	4.94%

BI Stock Index

[2/23 - 2/27]

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

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

BI Stock Index	
2344.49	0.68
Dow Jones	
10583.90	-0.33
S&P 500	
1144.94	0.07

Largest gains

Gainsco Inc.	16.67%
ProAssurance Corp.	11.23%
Zenith National	8.12%
Meadowbrook Ins. Group	5.81%
PacifiCare Health Systems	5.68%

Largest losses

Unico American Corp.	-9.88%
PMA Capital Corp.	-9.02%
ING Groep	-4.21%
Seibels Bruce Group	-3.40%
SCOR	-3.35%

Weekly change by market segment

Brokers	-0.10%
Insurers/Reinsurers	0.66%
Managed Care Organizations	2.44%

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