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# Business Insurance

March 17, 2003

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\$4

## 'Counter-detailing' takes on name-brand sales ploys Generic Rx for savings

By **ROBERTO CENICEROS**

Large employers and state legislators want to counter the promotional practices pharmaceutical companies employ to influence doctors' writing of prescriptions.

Although employer and legislator efforts differ, they both hope to stem the rising cost of prescription drugs.

Employers and some pharmacy benefit managers and health plans increasingly are engaging in a practice known as "counter-detailing." "Detailing" is a commonly used industry term to describe visits to doctors' offices by pharmaceutical manufacturers' sales representatives. The sales representatives promote name-brand prescription

drugs that often cost more than available generics.

To offset those efforts, employers—through their health plans, PBMs and other vendors—are stepping up efforts to send their own representatives into doctors' offices to encourage physicians to promote generic drugs.

In some cases, these efforts include providing free generic drug samples to doctors. The practice is a countermeasure to the free samples of new, more costly name-brand drugs that manufacturers' marketing representatives regularly provide physicians to give to patients.

Meanwhile, consumer protection legislation, recently introduced in several states and adopted last year

See **DRUGS**/page 25

## Late News

### House passes med mal reform measure

The House of Representatives approved a medical malpractice liability reform bill on a 229-196 vote last week. The Help Efficient, Accessible, Low-Cost Timely Healthcare—or HEALTH—Act calls for limiting noneconomic damages in medical malpractice cases to \$250,000. It would also cap punitive damages at the greater of \$250,000 or twice compensatory damages. The measure would also limit any one defendant's financial liability to the proportion of its responsibility. The bill's chances for Senate approval remain uncertain.

### U.K. employer blocks pension plan exits

U.K. engineering company Invensys P.L.C. has blocked employees from leaving its pension plan under temporary rules issued by the U.K.'s Occupational Pensions Regulatory Authority last month. The OPRA guidelines allow trustees of underfunded pension plans to prevent employees from rolling over their pension proceeds to other accounts, such as when they change employers. London-based Invensys is one of the first companies to take advantage of the OPRA guidelines. OPRA stressed that the guidelines are a temporary relaxation of the rules pending legislative changes on the calculation of pension transfer values.

### Schwab suspends 401(k) matches

Charles Schwab Corp. has stopped matching contributions to employee 401(k) retirement accounts. David S. Pottruck, Schwab president and co-chief executive officer, said in a statement that the financial services company had undertaken a series of expense reduction measures that include "adjustments to certain employee benefits." A company spokesman said that halting 401(k) matching contributions is a temporary measure.

### Securities class actions grow in 2002: Study

The number of new federal securities class-action lawsuits

See **LATE NEWS**/page 27

## Employers seek change in valuation index PBGC head urges funding level hikes

By **JERRY GEISEL**

**WASHINGTON**—Alarmed by the deteriorating financial condition of the Pension Benefit Guaranty Corp., the Bush administration is examining and likely will propose a PBGC reform package by the end of the year, according to the agency's executive director.

PBGC head Steve Kandarian, while declining to give specifics until final decisions are made by administration officials, said that a key goal of the reform package will be to improve pension funding levels.

Speaking at a Senate Finance Committee hearing last week, Mr. Kandarian said current pension funding requirements for "chroni-

cally" underfunded plans—rules Congress last strengthened in 1994—are inadequate.

"The funding targets are simply not high enough for the plans of companies at the greatest risk of termination," he said.

Mr. Kandarian described as "misguided" the argument—heard in employer benefit lobbying group circles—that proposals to shore up the financial base of the PBGC can be put off because the agency is not in imminent danger of running out of cash to pay benefits to participants of plans the agency has taken over.

Employers, for their part, are more concerned about changing the index—currently based on the

See **PBGC**/page 26

## Nightclub deaths shine spotlight on safety practices Tragedies may toughen market

By **SALLY ROBERTS**

The recent nightclub tragedies in Chicago and Rhode Island are putting loss control and safety onto center stage at such establishments.

However, even though the two catastrophes occurred within days of each other and resulted in a total of 120 deaths, a nightclub industry representative says they are anomalies and not symptomatic of a wider problem.

The first two lawsuits stemming from last month's Rhode

Island nightclub fire, which killed 99 people and injured scores of others, have been filed, and plaintiffs attorneys predict that as many as 1,000 wrongful death and personal injury suits could follow.

The fire at the West Warwick, R.I., nightclub came three days after 21 people were killed and at least 20 more were injured in Chicago when patrons fled the E2 nightclub in a panic after security guards used pepper spray to stop a fight. A number of lawsuits have been filed in Chicago

See **NIGHTCLUBS**/page 25

## International

### LLOYD'S NO LONGER SEEKING CAPTIVES

Begins on page 23



March 17, 2003

# Cryptic quote by Buffett roils reinsurance market

By DOUGLAS McLEOD

**OMAHA, Neb.**—The Oracle of Omaha, like other oracles before him, can be maddeningly obscure.

Berkshire Hathaway Inc. Chairman Warren Buffett caused a stir in reinsurance circles last week by remarking in his annual letter to shareholders that one of the world's largest reinsurers—which he did not name—“has all but ceased paying claims, including those both valid and due.”

Market observers immediately targeted Cologne, Germany-based Gerling Global Re, which stopped underwriting last year, as the likely subject of Mr. Buffett's comments. It remained unclear last week, though, whether this is in fact the reinsurer he had in mind and, if so, whether he is right about its claims practices.



ILLUSTRATION: ROBERT EDWARDS

Gerling has recently slowed reinsurance claim payments, but several brokers and ceding insurers say that it is still paying. A Gerling spokesman also denied any halt to

payments.

“We are paying all claims that fall due,” the spokesman asserted.

No clarification was forthcoming from Omaha: A Berkshire spokeswoman said Mr. Buffett would not elaborate on comments in his shareholder letter but that he would be available for questions at the company's annual meeting May 3.

News of Mr. Buffett's remarks raced through an insurance and reinsurance industry already rattled by multibillion-dollar reserve additions, investment losses and falling interest rates.

In his letter to shareholders accompanying Berkshire's 2002 annual report, Mr. Buffett discussed—among other topics—the importance of dealing with secure reinsurers. While touting the high fi-

See **BUFFETT**/page 27

High court ruling may spur legislative reforms

## Fear of asbestos-related illness ruled grounds for damages

By MARK A. HOFMANN

**WASHINGTON**—Employer groups say that last week's Supreme Court decision holding that workers suffering from asbestosis can recover damages for mental anguish caused by fear of developing asbestos-related cancer underscores the need for congressional action.

In fact, the justices themselves said as much in the 5-4 decision in *Norfolk & Southern Railway Co. vs. Freeman Ayers et al.* Writing for the majority, Associate Justice Ruth Bader Ginsburg ruled that the Federal Employers' Liability Act did not ban such suits.

FELA is a 1908 federal statute that was designed to protect railway workers in an era before workers compensation existed. FELA applies to only a small number of workers,

but employment experts had watched the case with interest because of its possible impact on efforts to reform the asbestos liability system.

The suit had been brought by six retired railway workers, who claimed that their noncancerous asbestos illness caused them undue fear of developing cancer and that they should receive damages for that fear.

A West Virginia jury agreed and awarded the workers damages for their injuries, including emotional distress.

Business groups had argued that the workers should not receive compensation for fear alone, even if they had manifested other asbestos-related illnesses. Although the court majority rejected this argument,

See **ASBESTOS**/page 6



BERMUDA



VERMONT

The decision to form a captive onshore or offshore requires consideration of many factors, but cost is usually not the most important component, captive experts say.

## Captive sponsors face host of issues in picking domicile

By RODD ZOLKOS and MICHAEL BRADFORD

Many captive insurance company managers say that cost is rarely the determining factor in a U.S. parent company's decision to locate its captive on or offshore.

Still, a highly unscientific study of the cost differences between establishing a facility in Vermont and Bermuda make for an interesting, if inconclusive, exercise.

Looking at the most concrete comparisons first, one can compare the required costs of forming a pure captive with minimum capital and surplus in either domicile.

Vermont requires a minimum \$250,000 capital and surplus for a pure captive. The state also has a \$200 initial application fee and a \$300 annual license fee. Under the multi-tiered premium tax system, the minimum tax is currently \$5,000. The total of those

costs is \$255,500.

Meanwhile, a single-parent captive in Bermuda insuring only the risks of its parent would incur the following costs imposed by regulators: capital and surplus of \$120,000, registration fees of \$880 and company tax at a minimum of \$3,635, for a total of \$124,515. Advantage: Bermuda.

Travel to the two domiciles is another story. Bermuda has no requirement that captive owners travel to the island for meetings, while Vermont does require captives' boards to meet annually in the state. But, assuming that an officer of our captive, whose parent is a Chicago-based company, does want to travel to either domicile, the costs here break in Vermont's favor.

Traveling to Bermuda, airline fare will be about \$800, while three nights at the Hamilton Princess including taxes, gratuities and resort fee will run \$876.

See **CAPTIVES**/page 21

## Inside Business Insurance

### Managed care firms' price hikes sticking

A report on managed care companies' results indicates that employers can expect continued price increases in 2003. **Page 4**

### Bartell Drug settles suit on contraceptive cover

A Bartell Drug Co. settlement will ensure its benefit plan covers prescription contraceptives. **Page 4**

### What's driving insurers' auto safety efforts?

Editor Paul Winston squirts cold water at some bizarre proposals to lessen auto insurance risks. **Page 6**

### Tort reform opponents hide system's costs

Arguments against reforming the asbestos litigation system ignore the true costs, Debra T. Ballen writes in Perspectives. **Page 10**



### U.K. project financiers fight coverage cost hikes

Private-sector companies set up to help finance public construction projects in the United Kingdom are balking at sharp increases in their insurance costs. **Page 23**

## Online

- The **Datebook** calendar lists upcoming industry seminars and meetings and allows visitors to add information on their own events.
- Searchable **directories** of all the listings of industry vendors found in *BI's* Market Sourcebook.
- New **Opinion Poll** for readers: How effective will OSHA's new voluntary program for employers be in reducing ergonomics-related injuries?

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS.

Business Insurance (ISSN 0007-6864) Vol. 37, No. 11, is published weekly by Crain Communications Inc., 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Periodicals postage is paid at Chicago and at additional mailing offices. POSTMASTER: Send address changes to Business Insurance Circulation Department, 1155 Gratiot Ave., Detroit, Mich. 48207-2912. \$4 a copy and \$97 a year in the U.S. \$130 in Canada and Mexico (includes GST). All other countries, \$230 a year (includes expedited air delivery). Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 0293512, GST No. 136760444, Printed in U.S.A. Copyright © 2003 by Crain Communications Inc.

Companies' finances healthy, but 2004 may bring end to cost increases

# Managed care price hikes sticking for now

By JUDY GREENWALD

Although many managed care organizations are continuing to enjoy good results at employers' expense, buyers' acceptance of the double-digit rate hikes may not last much beyond this year.

Whatever its ultimate duration, the ongoing price increases definitely led to strong results in 2002. "The companies are performing well," said Greg Crawford, an analyst with Fox-Pitt Kelton Inc. in San Francisco. The earnings quality and the cash flow "have been solid."

"The results were phenomenal," said Michael LeConey, an analyst with Gilford Securities in New York. The major companies have had impressive revenue and enrollment gains, he said.

John L. Ward, chairman of the Cincinnati-based Ward Group, said, "In general, the core fundamentals

of the segment look relatively strong." Most companies have experienced a slight improvement in their loss ratios, "and there's a big push to grow the membership base."

Douglas L. Meyer, senior director at Fitch IBCA in Chicago, said 2002 results "were pretty much in line with our expectations overall, which were for a continuation of the positive trends that we saw in 2001," including improved pricing on the commercial side. Furthermore, some companies made "fur-

ther progress in terms of their own internal restructuring and acquisition and integration activity," he said.

Philadelphia-based CIGNA Corp., which reported a \$398 million loss for 2002, was "the one exception if you look at the aggregate results for the industry," Mr. Meyer said. CIGNA's results reflect more than \$1 billion in special charges, the bulk of which are related to increased life reinsurance reserves and to the insurer's exposure to losses from the Unicovert Managers Inc. workers compensation pool.

Operating results for some companies were better than their net income would suggest. For instance, Cypress, Calif.-based PacifiCare Health Systems Inc.'s \$757.8 million loss for 2002 reflected an \$897 million charge in connection with its adoption of Financial Account-

See RESULTS/page 26

## Managed Care 2002 RESULTS

## MAJOR MANAGED CARE ORGANIZATIONS' YEAR-END 2002 RESULTS

Ranked by change in net income. Dollar figures in millions.

Company	Net Income 2002	Percent Increase (Decrease)
Health Net Inc.	\$228.6	164.2%
Coventry Health Care Inc.	145.6	72.5
WellPoint Health Networks	703.1	69.5
UnitedHealth Group	1,352.0	48.1
Anthem Inc.	549.1	60.5
Humana Inc	142.8	21.8
Oxford Health Plans Inc	220.0	(31.8)
Kaiser Permanente	70.0	(89.7)
CIGNA Corp.	(398.0)	(140.3)
Aetna Inc.	(2,522.5)	(802.3)
PacifiCare Health Systems Inc.	(757.8)	N.M.

Source: Company reports



PHOTOS: TIM MATSUI/GETTY IMAGES

In a settlement, Bartell Drug Co. has agreed to provide coverage through its self-insured benefits plan for women's prescription contraceptives.

## Plan agrees to cover contraceptive drugs Bartell case was closely watched

By SALLY ROBERTS

**SEATTLE**—The Bartell Drug Co. will continue to offer insurance coverage for prescription contraceptives within its self-insured health plan as part of a settlement agreement reached earlier this month with a class of women employees.

In September 2000, Jennifer Erickson, a Bartell pharmacist, sued the company alleging it violated Title VII of the federal civil rights law, as amended by the Pregnancy Discrimination Act of 1978, because the company's health plan excluded a class of prescription drugs used only by women. In June 2001, a U.S. district court judge in Seattle agreed with Ms. Erickson, who was represented by Planned Parenthood

of Western Washington and Planned Parenthood Federation of America (*BI*, June 18, 2001). Bartell, which began providing prescription contraceptive coverage after the decision, appealed the ruling to the 9th U.S. Circuit Court of Appeals, contending that the company's health plan was not discriminatory.

At the time, Bartell argued that there had never been a court ruling that said the exclusion of contraceptives constituted discrimination. Also, the company had added prescription contraceptive benefits for union employees in April 2001 and had planned to do the same for nonunion employees, including Ms. Erickson, after the ruling.

See CONTRACEPTIVES/page 24

## 401(k) participation dropping

### Buck survey finds fewer workers joined plans in 2002

By JOANNE WOJCIK

Employee participation in 401(k) plans is slumping.

A survey conducted by Buck Consultants Inc. found that the average plan participation rate in 2002 was 73% of eligible employees—the lowest level since 1991, when plan participation averaged 74%. Results for 2002 are based on New York-based Buck's survey of 524 companies that sponsor a 401(k) plan.

Participation peaked in 1995, when 79% of eligible employees participated in their employer's

401(k) plan, Buck said.

Rich Koski, a principal at Buck in Seacaucus, N.J., and author of the study, says he plans to do a follow-up study to examine the reasons behind the drop in participation.

"Normally, in this situation, you'd attribute it to new employees not signing up," he said. "But why aren't they signing up?" Mr. Koski speculated that the stock market's

poor performance in the last two years may have influenced employees' investing behavior.

The decline in participation occurred despite employers' efforts to educate employees about the need to save for retirement. Ninety percent of survey respondents said that their organizations have taken steps to educate plan participants about investment and savings principles, the survey found.

See SURVEY/page 24

## NAIC stir over AHP testimony

By MEG FLETCHER

**ATLANTA**—The National Assn. of Insurance Commissioners is reaffirming its opposition to association health plans, in the wake of recent testimony by a state regulator before Congress that some say undermines the organization's position.

The damage control effort provided a rocky start to Arkansas Insurance Commissioner Michael Pickens' tenure as president of the NAIC. That is because the written

testimony at issue was delivered to a House committee by his deputy commissioner, John Hartnedy.

AHPs are group health insurance plans sold by associations. Two bills now in Congress—H.R. 660 and S. 545—would create federally certified AHP plans under the jurisdiction of the U.S. Department of Labor that would be free from state insurance oversight.

The Bush administration and several business and farm groups, including the U.S. Chamber of Commerce, support AHPs as a way to

give small businesses greater purchasing clout and economies of scale. Bypassing state oversight also would give AHPs some of the freedom from costly state benefit mandates that large employers enjoy.

But that lack of state oversight underpins opposition to the proposals. The NAIC contends, among other things, that AHPs would operate outside of established state protections for consumers, including mandatory standards of coverage, appeals mechanisms and solvency

See NAIC/page 6

### Errors & omissions

- Due to an editing error, a March 10 story on Kemper Insurance Cos. contained conflicting information. Liabilities associated with Kemper's writings will remain with the original company, a spokeswoman said. In addition, remarks attributed to Joe Lombardo,

chief market relations officer with Aon Risk Services, were unclear. He said a higher rate of account retention at renewals could result from the transfer of business to the new Kemper.

- The March 10 Cayman Islands profile misspelled the surname of Wayne Cowan, a partner at JLT

Risk Solutions (Cayman) Ltd.

- A March 10 story on a Washington Business Group on Health/Watson Wyatt Worldwide survey omitted the word "not" from a finding. Sixty-seven percent of employers responding are not confident that consumer-driven approaches will control costs.

# Employer groups join to lobby for new pension regulations

By JERRY GEISEL

**WASHINGTON**—More than 50 employers have banded together to urge the Bush administration to re-draft pension age non-discrimination rules the Treasury Department issued in December.

While many cash balance plans could comply with the rules, another pension hybrid—pension equity plans—generally would be considered age discriminatory (*BI*, Dec. 16, 2002).

The coalition will work to ensure that the final regulations allow employers to offer plans, such as cash balance and pension equity programs, that meet the benefit needs of today's workforce and that do not discriminate against older em-

ployees, it says.

"We are encouraging Treasury to issue rules that will allow employers to continue to provide this critical source of retirement income for many working Americans," Geoffrey Kusch, director of global benefits at The Dow Chemical Co. in Midland, Mich., said in a statement.

The group, the Coalition to Preserve the Defined Benefit System, will soon send a letter to President Bush commenting on the proposed regulations and aiming to correct some of what it describes as "recent misinformation" surrounding defined benefit plan design.

The coalition was formed by consultant Watson Wyatt Worldwide. Members include Blue Cross & Blue Shield of Minnesota, Caterpil-

lar Inc., Dow Chemical, Fortis Inc., Fortune Brands Inc. and Wells Fargo & Co.

The coalition's formation comes a few weeks before the Treasury Department's planned April 9 hearing on the proposed regulations and as dozens of organizations and employers have been filing comments.

For example, the American Benefits Council said it could see "no policy rationale for deeming pension equity plans age discriminatory."

That is a "particularly odd result," the Council said, noting that the plans combine the popular account feature of cash balance plans with a final-pay approach, which rewards longer-service employees.

# Asbestos: Fears compensable

Continued from page 3

Justice Ginsburg wrote in her opinion that in order to prevail in an emotional stress claim such as the one presented in the *Ayers* case, a claimant would have to prove that the fear of contracting cancer was serious.

Business groups stressed the fact that both Justice Ginsburg in the decision and Associate Justice Stephen Breyer in his partial dissent said that solving the asbestos litigation situation was a job for Congress.

The mass of asbestos-related lawsuits in state courts "defies customary judicial administration and calls for national legislation," Justice Ginsburg wrote. Justice Breyer noted that "members of this court have indicated that Congress should enact legislation to help resolve the asbestos problem. Congress has not

responded." The court has called on Congress to act on the issue twice before.

The Senate Judiciary Committee held a hearing on asbestos liability earlier this month, and Judiciary Committee Chairman Orrin Hatch, R-Utah, has said he would like to have a bill ready by the end of the month (*BI*, March 10).

Victor Schwartz, counsel to the insurer-backed Coalition for Asbestos Justice Inc., said it is "important to note that the court has once again called on Congress to pass national legislation to address the asbestos litigation crisis. It is virtually unprecedented for the court to call upon Congress three times to fix a serious problem."

Noting the Judiciary Committee hearings, Michael Baroody, executive vp of the National Assn. of Manufacturers and chairman of the

business-backed Asbestos Alliance, said it was "very encouraging" that the court has called again for congressional action. "The Supreme Court has added to the urgency that we need legislation and we need it soon," he said in a statement.

Although the court split on the issue of permitting emotional distress claims stemming from a fear of asbestosis becoming cancer, the justices agreed unanimously on a second issue raised in the case, which held that a railroad could be held responsible for all the damage that led to the asbestosis even if other parties contributed to the alleged negligence.

*Norfolk & Western Railway Co. vs. Freeman Ayers et al., U.S. Supreme Court; No. 01-963. Decided March 10, 2003.*

# NAIC: Stir over AHP testimony

Continued from page 4

versight. That invites fraud as well as uncovered claims, the NAIC says. Others opposing AHPs include some groups representing the insurance industry, governors, state legislators and consumers, as well as the AFL-CIO.

The controversy—which overshadowed other action at the NAIC's recent quarterly meeting in Atlanta—stems from written testimony that Mr. Hartnedy of Arkansas presented March 5 before the U.S. House Committee on Small Business. Among other comments, Mr. Hartnedy stated: "AHPs can effectively pool segments of the market without disturbing the current overall market if done correctly."

In brief verbal testimony before the panel, he did offer some criticism of AHPs and emphasized he was speaking only for the Arkansas Insurance Department. The department opposes the plans.

But at least one proponent of

AHPs seized on his written comments and circulated an excerpt that appeared to support AHP plans. Critics say that implied that state regulators had reversed their position.

As a result, other regulators, as well as industry and consumer representatives, expressed concern that Mr. Pickens' deputy undermined the NAIC's credibility on the issue.

"There is a fair amount of concern" among state insurance commissioners "that Congress could be confused on the basis of this testimony about the position of the NAIC," complained Mike Kreidler, Washington's commissioner, in an interview at the NAIC meeting. Having "a mixed message" out there "weakens our ability to influence the public policy debate," he said.

"The written testimony was highly damaging to the NAIC," said Alice M. Weiss, director of health policy for the Washington-based National Partnership for Women & Families.

"The NAIC is into damage control," said Sandy Praeger, the Kansas insurance commissioner. She had testified against AHPs before a Senate committee one month before Mr. Hartnedy's House testimony. She testified that within the last year 16 states have shut down nearly 50 AHP-style programs, leaving millions of dollars in unpaid claims.

Other regulators, though, were less critical. "It was unfortunate that it happened, but I don't think it has hurt the NAIC's credibility," said Iowa Insurance Commissioner Terri Vaughan.

In an interview, NAIC President Mr. Pickens "apologized to commissioners for the misperceptions" arising from his deputy's testimony. Mr. Pickens said he did not read the testimony before it was submitted.

Mr. Pickens said Mr. Hartnedy would revise and resubmit his testimony. Mr. Pickens also wrote to key House and Senate panels, reaffirming the NAIC's position.

## Paul Winston

# Safety innovations driven by faults

You can be forgiven for thinking that all auto insurers care about these days is getting stuck with a bill after a nuclear event wreaks havoc on paint finishes and the integrity of radial tires.

Even after hearing State Farm explain that exclusions for nuclear perils are standard in other policies and that it was merely rectifying a mistaken omission from auto policies, I still thought the timing of such a statement was unfortunate and even crass. For the record: I am a State Farm policyholder and in the event of a nuclear attack, I think it's safe to say that filing an auto claim would be the last thing on my mind.

In reality, though, preparing for the extreme rarity of a nuclear attack is not getting a lot of attention at most insurers. Rather, auto insurers are paying much closer attention to more mundane causes of automobile claims and striving to improve vehicle safety.

It is true that cars today are generally much safer for their occupants than they were 30 or even 20 years ago. But there is still a key element involved in many car crashes that demands continued attention: Human error.

One day, I am sure that all cars will have autopilot systems that take their cues from complex highway management systems, making collisions a thing of the past. It won't be anywhere near as fun as pushing a car to 140 mph on the Interstate today, but it will be safer for us and for others on the road. And for those of you who lament becoming a mere passenger in your hot rod, cheer up: We all know that even if cars won't crash, computers do. So there probably will still be a need to know how to use a brake pedal and steering wheel.

Until that day in the future, however, various researchers and inventors are striving to reduce the risk that human frailties will cause accidents. Some might soon turn up at a car dealer near you.

According to a bulletin from the Ohio Insurance Institute, International Business Machines Corp. is working on a dashboard-mounted device to combat drowsy drivers. This device would periodically ask the driver questions and monitor the speed and clarity of his responses. If the computer decides that the driver is nodding off, it would shoot jets of cold water in his face, roll down windows, sound an alarm and switch radio stations.

I'm skeptical that shooting a liquid in a driver's face is a good idea, as a reaction might be to

remove one's hands from the wheel and wipe one's eyes at a dangerous time. And I really hate it when anyone—or anything—changes my radio station in the car. I would probably rip the device off the dashboard and chuck it out the window if I awoke to find I was listening to light rock or hits of the '80s.

IBM hopes to have its device in new cars within five years, according to the Ohio Insurance Institute. I think it needs a little more work.

From the National Assn. of Independent Insurers comes news of another safety innovation for cars: auto event data recorders, or black boxes. The NAII is urging the

federal government and carmakers to develop private automobile versions of these devices, which would transmit data to satellites. The theory is that having greater data about the causes of collisions will lead to improved safety.

Sounds like a good plan, but I'm a little leery of how this information would be used and by whom.

Who would pay for this information delivery and tracking system? And how would the privacy of this information be guaranteed? I can readily envision it being misused not only by private parties but also by overzealous local authorities. Why set up speed traps, for example, when a police department could mine satellite data for various traffic violations, from failure to signal to minor lane violations?

The idea of better understanding accidents makes sense, but I think the system raises too many potential privacy concerns to be widely embraced.

Searching the Internet for other car safety innovations I came across a site on the Internet, the Invention Submission Corp., that included among its many innovations an invention called the Cell Block. The device is designed to require drivers to pull over and stop their cars before they could receive or make a cell phone call. The inventor touts the product as ideal for parents of teenagers, businesses operating fleets of vehicles and car rental agencies looking to protect their vehicles. I'm not clear on how the device would work, but I assume it's safe to say it doesn't involve squirting water in the face of drivers on the phone.

Until these and other devices make their way into your vehicles, drive safely.

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Paul Winston

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Published weekly at 360 N. Michigan Ave., Chicago, Ill.  
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Offices: 711 Third Ave., New York, N.Y. 10017-5806. Fax:  
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Graftiot Ave., Detroit, Mich. 48207-2912. Phone: 888-  
446-1422 or 313-446-0450. Fax: 313-446-6777.

Microfilm copies available: University Microfilms, 300  
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## Editorial

## Claims fraud inflates cost of health care for all

AT A TIME when employers and insurers are struggling to rein in health care cost increases, evidence of mounting medical claims fraud and overbilling is troubling indeed.

As *Business Insurance* reported on page 1 of its March 10 issue, studies suggest health insurance fraud is becoming an epidemic. Health insurers and government sources offer a range of estimates, but there appears to be consensus that fraud currently accounts for 5% to 10% of all health care spending in the United States.

Consider: health care spending in 2002 was projected to total more than \$1.4 trillion. Even at the low end of the estimated range, health insurance fraud would cost at least \$70 billion—and the real number could be much higher.

Most of the abuse in health care

claims comes in the form of "up-coding," or billing payers for higher-cost services than those actually provided, according to industry sources.

Why are health care providers padding claims? To begin with, managed care companies have lowered payment rates, and some have a reputation for foot-dragging when it comes to reimbursing providers. Some national managed care organizations face class-action lawsuits from doctors for allegedly delaying payments, and CIGNA Corp.'s proposed \$200 million settlement with physician plaintiffs in Illinois—who allege they have been short-changed—has been widely publicized (*BI*, Dec. 16, 2002).

Yet another motivation for up-coding may be that health care providers feel constrained in the practice of medicine by rigid man-

aged care requirements and are tempted to strike back, often on patients' behalf.

Whatever the motive, health care fraud is still a deliberate attempt to deceive a payer, and it is a crime. It also results in higher costs for claimants and, in the long run, for everyone who buys health insurance.

If describing the problem is easy, finding a solution is not. We think that growth in claims fraud can be slowed, however, through greater enforcement of anti-fraud laws and reform of claims-payment systems. Employers also could urge employees to look closely at their explanation-of-benefits statements to see whether anything looks suspicious.

Employers and insurers can ill afford to allow overbilling and claims fraud to continue unchecked.

## New safety focus sensible

WE'VE CERTAINLY HAD our disagreements with the Occupational Safety and Health Administration in the past, most vehemently over a controversial—and ultimately ill-fated—attempt to impose an inflexible and scientifically questionable workplace ergonomics standard on the nation's employers.

But we have nothing but praise for OSHA's new enhanced enforcement policy, which seeks to lower

the boom on the country's worst workplace safety offenders. Employers that have received "high-gravity" citations—citations issued only to those whose violations of workplace health and safety rules are the most severe—can expect more, and more-comprehensive, inspections, public disclosure of their wrongdoing and other sanctions.

If for some reason corporate wrongdoers still don't get the message, federal courts will enforce

OSHA's orders.

The new policy makes a lot of sense. After all, the reason OSHA exists is protect workers. Odds are that those most at risk labor at the nation's most dangerous workplaces. And, of course, OSHA's resources, in terms of both money and personnel, are limited.

Targeting the worst workplaces and, thus, protecting those most at risk, will put those resources to the best possible use.

## Schillerstrom



## Letters to the Editor

## Don't overlook the value of actuarial education

To the editor: I commend *Business Insurance* for undertaking the massive effort to survey and report information on risk management and insurance education. Your report highlights nicely many of the prominent programs and should be helpful to prospective students, employers and others interested in the important work under way at universities to educate future leaders.

While I found the report informative, I offer two suggested modifications that would make it even more useful. First, your stipulation that actuarial science faculty and course offerings not be reported is highly unfortunate. Actuaries are trained to model risks and price them—the heart of risk management and insurance. Probably like most AS programs, we see more than half of our graduates accept positions in employee benefits and property/casualty insurance, which are services that relate directly to your magazine's readership. I urge you to include this area in future surveys.

Second, while prominence was given to a table showing numbers of undergraduate majors at the various programs, no parallel table showed numbers of masters degree candidates. Several universities place equal or even greater emphasis on graduate education, and your readers looking for more advanced educational programs would find this summary information useful. I urge you to include a parallel table in the future.

Again, thanks for this important contribution.

**Harold D. Skipper**

Chairman and C.V. Starr Chair  
of International Insurance

J. Mack Robinson

College of Business

Georgia State University

# Tort reform foe's argument hides system's real costs

By Debra T. Ballen

Like a broken clock that is accidentally right, Jackson Williams correctly says the asbestos tort system is broken in his Feb. 24 Perspective, "Tort Liability Needed for its Deterrent Effect." He is wrong, though, about why it has broken and what that broken system means for victims and our economy.



A fair, just tort system should be an incentive for manufacturers to make safe products, as Mr. Williams asserts.

What he doesn't tell you is that many of the companies now being hauled into court over asbestos never mined or manufactured the product. The RAND Institute says they come from industries such as food and beverage,

durable goods and paper. How these nonasbestos companies were to have planned for these lawsuits is a question Mr. Williams does not answer.

Yet, shocking as that might be, this is hardly the worst distortion and abuse in our present asbestos liability system.

The greatest miscarriage of justice involves not those who pay but who gets paid. Nearly 90% of all claims, according to RAND, are filed by people who are healthy. They are people who are, in the words of a leading plaintiffs lawyer, "not sick, and if they were your children, you would not keep them home from school."

Mr. Williams argues that the purpose of the tort liability system is to make companies pay for the costs of the injuries they caused. But, in the asbestos liability system, we have companies that neither manufactured nor mined the product and we have plaintiffs

who have no real injury.

The surge of asbestos-related bankruptcies discussed by Mr. Williams is another consequence of the broken asbestos liability system. More companies declared bankruptcy in 2002 than in the previous five years combined. Those lawsuits filed by healthy people have led to a loss of about 60,000 jobs, according to the American Insurance Assn. study conducted by Nobel laureate Joseph Stiglitz.

The toll for these workers, according to Mr. Stiglitz, is devastating: an average 25% loss in their 401(k) investments; \$25,000 to \$50,000 in lost wages over their career; and the likelihood of having to take a lower-paying job as the result.

These are real people, with middle-income wages, who are victims of the asbestos litigation system.

Unless Congress acts soon, more workers are going to feel the brunt of this unjust system. As Mr. Stiglitz wrote, "Perhaps only a quarter of the estimated eventual costs associated with asbestos claims have been paid to date, raising the specter of many more companies facing severe financial effects and additional asbestos-related bankruptcies in the future."

All this pain, and presumably the pain to come, Mr. Williams calls a "bargain" for society. He terms it "silly" to worry about the sickest victims and to try to protect American jobs from the ever-widening asbestos lawsuit crisis. His are not serious arguments, and, fortunately, it appears Congress is unlikely to listen to them.

A bipartisan consensus is finally emerging for reforms to ensure that those who are truly sick from asbestos get compensation, while those who are healthy do not. That would be a just system.

*Debra T. Ballen is executive vp of the American Insurance Assn. in Washington.*

# 7 steps to obtaining favorable D&O renewal terms

By Larry Goanos

Directors and officers liability insurance rates are skyrocketing while terms and conditions are constricting. From an insurer's point of view, however, these two phenomena are necessary to bring D&O insurance back to profitability. Insurers also must be able to maintain adequate reserves to protect the many policyholders that rely upon their D&O policies.



Many risk managers wonder what they can do to get the best possible renewal. No matter what a company does, it will always remain part of the greater D&O risk pool, and certain rates, terms and conditions are

inevitable. The following steps can help a policyholder secure the best possible renewal terms:

• **Start early.** Few things irk a D&O underwriter more than a last-minute call from a broker needing a quote overnight. Dropping a submission on someone's desk at the 11th hour is not a good strategy. Last-minute submissions often get declined for lack of underwriting time. Also, the insurer that you approach at the 11th hour feels like an afterthought and is less likely to provide favorable terms. Finally, the underwriter's questions probably won't be answered in time and any doubts will be resolved against you.

The ideal renewal process begins 60 days before the expiration date. Start too soon and you'll be put on hold. Underwriters want current information. For example, June information will need updating for a December renewal. Also, most insurers won't quote more than 30 to 45 days before renewal. Because most quotes contain a "change in material conditions" clause, if anything significant happens between the quote and renewal dates, your quote will be invalidated, so you might as well wait.

• **Use a theme.** Choose an overriding message to present. Underwriters deal with many renewals, and you want yours to stand out. The theme should accentuate the positive and differentiate your company. Good examples are "20 Years of Earnings Growth" or "New Management Turning the Company Around." The goal is to leave the underwriter with a positive impression.

• **Determine priorities.** Are you price-driven? Does your board only care about 100% entity coverage? Determine priorities and communicate them early and clearly. Your broker should call each insurer to communicate what's important; otherwise, you'll receive quotes that may not meet your needs. Revising quotes wastes time and the underwriter may hold it against you, even though he or she shouldn't. Also, try to keep your requested options to a minimum.

• **Meet with your underwriters.** Despite actuarial tables, financial analysis, corporate governance ratings and other underwriting tools, D&O insurance remains a relationship-driven business. People matter as much as numbers.

If a primary insurer is going to service your account, provide fair terms and pricing and, most importantly, handle your claims, you want to know and trust the insurer's decision-makers. A videoconference or teleconference is no substitute for shaking someone's hand and looking him or her in the eye. Also, it's absolutely imperative that you have the right executives from your company on hand. Your broker should know the underwriters' areas of concern and should be able to guide you on required attendees.

If possible, hold individual meetings with each insurer. It's hard to build relationships in group meetings, especially large sessions where applicants are sometimes not even sure which company each underwriter represents. The meeting should be a two-way

street: it's an opportunity for both companies to learn about each other.

Going through your presentation five or six times in a day is not fun, but it can pay big dividends.

**Despite actuarial tables, financial analysis, corporate governance ratings and other underwriting tools, D&O insurance remains a relationship-driven business. People matter as much as numbers.**

• **Don't hide problems.** If your company was hit with a securities class action, have an in-house lawyer explain exactly what happened and why it won't recur. D&O underwriters respect those who address problems head-on.

Trying to minimize the importance of a major problem only arouses suspicion and damages your credibility. This also applies to potential problems. For example, if your company has off-balance-sheet entities, explain them up front; don't wait for the probing questions. If need be, ask for a confidentiality agreement from each

underwriter.

• **Emphasize relationships.** Make clear that your company is relationship-oriented and you expect your insurers to be that way also. No insurer likes a buyer that jumps from insurer to insurer each year.

• **Don't burn bridges.** If a particular insurer doesn't get your business or doesn't get the placement it wants, you or your broker should call the underwriter to explain what happened and say that you appreciated its efforts. One phone call can go a long way toward creating future goodwill.

These are just a few of the major points to consider.

Again, D&O insurance is primarily a relationship business. Establishing a strong and truthful relationship with your broker and underwriters will pay off during the renewal process and in the long run.

*Larry A. Goanos is senior vp in charge of ACE USA's directors and officers group in New York.*

## Guidelines for submitting Perspectives articles to BI

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

The section is intended to be a forum for readers' opinions as well as a forum for the discussion of technical topics that do not lend themselves to news stories.

Therefore, Perspectives articles should take a point of view, offer advice and/or explain a technical subject. They should not present case studies or promotional information.

To submit an article for the Perspectives section:

• Send us a letter describing the topic you would like to address. Briefly de-

scribe what you want to say and accomplish in the article.

• We will inform you as to whether we will accept or decline your article idea.

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

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

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

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

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

## Book provides artful discussion of self-insurance

### "The Art of Self-Insurance"

By David A. North and Catherine D. Bennett

Published by Sedgwick Claims Management Services Inc.

Free to risk managers and financial officers. Requests from others are considered based on their professional involvement with risk management.

Requests for copies of the book should be sent to: Director of Corporate Communications, Sedgwick Claims Management Services Inc., 1100 Ridgeway Loop Road, Memphis, Tenn. 38120; 901-415-7400.

By Michael Bradford

A little whimsy can sometimes make a complex subject easier to absorb. In a departure from the usual textbook appearance of most insurance tomes, a new book, "The Art of Self-Insurance," brings a fresh approach to the sometimes not-too-enthralling subject of alternative risk financing.

Let's face it, few risk managers look forward to curling up in bed with a good

## Book review

book on how to save insurance costs. And that's not to say "The Art of Self-Insurance" will replace what's currently on their nightstands. But it is a well-written guide to a subject that is on the minds of many insurance buyers these days.



The book's authors, David A. North and Catherine D. Bennett, bring worthy credentials to the work. Mr. North is president and chief executive officer of Sedgwick Claims Management Services Inc. in Memphis, and Ms. Bennett is vp and communications director of Cost Control Concepts Inc. in

Goodlettsville, Tenn.

It's the book's artwork, though, that first grabs the reader. Illustrator Bill Ross's cartoonlike jacket drawing of an artist painting the book's title makes it difficult to resist the temptation to see what's inside. A full-page color drawing begins each chapter and reflects the chapter theme. The volume has an art-book feel to it, oversized, with bright and slick pages that make the colorful drawings stand out.

"The Art of Self-Insurance" is structured to give readers a familiarity with the process of setting up and maintaining a self-insurance program. For purposes of clarity and consistency, the authors explain, they use the example of workers compensation self-insurance throughout the book.

Written chronologically and in an easy-to-read format, the chapters walk readers through the process that begins with information gathering and ends with implementation.

The first eight chapters of the 112-page book focus on issues such as identifying various types of self-insurance, advantages and disadvantages of the plans, state rules

and regulations governing self-insurers, and important factors to consider when evaluating the feasibility of self-insurance.

In the remaining chapters, the focus shifts to managing a self-insurance plan and covers such issues as analyzing risk management data, building a strong safety culture, streamlining claims management and launching a successful communications campaign.

In the back of the book, there is a list of contacts for each state department that can provide regulations on self-insurance and workers compensation. Self-insurance associations and organizations providing statistical and other information that can help self-insureds are also listed.

Whether it's coincidence that an out-of-the-mainstream treatment of an insurance topic happened to focus on the nontraditional side of the business is unclear. But coincidence or not, it's one of the more pleasing ways to read about self-insurance.

Michael Bradford is a senior editor of *Business Insurance* based in New Orleans.

## Termination of comp benefit ruled constitutional

Did a Kentucky statute requiring termination of workers compensation benefits upon the date a claimant qualified for Social Security retirement benefits violate the equal protection clause of the U.S. Constitution? The Supreme Court of Kentucky ruled that it did not.

Barbara McDowell was employed by Jackson Energy RECC until May 29, 1997, when she became permanently and totally disabled due to bilateral carpal tunnel syndrome.

Ms. McDowell was awarded workers comp benefits for permanent total disability. However, the award noted that Ms. McDowell would turn 65 on Dec. 18, 2001, and that, pursuant to Kentucky law, her entitlement to compensation benefits would terminate. She appealed. Both the trial court and Court of Appeals ruled against her.

On appeal, Ms. McDowell made a general claim that the statute terminating benefits at age 65 was "unfair." But, the court said that its task was to determine whether a statute is unconstitutional. The court said the issue was whether there was a rational basis for the alleged perceived discrimination.

Avoiding duplication of income benefits and reducing the overall cost of maintaining the workers compensation system, thereby improving the economic climate for all citizens of the state, provided a rational basis for any perceived discrimination in the statute, the court ruled.

The court upheld the constitutionality of the statute terminating workers comp benefits when the employee qualifies for Social Security retirement benefits.

*McDowell vs. Jackson Energy RECC*, Supreme Court of Kentucky, Aug. 22, 2002 (BI/04/F.-\$10)

### Self-inflicted wound ruled compensable

Wyoming's workers compensation law did not preclude an award of benefits for a self-inflicted gunshot wound, according to the Supreme Court of Wyoming.

After incurring a compensable back injury in 1999, Lynn J. Brierley suffered chronic, intense pain. His treating physician

diagnosed Mr. Brierley as suffering from depression caused by the pain from his work-related injuries. A licensed clinical psychologist diagnosed Mr. Brierley with an anxiety disorder and a pain disorder and concluded that he was not a candidate for back surgery.

In 2000, Mr. Brierley unsuccessfully attempted suicide, inflicting injuries that generated medical costs. He filed a claim for medical and temporary total disability benefits that was denied. The hearing examiner concluded that Mr. Brierley had failed to prove that his compensable work-related injury caused a compensable mental injury that, in turn, led to the self-inflicted gunshot wound.

On appeal, the court said that clear and convincing evidence established that Mr. Brierley's attempted suicide was the result of a mental injury suffered subsequent to a compensable physical injury, when an expert witness testified unequivocally that it was highly probable that Mr. Brierley's compensable injury caused pain and depression that led to the suicide attempt. The court ordered entry of an order granting benefits.

*Brierley vs. State*, Supreme Court of Wyoming, Aug. 14, 2002 (BI/02/F.-\$10)

### Autoerotic asphyxiation deemed accidental

A policyholder's death from autoerotic asphyxiation resulted from an "accident" within the meaning of a group life insurance policy that provided accidental death benefits for death caused by an accident, according to the Court of Special Appeals of Maryland.

David Callaway was covered under a group life insurance policy issued by MAMSI Life & Health Insurance Co. The policy provided for the payment of death benefits if the policyholder sustained a covered loss, which was defined to include loss of life "because of an injury caused by an accident."

Mr. Callaway died in July 2000 at age 39 as a result of autoerotic asphyxiation. Mr. Callaway's beneficiaries sought payment of the death benefits.

## Legal briefs

The insurer refused to pay, asserting Mr. Callaway's death was not the result of an accident and the policy excluded coverage for death resulting from intentional self-injury. The beneficiaries sued the insurer for breach of contract. The trial court ruled for the insurer.

But after an extensive review of decisions from other jurisdictions and expert opinion, the appellate court concluded that the injuries sustained by Mr. Callaway were the result of an accident, and were not intentionally self-inflicted.

"The noose and plastic bag were not used with the intent to cause injury," the court observed, "and the insured reasonably did not foresee or expect such injuries." The trial court decision was reversed.

*Callaway vs. MAMSI*, Court of Special Appeals of Maryland, June 26, 2002, *Reconsideration Denied* Sept. 30, 2002 (BI/04/A.-\$10)

### Subcontractor entitled to defense: 9th Circuit

A subcontractor's unintentional mismanufacture of and negligent installation of cement piles on a construction site constituted an "occurrence" supporting coverage under a commercial general liability insurance policy, according to the 9th U.S. Circuit Court of Appeals.

DeWitt Construction Inc. was a subcontractor on a large-scale commercial construction project in Washington. DeWitt subcontracted with the general contractor, Opus Northwest L.L.C., to drill and place concrete piles into the ground to serve as a primary component of a building's foundation. DeWitt failed to construct the concrete piles so that they achieved the required strength. The cement in the piles did not harden properly. As a result, the original holes and pile assemblies were unusable.

DeWitt had to install about 300 more piles at the site in other locations. This resulted in delays in the overall project pace, abandonment of defective piles, re-engineering of the site's foundation and the removal and reinstallation of other subcontractors' work. Opus asserted a \$3.5 million claim against DeWitt for damages.

DeWitt was covered under CGL insurance policies issued by Travelers Indemnity Co. of America that provided coverage for property damage caused by an "occurrence," which was defined as an accident. DeWitt tendered Opus' claim to Travelers, which made no decision on indemnification. DeWitt then brought this lawsuit against Travelers seeking defense costs and indemnification benefits.

The trial court concluded that Travelers did not have a duty to defend DeWitt. DeWitt appealed.

The appellate court agreed with DeWitt that the defective manufacturing of the concrete piles constituted an "occurrence" within the meaning of the policies. According to the court, under Washington law, a subcontractor's unintentional mismanufacture of a product constituted an "occurrence."

However, the court also concluded that the damage to the construction site caused by DeWitt impaling it with unremovable piles was not "property damage" under the policy. But, the court also concluded that the damage to the work of other subcontractors, which had to be removed and destroyed as a result of DeWitt's installation of defective piles, was property damage within the scope of the policies.

Thus, the court said that Travelers had a duty to defend DeWitt in the claim filed by Opus.

*DeWitt Construction Inc. vs. Charter Oak Fire Insurance Co.*, 9th U.S. Circuit Court of Appeals, Oct. 9, 2002 (BI/02/A.-\$10)

*These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available at \$10 each. To obtain a copy of a decision, submit 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.*

# Comings & Goings

## Insurers:

**Charles H. Dangelo**, president of AIG Risk Management Inc., American International Group Inc.'s domestic risk management unit, has been selected to head the newly formed AIG Global Risk Management. AIG established the unit to consolidate its global risk management and captive capabilities to provide creative alternative risk transfer options to its clients worldwide.

**David Foy** has joined White

Mountains Insurance Group Ltd. in Guilford, Conn., as executive vp and chief financial officer. Mr. Foy previously was senior vp and CFO at Hartford Life Insurance Co.

## Brokers:

**Robert Munao** has left his post as president of Kaye Benefits Consulting to help expand New York-based Tesco Benefits L.L.C., one of the nation's largest benefits brokers. Mr. Munao, who will serve as president of Tesco Benefits, will con-

centrate on creating new business opportunities as well as growing the business of the broker's outsourcing affiliate, Benefit Outsource Solutions L.L.C. Mr. Munao's replacement at Kaye has not yet been named.

**Ray Watson** was named senior vp of Mullis Newby Hurst L.P., a provider of construction surety bonds in Texas. Before joining Mullis Newby Hurst in Dallas, he



Mr. Munao

operated his own surety agency.

## Reinsurers:

Hamilton, Bermuda-based Endurance Specialty Holdings has made several key promotions at its Bermuda operating subsidiary, Endurance Specialty Insurance Ltd.:

• **Thomas D. Bell**, executive vp of reinsurance operations, was promoted to president.

• **Louis A. Adanio**, executive vp of direct property insurance, was promoted to executive vp of reinsurance operations.

• **Thomas H. Bonarrigo Jr.**, vp of direct property insurance operations, has been promoted to senior vp of direct property insurance operations.

## Other suppliers:

**Connie O'Connell**, who served as Wisconsin insurance commissioner from 1999 to 2003, has joined LaFollette Godfrey & Kahn in Madison in the law firm's insurance practice group. Before her appointment as commissioner, Ms. O'Connell held positions in state government for 12 years, including serving as policy director and chief adviser for former Gov. Tommy G. Thompson on state and national insurance issues.

**William F. Knowles** has joined Cozen O'Connor in Seattle as part of the expansion of the law firm's insurance practice. Mr. Knowles had been a shareholder and managing partner with the law firm of Knowles Ferguson P.L.C., where he concentrated on insurance coverage and defense.



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# INSURER TOPICS

A MONTHLY EDITORIAL SECTION SENT EXCLUSIVELY TO INSURERS AND REINSURERS



## Consolidation

### Should the potential buyers beware?

By **RODD ZOLKOS**

**W**ith concerns such as reserving challenges, ratings issues and a difficult investment environment driving many insurance companies to tighten their focus on core elements of their business, opportunities exist for stronger companies to acquire blocks of business at very favorable terms, according to several industry experts.

The recent experience of Long Grove, Ill.-based Kemper Insurance Cos. selling off its various lines of business is seen by some industry consultants as an example of the kind of activity that is likely to occur again among insurance companies in the months

*As troubled insurers retrench, will others seek their cast-off lines?*

ahead.

"I would expect there to be continued consolidation," said Barbara Stewart, president of Stewart Economics in Atlanta.

"Some of it may be ratings-driven," Ms. Stewart said. "I've been watching some of the downgrades, and it has become apparent that once a rating reaches a certain level, it's over."

Faced with a rating that has fallen out of the A range, a company is forced by market realities to consider whether to sell off its

underwriting activities or find an opportunity to merge with someone stronger, she said.

Christopher J. Swift, industry sector leader in the insurance practice at KPMG L.L.P. in Chicago, offered a similar view.

"I do think the rating agencies are going to drive a lot of this activity, and the thinking out there," Mr. Swift said.

"I think there is an air of desperation out there on the part of certain companies," he said. "If companies are downgraded below A,

A-, you really can't be a national player. Once Kemper lost their A- rating, they were basically done."

But selling off some or all of their business may be difficult for some ratings-troubled insurers, according to Owen Ryan, global and national managing partner in the insurance practice at Deloitte & Touche L.L.P. in New York.

"I think there is a certain level of anxiety among P&C insurers who have some legacy issues with regard to concerns of being downgraded," Mr. Ryan said. But property/casualty insurers that rely on an independent agency sales force can find it difficult to sell off books of business.

"It's kind of hard to sell those assets, because who owns the customer

See **ACQUISITIONS**/next page

**Accounting rules raise more questions / 14D**

**Workplace diversity advantageous / 14F**

**Targeting teens as a future market / 14F**

**Pollution claims-handling clarified / 14H**

## INSURER TOPICS

# Acquisitions: Should the potential buyers beware?

**Continued from previous page** relationships?" Mr. Ryan asked. A smart buyer won't put a great deal of cash into buying that book of business unless there's some mechanism to guarantee transferring the business, he said.

Much of the insurance industry consolidation activity that will occur in the months to come is likely to involve companies selling off particular lines of business as they look to narrow their focus, according to several of the consultants.

"Quite honestly, the low-return environment is really forcing a lot of these management teams to look at how they're operating and what their core business is," said Deloitte's Mr. Ryan.

And, in the current environment, there are bargains to be had for some buyers.

"If you're reasonably well capitalized and you know what you want, there are some blocks of business that can certainly be had for much less than they could be 24 months ago," Mr. Ryan said. "I would be surprised if there was anything that would not at least be considered available for sale at this point in time."

Ms. Stewart offered a similar assessment. "The thing I'm seeing more of these days is a lot of companies are pulling back," she said, while strong companies will be looking for opportunities to

grow their top lines.

Selling off lines to focus on core lines of business or making acquisitions with an eye toward specialization makes sense, according to Dan Oakley, director of knowledge management for the financial services practice of Ernst & Young L.L.P. in New York.

"We've been believers for the last few years that focus and specialization in particular lines benefits companies a great deal," Mr. Oakley said. "So, rather than being a multiline, broad insurance company, what you probably will see are lines concentrated in specialty companies."

That sort of acquisition activity "is much more likely than companies being acquired in their whole," Mr. Oakley continued. "It's more manageable because it's supported by that concentration objective, and the buyer can get good confidence that what they're acquiring does not have land mines in it that an entire legal entity might have."

Several consultants see a variety of reasons to expect less acquisition activity among insurance companies, though.

On the life side, "the industry analysis that we've taken a look at seems to indicate that the industry activity for M&A is probably going to be down," said E&Y's Mr. Oakley. He attributed that decline in life company M&A activity to

the drop in equity markets and its impact on some of those companies' business with products such as guaranteed death benefits and variable annuities.

"Any company that will be a good target for acquisition is going to have to clean up some of those problems, which, for a life company, is pretty likely," he said.

Meanwhile, Mr. Ryan said, "what we are seeing and what I expect to continue to see for the rest of this year and maybe the first six months of next year is the continued study by some of the life companies of what their options are and then the sale of blocks of business or perhaps looking for a merger partner."

Some M&A activity may be generated by mutual life companies demutualizing and becoming acquisition targets, Mr. Oakley said. While those deals will be small, they "will probably fill in some of the void where big deals don't get done," he said.

E&Y sees the commercial property/casualty side having its own problems that might hinder some M&A activity, Mr. Oakley said.

"We see that a number of years of reserve deficiencies have to be dealt with to get their balance sheets back in order, and that's going to make it difficult for outsiders, acquirers, to decide on the right price," he said.

"Unfortunately, insurance is one of those kinds of businesses that when companies get in trouble the price might go down but it becomes more difficult for them to be bought," Mr. Oakley said.

In addition, despite the creation of the federal terrorism reinsurance backstop, "I think the overhang from terrorism coverage is creating more uncertainty," Mr. Oakley said. "Whenever there's uncertainty, that suppresses the number of deals that get done."

Mr. Ryan noted that much of the investor interest that exists on the property/casualty side is directed toward the companies that have started up since Sept. 11, 2001. "And those companies, while they have the capital, are not looking at acquiring another company's past sins," he said.

"I think the other thing that's out there that's something of a concern for people is what's going to happen if we go into a deflationary cycle," Mr. Ryan said. Potential acquirers concerned about the possibility of deflation in the U.S. economy might consider the experience of Japanese insurance companies, and, "if you look at what's happened there, it's not a pretty situation," he said.

KPMG's Mr. Swift said, though, that the pressure insurance companies are facing is going to drive some of the M&A activity that does occur.

"I just see 2003 as sort of a shakeout," he said. With companies facing reserving issues, poor equity market results and other concerns, "it's going to put pressure on the whole industry," Mr. Swift said. "I think it's going to drive some significant consolidation."

Mr. Oakley said he also doesn't expect to see consolidation between banks and insurance companies over the next years. "They haven't in the past, and the same conditions still exist," he said. He added that banks will continue gaining access to customer lists by acquiring insurance agencies but will steer clear of insurance underwriting.

And another previous source of insurance industry M&A activity will be absent from the market for the foreseeable future, Mr. Oakley predicted. While much recent activity involved foreign financial institutions buying U.S. companies as a way to enter the U.S. market, "due to the trouble European financial institutions are having, their just won't be cross-Atlantic activity in the next couple of years," he said.

Of late, the market capitalization of European companies has dropped dramatically, Mr. Oakley said. "They have no currency to make those acquisitions," he said, "and their own capital structure has been driven down."

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## INSURER TOPICS

# M&A accounting rule leaves questions unanswered

By JUDY GREENWALD

When the Financial Accounting Standards Board first issued new accounting rules in 2001 that regulate how companies should account for mergers and acquisitions, much of the attention focused on Financial Accounting Standard No. 141, which eliminated pooling and required that companies use only the purchase method of accounting.

But attention is now focused on a second standard issued at the same time. FASB 142 changes how companies carry goodwill on their books with the purchase method, and some observers contend it is being improperly implemented. Goodwill is the premium paid over the market value of a brokerage's tangible and specific intangible assets, such as customer lists.

Both of the new accounting standards changed how companies report their M&A activity. Pooling-of-interest deals, which FASB 141

eliminated, were tax-free, all-stock transactions in which the balance sheets of the two merging companies were simply added together. Pooling was widely used by banks acquiring insurance agencies, although some brokers used it for their deals as well.

Observers say eliminating pooling under FASB 141 facilitates the analysis and comparison of deals because everyone now uses purchase accounting.

"It now makes it very consistent among all the brokers," said David L. Eslick, chairman, president and chief executive officer of San Francisco-based USI Holdings Corp.

Under purchase accounting, the acquired company is considered an investment. But the way goodwill is treated has changed under FASB 142. Previously, goodwill was typically amortized, or written off of the company's income statement, over a period of up to 40 years, creating a hit to the buyer's balance sheet.

Under FASB 142, goodwill is

instead regarded as an intangible asset that is considered to have an indefinite useful life. It is periodically evaluated and written down only when impaired. Other intangible assets, though, must still be written off over their finite useful life.

For insurance companies, the value of goodwill is something that must be examined, though it isn't something likely to have a major impact on U.S. companies, according to Owen Ryan, global and national managing partner in the insurance practice at Deloitte & Touche L.L.P. in New York.

"Obviously, audit firms will be going through with their clients the assessment of goodwill," Mr. Ryan said. "I don't expect to see massive write-offs as you have seen in some other industries, telecom, for example."

It is possible, though that some European insurance companies that were more aggressive in acquisitions during the 1990s than their U.S. counterparts might be

more affected by goodwill write-offs, he said.

At least in part because the accounting regulation is still relatively new, though, there are still no established standards for determining what should be considered goodwill and which intangible assets must still be written off.

The issue is an important one in the acquisition of insurance agencies and brokers, where about 90% of the purchase price may be accounted for by intangible assets, according to John Wicher, of San Francisco-based John Wicher Associates, an insurance investment bank.

Some observers say FASB 142 is being inconsistently implemented.

Corey T. Walker, vp, treasurer and chief financial officer at Brown & Brown in Daytona Beach, Fla., said, "It's unfortunate that the true economics of the deal have never been changed, but there are certain agencies that are buying acquisitions and hiding behind FASB 142 and claiming that the majority of the purchase price they made represents payment of goodwill simply to avoid having a (profit and loss) charge on their (generally accepted accounting principles) financial statements."

"I think it's a terrible misinterpretation of the value of what you're buying," Mr. Walker said, "because when you buy an acquisition, you're buying the underlying cash flows that you expect from those policy renewals, and trying to say that that it is really in payment of goodwill is intellectual dishonesty."

Kevin Donoghue, managing director at New York-based Mystic Capital Advisors Group L.L.C., said: "There's no clear accounting guidance on how to truly allocate and quantify intangibles amongst an acquisition price. Therefore, it leaves a great deal of latitude, from the purchaser's perspective, of what goes into intangibles and is amortized and what goes to goodwill and is not amortized."

Mr. Donoghue said he thinks there has been "some aggressive behaviors accountingwise" among some entities that are allocating more to goodwill than they should. Patrick Gallagher, president and chief executive officer of Itasca, Ill.-based Arthur J. Gallagher & Co., said, "It's just all over the board in how people are doing this. There's no real direction, and deals differ."

A certain amount must be allocated to both goodwill and other intangibles, Mr. Gallagher said, "and there's just different philosophies as to how much has to go into each bucket." On its larger deals, Gallagher obtains the services of independent appraisers "to help us decide which bucket" to use, he said.

John Pottridge, of Alexandria, Va.-based Pottridge & Associates, a consulting firm, said, "I would say there are not consistent applications or treatment in terms of determining goodwill. It's all over the board."

"Obviously, banks would like, under most circumstances, to book on their balance sheet as much goodwill as possible," Mr. Pottridge said. "If they can prove that the value of that goodwill holds up, they have a large asset on their book that maintains value and is there for years. But they have to meet reasonable criteria in order for that to happen, and...there's very little industry practice to look to."

"There isn't any real, solid test, in our view, to determine that goodwill. It's mostly trying to be reasonable and verifiable, testable, and if the assumptions are good and reasonable, it should pass," Mr. Pottridge said.

Bobby Reagan, chairman and CEO of Reagan Consulting Inc. in Atlanta, said: "We are seeing a variety of opinions as to how the allocations between goodwill and other identifiable assets should be handled. The most prevalent approach that we are seeing is that approximately 50% of intangible values are being assigned to goodwill, with the balance being assigned to other intangibles, with those being written off over 10 to as much as 20 years."

"We're also seeing some more-aggressive approaches, where a heavier percentage is being assigned to goodwill," Mr. Reagan said. "Most of the financial institutions or bank buyers who are using the national accounting firms are tending to be very conservative today. Some other acquirers that may not be public corporations may be a little more aggressive."

Mr. Wicher said, though, that there is no CEO of a public or private firm today of significant size "who isn't thinking about the implications of being aggressive and moving outside what might be viewed as the acceptable boundaries between being conservative, and being more generous in their treatment and moving outside the box. The accountants aren't going to go for it, the boards (of directors) aren't going to go for it, and, certainly, the independent accountants are not going to go for it."

Observers say that standards will be developed, although not immediately. "I think it will probably be some period of time before we know what is right, what is acceptable practice," said Mr. Reagan.

"Organizations like ours are coming up with some pretty fair models that I think will hold up over time," Mr. Pottridge said. "But, clearly, we need to get some experience behind us and industry practice behind us, so we can look to see how it works over time."

In insurance company acquisitions, the accounting rules generally aren't a major factor, according to Christopher J. Swift, industry sector leader in the insurance practice at KPMG L.L.P. in Chicago.

"It's not that big of a deal. I think people are still looking at deals from an economic perspective," he said. "The accounting will fall out."

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## INSURER TOPICS

# Workplace diversity a competitive advantage

By Roderick Hudson

Providing opportunities for people of all backgrounds in the workplace is not just the right thing to do—it's the smart thing to do to gain a competitive advantage in the insurance industry.



Recent government statistics estimate that minority groups have a collective spending power of well over \$1 trillion. Women and minorities are starting new businesses and growing existing ones at a much faster pace than their more-established counterparts, and they represent a huge market for professional and commercial insurance products.

Estimates for the property/casualty marketplace for minority groups range between \$10 billion and \$15 billion in commercial premiums. It is also estimated that, within the next four years, 85% of new entrants to the workforce will be women or minorities.

A talent pool comprising diverse backgrounds and experiences will

## Perspective

### Women and minorities represent a huge market for insurance products

help provide stronger communications, new ideas and innovative solutions for this emerging marketplace, resulting in a distinct business advantage.

Although there has been noteworthy improvement, management and professional positions at most insurance industry companies fall far short of the statistics above and do not reflect the diversity of the marketplace the industry serves. In fact, claims alleging job discrimination based on religion, age, race or national origin experienced double-digit increases in 2002, according to the Equal Employment Opportunity Commission (*BI*, Feb. 10).

#### Hiring myths

Many companies do not promote diversity or are reluctant to do so because they believe it is a social issue synonymous with affirmative action. This is not true. The distinction between the two became blurred over time because legal efforts to hire employees of diverse backgrounds (affirmative

action) were linked to voluntary programs to provide a work environment in which all employees can be successful (diversity in the workplace).

It is also mistakenly believed that diversity efforts involve lower standards for hiring and promotions and are designed to benefit only women and nonwhites. Diversity efforts do not mean lower standards, quota systems or preferences and must not rely on fixed categories or numbers. Poor public relations and resentment have undermined workplace diversity when companies hired people primarily based on demographics to polish their public image.

Questionable personnel choices are not limited to misguided attempts at diversity, though, and it is a mistake to hire anyone for reasons that are not based on qualifications.

To be effective, diversity initiatives must involve hiring and employment practices that focus on individual qualifications based on merit, productivity and success, with the goal of helping ensure that

everyone in an organization has the opportunity to succeed. Company policies, procedures, compensation systems, work arrangements, training and orientation programs must be reviewed and modified as part of an ongoing process to provide support as necessary. These policies and procedures must be carried out on a consistent basis for diversity efforts to succeed but would not constitute a set-aside program.

Although corporate policies are a crucial element of success, aspiring executives must not assume that credentials alone will ensure advancement. Once on board, individuals must take responsibility for their own career development; they will rise or fall based on merit.

#### Suggested actions

Insurance industry staff who want to advance should consider the following:

- Make an honest assessment of your job, skills and career path and company plan for the future.
- Develop a game plan for your career with continuous reviews and updates. Use your career strategy as a guide to assess what is important to you and your career and how you want to spend your time.
- Enhance your skills whenever possible.
- Network within and outside your company.
- Take the initiative to ask for visible or challenging assignments.
- Do not be afraid to challenge sacred cows.

- Strive to exceed expectations.
- Maintain a positive attitude about your work; stay focused and persistent.
- Be smart, keep informed and stay motivated.
- Reach out to get and give as much support as possible as your career evolves.
- Above all, make sure you have the skills, tools and strategy to move forward.

An insurance organization's most valuable asset is its workforce, and diversity increases this asset. Demographic trends suggest that companies will gain a strategic advantage by aligning supply and demand: diverse customers will gravitate to diverse companies. For this reason, a diverse workforce must be part of a company's strategic process and treated as critical to its future growth and success.

Any company that doesn't support diversity—attracting, developing and retaining qualified people, regardless of race, age, ethnicity or gender, at all levels of its operation—is cutting itself off from more than half of the talent pool.

Insurance organizations whose employees understand—and reflect—the diversity of the marketplace will be better positioned to increase market share and, ultimately, profits.

Roderick Hudson is eastern region manager-national accounts at Allianz Insurance Co. in New York.

# Auto insurer targets teen-agers as a future market

By SHANNON MORTLAND

Insurance to guard against pimples? Progressive Corp. isn't actually selling pimple insurance, but it's using the concept to plant the Progressive name in teen-age minds so the young consumers will remember the company when it's their turn to buy auto insurance.

The Mayfield Village, Ohio-based auto insurer recently launched its first advertising campaign aimed at teen-agers—specifically, those ages 15 to 17—in hopes of increasing its sales once that age group reaches its early 20s, said Alex Ho, Progressive's brand development director.

The TV and print campaign will run nationally for at least three years, which is the earliest point at which it's expected to show results, Mr. Ho said.

"This campaign is not designed to get immediate sales from teens," he said. "Typically, the people who buy their first insurance policy are in their early 20s."

But Mr. Ho said that Progressive, which a decade ago catered only to high-risk drivers such as teen-agers, wanted to target the group now by

"showing them we care" about the current dilemmas and earth-shattering events in their lives, such as having pimples or being embarrassed in front of an individual on whom one has a crush.

Progressive hired G Whiz, a New York agency that specializes in youth-focused advertising, to create the ads.

Mr. Ho would not disclose how much Progressive is spending on the effort to market to teens, but he said it is "significant" because the company is conducting a "multimillion-dollar, multiyear" campaign.

The result of G Whiz's work was two 30-second spots that will run on seven youth- or family-oriented cable networks, including MTV, Cartoon Network and ABC Family.

In the first spot, a teen-age girl is walking through a school hallway when she sees the boy she has a crush on eyeing her. She then trips and falls, prompting the ad to suggest that "social disaster insurance" could guard against such tragedies.

The second ad suggests "boredom insurance" is needed when a group of teen-agers sitting

around in a backyard decides to alleviate their boredom by launching items such as tricycles, lawn ornaments and even a fellow friend into the yard with a makeshift catapult.

**Progressive Corp. recently launched an advertising campaign that is aimed at those ages 15 to 17, in hopes of increasing its sales once that age group reaches its early 20s.**

The print ad, which shows a boy on yearbook photo day with bad hair and a huge pimple on his nose, will run in 10 national magazines such as *YM*, *Seventeen* and *Transworld Skateboarding*, Mr. Ho said.

The ad's tagline reads, "We wish we could guard you against everything from volcanic zits to crappy haircuts. But for now, we can just offer real simple car insurance. When you need some, think Progressive."

The concept of targeting teen-agers as a potential sales booster is a new one in the auto, home and business insurance sectors, said Mary Bonelli, a spokeswoman for the Ohio Insurance Institute, a Columbus-based organization that represents personal lines and commercial lines insurance companies.

"It does make some sense to me, though, because 7% of the drivers in Ohio in 2000 were teen-agers," she said.

Progressive's approach is bringing insurance "to a level that teen-agers understand," Ms. Bonelli said.

"Anything that drives home the concept of insurance is definitely something the insurance industry could get behind," she said.

Mr. Ho said the ads aren't an attempt to put Progressive's focus once again on high-risk drivers, even though teen-agers tend to fall into that category.

Instead, he said, the ads are one marketing tactic Progressive plans to use to boost insurance sales. Mr. Ho would not discuss other tactics Progressive will employ.

Progressive will need to change the ads frequently to keep teen

interest, Mr. Ho said.

While Progressive knows teens "find about a zillion other things in their lives right now more important than insurance," he said, the company also believes teens will pay attention to the ads because they view advertising as a form of entertainment.

Shannon Mortland is a reporter for *Crain's Cleveland Business*, a sister publication of *Business Insurance*.

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## INSURER TOPICS

## IT briefs

## Fitch consulting unit launches new service

**GREENWICH, Conn.**—Fitch Risk Advisory has launched NetRisk Insurance Services, a specialty consulting practice providing advisory support in the design, pricing, underwriting and claims adjustment of insurance policies written on financial institution and capital market risks in North America and Europe.

By bridging the ways financial institutions and insurance companies understand capital markets activities and risk, NetRisk aims to facilitate more efficient design, pricing and loss adjustment of risk transfer activities within the financial services market.

NetRisk's primary service offerings include risk management benchmarking and underwriting due diligence, risk transfer analysis and pricing and claims support services.

Fitch Risk Advisory offers enterprise risk management consulting services to the financial services industry in North America and Europe as part of Fitch Risk Management Inc., an independent affiliate of Fitch Ratings with offices in Greenwich, Conn., New York and London.

## Employer Re donates computers to nonprofits

**OVERLAND PARK, Kan.**—A division of Employers Reinsurance Corp. is donating 74 personal computers to nonprofit organizations in Connecticut.

The PCs were donated by ERC Long Term Care Solutions Inc. in Avon, Conn., to the following organizations in the Avon-Hartford area: Immaculate Conception Shelter and Housing Corp., Canton Public Library, Adoption Resource Center of Conn., Mercy Housing & Shelter, the Salvation Army, Shepherd of the Hills Evangelical Lutheran Church and Farmington High School.

The PCs were donated after a systems upgrade at ERC's Avon office. As other upgrades take place, ERC plans to make similar donations to other nonprofits.

Last November, the Indianapolis office of Overland Park, Kan.-based ERC donated PC equipment to 14 community centers.

## Allmerica CEO is new AIA chairman

**WASHINGTON**—Robert P. Restrepo Jr. has been chosen the new chairman of the board of the American Insurance Assn. Mr. Restrepo is president and chief executive officer of Allmerica Property & Casualty Cos. Inc.

Serving with Mr. Restrepo as the AIA board's chairman-elect is Jay S. Fishman, chairman and CEO of The St. Paul Cos. Inc. AIA's two vice chairmen are John J. Amore, CEO of Zurich North America; and Douglas G. Elliot, chief operating officer of Travelers Property Casualty Corp.

Bernard L. Hengesbaugh, chairman of CNA Insurance Cos., is the Washington-based AIA's immediate past chairman.

## Accenture offers insurer software

**NEW YORK**—Accenture has launched two new software tools designed to help insurers streamline business processes, reduce costs and improve customer satisfaction.

The first, the Accenture Insurance Solution, is a multichannel, multilanguage software platform that insurers can use to help manage all types of products and functions. The solution includes components for product development and policy administration and also supports other core insurance functions, including rating, billing, processing, financial reporting and customer acquisition management.

The second, Accenture Underwriting Components, comprises diagnostics and rules-based technology to help support

more consistent underwriting decisions and automates routine administrative processes that can help result in expense and loss cost improvement. This tool also can help provide accurate and timely data for more insightful customer segmentation and more tailored

products and services.

The two new tools complement Accenture's existing Claim Components Solution, which is currently being used by more than 8,000 claim handlers at several of the world's largest insurers.

## Claims handling clarified for La. pollution exclusions

By MICHAEL BRADFORD

**BATON ROUGE, La.**—Louisiana insurers have a clearer idea of how to handle claims related to absolute pollution exclusions in commercial policies after the state's Insurance Department clarified those procedures.

The Louisiana Department of insurance issued a letter of clarification in late January in response to concerns raised by the American Insurance Assn.

"We have been working with the department for a number of years" to develop definitions and guidelines for absolute pollution exclusions, said John Marlow, AIA assistant vp, Southwest region, in Austin, Texas.

The recent clarification was needed after confusion over claims-handling procedures arose when the Insurance Services Office Inc. introduced a new absolute pollution exclusion in 2001, along with an advisory letter as to how claims should be handled.

It was unclear, though, whether a 1997 advisory letter, which detailed strict claims-handling guidelines for pollution claims, also applied to the 2001 exclusion.

The department's letter clarifies the claims handling procedures that are in place for the 2001 exclusion and states that any guidelines in previous advisories are not applicable to the 2001 exclusion.

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## Employers slow to adopt plans that make employees more accountable

# Jury still out on consumer-driven health care plans

By LAURA B. BENKO

Logan Aluminum wasn't about to wait for the health care system to fix itself.

Faced with skyrocketing insurance premiums, the Russellville, Ky.-based sheet metal manufacturer decided to replace its preferred provider organization this year with a new consumer-driven health plan offered by Aetna Inc.—one that makes the company's 1,000 employees more accountable for their own health care spending. In doing so, Logan hopes to reverse a cost trend that has been eating into company profits and slicing into employee paychecks at an alarming rate.

"Our health insurance costs jumped 23.7% in 2001, followed by an 8.5% increase in 2002," said Howard Leach, Logan's director of human resources. "That was a red flag that we needed to try something different."

Logan is among a small but fast-growing number of employers exploring consumer-driven health plans as an answer to soaring benefit costs and managed care's growing inability to control medical spending. According to benefits consulting firm Towers Perrin, 44% of large employers are now considering the plans as an option to their traditional health maintenance organization and PPO offerings, up from just 13% last year.

But whether that interest will translate into widespread adoption remains to be seen. The provider community, and even consumer groups, are divided over the plans.

The jury is also still out on whether the consumer-driven approach will ultimately succeed in containing the nation's health care costs. Enrollment in the plans remains low, and critics say the new "freedoms" they afford involve tough choices about how to stretch health care dollars and could ultimately leave many workers paying much higher medical bills.

"These plans have brought their own share of challenges," said Scott Keyes, senior consultant for Watson Wyatt Worldwide in Minneapolis. "They are part of the solution, but they aren't the solution by any means."

### New frontier

The consumer-driven model represents the latest stage in the evolution of health insurance, which first retreated from fee-for-service plans in the 1980s but is now steadily relinquishing the managed-care cost controls that were so popular in the 1990s.

Some experts believe managed care has failed to contain costs because workers have had little reason to shop for the best buys as long as their companies continue to pick up the bulk of the tab no matter what the cost. The idea behind consumer-driven plans is to give workers greater responsibility for how they spend their health care dollars so they will have a stronger incen-



tive to seek the most cost-effective care and reduce their use of unnecessary services.

"The goal is to get consumers to buy health care as if they were spending their own money," Mr. Keyes said. "I went shopping for a new car the other day, and when I saw a really fancy model, my mind said 'yes' but my pocketbook said 'no.' We make these kinds of decisions every day. So why not with health care?"

Consumer-driven plans come in many varieties. With some, an employer sets up a personal spending account for each employee and makes a yearly contribution of, say, \$500 into each account. Employees can use the money for whatever medical purposes they choose, and any unspent funds are rolled over and available the following year.

Employers generally couple these accounts with a high-deductible insurance policy that covers expenses above a certain level, for example, \$1,500. Workers use the \$500 from their employer, and then are responsible for paying another \$1,000 in medical costs before the coverage kicks in. From then on, the policy typically covers 80% of medical costs, leaving workers to pay the other 20%.

These plans are a revamped version of medical savings accounts, which generated a lot of buzz in the late 1990s but never gained any real traction. In 1996, Congress passed legislation allowing 750,000 MSAs to be opened in a pilot project, but only about 100,000 people ever signed on. Experts say that's largely because MSAs—which also pair a personal spending account with catastrophic coverage—have several more restrictions, are confusing to manage and are limited to businesses with no more than 50 employees.

The Internal Revenue Service

gave the latest breed of consumer-driven plans a boost in June 2002 when it ruled that personal spending accounts are tax-exempt and that unspent balances can be carried over into the next year without the "use or it lose it" limitations of flexible spending accounts.

Flex plans, which have exploded in use since the IRS approved them in 1986, allow employees to set aside part of their paychecks on a pretax basis to pay for medical expenses that aren't typically covered under traditional insurance, such as vision care. But, unlike with personal spending accounts, any unused contributions are forfeited at the end of each year—a circumstance that experts say leads to unnecessary health care spending as workers race to use the funds before they vanish.

Startup companies like Definity Health and Destiny Health were the first to offer the personal spending account-based plans about three years ago, but they have since been joined by some large insurers, including Aetna and Humana Inc. So far, some 420,000 enrollees have signed on.

Another type of consumer-driven plan, offered largely by startups such as Vivius and MyHealthBank, allows employees to select benefits a la carte from an online menu of coverage arrangements, and to balance deductibles, premiums and copayments to suit their personal needs. These plans now cover about 40,000 people.

Several other companies, including a large number of Blues plans, also offer insurance policies with consumer-driven elements, including tiered drug formularies and hospital networks. These plans allow employers to design their own networks and benefit packages. Employees' benefit selections determine the premium for their indi-

vidual plan, and they bear the financial risk for these choices above some fixed contribution from the employer.

Regardless of their design, however, all consumer-driven plans share a common goal: to rein in health care costs by turning workers, who are now insulated from the real costs of medical care, into smarter shoppers.

Consumers don't have a true understanding of how much medical services really cost, largely because the percentage they've had to pay out-of-pocket has declined greatly since managed care started to take off 20 years ago, experts say.

Although that trend has bottomed out in the past few years—with employers now starting to shift more of the costs onto their workers—many people still think of health care expenses only in terms of their copayments, said Kenneth Linde, president and chief executive officer of Bethesda, Md.-based Destiny Health, whose parent company spearheaded the consumer-driven model in South Africa a decade ago and now covers 1.4 million people there.

"When you buy a TV, you run back and forth from Target to Circuit City comparing prices. Yet when you go to the doctor, you have no idea how much it really costs," said Mr. Linde, a veteran of the managed care industry. "We've taught people that health care costs \$10, but it doesn't. That's only the copayment on a service that really costs \$75 or \$100."

Others point out that consumer-driven plans allow employees to select their own doctors, see specialists without referrals and visit any health care facility for treatment—freedoms not generally afforded by more restrictive managed care plans. Greater choice will be attractive to consumers, who are fast be-

coming more active in their health care decision-making, thanks partly to the barrage of direct-to-consumer advertising by the drug industry and providers, said Robin Downey, Aetna's director of product development. "A whole new world has opened up to consumers in terms of information."

### Provider concerns

Providers, however, remain divided on consumer-driven plans.

On one hand, physicians largely support the new plans, which they say strengthen the doctor-patient relationship by giving individuals more freedom to choose and remain with their favorite providers.

According to the American Medical Assn., consumer-driven plans encourage greater communication between doctors and patients about the necessity of various procedures, and reduce administrative hassles by eliminating the middleman (i.e., the HMO) from the medical decision-making process. The plans also allow employees to stick with their chosen doctors even when they change jobs or if their employers switch health plans.

Yet perhaps most important, according to the Chicago-based AMA, is that consumer-driven plans stand to improve overall health care quality by injecting more competition into the system.

"The system as structured now restricts choice by dictating which physicians and other health care providers are available to employees," said Richard Corlin, the AMA's immediate past president, during the Consumer-Driven Healthcare Congress held in Chicago last July. "And when employees have a limited choice of health plans, there's no pressure on those plans to be responsive. ... There's no need to be competitive."

Hospitals, however, fear that consumer-driven plans could backfire by discouraging individuals from seeking preventive care. Employees who want to build up their account balances may put off seeing a doctor until their conditions worsen and require costly emergency or inpatient treatment, said James Bentley, senior vp of strategic policy planning for the American Hospital Assn. in Chicago.

To address this, some plans have made special provisions for preventive services, such as mammograms, colorectal cancer screenings, immunizations and Pap smears. Some companies cover these services with a traditional copayment arrangement, and others have designed wellness programs that reward members who practice healthy behaviors.

Still, hospitals worry the new plans could leave providers saddled with more bad debt, which is already straining many health systems' budgets. Providers, for instance, would be forced to cover the cost of treating patients who choose an insurance policy with a very high deductible or minimum bene-

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March 17, 2003

# Health care: Employers slow to adopt new plans

Continued from page 16

fits only to discover that they cannot meet the out-of-pocket requirements, Mr. Bentley said.

## Cost controversy

So far, most employers have approached consumer-driven plans cautiously, either by introducing them to employees as a pilot program or by offering them as an option alongside traditional insurance offerings. But ongoing health care-cost increases—driven largely by new medical technologies, increased drug spending, rising hospital expenses and growing demand from an aging population—are increasing employers' appetite for the plans, experts say.

Job-based insurance premiums jumped an average of 13% in 2002 and are set to rise another 15% this year, the fourth straight year of double-digit increases and the highest year-over-year percentage increase since 1989, according to Towers Perrin. Not surprisingly, employers have responded by cutting benefits or shifting a greater share of the costs to their employees in the form of higher premiums, deductibles and copayments.

Early boosters of consumer-driven health care are optimistic the ap-

proach will slow this trend.

Louisville, Ky.-based Humana, for instance, said it saved \$2.1 million in its first year after adopting a consumer-driven plan for its own employees in June 2001. Under its plan, called SmartSuite, the insurer's 10,000 Louisville employees and their dependents choose from a variety of flexible deductible and copayment structures based on their health care and budget needs. Options included traditional HMO and PPO offerings, as well as more customized plans with personal spending accounts.

The result: For the 12 months ending June 2002, Humana's medical claims costs rose just 4.9% instead of a projected 19.2%, which would have been in line with the trend for the region, according to a company spokesman.

"A lot of it was behavior modification," the spokesman said, adding that Humana has since expanded SmartSuite to cover its 9,000 other employees and their dependents nationwide. "Employees would ask more questions like, 'Is it worth me using (the heartburn medication) Prevacid, which has a \$50 copay, instead of Prilosec, which has a \$25 copay?' Or if someone had a scratchy throat, they might have decided to wait a cou-

ple days instead of going straight to the doctor for a prescription."

Destiny Health also has seen early signs of success in Illinois, where the company first rolled out its product in 2000. While insurance premiums are rising an average 20% to 30% statewide, Destiny's roughly 500 client companies, which now cover some 20,000 people, are seeing an average increase of only 12%, Mr. Linde said. And when you factor in the account money that's rolled over into the following year—55% of employees carry something over—the increase is really more like 7%, he added.

Not everyone is as optimistic, however.

Some consultants say that consumer-driven plans, if not designed correctly, could actually boost health care costs in the long run by overcompensating healthy workers. Traditionally, employers have spent most of their health care dollars on a small group of sick people and very little on the majority of people, many of whom don't incur any medical expenses in a year. Yet, under personal spending account plans, employers are required to continue making annual payments into every employee's account, even if that money is never spent, said Michael Taylor, a principal

with Towers Perrin in Boston.

"Theoretically, if you have a large percentage of people who normally wouldn't spend even \$1 on health care, and all of a sudden you're giving each of them \$1,000, your costs are going to go up," Mr. Taylor said.

And according to New York-based consulting firm Segal Co., once employees meet a plan's deductible, their tendency to spend increases tremendously. Using client utilization data, Segal projected that an employer contributing \$1,000 to each employee's PSA and providing insurance coverage for claims of more than \$2,500 would spend \$2,723 per employee annually. By contrast, a PPO would cost \$2,651 per year for each employee, and an HMO would cost \$2,194, Segal estimates.

Opponents also argue that consumer-driven plans, while good for young and healthy workers, could hurt employees who have chronic health problems or sudden illnesses that require extensive medical attention. Indeed, workers with few health care needs could quickly accumulate thousands of dollars in their accounts, while sick employees would face considerably higher out-of-pocket costs than they had under an HMO or PPO, said Ron Pollack, executive director of Fami-

lies USA, a Washington-based consumer advocacy group.

"Consumer-driven plans are a misnomer, because they're not something that consumers have asked for. They're a way for employers to shift more of their costs onto consumers," Mr. Pollack said. "There's no doubt that the young, healthy part of the population will find these plans appealing, but they will ultimately be detrimental to those who need health care the most."

As a result, Mr. Pollack said, the new plans could drive up the price of traditional insurance options by forcing older and sicker workers into HMOs and PPOs, which would then have to raise rates even higher to adjust for their riskier membership base. And providers could end up paying even more in uncompensated care as more people are priced out of the market, adds the AHA's Mr. Bentley.

## Wait and see

Adoption of these new plans remains modest. Although more companies are studying the plans, only 7% of employers are expected to offer a consumer-driven option by year end. And experts estimate

See HEALTH CARE/next page

What word describes many employees' current life insurance coverage?

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## Between the Lines

Compiled by Joanne Wojcik



### Chipping in

German insurer Gerling Group, which recently pumped £200 million (\$220.4 million) into its beleaguered reinsurance unit, might have another



source of cash: money loaned to a U.K. soccer club. In 2001, the Leicester City Football Club borrowed £4.12 million (\$5.9 million) from Cologne-based Gerling to acquire new players, pledging the value of three players as collateral. Gerling also

wrote coverage for the club. The club entered bankruptcy in October 2002, when its revenues plummeted after it was relegated to a lower division. Leicester City was rescued last year by a consortium headed by former player and television pundit Gary Lineker, but those investors did not assume the entire debt to Gerling. As a result, the club's new owners will pay Gerling 10 pence on the pound—and possibly up to 40 pence on the pound if the club is promoted back into the English Premier League by the end of the season, sources say.

### Uninsured: The Movie

Moviegoers may see the American Assn. of Health Plans' version of a preview this month. The AAHP launched an ad campaign Feb. 28 at theaters across the country featuring a still photo of a man and two children underscored with the statement: "By the end of this movie, another 465 Americans will lose their health insurance because of runaway costs." The campaign is designed to raise awareness of the growing number of uninsured, explained a spokesman for the Washington-based AAHP. The AAHP hopes the campaign—launched in Chicago, Houston, Los Angeles, New York and Washington—will attract viewers to the organization's Web site for details on the AAHP's solution to the uninsured problem.



### Neck and neck on work attire

A government worker in Manchester, England, has won the right not to wear a tie. Mathew Thompson sued his employer, asserting it was sexual discrimination to insist that male employees wear ties at work. At an employment tribunal, he argued that while it was not conventional for women to wear ties, dress codes for women were more flexible and "a similar standard of business dress is not applied to women as it is to myself." Mr. Thompson wore a tie to the hearing.

### An apple a day keeps employers dismayed

An Australian worker who cut his finger while eating an apple on his lunch break is entitled to file a workers compensation claim, the Victoria Court of Appeal has ruled. In response, the Victorian Workcover Authority stated that the ruling, which involved a \$300 Australian (\$185) claim for medical expenses, "significantly changes the concept of compensable workplace injuries. For example, if a person were to have an attack of appendicitis at work or burn their nose lighting a cigarette, they may be able to make a claim." The worker's lawyer argued the case has implications for workers killed or injured in major incidents not directly related to their jobs, such as terrorist attacks or mass shootings.



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

## Health care: Jury still out

Continued from previous page

that a total of just 1.5 million individuals—or a tiny sliver of the 175 million Americans with employer-provided insurance—are currently enrolled in such plans.

Consultants say companies are generally taking a wait-and-see approach to the plans, much as they did in the 1980s when managed care was new and indemnity plans were the norm. Many employers are in "learning mode" as they try to discern how best to structure the new plans to achieve maximum cost savings and employee satisfaction, Mr. Keyes said.

"Some employers are saying the plans need to be more aggressive, while other employers are saying they should be more generous" with benefits, Mr. Keyes said. "When you're stuck in that kind of quandary, you're unlikely to pull the trigger."

Other experts say companies have been cautious about implementing consumer-driven plans because of concerns that they won't go over well with employees. Indeed, where the personal spending account plans are offered as an option, employers are seeing average enrollment of just 10%, Mr. Taylor said. "While some consumers may be equipped to make their own health care decisions, other may not have the time, tools or inclination," he said.

Consumers have been gun-shy about switching to the new plans because they fear they will lose something in the tradeoff, said Mary Jo Payne, vp of the Orange, Calif.-based consumer advocacy group California Health Decisions. "Consumers are not used to paying

more out of pocket," she said, pointing to the 17,500 General Electric Co. workers who went on strike nationwide in January after the company raised their copayments.

In a recent survey of 800 California consumers, California Health Decisions found only 46% consider consumer-driven plans either "somewhat" or "very" appealing, and another 46% consider them "not too" or "not at all" appealing. And while 86% of respondents approved of the plans' increased freedoms and roll-over features, only 35% said they were willing to accept higher deductibles in exchange for lower premiums or to pay more to see an out-of-network doctor, according to the study released last month.

Mr. Leach of Logan Aluminum admits that employees there have had "mixed emotions" about the company's new plan, which provides individuals with a \$400 personal spending account contribution and an insurance policy that kicks in after \$600 is paid out of pocket. Logan's previous benefit package had been very generous, covering 100% of employees' in-network costs after the copayment.

Christopher Delaney, chief marketing officer for Definity Health in Minneapolis, acknowledges that it's a "big challenge" to get consumers to enroll for the first time. But once they do, he added, they are very satisfied. Definity's re-enrollment rate among members is 95%, compared with an 85% to 88% average for traditional insurance plans, he said. "Clients are seeing higher satisfaction and higher retention with our product," Mr. Delaney said.

Ultimately, however, the future of consumer-driven plans will hinge on the availability of useful health care information and comparative pricing data that help employees make informed health care decisions, experts say.

In an effort to educate members and help them to more easily compare shop, most consumer-driven plans provide varying degrees of information on the cost and quality of medical services. Some companies, such as Portland, Ore.-based MyHealthBank and Minneapolis-based Vivius, let enrollees use a Web site to choose providers and learn more about specific health care issues. Others, such as Definity, provide a hot line that members can call to discuss their health care options with a registered nurse.

Still, much of the information now available to the public is incomplete, conflicting or too complex for the average consumer to understand, some experts say. Providers remain reluctant to publish their price lists, and critics argue that information on provider quality is not yet adequate to meet consumer needs. Although significant progress has been made recently in rating hospital quality, for example, less progress has been made on the physician front.

"There's a lot of information out there, and that's what's confusing," Mr. Taylor said. "That aspect will have to be cleaned up a bit before health care becomes truly consumer-driven."

Laura B. Benko is a reporter for Modern Healthcare, a sister publication of Business Insurance.

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# Captives: Costs, benefits vary in domiciles

## Continued from page 3

Three meals per day at about \$80 per day will total \$240 for the stay, and round trip taxi from the airport to Hamilton will cost \$50, bringing the total travel cost to \$1,966, or, with miscellaneous costs, around \$2,000.

For the Vermont captive owner, meanwhile, round trip from Chicago to Burlington will currently run around \$459. Three nights at the Sheraton Burlington Hotel will cost \$408.75, while three days' car rental (to make the drive from Burlington to the captive division office in Montpelier) will cost \$165.47. Three meals a day at about \$55 per day will total \$165, bringing the total cost of the trip to Vermont to \$1,198.22, or approximately \$1,200.

Beyond that, other cost differences, such as manager fees and other related captive costs, become a bit less clear cut.

Leonard D. Crouse, Vermont's director of captive insurance, said that start-up fees, operational fees and management fees are all higher in Bermuda than in Vermont, and many agree.

Bermuda managers generally charge minimum annual fees of \$15,000 to \$25,000. Hourly professional charges are in the range of \$200 to \$400 for professional ser-

vices, and clerical charges generally cost \$100 to \$150 per hour.

Managers agreed that Bermuda charges are slightly higher than such fees charged to manage captives in Vermont.

"The cost of operating in Bermuda is a little bit more, but not that much," said Gary Osborne, senior vp at USA Risk Group in Montpelier. USA Risk manages captives in Bermuda as well as Vermont, and Mr. Osborne said a large restaurant chain his company worked with recently chose to form in Bermuda rather than Vermont because of the premium tax issue.

"When we do an analysis, if you do a program that has less than \$15 million in premium, we look at it as cost neutral," said Guy F. Ragosta, managing director at Willis Management (Vermont) Ltd. in Burlington, Vt., which also manages captives in Bermuda.

Ultimately, the choice often comes down to a variety of "intangibles," with both domiciles having a variety to offer, depending on what the captive parent is looking for.

"Bermuda's strength has been in the highly workable and consistent regulatory climate," said David Ezekiel, president and managing director of International Advisory Services Ltd. in Hamilton, Bermuda.

"There aren't many domiciles where the offshore industry is as important to the economy, which keeps everyone focused and doesn't allow anyone to get stupid in any area."

**'Bermuda's strength has been in the highly workable and consistent regulatory climate.'**

*David Ezekiel  
International Advisory Services Ltd.*

The Bermuda infrastructure that supports captives is "tremendous," Mr. Ezekiel said. "There is a huge body of expertise here in every discipline."

Philip A. Barnes, managing director with Aon Insurance Managers (Bermuda) Ltd., pointed out that Bermuda has its own insurance act, "which is very flexible and works very well." Vermont-based captives, he added, are subject to state insurance regulation and "some federal issues as well."

Bermuda captive managers pointed out that Vermont favors "pure" captives, whereas captives that write third-party business are welcome in Bermuda.

"I think it's fair to say that Vermont doesn't like third-party cap-

tives," said Alan C. Cossar, group managing director with Aon Insurance Managers (Bermuda). "Whereas as long as you've got a sound business plan," such insurers are not unwelcome in Bermuda, he said.

Bermuda is a convenient place for a captive owner to conduct other business, according to the island's captive managers. Mr. Ezekiel pointed out that a captive owner can visit the island, meet with the captive manager, and, during the same visit, do business with direct insurers, reinsurers and excess underwriters regarding other exposures.

Colin C. James, president of Atlantic Security Ltd. in Bermuda, suggested that potential captive owners visit both domiciles before deciding where to locate. Bermuda, he said, has some distinct advantages.

"With all due respect to Vermont, it's just a captive domicile," Mr. James suggested, whereas Bermuda is an insurance center. "It is dwarfed by the industry in Bermuda," he said of Vermont. "For a large company, it would be very unusual not to have some capacity support in Bermuda."

There is a depth of knowledge and wealth of insurance-related facilities in Bermuda that make it "so

much more of a working environment than any other domicile," Mr. James remarked.

While Bermuda does offer ready access to the reinsurance markets, Vermont's partisans suggest that with the growth in the domicile, it now boasts captive industry expertise second to none.

"There's as much captive knowledge in Vermont as there is anywhere in the world," Mr. Crouse said.

With the mass the Vermont domicile has acquired, for those in the captive industry, Vermont isn't seen these days as a stepping stone to something else, according to Daniel D. Towle, director financial services in the Vermont Department of Economic Development's Agency of Commerce and Community Development.

"And that's one of our strongest selling points," Mr. Towle said. "People don't come to Vermont on a three-year visa."

And, as captive managers need to add to staff to keep up with the demands of captive growth, it's easier to do so onshore than off, some in Vermont assert.

"We certainly don't have the problem you would face in the offshore domiciles," said Nancy Gray, managing director at Aon Insurance Managers (USA) Inc. in Burlington. With no issues of work permit requirements, "Once we make an offer to someone, they can usually start in two weeks," she said.

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# Ohio colleges see steep health insurance cost hikes

By SHANNON MORTLAND

Already preparing for a nearly \$2 million cut in state support, Cleveland State University now is bracing for the second half of a financial double-whammy—a more than 30% increase in health insurance costs. And the campus is not alone.

Employees of private colleges and state institutions this year could get hit with higher take-home insurance costs and smaller raises, and students likely will see tuition hikes as the schools try to absorb the increases.

CSU, Baldwin-Wallace College and John Carroll University this month are trying to find creative ways to control the insurance rate hikes and to figure the increases into their budgets. Kent State University and Notre Dame College were able to control their rates for at least another year, but those who are experiencing rising health insurance fees agree that absorbing the costs won't be easy.

CSU stands to take the hardest hit, with proposed increases by its insurance companies, Medical Mutual of Ohio and Kaiser Permanente of Ohio, of 31% and 22.3%, respectively, said Joseph S. Nolan, vp for administration and executive assistant to the president at CSU. Such increases would boost CSU's annual cost of health insurance to \$10 million from \$7.8 million, he said.

"It's going to be very difficult" to absorb the costs, Mr. Nolan said, especially as the state cuts its financial support to CSU by \$1.7 million this fiscal year, which ends June 30.

CSU at its March 26 board meeting will propose a tuition hike of "under 10%" for the fall to cover operations, which include health insurance for employees, said Jack Boyle, vp of finance at CSU.

Private schools also are feeling the pinch.

John Carroll University expects another spike of 20% to 25% in health insurance costs next fiscal year, which begins July 1, said John Polk, co-director of the Muldoon Center for Entrepreneurship at JCU. That's on top of the 35% increase the school absorbed last year, which added \$1 million to the university's annual health insurance costs, Mr. Polk said. It's too early to tell how the coming increase will affect JCU, he said.

Mr. Polk said colleges and universities, some of the Cleveland area's largest employers, are seeing higher average rate increases than other businesses. He suspects one reason for the disparity is that the workforces at colleges and universities on average might be older than those of companies and corporations.

However, it's hard to tell whether colleges and universities are seeing larger increases or if they're just

catching up to other businesses, said Greg Mercer, vp of health plan operations for Kaiser Permanente's Ohio region.

"Most everybody has experienced double-digit increases" in the 15% to 30% range, Mr. Mercer said. "I do not believe rates the universities are being charged necessarily vary significantly from others that are out there."

A number of factors are pushing up insurance rates, said George Stadlander, vp of underwriting for Medical Mutual. The population in general is aging, more maintenance drugs have been introduced during recent years, and as medical technology improves, patients receive more and better health care, which helps people to live longer.

The struggling economy also is a factor, Mr. Stadlander said. Hospital systems' endowments have been hit hard by the stumbling stock market, which is forcing hospitals to raise rates or to increase business to come up with money for capital projects they might have begun when the economy was stronger, he said.

People also are delaying retirement because their retirement savings took a tumble along with the stock market, so they're staying on the insurance rolls longer, Mr. Stadlander said.

"This is an emerging trend within the last year," he said.

Combine all those factors and "you have an inflation driver," Mr. Stadlander said.

Whatever the reasons, officials at the local colleges and universities know they can't sustain skyrocketing rates.

The University of Akron will shop its health insurance plan in the next two months in hopes of reducing expected rate increases of up to 20% come Jan. 1, 2004, which would cost the university another \$2.2 million per year, said Roy Ray, vp of finance and administration and chief financial officer.

The University of Akron recently announced a 9.9% tuition increase to go into effect this summer to cover increased operating costs. Mr. Ray said the university likely will need employees to help share the increase in health insurance rates. The university now pays 100% of its employees' coverage, which costs \$12 million per year, he said.

Baldwin-Wallace last year made cuts in areas such as travel and entertainment, contract maintenance and even postage to help absorb a 30% health insurance rate increase that took effect Jan. 1, 2002, said Tom Lee, vp of finance and administration.

B-W also saw another health insurance rate increase of 10.25% beginning Jan. 1, 2003, and it anticipates another 10% hike next January, Mr. Lee said.

"If it's 10%, I think we've got it covered. If it's beyond 10%...we'll be scrambling again," he said.

B-W already plans to increase tuition next August by another 6% to cover operations, which include health insurance for employees, Mr. Lee said. Tuition went up 6.75% last fall and the school is leery about raising tuition too much, he said.

Cuyahoga Community College now is deciding whether to raise tuition to cover rising operational costs and to fill the nearly \$1 million gap left by the state's budget cuts related to higher education, said Wayne Davis, vp of human resources. Tri-C last year renegotiated its health insurance plans and cut the rate increase down to 16% from an expected 20%, he said.

At CSU, some of the burden of higher insurance costs likely will be placed on higher-paid employees to soften the blow for those who make less than \$35,000 a year, CSU's Mr. Nolan said.

"Monthly health care contributions should be based on salary—the more you make, the higher your monthly contribution should be," he said. "I don't think there's going to be a big flap on campus about that."

Shannon Mortland is a reporter for Crain's Cleveland Business, a sister publication of Business Insurance.

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### LEGAL NOTICE

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CIVIL JURISDICTION  
2002 : No. 514

IN THE MATTER OF MUTUAL RISK MANAGEMENT LTD.  
IN THE MATTER OF THE COMPANIES ACT 1981, SECTION 99

ADJOURNED SCHEME MEETINGS

NOTICE IS HEREBY GIVEN that by an Order dated 6th March 2003 the Supreme Court of Bermuda has directed meetings (the "Scheme Meetings") of certain creditors ("Scheme Creditors" as defined in the scheme of arrangement referred to below) of Mutual Risk Management Ltd. (the "Company") to be convened for the purpose of considering and if thought fit approving (with or without modification) a scheme of arrangement (the "Scheme") proposed to be made between the Company and its Scheme Creditors which were scheduled to take place on 5th February 2003 and which were adjourned by order of the Supreme Court dated 3rd February 2003, will be held on **10th April 2003**.

The Adjourned Scheme Meetings will be held at 44 Church Street, Hamilton HM 12, Bermuda on 10th April 2003. The Adjourned Scheme Meetings will be held as follows:

Class A Scheme Creditors Scheme Meeting commencing at 11:00 a.m. (Bermuda time);  
Class B Scheme Creditors Scheme Meeting commencing at 11:30 a.m. (Bermuda time) or at such time as the Scheme Meeting of Class A Scheme Creditors concludes; and  
Class C Scheme Creditors Scheme Meeting commencing at 12:00 noon (Bermuda time) or at such time as the Scheme Meeting of Class B Scheme Creditors concludes.

All Scheme Creditors are requested to attend on the date and time set out above. Registration for all Scheme Meetings will commence at 10:30 a.m.

If you have not received copies of the Scheme, Explanatory Statement (required to be furnished to all Scheme Creditors under the provisions of section 100 of the Companies Act 1981) and/or the Proxy/Voting Claims Form for the Scheme Meeting in respect of which you are a Scheme Creditor, you may obtain copies from the Company at 44 Church Street, Hamilton HM 12, Bermuda (attn: Angus H. Ayliffe; Fax (441) 292-1867).

Scheme Creditors may vote in person at the said Scheme Meetings or they may appoint another person, whether a Scheme Creditor or not, as their proxy to attend and vote in their stead.

Scheme Creditors must either:

- have forwarded a completed Proxy/Voting Claim Form so as to have reached the Company on or before 31st January 2003 and not have filed a further Proxy/Voting Claim Form prior to 3:00 p.m. (Bermuda time) on 8th April 2003; or
- return a completed Proxy/Voting Claim Form so as to reach the Company at 44 Church Street, Hamilton, Bermuda (attn: Angus H. Ayliffe) on or before 3:00 p.m. (Bermuda time) on 8th April 2003. Faxed Proxy/Voting Claim Forms will be accepted.

ANY SCHEME CREDITOR WISHING TO AMEND OR CHANGE A PROXY/VOTING CLAIM FORM MAY DO SO AT ANY TIME BY COMPLETING AND FILING A NEW PROXY/VOTING CLAIM FORM PROVIDED THAT SUCH FORM REACHES THE COMPANY AT THEIR OFFICES ON OR BEFORE 3:00 P.M. (BERMUDA TIME) ON 8th APRIL 2003.

By the said Order the Court has directed that the Chairman of the Scheme Meetings shall be Mark W.R. Smith of Deloitte & Touche, Bermuda and has directed the Chairman to report the results of the said Scheme Meetings to the Courts. In addition, the Court has ordered that the Chairman shall have the ultimate discretion to determine the value, if any, to be attributed to a Scheme Creditors vote.

The said Scheme will be subject to the subsequent approval of the Supreme Court of Bermuda.

DATED this 7th day of March 2003.

Mutual Risk Management Ltd.  
44 Church Street  
Hamilton, HM 12  
Bermuda

### LEGAL NOTICE

### LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT  
SOUTHERN DISTRICT OF NEW YORK

IN RE PETITION OF DAN YORAM  
SCHWARZMANN, AS ADMINISTRATOR OF  
FOLKSAM INTERNATIONAL  
INSURANCE COMPANY (UK) LIMITED,  
DEBTOR IN A FOREIGN PROCEEDING  
CASE NO. 02-14070 (PCB)

NOTICE IS HEREBY GIVEN THAT ON MARCH 4, 2003, THE BANKRUPTCY COURT ENTERED AN ORDER (THE "ORDER") CONTINUING THE PRELIMINARY INJUNCTION ORDER PURSUANT TO 11 U.S.C. §304 ORIGINALLY ENTERED IN THIS CASE ON SEPTEMBER 9, 2002. THE ORDER SHALL REMAIN IN EFFECT PENDING A HEARING SCHEDULED TO BE HELD ON SEPTEMBER 11, 2003 AT 2:30 P.M. (THE "RETURN DATE") BEFORE THE HONORABLE PRUDENCE CARTER BEATTY, UNITED STATES BANKRUPTCY JUDGE, IN THE UNITED STATES BANKRUPTCY COURT LOCATED AT ONE BOWLING GREEN, NEW YORK, NEW YORK. ALL PAPERS SUBMITTED FOR THE PURPOSE OF OPPOSING THE CONTINUATION OF THE ORDER AFTER THE RETURN DATE SHALL BE FILED WITH THE COURT, WITH A COPY TO THE CHAMBERS OF THE HONORABLE PRUDENCE CARTER BEATTY AND SERVED ON COUNSEL FOR THE PETITIONERS LISTED BELOW, SO AS TO BE RECEIVED AT LEAST FOURTEEN (14) DAYS PRIOR TO THE RETURN DATE. ANY PERSON WISHING TO OBTAIN A COPY OF THE ORDER SHOULD CONTACT COUNSEL TO THE PETITIONERS.

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# Lloyd's not pursuing captive formations

## Its sole captive in runoff, the market is losing business to other domiciles

By SARAH VEYSEY

**LONDON**—At a time when many domiciles are reporting surging interest in captives, Lloyd's of London has said it is not actively seeking new captive companies.

"We remain open for captive business; however, we are not actively seeking captives at this time," said Roger Selleck, commercial director at Lloyd's. "We will be reviewing our long-term strategy on captives in the near future."

A Lloyd's spokesman declined to comment further on why Lloyd's was not pursuing new captive business at the present time.

Lloyd's, which currently has no captive members, opened to captive business to much fanfare in January 1999, when pharmaceutical company SmithKline Beecham P.L.C. set up the first captive syndicate to be licensed in the more than 300-year-old market. SmithKline Beecham moved part of its business from its Guernsey-based captive insurer to Lloyd's.

But when SmithKline Beecham merged with pharmaceutical rival Glaxo Wellcome P.L.C. in 2000, the

enlarged company opted to place its Lloyd's captive into runoff.

Since then, though Lloyd's captive regulations remain in place, no new captive syndicates have been admitted to the market.

Market sources suggest that the Bain & Co. report into the Lloyd's market—which prompted the 2002 Chairman's Strategy Group reforms (*BI*, Jan. 17, 2002)—may have recommended to Lloyd's management that the captive model was not beneficial to the market.

And one London-based accountant, who said that even last year Lloyd's was receiving numerous inquiries from companies interested in setting up captives there, believes that Lloyd's became worried about a potential threat to the market's Central Fund posed by captive insurers.

"Lloyd's officials became uncomfortable about exposing the Central Fund to extra liabilities," the accountant said, "because captives may not be as tightly focused on underwriting profit as a Lloyd's syndicate."

Another source suggested that existing Lloyd's syndicates became nervous about competition from

captives and sought to block business plans of companies looking to set up captives within the market.

Business plans "had to be approved by peers," the accountant said. "And turkeys don't vote for Christmas."

But some brokers believe that the cost of setting up a captive at Lloyd's may have been a deterrent to interested parties.

New captive syndicates at Lloyd's are subject to fees of £20,000 (\$32,052), while captive corporate members must pay fees of £25,000 (\$40,065) plus value-added tax of 6.1%. They are then charged annual fees of about 2.1% of the captive's overall premium limit.

"It's very expensive," said Brian Souter at Heath Lambert Group in  
**See LLOYD'S/next page**



PHOTO: NEWSCAST

Lloyd's of London is no longer seeking to attract captives.

# Rate hikes squeeze financiers of U.K. public-service projects

By CAROLYN ALDRED

**LONDON**—Skyrocketing insurance costs are causing concern about the availability of coverage for public services and infrastructure projects in the United Kingdom and jeopardizing the profitability of the projects for the contractors and investors involved, according to experts.

The long-term fixed-costs contracts that are used in many public-sector contracts are inflexible and do not respond to the huge increases in insurance costs that the projects are facing, these experts say.

Government action is needed to ensure that rising insurance

costs do not make such projects impractical, they say.

The problems faced by contractors involved in public-sector projects in the United Kingdom stem from the public finance initiative that the U.K. government introduced in the mid-1990s to permit public entities to tap private investors to fund projects.

Since the PFI infrastructure projects began, billions of pounds have been raised from private investors to build, refurbish and maintain schools, hospitals, prisons, roads, railways and even military facilities and flood defenses. Similar public/private projects now are being established in several other countries, including

Australia, Ireland, Italy, the Netherlands, South Africa and Spain.

A PFI project usually entails the establishment of a special-purpose company that contracts to build or refurbish a public-sector facility and manage that facility in the long term, often for up to 30 years. Local authorities then pay an agreed annual amount for the use of the facility. PFI company shareholders usually include the building contractor, facilities management contractor and finance companies involved in the project. In most cases, the PFI company is responsible for buying insurance for the project it has financed.

When the programs first began, in the midst of the last soft market, insurance was rarely an issue. Now, though, with huge increases in insurance rates overall and for public projects in particular, many PFI companies say that the profitability of the projects has been drastically eroded.

In light of the increased insurance costs, the Office for Government Commerce, a division of the Treasury department, last year amended its guidelines to allow new PFI companies to share some of the insurance costs with the local authorities over a seven-year period if agreed-upon benchmark insurance premiums increase by  
**See PROJECTS/next page**



PHOTO: NEWSCAST

The Edinburgh Royal Infirmary in Scotland was built using a public finance initiative.

# AMRAE plans to create a mutual for members

By SARAH VEYSEY

**PARIS**—The French risk management association is making plans to create a mutual insurance company for industrial companies that have been hit hard by rising commercial insurance rates.

The Paris-based Association pour le Management des Risques et des Assurances de l'Entreprise, first proposed the idea of a French industry mutual in October 2001.

Now the risk managers' association is presenting a feasibility study to approximately 50 interested companies.

Under the proposal, French industrial companies would invest the equivalent of about a year's premium for property and business interruption coverage to capitalize the new entity.

AMRAE is seeking to establish a capital base of about 50 million euros (\$55.03 million) for the new insurer.

The company would initially write property and business interruption risks between 15 million euros (\$16.5 million) and 25 million euros (\$27.5 million).

AMRAE, founded in 1901, has more than 400 risk and insurance management members, representing more than 230 public and private-sector organizations.

# World Updates

## Terrorism insurer closing to new business

Specialist terrorism insurer Special Risk Insurance & Reinsurance S.A. is closing to new business less than a year after it started, due to a lack of demand for its products. SRIR was formed by six international insurers and reinsurers in April 2002 to offer European companies and their worldwide operations insurance for property damage, physical loss and business interruption caused by terrorist attacks. But Alan May, chief executive officer of Luxembourg-based SRIR, said that despite greater awareness of terror risk, demand for the coverage has not met company expectations. Allianz A.G. Holding, Zurich Financial Services Group, XL Capital Ltd., Swiss Reinsurance Co. Ltd. and Hannover Re Group each hold stakes of approximately 18% in SRIR. Paris-based reinsurer SCOR S.A. holds a stake of approximately 9%.

## Lloyd's returning to profits: Moody's

Lloyd's of London is on track to report profits of about £1.6 billion (\$2.58 billion) for the 2002 year of account and £1.4 billion (\$2.24 billion) for 2003, according to Moody's Investors Service in London. Lloyd's has not reported a profitable year since 1997, and Moody's predicts that Lloyd's will post a marketwide loss of £2.2 billion (\$3.52 billion) for the 2001 year of account—the next to close under the market's three-year accounting system. Still, the ratings agency said that improved rates and increased writings in 2002 and 2003 should lead to substantial profits for those years.

## Reinsurers release natural cat reports

Natural catastrophes caused about \$13 billion in insured losses in 2002, up from \$11.5 billion a year previously, according to Munich Reinsurance Co. Floods on the European rivers Elbe, Vltava and Danube in August resulted in insured losses of more than \$3 billion, according to the report. Tornadoes in the Midwest and Eastern United States in April caused an insured loss of \$1.6 billion—the most expensive tornado loss of all time, according to the report by the Munich, Germany-based reinsurer. In a separate study, Swiss Reinsurance Co. Ltd. estimated that natural catastrophes and manmade disasters cost nonlife insurers \$13.5 billion in 2002, down from \$35 billion in 2001. Zurich, Switzerland-based Swiss Re said natural catastrophes accounted for \$11.4 billion of insured losses in 2002, while manmade losses cost insurers \$2.1 billion.

# Lloyd's: Market no longer pursuing captive business

Continued from previous page

London. Mr. Souter said Heath had not really seen much interest from clients in setting up captives at Lloyd's because of the cost, and he added that, to the best of his knowledge, most of the broker's rivals had had similar experiences.

Other sources, who asked not to be identified, echoed this view.

According to Lloyd's, access to Lloyd's licenses around the world would give a captive the opportuni-

ty to write direct business in about 60 countries without the need of a so-called fronting facility.

If companies wish to issue admitted paper from a European-based captive, from a practical standpoint they have the choice of Lloyd's, Dublin and Gibraltar, explained John English of the London-based broker Jardine Lloyd Thompson Group P.L.C.

"When analyzing it, I think they generally found that the capital

commitment and operating cost of a captive vehicle at Lloyd's would have been greater than other locations," he said.

One broker who preferred not to be named said that during the 1990s, many new ideas were "kicked around" at Lloyd's "as a function of the soft market" and in a bid to stave off perceived competition from Bermuda. Lloyd's, he said, is quite bureaucratic and perhaps more intensively regulated

than other domiciles, though, and the idea never fully took off.

But despite this, there was great interest from companies in setting up at Lloyd's to reap the benefits of an onshore captive structure, said to the London-based accountant.

One large telecommunications company, he noted, was closely watching the progress of the SmithKline Beecham captive; "they wanted to go in, but they didn't want to be the first," he said. When

the SmithKline Beecham captive withdrew from the market, some of the momentum for other captives to set up was lost, he said.

Captive specialists in London, he said, became less inclined to approach Lloyd's once they became aware of the market's likely reaction. "Many of the parties who may have been interested in establishing an onshore captive at Lloyd's," he said, "were directed offshore by the specialist brokers."

# Projects: Financiers fear increased insurance costs

Continued from previous page

more than 200%. Prior to that amendment, the OGC had insisted that any cost increases were the sole responsibility of the PFI companies. The sharing provision does not apply to existing projects.

Contractors and financing companies involved in the PFI sector say that the 200% threshold is too high, and they are calling for more measures to alleviate the problem. A committee of contractors and PFI financiers are scheduled to discuss the issue this week, said Robert Ure, chairman of the committee and PFI practice leader at Marsh Ltd. in London.

"We need to distinguish between insurance rises beyond our control and those we can influence," Mr. Ure said. He said that the private sector alone cannot bear the huge increases in insurance caused by external events such as the Sept. 11, 2001, terrorist attacks and the current slump in stock prices.

Insurance rates for PFI projects are increasing dramatically due, in part, to the hard market but also because of the complexity of the projects, said Tracy Hazell, director of

the global public/private partnerships practice at Willis Group Ltd. in London. Ms. Hazell noted that the projects often involve a large number of parties. Also, she said, many insurers charge higher rates for PFI projects because they have little loss data with which to make underwriting decisions.

In addition, many of the risks hold little appeal for insurers, brokers note.

Schools, for example, "have had a bad reputation with insurers for a long time because of arson and vandalism and being unoccupied for long stretches of time," said Mark Playle, a partner at JLT Risk Solutions Ltd. in London.

The long-term nature of the financing contracts also causes problems, pointed out Andy Kirby, a specialist PFI insurance broker for Markfield Group Ltd. in Wolverhampton, England.

"In the current market, it is impossible to predict what insurance cover will be available in six months, let alone 30 years," Mr. Kirby said. PFI companies "are telling the government that they are not prepared to take on the risk

of increasing insurance premiums."

"Swingeing increases, the downgrading of many insurers and lack of capacity has led to considerable

**'The government is very concerned about uninsurability. In the soft market, it was barely a prospect, but the problems of capacity shrinkage' mean some classes of business may become uninsurable.**

Stephen Tester  
CMS Cameron McKenna

discussion between companies and local authorities" about who should bear the additional costs and increased risks, said Greg Bond, a director of the projects division of Heath Lambert Group in London.

The profit margins for most PFI projects "are always balanced on a knife edge," and the huge rate increases being seen in the PFI sector

will strain the finances of many PFI companies, predicted Simon Lewis, a construction lawyer and a partner at Dickinson Dees in Newcastle-Upon-Tyne.

The revised contract guidelines issued by the Office for Government Commerce, by which most government agencies and local authorities operate, must be made more flexible, Mr. Lewis said.

A spokesman for the OGC confirmed that it was aware of the private sector's concerns and indicated that more flexible approaches might be taken if contractors could prove that the projects provide "value for money" even if they do not meet all the government's insurance criteria for PFI projects.

"The government is very concerned about uninsurability. In the soft market, it was barely a prospect, but the problems of capacity shrinkage means that there is a possibility that certain classes of cover or parts of classes may become uninsurable," said Stephen Tester, a partner with the London law firm of CMS Cameron McKenna.

Mr. Tester predicted that if the

market continued to harden, more risks would remain with local government authorities. Already, some authorities have been unable to transfer their insurable risks to PFI companies.

For example, the PFI company that provides and maintains vehicles for the London Fire Brigade is not responsible for insuring the property/casualty risks for the 20-year project contract, said Bob Cope, assistant head of finance for the London Fire Brigade and treasurer for the Assn. of Local Authority Risk Managers.

Mr. Cope said that a lack of appetite for the London Fire Brigade's risks and employers liability issues resulted in the fire brigade retaining the risk and facing increased insurance premiums of 30% to 40% last year, with a similar increase likely this year.

Robert Tucker, head of PFI underwriting at Zurich Public Private Solutions in London, said he believes that insurance costs could be reduced substantially if insurance and risk management issues were tackled at a much earlier stage in the PFI process.

# Contraceptives: Plan adds cover

Continued from page 4

Under the settlement agreement, reached March 4, Bartell agreed to continue to offer coverage for prescription contraceptive drugs, devices and related clinical services. It also agreed to give each class member still employed at Bartell all prescription contraceptives and related clinical services with no copayment through 2006. Any class member who is no longer employed by Bartell will be reimbursed \$100 for monies spent on prescription contraceptives.

"There was a judgment. We complied with that judgment. We then resolved that litigation and now we are focusing on our business," said Mike McMurray, assistant vp-marketing for Bartell, who declined to discuss the settlement further.

Roberta Riley, the Planned Parenthood of Western Washington attorney who represented the class of women in the case, said that she hopes the recent Bartell settlement "serves to convince more employers that they need to add this impor-

tant women's health care coverage."

While the trend today is toward offering contraceptive coverage, "we know there are lots of companies still not covering it," she said.

Although benefit consultants originally thought that the 2001 ruling would encourage more employers that still did not offer contraceptive benefits to begin doing so, plan design changes have been more gradual, they say.

"Based on the number of questions I received, I thought there may have been a huge rush to change policies, but that did not happen," said Joanne Sica, assistant vp-pharmacy benefits for Aon Consulting in Philadelphia, referring to the 2001 decision. "I think it just gave employers food for thought and brought it more to the forefront and made them think about it a little more," she said.

Helen Darling, president of the Washington Business Group on Health, said that she thinks the recent settlement "is more symbolic to women" than something that

will result in more plan design changes.

Most managed health care plans cover contraceptives and because most employees enroll in managed care plans, most employees in the United States have that benefit, she said.

Since 1998, 20 states have enacted legislation requiring insured health plans and HMOs that provide prescription drug coverage to equally cover contraceptives. An additional 13 states have similar bills pending.

These state laws, though, do not pertain to self-insured employers, and the exact number of all employers that do not offer contraceptive coverage is unknown.

Union Pacific Railroad Corp., however, is one employer that doesn't offer contraceptive coverage and now faces a lawsuit as a result. Three female workers filed suit earlier this month in the U.S. District Court in Oregon alleging that the Omaha, Neb.-based railroad is in violation of Title VII because it doesn't cover birth control drugs.

# Survey: 401(k) plans losing participants

Continued from page 4

Buck also noted that employees' use of Internet-based 401(k) applications has grown dramatically over the past several years. Ninety-three percent of respondents said their plan participants use the Internet to access account information, compared with just 57% in 1999, according to report.

Technology also is allowing more participants to make changes to their investment elections on a daily basis.

Currently, 86% of employers permit daily changes to investment elections, up from 80% in 1999. This is up dramatically from 1989, when just 4% of employers offered participants the ability to make daily changes to their investment elections.

The survey also revealed that the average number of investment options offered through 401(k) plans was 16 in 2002, up from 13.5 in 1999. In 1984, the first year Buck

asked this question in its survey, employers offered an average of just 2.8 investment options. The most popular investment option offered by employers in 2002 was equities, available in 99% of 401(k) plans; followed by fixed income, 98%; balanced funds, 84%; other nonspecified investments, 39%; and company stock, 35%.

In addition, Buck found that due to changes permitted under the Economic Growth and Tax Relief Reconciliation Act of 2001, 48% of respondents have raised the pretax contribution limits for highly compensated employees, while 61% have raised the limits for non-highly compensated employees.

*Copies of the full survey report, "401(k) Plans: Survey Report on Plan Design—2002 Plan Year," are available at no charge to Buck clients. The cost to nonclients is \$250. To order, call 201-553-6400 or visit www.buck-*

# Drugs: Generics take on brand-name sales ploys

Continued from page 1

in Vermont, would force pharmaceutical companies to publicly disclose the gifts they make available to physicians.

Pharmaceutical companies spent nearly \$16 billion promoting their products during 2000, according to a May 2002 health care marketplace trend report from the Henry J. Kaiser Family Foundation.

More than 80% of those expenditures were focused on marketing drugs to physicians, dwarfing the growing amount spent on advertising to consumers, according to the report. The billions of dollars pharmaceutical companies spend on reaching doctors pay for things such as doctor education, advertising in professional journals, drug samples provided to physicians, and the training and sending of sales representatives to make office visits.

In contrast, the generic industry spends very little to market its products, observer say.

While the manufacturers of brand-name pharmaceuticals each hire thousands of sales representatives to visit doctors' offices, a large generic company may employ fewer than 500 sales reps, according to the National Institute for Health Care Management, a research and educational foundation sponsored,

in part, by health care insurers.

The marketing efforts of name-brand drug companies can offset current employer and health plan efforts aimed at encouraging employees to use generic drugs, say benefit consultants.

But employers are trying to reverse the promotional practices of name-brand drug companies when generic products provide better value.

Eric Michael, a consultant in Minneapolis for Mercer Human Resource Consulting's managed pharmacy consulting group, currently advises several large employers that formed a consortium to contract with a "counter-detailing firm," he said. Without approval from all of the employers, though, Mr. Michael declined to identify consortium members or provide the name of the counter-detailing firm.

Mr. Michael did say that, beginning April 1, the counter-detailing company will gather data on the prescribing patterns of doctors serving about 100,000 employees and retirees who receive benefits from the consortium's employers, Mr. Michael said.

The company will review several factors, including the doctors' use of generics. When appropriate, the counter-detailing firm will send its staff pharmacists to meet face to

face with the doctors. Their goal will be to help educate the physicians about available generic drugs, Mr. Michael said.

The employers involved in the consortium spend hundreds of millions of dollars annually on prescriptions and their employees are geographically concentrated, Mr. Michael explained.

Extensive counter-detailing is a new tactic among employers, Mr. Michael said. It has been available, however, in limited forms, he said.

Detroit-based General Motors currently collaborates with its PBM, Medco Health Solutions Inc., for counter-detailing services, a GM spokeswoman said.

The Franklin Lakes, N.J.-based PBM, through its Generics First program sends pharmacists to promote generic drugs through face-to-face meetings with doctors. Medco's pharmacists provide the doctors with order forms for free generic drug samples they can give to patients.

The idea is to get doctors to stock their shelves with generics, a Medco spokeswoman said. Then they are more likely to start a patient on generic drugs rather than on more-expensive name-brand products.

Other Detroit-based auto manufacturers and Detroit-based Blue Cross & Blue Shield of Michigan

also participate in the Generics First program, the GM and Medco spokeswomen said. Additionally, Blue Cross & Blue Shield of Michigan has its own counter-detailing effort to meet employer requests for the service, a spokeswoman for the health plan said.

Medco launched Generics First over two years ago as a pilot program. It initially included 12 pharmacists who met with doctors. Medco reviewed the prescribing habits of physicians in areas where its clients operate. It then focused its pharmacists where they could do the most good, the Medco spokeswoman said.

In November, Medco announced it was expanding the Generics First program after finding several favorable results, including that each of its visiting pharmacists saved Medco clients \$1 million during a 12-month period.

In another front aimed at the detailing and marketing practices of pharmaceutical companies, lawmakers in California, Connecticut and Washington recently introduced legislation that would force drug makers to publicly disclose their gift giving. Supporters of the legislation say they hope it will reduce pharmacy costs and improve the quality of care.

Vermont adopted similar legisla-

tion last year. But its effect will not be known for another year, according to the state's attorney general's office, which is charged with tracking the law's impact.

Backers of such legislation note, though, that the extensive giving of gifts to doctors—including meals, vacations and bonuses—is a long-established practice by pharmaceutical representatives.

In theory, employers might support such legislation because increasingly they are concerned about the amount of money manufacturers spend on marketing their products, said Kevin DeStefino, national leader, pharmacy benefits consulting at Watson Wyatt Worldwide in Phoenix.

Employers have not voiced support for such proposed laws, sponsors of the legislation say.

Mercer's Mr. Michael said employers are not likely to favor such laws because they typically oppose government regulation of their own trade practices.

Consultants say that passage of such legislation may not change drug company practices anyway. They note that, under pressure from regulators, pharmaceutical companies already have significantly scaled back their gift giving, which is only a tiny part of their overall marketing efforts.

# Nightclubs: Tragedies expected to toughen market

Continued from page 1

as a result (BI, Feb. 24).

In the most recent suit, filed last week in Superior Court in Providence, R.I., the family of Lisa Kelly, who perished in the fire, is suing The Station nightclub and others associated with the Feb. 20 concert in which pyrotechnics ignited walls and ceilings and quickly engulfed the building in flames.

In addition to the nightclub and its owners, the suit targets virtually every individual and company even peripherally connected to the concert, including such defendants as Anheuser-Busch Inc., an alleged co-sponsor of the event with radio station WHJY-FM, as well as the station's parent company, Clear Channel Communications Inc.

"The events at The Station nightclub in Rhode Island were tragic, and our sympathies are with the victims and families," said Stephen K. Lambright, group vp and general counsel for Anheuser-Busch, in a statement. "Anheuser-Busch did not advertise, sponsor or promote the band that appeared at The Station that night and should not have been named in this lawsuit."

Anheuser-Busch did not return calls seeking information on its liability insurance coverage.

San Antonio-based Clear Channel said in a statement that it has not yet seen the lawsuit and therefore could not comment on its specifically. In regard to its involvement at the nightclub the night of the fire, though, the statement said it was "merely paid by the club

owners to run advertising for the event."

"We are deeply saddened that plaintiffs lawyers are looking for deep pockets to pick rather than allowing people the requisite time to grieve for those whom we have lost," the broadcasting company said. Clear Channel said it lost two employees in the fire. A spokeswoman declined to discuss its liability insurance.

Glen Allen, Va.-based surplus lines insurer Essex Insurance Co. confirmed it is The Station's general liability underwriter but declined to be interviewed for this story.

As the lawsuits pile up, those familiar with the nightclub industry say that clubs are generally safe despite being a difficult risk to insure due to the liquor liability and crowd issues inherent in the business. Liability associated with drunk driving, bar fights and slips and falls are nightclubs' biggest exposures. But, as with any other business, the level of loss control and safety implemented varies from venue to venue.

"If this was a widespread problem, more tragedies like these would have taken place," said Steve Riedl, executive director of the Illinois Licensed Beverage Assn., the Springfield, Ill.-based association that represents nightclubs and other establishments. The E2 nightclub is not a member of the ILBA, which offers property and liability insurance to members.

"By and large, it's a very safe industry, and I give the insurance industry a lot of credit for that," Mr.

Riedl said.

Others, though, are questioning what role, if any, insurers and club owners played in the loss control and safety measures at the E2 and The Station nightclubs.

One of the basic elements that stands out in both incidents is that neither nightclub appears to have engaged in any serious loss control,

**"If this was a widespread problem, more tragedies like these would have taken place."**

Steve Riedl  
Illinois Licensed Beverage Assn.

said Carolyn Norton, senior vp-entertainment for broker New Century Global of New York Inc., a subsidiary of American Wholesale Insurance Group Inc.

"One of the nightclubs didn't have proper ingress and egress into the premises, causing people to get trampled trying to get out, and the other had flammable material around the stage area where an act was setting off unauthorized pyrotechnics," Ms. Norton said. "It would appear that both the insurance companies and club owners were not proactive in trying to manage the risk and eliminate a lot of the hazards that were responsible for causing these losses."

"Loss control is the issue of the day," agreed Steven H. Rosenfeld, a partner in the law firm of Ohrenstein & Brown in New York. Mr.

Rosenfeld's practice includes premises liability litigation with a focus on concert- and venue-related accidents.

"If you want to minimize the exposure you have as an insurer, then you obviously want to minimize the losses your insureds suffer. And the best way to do that is to maybe spend a little more money up front on loss control."

To improve nightclub safety, the ILBA has released a variety of legislative proposals and business recommendations in conjunction with a local Illinois state senator.

Among the recommendations, the ILBA suggests battery backup for all exit lighting; hiring only qualified, trained security personnel; developing an emergency plan and training staff; and configuring tables and seating to provide ample room for patrons to make an orderly exit in an emergency.

Mr. Riedl said that while most nightclubs already adhere to such safety measures, very few club owners have formalized emergency response plans with consistent training and drills.

"I think virtually any tragedy can be prevented," Mr. Riedl said. "It simply comes down to having the foresight to do so. One of the main things we're trying to do now is to make sure everyone has the foresight so that tragedies like these don't occur in the future."

Even the best loss control, though, may not help club owners maintain the same insurance rates, terms and conditions in the future.

Although the insurance market for clubs has yet to respond to the recent tragedies, experts say a much-tougher nightclub market will likely develop.

The knee-jerk reaction is that insurers will walk away from the business, predicted Lee Orabona, president of New Century Global, which places nightclub risks.

"It's going to be a challenge for us to get some of these things placed," he said. "We'll be a hell of a lot more selective than we have before. By the same token, it may force us to focus on a different area. We may not be able to get these risks placed."

"One would imagine that, all of a sudden, we would get coming over the fax something saying, 'Thou shall not write this,' but we haven't seen that yet," said Kenneth A. Schneider, vp and director of product development for Burns & Wilcox Ltd., a Farmington Hills, Mich.-based managing general agency that places nightclub risks. "The markets, however, will respond to this, and they will start looking that these things much more closely."

"Incidents like what happened in Rhode Island and Chicago are going to scare off underwriters," said Mr. Rosenfeld, the attorney.

"I suspect we'll see a much harder market for clubs as a result of the recent incidents," he said. "Maybe it will only last for six months or one year, but it's going to be fresh in people's minds. They're going to ask, 'Is this club the next Station?'"

# PBGC: Reform package likely before end of the year

Continued from page 1

yield of the 30-year Treasury bond—used in valuing pension liabilities (*BI*, Sept. 2, 2002)

Employers made that same argument the last two times—in 1987 and in 1994—when Congress stiffened pension funding rules, Mr. Kandarian said.

Without those earlier reforms, “workers and the PBGC would be in even worse shape today,” he said.

While business groups and others say funding reforms might be necessary, they say the urgent need is for Congress to find a replacement for the 30-year Treasury bond to value liabilities.

“The PBGC’s financial condition needs to be monitored, but it does not require immediate resolution,” said Janice Gregory, a vp at the ERISA Industry Committee, a Washington-based benefits lobbying group.

By contrast, the 30-year Treasury bond rate issue has to be resolved so employers have certainty as to how much they will have to contribute to their pension plans next year, Ms. Gregory said.

“It is imperative we do something about the 30-year rate,” concurred Chris Bone, chief actuary with Aon Consulting in Somerset, N.J. Without a change, more employers will exit the defined benefit plan system, eroding the PBGC’s premium base, Mr. Bone said. Such a development is the last thing the agency would want at a time that it

is running a deficit, he said.

The need to find a new index to replace the 30-year Treasury bond to value pension liabilities is compounded by several factors.

One factor is that the yield on the bonds, which no longer are issued, is artificially low. Business groups say this inflates pension liabilities,



**A premium hike ‘seems unfair to those well-funded plans that are already subsidizing the system.’**

Steve Kandarian  
Pension Benefit Guaranty Corp.

resulting in employers contributing more to the plans than is necessary.

In addition, legislation Congress passed in 2002 that temporarily allows employers to use somewhat higher interest rate assumptions expires at the end of this year, creating uncertainty for employers as to how they will calculate liabilities next year.

A new PBGC reform drive that the administration may lead comes in the wake of a report the agency released last month detailing what was the biggest and most adverse one-year change in the PBGC’s financial condition in the agency’s 28-year history.

The PBGC last year was hampered by huge losses related to the takeover of several massively underfunded pension plans sponsored by bankrupt or failed steel manufacturers, including LTV Corp. and Bethlehem Steel Corp. As a result, the agency ended fiscal 2002 with a deficit of \$3.6 billion—its biggest

thing Mr. Kandarian wants to avoid.

A premium hike, he told the committee, “seems unfair to those well-funded plans that are already subsidizing the system.”

Even bigger losses may be in the offing. The PBGC faces exposure to \$35 billion in new losses from companies whose credit ratings are below investment grade and whose pension plans may be terminated.

“We expect that our deficit may increase dramatically,” Mr. Kandarian said.

Indeed, nearly a third of that \$35 billion in “reasonably possible exposures” comes from companies within the severely troubled airline industry. One such company, US Airways Inc., wants to terminate its pilots’ pension plan, which would saddle the PBGC with about \$500 million in new liabilities.

As the PBGC’s financial condition worsens, the Bush administration is examining a variety of ways to boost plan funding, Mr. Kandarian said.

One potential change involves a provision in the 1994 law that requires employers to accelerate contributions to their plans when funding levels fall below 60%, a level Mr. Kandarian suggests might be too low.

“We are examining whether the 60% threshold should be increased,” he said.

In addition, the PBGC is examin-

ing its premium structure, noting that the formula currently is exclusively based on the number of participants and the amount of plan underfunding. Such an approach does not take into account the potential risk of a claim, such as the financial health of the plan sponsor or the type of assets held in its pension plan.

Still, Mr. Kandarian said, taking steps to improve plan funding is a better solution for both participants and the agency than is changing premium arrangements.

Mr. Kandarian warned that if legislators do nothing, there is a risk, in the wake of escalating PBGC premiums, that employers with well-funded plans will terminate those plans.

At some point, financially strong companies “will have enough,” leaving a greater proportion of plans that pose the greatest risk to the agency.

Congress, Mr. Kandarian said, has to make sure that doesn’t happen.

Finance Committee Chairman Charles Grassley, R-Iowa, said a middle ground is needed to ensure that regulations aren’t too harsh to discourage employers from offering pension plans. At the same time, the rules must prevent employers from making pension promises that they can’t afford and that the PBGC ultimately would have to provide for if the plans were terminated.

## Results: Managed care rate increases continuing

Continued from page 4

ing Standard No. 142, which changes how companies account for goodwill. Absent the charge, PacifiCare would have had \$139.2 million in net income.

### Prices remain high

Employers likely will continue to face a tough pricing environment.

“Right now, it appears that premium rates will continue to track with medical costs,” Mr. Crawford said. “Medical costs are escalating, so you’ve got a situation where the companies are pricing in line with their expected cost, and I don’t see any of the underlying economics of the industry disrupting that, so I think the outlook is stable and strong.”

The outlook is “relatively positive,” Mr. Ward said. “The investment side of the house looks very gloomy, but from an underwriting side, I think the pricing discipline and the loss ratio performance outlook looks relatively good.”

David Olson, vp-investor relations for Woodland Hills, Calif.-based Health Net Inc., said “the commercial pricing environment is healthy.” He added: “Cost trends in pharmacy and physicians are certainly moderating. Hospital costs

remain the primary challenge in managing the cost trends lower, which we are trying to do.”

“It looks like pricing is very strong, (though) maybe a little weaker than where it was in recent years,” said Rob Mains, an analyst with Advest Inc. in Albany, N.Y. Rate hikes are “still in excess of medical cost trends, which suggests margins should be at least sustainable in 2003.”

Mr. Meyer said Fitch’s 2003 outlook mirrors its expectations for 2002, “so we expect a continuation of the trends we saw in 2002. We think the industry continues to demonstrate some pricing power.”

“From a pricing standpoint, they’re getting what they need in terms of rates to sustain margins in 2003,” he said. Earnings growth, though, “will be driven more by top-line revenue growth and membership growth” than by increased margins, Mr. Meyer said.

“Longer term, our concerns relate to challenges the companies have managing their costs down, recognizing that these double-digit rate increases aren’t sustainable,” Mr. Meyer said.

Richard Shaw, an analyst with Oldwick, N.J.-based A.M. Best Co., said, “We anticipate profitability to still be pretty good” this year, with many managed care firms’ rate

hikes already locked in.

But there may be some challenges in 2004 and 2005, “because employers won’t continue to accept that high rate increase, so (managed care firms are) going to have to really start to find ways to work within the system to keep their rate increases down.”

Health Net’s Mr. Olson also pointed to 2004 as uncertain. Most of Health Net’s book of business for 2003 is already priced, with increases in the 13% to 13.5% range, but it is still too early to speculate about 2004, he said.

“Our goal is to try to get enough of a moderation in the health care cost trend to create an environment where the premiums aren’t quite as high. We’re hearing from employers that they would like to find a way to lower premiums,” he said. A combination of better health care cost management and benefit design changes to enhance their flexibility “will help do that.”

### Plan-design changes

Gilford’s Mr. LeConey said he is seeing a shift toward lower-priced products. Consequently, plan design “is going to become vastly more important again this year after four, five, six years where it wasn’t,” as managed care firms develop products that focus on cover-

ing major medical events rather than providing first-dollar coverage, he said.

Jack Reichman, director at Standard & Poor’s Corp. in New York, said, “there’s going to be a strong growth in the defined contribution types of plans,” though growth will be slow initially because employers and employees must be educated about the approach. Such plans, which typically combine employer-funded reimbursement accounts and high-deductible coverage, aim to make employees more aware of the cost of health care.

Meanwhile, employers will continue to shift costs to employees. “Employers are not absorbing a lot of the high rate increases—they’re passing (costs) down” to a greater degree than they had in the past, said Best’s Mr. Shaw. Employers, he said, are “starting to achieve their goal of bringing the employee into the cost of health care.”

Cost-shifting is “a big cost management tool that employers are using in 2003,” said Mr. Meyer of Fitch.

Mr. Crawford of Fox-Pitt Kelton said that cost-shifting is “really the best strategy that (employers) have right now to deal with these escalating costs. Clearly, health plans aren’t trying to go out and buy busi-

ness any longer, so there’s not a lot of levers for employers left. And, clearly, trying to shift more of the cost and really design benefits to make people a little more conscious about their health care costs...is the main strategy moving forward for employers.”

However, Mr. Mains said cost-shifting “hasn’t happened as much as logic would suggest it should. I’m honestly completely puzzled by it. It’s not like three years ago, when unemployment was real low and you wanted to retain employees a lot.”

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## Late News

Continued from page 1

increased by 31% in 2002 compared with the prior year. There were 224 federal securities class-action suits filed in 2002, according to a study by the Stanford Law School Securities Class Action Clearinghouse and Cornerstone Research. Securities suits also involve larger sums of money lost. The median amount of lost market capitalization for those companies sued in 2002 was \$1.5 billion, more than double the \$700 million median loss in 2001.



### Nursing home ergo guidelines released

The Occupational Safety and Health Administration issued its first industry-specific ergonomics guidelines on last week. The guidelines are aimed at the nursing home industry and contain such recommendations as eliminating manual lifting of residents whenever feasible as a means of protecting nursing home employees from musculoskeletal injuries. OSHA does not require nursing homes to follow the guidelines.

### Consumer-driven drug plan launches

A prescription benefit management company has launched what it says is the first consumer-driven drug plan. Prime Therapeutics Inc. said

the plan, called Prime CDRx, will be available to employers starting July 1. The plan works like a consumer-driven health plan. Employers fund a prescription savings account for plan members. When that account is depleted, members are responsible for their own drug costs up to a deductible amount. Drug purchases above the deductible are covered by the plan.

### Liberty sells Canadian life/health business

Canadian life insurer Maritime Life Assurance Co. has agreed to buy the Canadian life and health insurance business of Liberty Mutual Insurance Co. for \$140 million Canadian (\$95.5 million). Liberty Health, a division of Liberty International, writes about \$700 million Canadian (\$477.5 million) in premiums from group life, disability and health insurance business as well as individual health insurance. Liberty International decided to sell Liberty Health in order to focus on property/casualty insurance, said Thomas C. Ramey, president of Liberty International.

### More insolvencies seen in 2002: Best

The pace of insurer insolvencies accelerated in 2002, with 38 companies being placed under regulatory supervision or into liquidation, compared with 30 insolvencies in 2001, according to A.M. Best Co. Inc. "Several years of inadequate pricing, escalating loss costs and the need to strengthen loss reserves fueled declining operating profitability and further weakened balance-sheet strength," according to the rating agency. Of the 38 insolvencies in 2002, about two-thirds were commercial insurers, with workers compensation insurers making up the bulk of the defunct companies.



### High-rise owners face coverage crunch: Serio

Owners of high-rise residential buildings in New York are having difficulty obtaining insurance, according to New York's top insurance regulator. Insurance Superintendent Gregory Serio says city builders and the Real Estate Board of New York have alerted him to an "acute shortage" of coverage for high-rise apartment blocks, reported Crain's New York Business, a sister publication of *Business Insurance*. Mr. Serio said Sections 240 and 241 of the state Labor Law, which hold employers 100% liable for worker injuries sustained in a fall, are driving up rates.

### Investment returns hit Canadian P/C insurers

Canadian property/casualty insurers recorded their worst profits ever in 2002, as they reported a big drop in investment income, according to the Insurance Bureau of Canada. Those companies' collective underwriting results improved in 2002, however,

with the Canadian industry's overall combined ratio falling to 105.8% from 110.4% the year before. But the aggregate investment income of the insurers surveyed fell 77.7% in 2002 to \$137 million Canadian (\$87.2 million), according to the IBC.

### Briefly noted

London-based **inreon Ltd.**, an online trading platform for reinsurance, has expanded its membership to Japanese companies. Two Japanese property/casualty insurers—Sompo Japan Insurance Inc. and Fuji Fire & Marine—have joined inreon....Metropolitan Life Insurance Co. has expanded into Latin America with the launch of **MetLife Mexico**. The Mexico City-based unit was formed following MetLife's acquisition of two major group life insurers in Mexico—Aseguradora Hidalgo and Seguros Genesis....**Arthur J. Gallagher & Co.** has acquired Benefits Planning & Insurance Agency Inc., a Larkspur, Calif.-based employee benefits brokerage. Terms were not disclosed....**Magellan Health Services Inc.** last week filed a voluntary bankruptcy reorganization petition to reduce its \$1 billion debt. The Columbia, Md.-based behavioral health company said that agreements with key creditors have cut its debt nearly in half and will enable the company to continue operating after the restructuring.

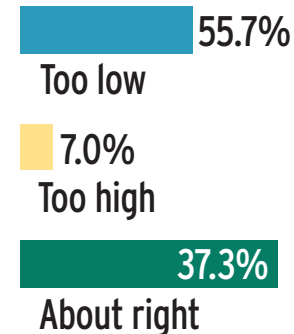
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## Online Poll

[ 3/10 - 3/14 ]

Is the proposed \$250,000 cap on non-economic damages in medical malpractice suits:



## BI Stock Index

[ 3/10 - 3/14 ]

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

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

<b>BI Stock Index</b>	1654.15	0.29
<b>Dow Jones</b>	7859.71	1.55
<b>S&amp;P 500</b>	833.26	0.53

### Largest gains

AXA-UAP Group	10.84%
AEGON N.V.	10.63%
ING Groep N.V.	9.31%
Baldwin & Lyons Inc.	7.96%
Berkshire Hathaway Inc.	5.09%

### Largest losses

UNUM Corp.	-40.05%
Gainsco Inc.	-20.00%
PMA Capital Corp.	-15.65%
SCPIE Holdings Inc.	-13.66%
SCOR	-11.70%

### Weekly change by market segment

Brokers	-1.25%
Insurers/Reinsurers	-1.72%
Managed Care Organizations	-2.72%

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

# Buffett: Statement roils marketplace

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financial strength ratings of Berkshire's own General Re Corp. unit, he noted that "recently, in contrast, one of the world's largest reinsurers—a company regularly recommended to primary insurers by leading brokers—has all but ceased paying claims."

"The company owes many billions of dollars to hundreds of primary insurers who now face massive write-offs," Mr. Buffett wrote.

Berkshire itself has been stung by unrecoverable reinsurance, he noted. The company's GEICO unit wrote a modest \$3.1 million in commercial umbrella and product liability business in the early 1980s that has produced \$94.1 million in losses. Of this total, \$90.3 million consists of unrecoverable balances from "deadbeat reinsurers," including \$19 million written off in 2002, Mr. Buffett reported.

The letter does not say whether the unnamed reinsurer that has "all but ceased paying claims" is one of GEICO's nonperforming reinsurers.

Speculation about the identity of

the reinsurer focused quickly on Gerling Global Re. German regulators recently blocked parent Gerling Group from selling the reinsurance operation to a runoff company, and Gerling has since asked regulators' permission to shift 200 million euros (\$220.4 million) from its contingency reserves to bolster the reinsurance operations.

**Gerling's payments have been 'slow but in accordance with terms. ...They certainly would not be on our problem list.'**

*William R. Berkley  
W.R. Berkley Corp.*

"A simple process of elimination points to no other likely reinsurer," wrote Chris Winans, an analyst with Williams Capital in New York. "Eliminating companies that couldn't have reinsurance obligations in the 'many billions' narrows the

population to a handful, only one of which—Gerling, which is privately owned—is essentially in runoff."

Gerling just as quickly denied any failure to pay claims, and several brokers and insurers confirm that Gerling payments are continuing, albeit at a slower pace than in the past.

A London market claims facility, Xchanging Ins-sure Services Ltd. of Chatham, England, notified brokers on March 6 that a Gerling reinsurance unit has switched from three-day settlement of agreed claims to monthly settlements. While the facility's roughly 80 active participants are required to cover claims within three days of a lead underwriter's agreement to pay, participants in runoff—of which there are about 40—have the option of making weekly or monthly settlements, explained Peter Hurworth, an Ins-sure official.

Chicago-based CNA Financial Corp. disclosed that it has \$600 million in reinsurance recoverables from Gerling Group, all but \$170

million of which is secured by collateral, and that it "continues to bill reinsured losses and collect payments from the Gerling Group in the normal course."

W.R. Berkley Corp. of Greenwich, Conn., has \$30 million in gross recoverables from Gerling, \$22 million of which is secured by trust accounts or withheld funds, said William R. Berkley, chairman and chief executive officer.

Gerling's payments have been "slow but in accordance with terms," he said. "They certainly would not be on our problem list."

A number of reinsurers have slowed claims payments while dealing with operational retrenchments or financial pressures, several insurer and brokerage officials note.

One broker who competes with Berkshire's direct-writing General Re simply dismissed Mr. Buffett's comments as "self-serving."

Whether Mr. Buffett's shareholder letter turns out to be prophetic—about Gerling or some other as-yet-identified reinsurer—remains to be seen.