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\$4

Court prescribes cost recovery Payers can sue to recoup millions spent on withdrawn drug

By DAVE LENCKUS

NEW YORK—A federal appellate court ruling could be a multibillion-dollar booster shot for self-funded health plans and health insurers trying to recoup their prescription drug costs from manufacturers that allegedly concealed the drugs' health risks, attorneys say.

The three-judge panel of the 2nd U.S. Circuit Court of Appeals on April 18 unanimously ruled that a

union health plan and a health insurer may sue a unit of Pfizer Inc. to recover the \$1.4 billion that all health care plans spent on a diabetes drug that the pharmaceutical manufacturer was later forced to pull from the market. The plaintiffs, which are seeking class action status, contend that a Pfizer unit fraudulently hid known health risks of the drug Rezulin.

The ruling, which overturned a federal district court decision, sig-

nificantly expands health plans' and health insurers' cost-recovery rights, said plaintiffs attorney Richard Cohen, a partner with Lowey Dannenberg Bemporad & Selinger P.C. of White Plains, N.Y.

The 2nd Circuit is the first court to rule that health insurers are the direct purchasers of prescription drugs, rather than merely financial intermediaries for covered patients, explained Mr. Cohen, who represented the plaintiffs in the case.

As a result of the ruling, the plaintiffs can sue to recover the costs they incurred in covering the prescription drug for all of their plan members, regardless of whether the drug harmed all those patients.

Courts previously had limited insurers' and plans' recovery to the drug costs paid on behalf of health plan members whom the drugs actually harmed, attorneys said.

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Late News

EEOC to propose rule on retiree benefits

The Equal Employment Opportunity Commission expects to publish by mid-June a proposed rule that will make clear that altering, reducing or eliminating employer-sponsored health benefits when a retiree becomes eligible for Medicare does not violate federal age discrimination law. The proposed rule would mark another step in the EEOC's policy reversal on the issue and would allay employer fears that common retiree health care plan designs could trigger litigation by the EEOC.

Universal health plan proposal detailed

Blue Shield of California estimates its proposed universal health care plan could provide health care coverage to California's 6.6 million uninsured residents for an additional \$7.8 billion in private and public health care spending. Under the plan, the state government would contribute about \$4.5 billion, businesses would pay about \$3.2 billion and individuals would pay \$63 million. The state contribution could be financed through a 1% increase in the state sales tax or a 0.7% increase in the state income tax, said Bruce Bodaken, president and chief executive officer of the Blues plan.

N.Y. court refuses case with non-U.S. reinsurer

New York courts do not have jurisdiction over a non-U.S. reinsurer disputing coverage with a consortium of commercial aviation insurers that are licensed and suffered losses in the state, because the reinsurance policy was not delivered through the New York mail system, among other reasons, a federal court has ruled. The ruling dismissed the reinsurance claim that Associated Aviation Underwriters, a Short Hills, N.J.-based consortium of U.S. insurers, filed against Bahrain-based reinsurer Arab Insurance Group (B.S.C.) and parent company Arab Insurance Group for more than \$30 million related to losses from the Sept. 11, 2001, terrorist attacks and a passenger jet crash in Queens, N.Y., about two months later.

See **LATE NEWS**/page 23

California self-insurers see savings in new fund

By ROBERTO CENICEROS

SACRAMENTO, Calif.—Self-insured employers in California could soon use a hybrid capital markets and insurance-based arrangement to transfer about \$4.6 billion in workers compensation risks and free up millions of dollars in security deposits.

If the proposal wins final regulatory approval, self-insured employers in the state will no longer have to provide letters of credit or other funds to support their workers comp programs.

Instead, employers will pay an annual assessment that will be used, in part, to administer the capital markets arrangement for most self-insured employers in California.

Supporters say the capital markets approach will enable employers to make better use of their money.

"The intent is for self-insurance
See **WORKERS COMP**/page 21

Pharmacist oversight cuts cost of chronic diseases

By MICHAEL PRINCE

ASHVILLE, N.C.—A novel disease management program begun by a North Carolina city is now going national.

The program—dubbed the Asheville Project—has slashed medical costs for participants with, for example, diabetes by more than 25% on average, with larger savings over time.

Many employers now are turning their attention to the experience of Asheville, N.C., and with good reason. Since 1997, when the disease management program was launched to improve the health of a few hundred city workers with four chronic diseases—diabetes, asthma, hypertension and high cholesterol—the city has saved thousands of dollars in medical expenses.

Capitalizing on the project's success, five employers around the country now are participating in recently launched pilot programs based on the Asheville Project.

Besides the potential for savings on medical expenses for chronic

diseases, employers are attracted to the unique way the project operates. The program relies on specially trained pharmacists to monitor participants.

Patients agree to monthly meetings with the pharmacists, who

sign up to participate in the program and undergo specialized training. These regular meetings are designed to ensure the patients are taking their medications and are maintaining their health. In addition, patients agree to monthly meetings with the pharmacists, who

See **ASHEVILLE**/page 22



International

TORONTO FACES SARS CHALLENGE

Begins on page 17



City can't opt into, out of ERISA at will: Ruling

By JUDY GREENWALD

NEW ORLEANS—A city's benefit plan is not governed by the federal Employee Retirement Income Security Act, and saying it is doesn't make it so, a federal court has ruled.

In an April 2 decision in *Glen R. Michel vs. United Healthcare of Louisiana Inc. and the City of Gretna*, a judge ruled that, despite plan language that describes Gretna, La.'s, benefits plan as an ERISA plan, the city, as a governmental entity, is precluded from establishing an ERISA health benefit plan for its employees.

As such, the U.S. District Court for the Eastern District of Louisiana

ruled that the case was not subject to federal jurisdiction and remanded it to state court, where the plaintiff can pursue punitive damages and various claims that are not permitted in federal court under ERISA.

According to the decision, Mr. Michel, a former Gretna police officer, had filed the suit in state court, alleging various discrimination claims related to the administration of his health care benefit plan. The defendants had the case removed to federal court, claiming it was an ERISA plan.

Mr. Michel argued that the case should be remanded to state court, because ERISA expressly excludes government plans from its provi-

sions, according to the decision. The defendants maintained, however, that Gretna could "opt out" of the ERISA exclusion because nothing in the statute precludes a city from voluntarily establishing an ERISA plan.

"The sole issue before the court is whether a governmental entity...voluntarily submits itself to federal jurisdiction pursuant to ERISA when it purchases a 'private' welfare benefit insurance plan for its employees," the decision states.

Judge Marcel Livaudais Jr. ruled that such voluntary submission to federal jurisdiction is not allowed under ERISA. Quoting another deci-

See **GRETNA**/page 23

Capacity shrinking as rates continue to rise

D&O market staying hard

By MARK A. HOFMANN

The directors and officers liability insurance market continued its "widespread and dramatic hardening" last year, a study concludes.

Capacity has shrunk somewhat, and prices continued

to increase significantly, according to Tillinghast-Towers Perrin's "2002 U.S. and Canadian D&O Liability Survey," released last week.

In fact, "in 2002, D&O insurance purchasers faced the largest premium increases since the hard market of the mid-1980s, coming on the heels of similar increases in 2001," the report states. "Premium increases for generally equivalent coverage averaged more than 29%," according to Tillinghast-Towers Perrin's D&O premium index, which tracks median and average D&O premiums since 1974.

The survey's most significant finding was that real premium increases were at the same level as in the 2001 survey—nearly 30% on average—said Mark W. Larsen, a Chicago-based consultant and director of the study.

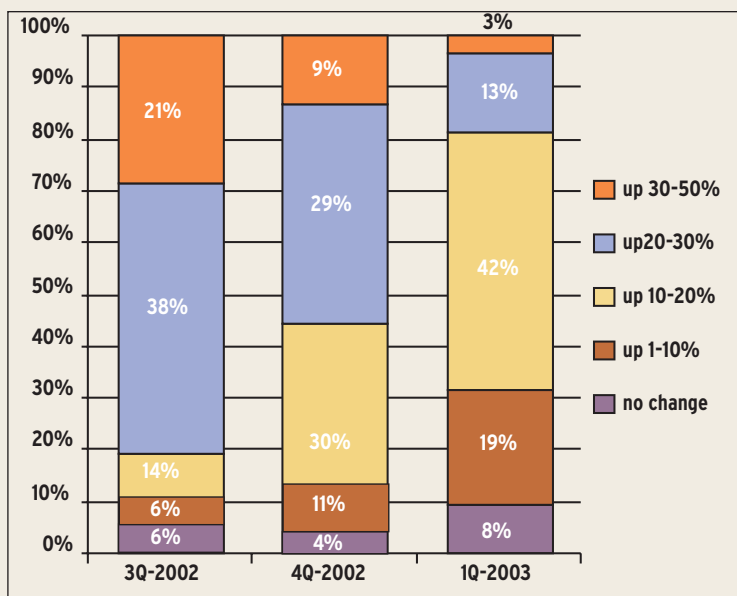
"Some sectors faced triple-digit premium increases," he said. "Very large companies, sometimes called 'trophy accounts,' saw dramatic premium increases in 2002 after avoiding the worst increases in previous years," said Mr. Larsen.

Among the hardest hit firms were for-profit health services companies, merchandisers, durable goods manufacturers, firms involved in recent initial public offerings and companies "exhibiting some degree of financial distress," the report found. Very large companies also felt the market crunch more than smaller ones. "Although carriers recognized that some of these firms were actually very good risks, underwriters were extremely selective," the report states.

See **D&O**/page 20

P/C RATE INCREASES MODERATING

Agents and brokers saw commercial property/casualty rate hikes ease in the first quarter of 2003, compared with previous quarters.



Source: Council of Insurance Agents & Brokers

P/C rate increases slow down: Survey

By MARK A. HOFMANN

Commercial property/casualty rates may be starting to stabilize, according to a survey released today by the Council of Insurance Agents & Brokers.

Roughly two-thirds of the 117 producer respondents to the CIAB's "First Quarter 2003 Commercial Property/Casualty Market Survey" reported that accounts of all sizes had experienced rate increases averaging 20% or less during the first three months of the year.

And, in contrast to other recent CIAB surveys, only a handful of accounts experienced increases of more than 30% on average. For example, only 3% of the respondents said that rates for large accounts—those that generate more than \$100,000 in fees and commissions annually—had experienced increases of more than 30% during the first quarter of 2003. Eleven percent of respondents had reported increases in

excess of 30% for large accounts during the fourth quarter of 2002 (*BI*, Jan. 27).

Rates for some lines, however, continued to soar. Forty percent of respondents said medical malpractice liability rates had increased by more than 30% for accounts of all sizes during the past three months.

In a statement accompanying the survey, CIAB President Ken Crerar noted that rate increases in both business interruption and commercial property accounts seemed to be relenting.

"There are still exceptions in major metropolitan areas, especially when a trophy property or major tourist attraction is involved, but our members are reporting that more competitive pricing may be returning to the market. Carriers are also more willing to write risks than a year ago, another sign of market stabilization," he said.

A copy of the complete survey is available at the CIAB's Web site, www.ciab.com.

D&O PREMIUMS BY INDUSTRY

Median premium for U.S. firms, with varying limits

Industry	premium
Utilities	\$375,000
Durable goods manufacturing	200,000
Merchandising	190,591
Nondurable goods manufacturing	178,690
Banking	170,000
Petroleum, mining and agriculture	150,000
Transportation and communications	112,500
Health services	90,000
Construction and real estate	82,800
Nonbanking financial services	80,000
Personal and business services	56,649
Biotechnology and pharmaceuticals	55,008
Technology	42,993
Education	40,000
Government and other nonprofit	3,496

Source: Tillinghast-Towers Perrin

Inside Business Insurance

Health care buyers investing in quality

Several large employers have launched a program to pay bonuses to physicians that implement quality-improvement measures. **Page 4**

Exec 401(k) loan denials not an ERISA violation

The Labor Department says employers can deny executive 401(k) loans without violating ERISA. **Page 4**

Will you still insure me when I'm 104?

Paul Winston wonders how life insurers deal with those who live into their hundreds. **Page 6**

Insurer, buyer splits create problems

Policyholders should take steps to ensure that cutting ties with an insurer doesn't result in a messy divorce. **Page 10**



Australia considers terror coverage levy

A plan to provide mandatory terror coverage is causing concerns among risk managers Down Under. **Page 17**

Online

- The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info on your own event.
- Searchable **directories** of all the listings of industry vendors found in *BI's* Market Sourcebook.
- New **Opinion Poll** for readers: In light of the World Health Organization warnings regarding SARS, has your company instituted a travel ban to affected cities or countries?

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS.

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Pay-for-performance plans seek to cut costs

Bonuses paid for quality health care

By MICHAEL PRINCE

In the latest move in the battle against rising health care costs, several major employers have created a program that will pay bonuses to physicians who implement quality-improvement measures.

The program, Bridges to Excellence, was launched earlier this month by a coalition of large employers and health plans that includes Ford Motor Co., General Electric Co. and Verizon Communications Inc.

So-called "pay-for-performance"

programs reward physicians who implement certain measures, such as proven treatments for medical conditions or steps that seek to reduce medical errors. And the concept is drawing increasing attention from health care buyers looking for ways to cut rapidly escalating health care costs over the long term.

"All progressive purchasers and health plans are thinking of ways to do this," said Suzanne Delbanco, executive director of the Leapfrog Group. The Washington-based

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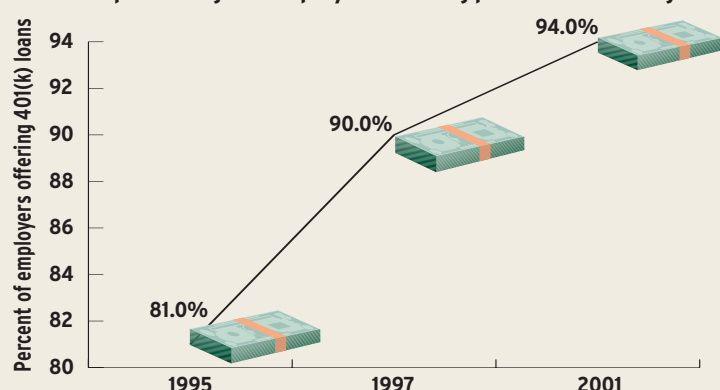


PHOTO: KRT

Physicians who adhere to high-quality medical practices, such as helping diabetics screen their glucose levels, will be rewarded by a group of large employers.

401(k) LOAN PROGRAM GROWTH

The percentage of employers offering plan loans is rising



Source: Hewitt Associates Inc.

Sarbanes-Oxley rule won't violate ERISA

401(k) loan denials allowed by DOL

By JERRY GEISEL

WASHINGTON—Employers fearful about violating a federal corporate governance law can deny 401(k) plan loans to corporate officers and directors without running afoul of pension rules, the government says.

In new guidance, the Labor Department has eased employer worries that complying with the Sarbanes-Oxley Act could lead to violations of the Employee Retirement Income Security Act for companies with 401(k) plan loan programs.

Under Sarbanes-Oxley, which Congress enacted last July in response to a wave of corporate and accounting scandals, public companies are prohibited from making or arranging, directly or indirectly, personal loans to corporate executive officers and directors. Benefit experts had warned that the wording of the statute was so broad that it could include loans offered through 401(k) plans.

However, employers were concerned that if they stopped making 401(k) plan loans available to officers and directors, they would violate ERISA. Under

that law, if savings plans offer loans, they must be available on the same basis to all plan participants.

But in Field Assistance Bulletin 2003-1, the Labor Department said that employers, concerned about the application of Sarbanes-Oxley, can deny corporate officers and directors 401(k) plan loans without violating the requirements that loans be available to all participants.

"In our view, a decision to disallow a participant loan based on a reasonable question concerning the legality of the loan would not be a failure to provide loans to all participants on a reasonably equivalent basis," the bulletin said.

Benefit experts welcomed the announcement, noting that it will end the uncomfortable position employers had faced in which compliance with either law could have resulted in violating the other statute.

"This is very good news. No longer are employers between a rock and a hard place," said Marilyn Scalia, a director at Mellon HR Solutions in Fort Lee, N.J.

"This bulletin provides the

See **401(k)**/page 14

Talks over middle-market business break down

Sale of Kemper book scrapped

By MICHAEL BRADFORD

LONG GROVE, ILL.—Kemper Insurance Co.'s plan to sell the renewal rights on its middle-market accounts to a group of investors appears to have fallen through.

Kemper said Thursday that negotiations with Securitas Capital L.L.C., Cypress Merchant Banking Partners II L.P. and Gilbert Global Partners L.P. had been called off. The investors had planned to form a new company that would operate under the Kemper name but would not assume any of the original Kemper liabilities or be affiliated with that company.

The Long Grove, Ill.-based insurer said in a statement that it is "evaluating its options" with respect to the failed negotiations. The accounts that were to be sold included workers compensation, marine, small-business accounts, professional liability for architects and engineers, fidelity and other lines.

Kemper was to receive \$9 million in the sale, as well as commissions on renewals in the lines of business acquired by the new entity and other benefits.

Kemper plans to transform itself into a third-party administrator (BI, March 10).

The insurer said it is unclear what impact the failed negotiations will have on its offer last month to buy back \$700 million in surplus notes issued by its Lumbermens Mutual Casualty Co. unit.

A Kemper spokeswoman could not be reached for comment.



PHOTO: COURTESY OF KEMPER INSURANCE COS.

Kemper plans to transform itself into a third-party administrator.

High court to review charges of reverse age discrimination

By MARK A. HOFMANN

WASHINGTON—Employers could face expanded liability and costs if the Supreme Court rules that federal law forbids them from treating older workers more favorably than younger workers in situations where all of the workers involved are at least 40 years old.

The case, *General Dynamics Land Systems Inc. vs. Dennis Cline et al.*, which the Supreme Court agreed to review on April 21, involves allegations of reverse age discrimination in retiree health benefits. Under a 1997 collective bargaining agreement, Sterling Heights, Mich.-based General Dynamics Land Systems changed its retiree health benefit policy to one that provided full retiree health benefits only to those workers who were at least 50 on July 1, 1997. The previous policy

guaranteed full benefits to retired workers who had accumulated 30 years of seniority.



A group of workers between the ages of 40 and 49 sued, holding that the provision of health benefits only to workers over 50 constitutes illegal age discrimination under the Age Discrimination in Employment Act. The 1967 federal law protects all workers who are at least 40 years old from age discrimination.

A federal district court in Toledo, Ohio, dismissed the claim, but a divided three-judge panel of the 6th U.S. Circuit Court of Appeals ruled last July that the workers did indeed have a case. Noting that the facts of the case are "unusual," the appellate court's majority held that "if Congress wanted to limit the ADEA to protect only those workers who are relatively older, it clearly had the power and acuity to do so. It did not."

General Dynamics appealed, and

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Recoup: Drug payers can sue

Continued from page 1

"For the large employer that self-funds the prescription drug benefit, this is a very big decision," Mr. Cohen said. "This decision has a billion-dollar-plus impact on pending cases against other drug manufacturers" if the 2nd Circuit's ruling influences courts in the jurisdictions where the other cases are pending, he said.

"I think it's a very important conclusion," agreed fraud attorney Howard D. Scher, a partner with Buchanan Ingersoll P.C. in Philadelphia. While it is not binding on courts in other jurisdictions, "it's going to be persuasive to other courts," Mr. Scher said.

That, in turn, likely will prompt drug makers in other cases to settle quickly, "rather than risk an adverse rule and dire consequences," he said.

A spokesman for the Washington-based Health Insurance Assn. of America called the case "important," because "the 2nd Circuit realized that an insurance company acting on behalf of patients can be harmed by fraud."

Other observers were more guarded in their assessment of the decision's potential impact on similar cases in different jurisdictions.

While the ruling "is an important first step," courts in other jurisdictions could rule that their state's laws do not give legal standing to health insurers and health plans to file such claims, said George Pantos, counsel for the Washington-based Self-Insurance Institute of America.

That is true, Mr. Scher acknowledged, but "courts generally want to give people their day in court."

The Washington-based Pharmaceutical Research & Manufacturers Assn. of America did not respond to requests seeking comment.

Pfizer has not decided whether it will appeal, a spokesman for the New York-based manufacturer said.

The case—a consolidation of separate lawsuits filed under the New Jersey fraud statute—seeks relief for all health care providers that covered the cost of the prescription adult diabetes drug Rezulin from February 1997, shortly after the U.S. Food and Drug Administration approved it, through March 2000, when it was pulled off the market. During that period, doctors prescribed the drug to 2 million patients, according to Pfizer.

The named plaintiffs are Baton Rouge, La.-based Louisiana Health Service Indemnity Co., which does business as Blue Cross & Blue

Shield; and New York-based Eastern States Health & Welfare Fund, a health plan for members of the Needletrades, Industrial, and Textile Employees Union.

The plaintiffs charge that Rezulin's manufacturer, Morris Plains, N.J.-based Warner-Lambert Co., a Pfizer unit, aggressively marketed the drug while knowing it caused liver damage and death in an unacceptably high number of patients.

'This decision has a billion-dollar-plus impact on pending cases against other drug manufacturers,' if it influences other courts.

Richard Cohen
Lowey Dannenberg
Bemporad & Selinger P.C.

To get Rezulin on the market, Warner-Lambert monetarily influenced National Institute of Health doctors who were involved in early studies of the drug, the plaintiffs assert.

The defendant then allegedly pressured the FDA to replace an influential agency doctor who advised the FDA to reject the drug; the drug was approved when the doctor's replacement was not as critical of the drug, the plaintiffs charge.

To keep Rezulin on the market after an abnormally high number of diabetes patients who took the drug began dying or suffering liver damage, Warner-Lambert issued a series of label modifications on how doctors should monitor their patients' liver function, the plaintiffs contend. All the time, the company publicly denied that the drug was unsafe, according to the plaintiffs.

But by March 2000, the FDA had concluded that the drug posed "an unacceptable risk" to patients, and Warner-Lambert withdrew it from the market.

In October 2001, several months after the plaintiffs' lawsuits were consolidated, U.S. District Court Judge Lewis A. Kaplan in New York dismissed the case. The judge ruled that the plaintiffs could not show they were directly harmed by Warner-Lambert's alleged actions.

The judge based his ruling on a 1999 2nd Circuit decision and a 1992 U.S. Supreme Court decision, both of which involved federal racketeering charges.

In the 2nd Circuit's 1999 case,

health insurers unsuccessfully demanded that tobacco companies cover their costs for policyholders' smoking-related medical expenses. A 2nd Circuit panel ruled that the tobacco companies' actions did not directly damage the health insurers. The insurers suffered losses only because their policyholders became ill, the court reasoned.

The Supreme Court case involved a private nonprofit insurer that covers securities investors when the insurer's securities broker/dealer members cannot fulfill their obligations. When a broker/dealer failed as the result of an alleged fraudulent scheme by another company, the insurer covered \$13 million of investors' claims and then sued the company suspected of fraud. The high court barred the racketeering claim, ruling that the link between the alleged fraudulent act and the insurer's losses was not sufficiently direct.

In its Warner-Lambert ruling, the 2nd Circuit panel unanimously rejected the lower court's decision for several reasons.

First, the panel ruled, the union health fund and the Blues cannot be held to the same direct—or proximate—cause of loss standard the earlier rulings established, because the plaintiffs are not alleging federal racketeering violations, wrote Judge Guido Calabresi.

The 2nd Circuit ruled that the plaintiffs meet the less-stringent proximate cause provisions in New Jersey's fraud statute.

Even if the 2nd Circuit had applied the federal racketeering law's proximate cause standard, the plaintiffs would have prevailed, the 2nd Circuit panel ruled.

Unlike the cases the lower court cited, the Blues and the union plan allege a direct injury, independent of whether any patient became ill after ingesting Rezulin, Judge Calabresi explained.

"Plaintiffs' claim is that the defendants' wrongful action was their misrepresentation of Rezulin's safety, and that this fraud directly caused economic loss to them as purchasers, since they would not have bought defendants' product, rather than available cheaper alternatives, had they not been misled by defendants' misrepresentations," the judge wrote.

Caesar Desiano et al. vs. Warner-Lambert Co. et al., 2nd U.S. Circuit Court of Appeals; Docket No. 01-9318, April 18, 2003.

Paul Winston

Hedge your bets, pay the premiums

The oldest living American died last week at age 113.

Having lived through the entire 20th century, Mary Dorothy Christian died on April 20 in San Pablo, Calif., from a case of pneumonia that had started as a common cold. The mantle of oldest American now is upon Elana Slough, a 113-year-old who lives in New Jersey, according to The Associated Press. But she is junior to Japan's Kamato Hongo, who is 115, and a youngster compared to the oldest person on record, Jeanne Calment of France, who died in 1997 at age 122, AP reports.

The first question that came to mind when I heard of Mrs. Christian's passing, I must confess, is whether she was insured. Then how long she had paid her premiums, whether her benefit had grown in size over all those extra years and, yes, whether the insurer would pay her claim.

Sorry to adopt such a cynical view, but in a business climate where insurers routinely question or reject claims arising from unanticipated occurrences or risks, I have to wonder whether living decades beyond a typical lifespan would cause an insurer to balk at paying the claim. That presumes, of course, that the policy wasn't canceled long ago for failure to keep up with payments. It also presumes that whatever life insurer Mrs. Christian might have purchased a policy from years and years ago is still around to pay the claim.

Very few insurers in business at the turn of the 20th century are still around today—or at least in the form they were in at their inception. Mrs. Christian probably wouldn't have recognized the financial services conglomerate of today as the little life insurer she first did business with anyway. All the same, I would hope that if her insurer is still around, it looks upon the opportunity to pay Mrs. Christian's survivors her death benefits as a great public relations opportunity. It would be a chance to prove not only its commitment to long-lived customers but also its own survival in an insurance industry where such a thing, once taken for granted, is now all too fleeting.

Since the names of the other longest-lived centenarians are a matter of public record, I hope that their insurers, if they still exist, are prepared to pay their claims with pride and in celebration of their lifelong achievement.

In fact, the number of people reaching age 100 or more is growing steadily. There are more than 70,000 centenarians today, and the Census Bureau has estimated the

centenarian population could reach 834,000 by 2050.

In an age of medical advances, better living conditions and the elimination of many diseases that previously shortened lifespans, it's not surprising. With continued research into the human genome, I believe we all can expect our lives to be extended beyond that of previous generations. I routinely assure my children that they should expect to live well beyond 100 (a feat they have a hard time imagining while still in elementary school), and I certainly hope to pass that mark, as well.

Unfortunately, some life insurers expect this as well and require endowment, or payout, of the policy at age 100. Luckily for me, my life insurance agent tells me that my policy will continue to grow as long as I continue to live.

If you plan to be around past 100, as I do, and your coverage comes up short, maybe in your 90s you can purchase one of those "guaranteed" life insurance policies advertised on television, as long as the claim that "you

cannot be turned down for any medical reason" is not accompanied by print too fine for your vision specifying an old-age exclusion.

The question of longevity also was in the news last week due to a new study by New York City's Department of Health and Mental Hygiene. The department found New Yorkers born in 2000 are now expected to live longer than other Americans by an average of five years (6.8 years for boys and 3.2 years for girls).

Cynic that I am, though, I again wondered what this development meant in insurance terms. Would premiums be lowered for New Yorkers, since actuarial tables would have to be adjusted to reflect five more years of premiums to collect?

I was also surprised that dwellers in such a large, dense urban environment would have a longer lifespan, not a shorter one. If dwelling in a city that is arguably the epicenter of stress, smog, crime, crowding and fast-paced living means a longer lifespan, what does that mean for those of us living in smaller, slower, calmer urban environments, or suburbs or rural settings?

I don't know, but maybe it's worth checking your life insurance policy and making sure you are current on your premiums for the next 100 years.

Editor Paul Winston can be reached at pwinston@crain.com.



Paul Winston

Pension ruling to cost Xerox

STAMFORD, Conn.—Xerox Corp. said it expects to record a \$183 million aftertax charge in the first quarter of this year to fund an expected award in pension litigation.

A federal court in East St. Louis, Ill., ruled last fall that Xerox's cash balance pension plan owed an estimated \$300 million, before taxes, to former workers and retirees to compensate plan participants for under-

payment of benefits. The participants charged that Xerox had used an incorrect methodology to calculate lump-sum benefits owed to the participants when they left the company (BI, Oct. 7, 2002).

Xerox is appealing, but it has "re-assessed the level of probability for a favorable outcome" following arguments this month before the 7th U.S. Circuit Court of Appeals.

Stamford, Conn.-based Xerox said that, in light of that reassessment, accounting rules dictate that it must now take the charge.

Xerox noted that any final judgment would be paid first from the assets of its Retirement Income Guarantee Plan. If a shortfall were to occur, the company itself would step in after 2004.

—By Meg Fletcher

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Editorial

Project offers hope for cost savings

IN A SIGN OF HOW widely businesses are searching for ways to reduce their health care costs, some employers around the nation are exploring an innovative new disease management program.

The program is unusual in several ways. For one, it was started not by a major health care organization but by a small employer—the city of Asheville, N.C. Another novel element of the program is its reliance on specially trained pharmacists to monitor the wellness of employees with certain chronic diseases. And finally, the disease management program is notable for its significant savings for Asheville in the six years it has operated.

Dubbed the Asheville Project, the program lowers costs by helping city employees better manage chronic conditions, such as diabetes, asthma and hypertension.

As we report on page 1, the project has saved the city thousands of dollars in health care costs for each enrolled employee, especially through a reduction in hospitalizations and emergency room visits. An added benefit is that absenteeism among participating employees has fallen by half.

Asheville's project offers to waive the prescription drug copayments of employees who agree to meet monthly with pharmacists. The pharmacists, who are paid by the

city, are trained to help the employees follow physicians' treatment instructions and perform basic health screenings.

While we applaud the effort to seek new ways to improve employee health and cut costs, we're not yet fully convinced that Asheville's experience can be widely duplicated.

For starters, the project requires an additional level of interaction with a health care provider. This necessitates clear communication between pharmacists and employees' physicians and health care payers, be they managed care organizations or self-funding employers. Furthermore, how many workers in urban

areas have a trusting relationship with their pharmacists? Some may be reluctant to enter a program that requires them to discuss their health habits with someone they don't know well.

Even so, the Asheville Project has clearly achieved success for its original sponsor and some area employers that have copied the program. To the extent that more employers can get employees and pharmacists to participate, copying this approach might help lower their costs of providing health care coverage to employees with chronic illnesses. At a time of runaway health care costs, it's a prescription worth trying.

Reverse ADEA decision

IT'S NOT EVERY DAY that a court gets a chance to put the lid back on a can of worms, but that's just the opportunity the United States Supreme Court accepted last week when it agreed to review an age discrimination case from Ohio.

As we report on page 4, the can of worms in question was opened by a three-judge panel of the 6th U.S. Circuit Court of Appeals last year. Ruling 2-1 in a case currently known as *General Dynamics Land Systems Inc. vs. Dennis Cline et al.*, the panel's majority gave the go-ahead for one group of employees covered under the Age Discrimination in Employment Act to sue their employer because it had allegedly favored another group of employees also protected

by the ADEA.

Unlike most age bias cases brought under ADEA, though, the employer came under legal fire for treating older workers better than younger workers when it changed a retiree health benefits plan to cover only those who had reached the age of 50 by a certain date. A group of workers aged 40 to 49 sued, claiming that their ADEA rights had been violated by reverse age discrimination. Although a lower court held for the employer, the 6th Circuit panel reversed, holding that if Congress had wanted to favor older workers under the ADEA, it could have explicitly said so in the 1967 law.

If the high court follows that reasoning, a host of employer-provided benefits would expose em-

ployers to allegations of reverse age bias.

What, for example, would happen to early retirement plans offered to workers over, say, 55 years of age? Would employers be forced to open them to anyone 40 years old or older, or would they be forced to rescind any financial incentives offered to older workers for fear of being sued? Similarly, would employers face legal obstacles if they attempted to alter retiree health benefit plans to hold costs in check?

This uncertainty created by the 6th Circuit's ruling is a huge can of worms for employers and their benefit programs. We hope the Supreme Court uses the General Dynamics case to put the lid back on it once and for all.

Letters to the Editor

Events help to ensure that industry will endure

To the editor: The Insurance Brokers Assn. for the State of New York held its semi-annual cocktail party the evening of April 24 at New York's South Street Seaport. Bravo!

Our industry continues its recovery from the events of 9/11 slowly but surely. Far more than any other business sector, the insurance industry suffered the greatest loss as a result of 9/11, and while those of us who work in downtown New York City have tried to move on, the memory of the event and loss of life continues. That is especially so when we get out of the subway at Wall Street and glance toward the reconstruction site of the World Trade Center.

Since 9/11, many traditional insurance networking events in New York City have been canceled or changed format for a variety of reasons. One of the pleasures of our business is the relationships we develop with fellow brokers, underwriters, wholesalers and regulators. Events such as the IBANY party provide a forum to foster and strengthen these relationships. Continuation of such well-attended events, by both young entrants to our industry as well as us old timers, ensures that ours is an industry that will endure.

Robert C. Meder
Director
Hagedorn & Co.
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Schillerstrom



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'Prenup' makes breaking insurer ties easier

By Mark Noonan
and Timothy Brady

To obtain the best available coverage given current insurance market conditions, many risk managers are



working with their brokers to market their casualty programs aggressively and are moving them to other insurers. At the same time, corporate mergers and acquisitions continue to result in the consolidation of insurance programs and the termination of relationships with insurers.



Regardless of the reasons for changing insurers, breaking old ties and forming new ones doesn't always result in a smooth transition.

Just as in marriage, divorcing an

incumbent casualty insurer can get messy.

While many risk managers understandably focus on making sure new coverage is in place and all aspects of the relationship with the new insurer are going well, often overlooked is the fact that they still need loss

Just as in marriage, divorcing an incumbent casualty insurer can get messy.

information and related claims services from their former insurer. For instance, problems can arise when a policyholder needs loss runs and other administrative services associated with claims covered by a former insurer. These requirements may continue for years due to the long-tail nature of some casualty risks.

Although a spurned insurer continues to be responsible for handling any claims it covers "from cradle to grave," it may choose not to provide much else, including needed loss information and other services, without tacking on hefty charges.

To avoid such situations, policyholders should work with their brokers to construct a prenuptial-type agreement at the start of a relationship with an insurer. That way, if the policyholder chooses another insurer at some point, key administrative and other services related to future claims will be spelled out, along with attendant pricing.

The agreements can cover a spectrum of claims-related issues that could arise during a relationship with an insurer and for a period of time afterward. They should spell out in writing the specific services to be provided, the operating entities involved and the need for potential adjustments, such as those that might result from acquisitions and divestitures. The agreement also should indicate how long the claim provider's

contractual responsibilities continue after the designated time frame ends.

A completed prenuptial agreement might include a variety of provisions, but here are some that are universal:

- **Transfer of files.** Spell out the third-party administrator or claim-service provider's obligation to send paper or electronic files to other providers according to your instructions. Specify timing, format and cost.

- **Data.** Make sure the claim-service provider will furnish data in an agreed format, medium and frequency—and that these obligations continue beyond the immediate contract period.

- **Cash management.** Delineate responsibilities and procedures for funding and drawing (including second signatories) on cash balance accounts, as well as for the ability to audit and the return of surplus funds to the client.

- **Excess insurance reporting requirements.** Specify the party responsible for reporting claims that potentially could penetrate excess layers, and spell out thresholds and triggers. Specify the format and distribution list in advance.

- **Indemnification provisions.** Beware of one-sided risk shifting provisions in "standard" TPA contracts. Define when the costs of state-imposed sanctions can be allocated to the claim file and, therefore,

passed on to the policyholder.

- **Limitation-of-liability provisions.** Avoid provisions that limit the TPA or claim-service provider's liability to a fixed dollar amount.

- **Insurance requirements.** Consider requiring TPAs to carry designated limits, professional liability and fidelity coverage, as well as to use surety bonds.

- **Dispute resolution.** Beware of provisions that waive the policyholder's rights, including the right to file a bad-faith suit on any coverage provided by an insurance entity related to the TPA or claim-service provider.

- **Confidentiality.** Spell out circumstances under which the insurer may disclose file information to others. Stipulate that compliance with the Health Insurance Portability and Accountability Act of 1996 is mandatory.

When relationships are severed without prenups, policyholders may still be able to enjoy a smooth transition. However, the odds of having an issue-free transition are significantly improved when the framework of the change is already agreed. If you have service issues with your incumbent insurer or TPA, work with your broker to arrange a meeting with the insurer to negotiate a service contract that clearly defines the service provider's roles and responsibilities. If you're further down the road and about to terminate the relationship, ask your broker to step in and negotiate some elements of the prenup. In some cases, these efforts can turn around your relationship and result in improved service for your account.

Mark Noonan and Tim Brady are managing directors of Marsh Inc., based in Boston and New York, respectively.

Output policies still merit consideration

By Joseph S. Harrington

Risk managers are finding that the hard market for commercial insurance has insurers reassessing underwriting practices developed over the prolonged soft market. As part of that reassessment, insurers are re-examining their use of so-called "output" policies to insure large commercial property risks.



Output programs provide property coverage distinguished by two characteristics:

- A broad range of inland marine and supplemental coverages that are written into the basic coverage parts—building and personal property, equipment breakdown, crime and business income.

- A flexible rating procedure that rates a risk as a single entity rather than as the sum of disparate exposures.

Output policies are designed to provide a comprehensive package of property coverages at relatively high limits. By doing so, they provide an alternative to the typical approach of adding individual endorsements, each with its own rating procedure, to a commercial package policy.

In this respect, output policies benefit insurance buyers who value simplicity in the

pricing of coverage, and who want added protection against coverage gaps. Other things being equal, having coverages embedded in a policy rather than attached by endorsement provides better protection against unintended gaps.

Output coverage dates from the development of the "manufacturers output policy" in the 1950s, which was used by industrial insurers to cover property exposures of large, multifaceted manufacturing operations.

Output policies are especially well suited to risks with multiple locations, such as a manufacturer and its dealers, but they are also used to insure risks as diverse as golf courses and school districts.

Today, more than 100 U.S. insurers offer some type of output program, most of them based on the Commercial Output Program, filed countrywide in 1993 by the American Assn. of Insurance Services, an advisory organization based in Wheaton, Ill. The AAIS COP added commercial and institutional risks to the range of operations eligible for output coverage.

Several national insurers also offer proprietary property programs that feature broad built-in coverage and a flexible rating procedure.

Output coverage grew rapidly in the soft market of the 1990s. The premium volume of COP business reported to AAIS rose to \$265 million in 2000 from \$104 million in 1996.

One reason for the growth was that rating plans commonly used in output programs provided underwriters with an efficient tool for addressing price competition.

The COP, for example, features a filed rating procedure, rather than filed rates. This procedure allows underwriters to modify manual loss loads through a systematic process of assigning "deficiency points" to reflect each risk's fire protection, construction type, deductibles and other risk characteristics.

Faced with intense competition for commercial coverage, insurers that wrote output coverage displayed three tendencies in the 1990s:

- They offered output coverage for classes of businesses they would not have previously.

- They offered output coverage for smaller risks than previously.

- They used output policies to renew commercial property accounts, essentially expanding coverage while holding the line on premium.

While the expansion of output coverage in the 1990s may have been price-driven, most of the COP writers contacted by AAIS in a recent study indicated that their COP business had been profitable.

Still, insurers are taking advantage of today's hard market to institute more rigorous underwriting of output policies, as well as other commercial lines.

AAIS has found that commercial property writers are responding in several ways to the hard market:

- Instead of renewing commercial property accounts with output policies, some output business is being shifted to commercial property forms, where coverage is not as broad.

- The use of output coverage for an

expanded range of risks may be slowing. Some companies indicate they use output policies only for accounts that are "marine-driven," i.e., those with relatively large transit or data processing exposures.

- Some companies are pulling back from providing blanket coverage under the COP, opting to provide scheduled location coverage or a combination of blanket and scheduled coverage.

Despite all this, there are still good reasons for insurers to write output coverage, and buyers should not get the false impression that output policies are not available in today's market.

For one thing, insurers find that the flexible rating procedures in output programs allow them to react to loss experience and changing exposures without having to make a rate filing. In addition, the built-in coverages that help protect policyholders against coverage gaps also help protect brokers and underwriters from errors and omissions exposures.

It is difficult to tell whether output policies will be used more or less in coming years. We may see increased premium as rates harden, but the number of accounts written with output policies may stabilize or decline.

Nonetheless, insurance buyers should not lose sight of the potential benefits of output coverage, and they should ask brokers to seek quotes on output policies for appropriate risks.

Joseph S. Harrington is director of communications for the American Assn. of Insurance Services in Wheaton, Ill.

April 28, 2003

Perspectives

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Time to separate financing, delivery of health care

By Hank Kearney

Perhaps it's time to take insurance out of the managed health care equation. Premium increases are in double digits, employers are canceling group coverage and the public's appetite for a nationalized health care system is growing. And the contrived system combining health care and health insurance that has evolved bears



examination.

The most common definition of a "managed care organization" is one that integrates the financing and management of health care for a group of individuals. I believe that the functions of health

insurance and the delivery of health care are two distinct tasks, and there seems to be little advantage in attempting to combine and centralize these disparate activities.

I strongly support clinical decision-making by clinicians rather than bureaucrats in centralized headquarters—be they clinical or administrative. A growing number of judges are of a like mind. But I also support the same professional recognition for insurance decisions. Let risk, actuarial, underwriting and market decisions evolve within the context of insurance.

The premise of all types of insurance is the spreading of risk among many. But this tenet

The functions of health insurance and the delivery of health care are two distinct tasks, and there seems to be little advantage in attempting to combine and centralize these disparate activities.

is in direct conflict with medicine, which is focused on the individual.

In an attempt to combine these two functions over the years, managed care organizations have evolved into a dispenser of aggregate or population-based health care. Or at least they are trying. Through statistical analysis, industry accreditation bodies examine and rate managed care organizations.

Ratings are based on factors such as percentages of eye exams for diabetics or follow-up care for psychiatric discharges. However, these are not insurance functions; they are clinical. And these same industry organizations have moved to impose noninsurance criteria on insurance companies, such as physician waiting room times or patient-satisfaction data.

But perhaps no area causes more confusion and misdirected energy than the industry's attempts to prospectively manage the delivery of medical care.

Today, when a primary care physician in a managed care organization diagnoses a patient and recommends a particular medical procedure, the physician is acting within the parameters and guidelines of the managed care organizations. This physician, one who

is fully vetted and credentialed by the managed care organizations in compliance with the accrediting bodies, must also make that medical decision in the patient's best interests.

If there is a conflict, an appeal is then made to the managed care organization's medical management team and medical director.

A recent study by the American Medical Assn. of managed care organization patient appeals clearly illustrates the bind in which insurers find themselves. Of the appeals for preservice denials, 57.6% were for medical necessity and out-of-network care, while only 36.6% were about covered benefits. Unfortunately for insurance companies, the public probably thinks that 100% of these appeals are justified.

Yet in an environment where health insurance is distinct from the delivery of care, treatment decisions are made between the patient and his or her doctor. If the treatment is a covered benefit, the insurance reimburses up to the limits of the policy. The insurance company does not interject its policies and procedures on the personal decisions between patient and doctor.

The logical conclusion of the blending of

medical care, medical management and health insurance is the increased exposure of managed care organizations to lawsuits. The 2nd U.S. Circuit Court of Appeals recently ruled that the Employee Retirement Income Security Act does not shield managed care organizations in cases where a managed care organization's medical director is involved with treatment decisions.

In short, the ERISA pre-emptions for managed care organizations are eroding. Medical decisions, triumphs and errors are the domain of the medical profession; the trouble is, courts now rightfully find little distinction between medical care and health insurance.

From network contracting and disease management to actuarial science and claims management, managed care combined the disparate functions of insurance and the delivery of health care.

Perhaps it's time for the health insurance sector to concentrate on its own fundamentals. The continued blending of the financing and delivery of medical care is a route that will ultimately result in stronger sentiment for a national health plan.

The public's dissatisfaction with the current managed care system raises a question. Outside the United States, the public is increasingly looking to private health care insurance; why does the public in the United States have the opposite sentiment?

Hank Kearney is president of PHM International, an insurance and managed care consulting firm based in Fort Lauderdale, Fla.

Amendment violates ERISA anti-cutback rule

A multiemployer pension fund's expansion of the definition of disqualifying employment had the effect of reducing early retirement benefits, according to the U.S. Court of Appeals for the Seventh Circuit. Thus, the court ruled that the change violated the anti-cutback rule of the Employee Retirement Income and Security Act.

Thomas E. Heinz and Richard J. Schmitt Jr. are participants in a multiemployer pension plan administered by the Central Laborers' Pension Fund. Both, who were 39 years old when they retired in 1996, qualified for and began receiving monthly benefit payments under a "service-only pension." The monthly payments under this plan were the same as those available at normal retirement age. Under the plan, monthly payments for those retiring before age 60 were subject to suspension for periods during which the participants worked in certain "disqualifying employment." After their retirement, both Heinz and Schmitt obtained jobs as supervisors in the construction industry, which was not disqualifying. In 1998, the plan was amended and the definition of disqualifying employment was expanded to include the type of employment both Heinz and Schmitt were then engaged in. Thus, the plan suspended their monthly benefit payments. Both sued the fund but lost in the trial court. They appealed the trial court decision.

The appellate court said that nothing in ERISA or Treasury regulations persuaded it to depart from the conclusion that the anti-cutback provision of ERISA applied to the plan amendment here. According to the

Legal Briefs

court, the amendment reduced the participants' early retirement benefits by expanding the conditions triggering a suspension of benefit payments. The trial court decision was reversed.

Heinz vs. Central Laborers' Pension Fund, U.S. Court of Appeals for the Seventh Circuit, Sept. 13, 2002 (BI/03/A.-\$10)

'Will develop' statement not an enforceable promise

In this Employee Retirement Income and Security Act case, the U.S. Court of Appeals for the Seventh Circuit ruled that statements in a welfare benefits plan that a company "will develop" and implement an appropriate separation program was not a legally enforceable promise.

XTRA Corp.'s 1992 welfare benefits plan promised severance pay in a specific amount if the company determined that there should be a reduction in the workforce for business reasons. The following year's plan replaced the severance provision in the previous plan with the following: "The company will develop and implement an appropriate separation program if business and economic conditions necessitate a reduction in force." Subsequently, XTRA terminated 55 employees when it transferred the part of its business in which they worked to ContainerPort. ContainerPort hired all of the 55 employees at the same wages plus 3% of what they had received at XTRA, with a

benefits package similar, though not identical, to what they had at XTRA. These employees brought this class action suit against XTRA, claiming that the welfare benefits plan entitled them to severance pay even though they were offered the same employment by ContainerPort without a break, on essentially the same terms. The trial court ruled against the employees and dismissed their suit.

On appeal, the employees argued that they were the victims of a reduction in force. But the appellate court said that the statement in the 1993 plan did not promise severance pay to workers who were terminated, whether because of a reduction in force or otherwise. According to the court, the statement in the plan that the company would develop an appropriate separation program did not create a legally enforceable promise. The trial court decision was affirmed.

Brines vs. XTRA Corp., U.S. Court of Appeals for the Seventh Circuit, Sept. 10, 2002 (BI/01/A.-\$10)

Unauthorized alien due workers comp

Public policy did not exclude an unauthorized alien from receiving workers compensation benefits, according to the Supreme Court of Pennsylvania.

Juan Carlos S. Astudillo immigrated to the United States in 1988, entering California from Mexico. He moved to Pennsylvania in 1990. Mr. Astudillo worked for Reinforced Earth Co. as a maintenance helper. The documents he obtained and presented to his employer in order to secure employment

were invalid, not having been issued by the Immigration and Naturalization Service. On May 20, 1994, as he was working, Mr. Astudillo was struck in and about the head, neck and back by a steel beam and was rendered unconscious. He was treated for a concussion, acute cervical and lumbo-sacral strain and sprain. His doctor concluded that he was unable to perform the duties of his pre-injury job. Mr. Astudillo filed for and was awarded workers compensation benefits. The Appeal Board and the Commonwealth Court affirmed the award. The employer appealed.

On appeal, the employer argued that public policy should exclude Mr. Astudillo from receiving relief under the Workers Compensation Act. The state supreme court said that the act is the legislature's definitive pronouncement of the law governing remedies for work-related injuries. Thus, the court said, it would not, in the face of the act, consider announcing public policy with respect to the receipt of workers compensation benefits by unauthorized aliens. "To do otherwise," the court said, "would be an exercise in judicial legislation, which we will not undertake." The court affirmed the award of benefits. *Reinforced Earth Co. vs. W.C.A.B.*, Supreme Court of Pennsylvania, Nov. 6, 2002 (BI/05/My.-\$10)

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

Michigan Blues to cut employees' health benefits

By KATIE MERX

DETROIT—Blue Cross & Blue Shield of Michigan plans to reduce health care benefits for its salaried employees and retirees as part of a plan to trim costs, executives at the health plan said earlier this month.

The Blues also have dropped plans for major new spending on information technology to modernize business-operating systems and claims processing.

The Detroit-based insurer said it plans to scale back benefit plans for its 4,000 nonunion employees even as it reported net income of \$161

million for the year that ended Dec. 31.



Blue Cross & Blue Shield of Michigan and its subsidiaries reported the gain on revenue of \$7.4 billion for 2002. That compares with net income of \$56.1 million on revenue of \$7 billion in 2001.

The 2002 results, buoyed by higher premiums paid by customers, included operating income of \$101.7 million for 2002, up from operating losses of \$48.3 million in 2001 and \$27.5 million in 2000.

Still, the company and its customers are struggling with the escalating costs of providing health care, executives said. The cost of health care benefits has risen by 15% to 18% a year this decade.

And health care customers are demanding that the company reduce its administrative costs, said a spokesman for the Michigan Blues. He said the Blues plan spends 8% of

the money it collects on administration.

So the insurer is looking to keep costs in line, he said.

To that end, Mark Bartlett, Blues senior vp and chief financial officer, said the company is looking to reduce the level of insurance coverage it provides to its employees and retirees. It's an effort to keep in check its administrative costs and the cost to its customers, he said. The company plans to announce its plan sometime this quarter.

The double-digit health care increases of the past few years are unsustainable, Mr. Bartlett said, be-

cause the company can't expect its customers to keep paying that for Blues employees when they can't afford it for their own.

The company isn't going at the problem with the goal of cutting a specific dollar amount, he said.

For one thing, he said, even if the Blues eliminated employee health benefits completely, it would cut only a fraction of 1% of the company's administrative costs.

The goal, instead, is to make the wage and benefits structure affordable for the long haul, Mr. Bartlett said.

At the same time, the company

BC/BS of Michigan can't expect its customers to keep paying for double-digit cost increases for Blues employees when they can't afford it for their own.

*Mark Bartlett
Blue Cross & Blue Shield
of Michigan*

also is evaluating how to reduce escalating commission costs and service fees, limiting capital spending, using attrition to reduce its job force and looking to make its operations more efficient by using its technology.

Mr. Bartlett said agent commissions and service fees in the past five years have risen between 60% and 70%. That level of increase also is unsustainable, he said. But the time line for changing commissions and service fees is a longer one, Mr. Bartlett said.

The issue will take time to sort out, he said, because agents are the main distribution system for the billions of dollars in premium that the Blues plan writes.

The company intends to spend in the \$50 million range for information technology this year, scaling back from the "hundreds of millions of dollars" that the Blues had planned to spend over several years to complete an upgrade of the company's computer system. Mr. Bartlett said the Blues had wanted to get business systems and claims processing on a new technology platform.

But the effort was going to be prohibitively expensive, especially in light of the efficient claims processing that the Blues now operate, he said.

With the \$161 million in net income in 2002 and \$70 million in unrealized gain on investment income, the nonprofit Blues contributed \$232 million to reserves in 2002. That raised the total reserve to \$1.5 billion, up from a \$1.3 billion reserve at the close of 2001, when the Blues recorded an unrecognized investment loss of \$2.8 million and made a \$53 million contribution to reserves. The Blues said reserves are within the regulatory requirements.

Katie Merx is a reporter for Crain's Detroit Business, a sister publication of Business Insurance.



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410(k): Sarbanes-Oxley rules

Continued from page 4

certainly some were looking for," added Rosina Barker, a partner with Ivins, Phillips & Barker in Washington.

Left unresolved, though, is whether 401(k) plan loans to corporate officers and directors are, in fact, banned by the Sarbanes-Oxley law. The Securities and Exchange Commission, the federal agency with primary responsibility for enforcing and interpreting the statute, has yet to put out official guidance on the 401(k) plan loan issue, and many believe it will be a long time, if ever, before it does.

The SEC is so inundated with issues related to Sarbanes-Oxley that this one has to be way down the priority list, said Ethan Kra, chief actuary for Mercer Human Resource Consulting in New York.

Among benefit attorneys and consultants, opinion is very much divided as to whether 401(k) plan loans are, in fact, affected by Sarbanes-Oxley.

Some say 401(k) plan loans would not be affected by the Sarbanes-Oxley ban on companies arranging or providing credit to top executives because so-called 401(k) loans, despite the term, really are not loans.

Since a participant can take only a portion of his or her vested ac-

count balance, the transaction really is only an advance of money already owed to that participant, Ms. Barker said.

Others, though, say that in the absence of a specific exemption for 401(k) plan loans, the transaction would be banned under Sarbanes-Oxley.

'For those that want to be 100% safe and don't want to do anything that hints at a possible securities law violation, amending their plans will be a safe route.'

Michael Weddell
Watson Wyatt Worldwide

In the wake of the Labor Department bulletin, many cautious employers will amend their 401(k) plans to not allow loans to corporate officers and directors.

"For those that want to be 100% safe and don't want to do anything that hints at a possible securities law violation, amending their plans will be a safe route," said Michael Weddell, a consultant with Watson Wyatt Worldwide in Southfield, Mich.

"For those who were on the line," this will push them over, said Valerie Miller, a legal consultant with Hewitt Associates Inc. in Lincolnshire, Ill. "On the other hand, those employers that are comfortable in their belief that 401(k) plan loans are not loans" under Sarbanes-Oxley will not change their policy, she said.

Employers that no longer will allow corporate officers and directors to borrow from their 401(k) plans will have to take two steps.

First, Ms. Scalia of Mellon HR Solutions noted, they will have to provide to recordkeepers the names of the affected individuals, updating the information as needed. "You want to keep that list current," she said.

Second, 401(k) plan documents will have to be amended to specify that corporate officers and directors cannot take loans.

Statistics are not available on what percent of 401(k) plan loans are taken by corporate officers and directors. The number, though, is likely to be small, given the hefty salaries that many of the top executives earn and the relatively small amount of money that can be borrowed from 401(k) plans. Plan participants, under law, can borrow up to the lesser of \$50,000 or half of their vested ac-

count balances.

Still, 401(k) plan loans are attractive to many executives, just as they are to rank-and-file employees, because of such features as an easy application process, repayment through salary deduction and because the interest paid goes back

into the account and not to a third party.

Roughly, 3% to 5% of plan participants take a loan each year, Mr. Weddell said. Loan provisions are nearly universal; a 2001 Hewitt survey found that 94% of plans permit loans.

Consumer Driven Health Plan directory deadline approaching

Business Insurance will publish its online Directory of Consumer-Driven Health Care Plan Providers in conjunction with the May 26 issue. The issue will feature a Spotlight report on consumer-driven health plans and a ranking of the largest such plans.

The directory is published as an editorial service; there is no charge to be included. Eligible companies must simply submit a completed directory questionnaire by the extended deadline of May 5.

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

To be listed in the directory, your organization must provide a consumer-driven health plan directly to employer clients. You must report the number of employer/institutional clients and total number of lives covered to be ranked.

Consumer-driven health plans are described as coverage arrangements involving health care spending accounts or health reimbursement arrangements, network and benefit selection, or customized benefit combinations.

If your company meets the criteria but has not received a questionnaire, please contact Directory Editor Kevin P. Edison at 312-649-5279. Questionnaires also can be downloaded at www.businessinsurance.com.

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Comings & Goings

Brokers:

Melodee S. Dixon has been named program manager of the Physicians Protector Plan program at Brown & Brown Inc. in Tampa, Fla. Ms. Dixon was previously with PHICO Insurance Co. Physicians Protector Plan underwrites and services medical professional liability insurance for small physician groups in Connecticut, Florida, Georgia and Kentucky.

Kansas City, Mo.-based Lockton Cos. Inc. has named **Russell B. Sands** chairman and chief executive officer of its new San Francisco office; **Tad Brockie** was named executive vp of the operation. Both joined Lockton from Aon Corp.

Julian Hall has been named executive vp specializing in worldwide direct and reinsurance business at Paragon International, a professional indemnity broker at Lloyd's of London. Mr. Hall has been a Lloyd's broker for more than 19 years.

Bruce Abernathy was promoted to senior vp from vp of the Daniel & Henry Co. in St. Louis.

London-based Willis Group Holdings Ltd. has made several senior executive appointments in the United States:

- **Chris Engstrom**, formerly chief executive officer of the Seattle office, has been promoted to regional executive officer of the Pacific Northwest Region. He will be replaced by **Chuck Leinas**, formerly senior vp.

- **Linda Kortlandt** was named president and chief executive officer of the broker's Pittsburgh office. Ms. Kortlandt has managed Chubb Corp.'s Pittsburgh office for the past 13 years.

- **Duncan B. Ashurst** was named senior vp of the risk solutions practice at Willis of Illinois. He previously was managing director and executive vp at Near North Insurance Brokerage Inc. in Chicago.

Insurers:

Carol Zacharias was named senior vp at ACE USA, the Philadelphia-based U.S. operating division of ACE Ltd. Ms. Zacharias most recently served as counsel to CNA Global Specialty Lines.

David A.J. Harland was elected senior vp of New York Life Insurance Co. He will continue to serve as deputy general counsel and assistant secretary of the New York-based insurer.

Klaus Gebhardt was named executive vp at ACE Bermuda Insurance Ltd. Mr. Gebhardt has been a senior vp in the property underwriting department since 1999.

At the Bermuda insurer's subsidiary ACE Financial Solutions International Ltd., **Mark Lima** and **Simon Burton** were promoted to executive vp. Both previously were senior vps.

Reinsurers:

Darren Harris was named claims director at GE Employers

Reinsurance Corp.'s Canadian Life & Health Reinsurance unit. Mr. Harris, who joined GE ERC in 2002, held a variety of claims positions at Canadian life/health insurers.

Other suppliers:

Annette Sanchez has joined third-party administrator Crawford & Co. in Atlanta as national sales manager of risk management services. She most recently was senior vp-business development for the Specialty Risk Services division of



Mr. Abernathy



Mr. Engstrom

Hartford Financial Services Group Inc.

Greg Carson has joined PHH Arval as director of business development in the Hunt Valley, Md.-based company's accident and risk management department. Mr. Carson has been in the fleet industry

for 17 years.

Robert N. Hughes was named chairman and chief executive officer of Robert Hughes Associates Inc. in Dallas, a consulting firm he formed in 1979. He has served as president since its inception.

Clark Gates and **Roland Anderson** have joined Centrix Fi-

nancial L.L.C. as executive vps. Mr. Gates had been president and head of investment strategies at Los Angeles-based HighMark Capital Management, while Mr. Anderson was president, chief executive officer and chairman of St. Louis-based Lyndon Insurance Group. Centrix,

a financial and risk management consulting firm, is based in Centennial, Colo.

Larry Kurzner has joined Mellon Financial Corp. as a director in the Human Resources Services sector, which includes Mellon HR Solutions, Buck Consultants Inc. and Mellon Investor Services. Mr. Kurzner formerly was director of global process and rewards at Exult Inc., a human resources outsourcing services provider.

Meg Barker has been named director of marketing at Digital Defense Inc., a provider of network security vulnerability and penetration testing services based in San Antonio. Before joining Digital Defense, Ms. Barker was an independent marketing consultant.

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Between the Lines

Compiled by Joanne Wojcik



'Big Jim' shares his incarceration insights

Former Louisiana Insurance Commissioner Jim Brown says prison made him a new man. While serving a six-month sentence for lying to federal investigators, he wrote a series of columns that he posted at www.jimbrown.la.com. His last appeared a day before he was released earlier this month and claimed the former regulator emerged fit, well-read and befriended by cellmates with monikers like Puff and Grill. His own handle was Big Jim. In his final column, Mr. Brown wrote that he had read "well over 100 books, mostly fiction," and wrote that incarceration is good for body and mind. He recalled intense workouts in the prison gym at Oakdale Federal Prison, where he shed 24 pounds. "I have lived through my darkest hour," Mr. Brown wrote.

PHOTO: AP/WIDE WORLD



Mr. Brown

Do as I say, not as I do

Despite numerous corporate ethics violations in recent years, nearly half of human resource professionals believe ethical conduct is not being rewarded in business today. More HR professionals say they are feeling pressure to compromise their organizations' ethics standards. But they also report personally observing less misconduct in the workplace. The findings are part of the 2003 Business Ethics survey by the Society for Human Resource Management and the Ethics Resource Center.

Nevada health insurance buyers beware

The Nevada Division of Insurance has launched a campaign to educate employers of the pitfalls of buying health insurance from unauthorized insurers. In the past three years, Nevada businesses have lost over \$10 million to fly-by-night health insurance scams. The division is advising employers to always check to see if the company is licensed in Nevada, ask medical providers what, if any, experience they have had with the company and check to see who is on the insurance company's provider list. Nevada Insurance Alert, sponsored by the Nevada Surplus Lines Assn., also is providing assistance regarding questionable insurance claims or companies. Its toll-free number, available in Nevada only, is 888-467-4195, or visit www.nvinsurancealert.com.



Sex change surgery is necessary, judge rules

Woodland Hills, Calif.-based Health Net Inc. is suing for reversal of a state administrative law judge's ruling that it must pay for a patient's sex change operation. The patient, a 57-year-old man enrolled in the state's Medi-Cal program for the poor and disabled, was denied the operation by the medical group providing his care. The decision was upheld by Health Net, a Medi-Cal contractor in whose HMO the man is enrolled. However, in January, an administrative law judge agreed with the patient that the surgery was necessary, and the Department of Health Services upheld the decision. Health Net is appealing that decision.

You are now entering the Twilight Zone...

Issued by California Consumer Health Care Council: "Contrary to the pervasive impression that medical privacy rights were strengthened by the Federal HIPAA regulations that became effective on April 14, 2003, they actually eliminate your right to control the use and disclosure of your medical information. Even if you object, you cannot prevent the release of the information. These regulations allow insurance and drug companies, and thousands of other 'covered entities' to review your lifetime medical record. They authorize the use and disclosure of your medical information without notice, consent or an accounting. You cannot prevent employers, banks and a host of other businesses from obtaining and misusing your confidential medical information. CCHCC has joined...a lawsuit to invalidate these provisions and re-establish your right to keep your medical records private."

Tips and feedback from readers are welcomed. Please send information to jwojcik@crain.com.

Quality: Seeking to lower costs

Continued from page 4

group promotes patient safety.

"Pay-for-performance is a movement," said Becky Cherney, president and chief executive officer of the Central Florida Health Care Coalition in Orlando, Fla. Her coalition is working on its own pay-for-performance program, slated to launch in 2004.

Underlying such efforts is a growing realization among employers that traditional methods of controlling health care costs are not as effective as they once were. Rather than changing health plan design, some employers are seeking to alter how doctors and hospitals deliver care. Their hope is that by making an investment in increasing the quality of care provided, they can reduce costs in the long run by, for example, avoiding hospital stays that result from poorly treated chronic conditions.

Most industries have shown that higher quality leads to lower costs, "and there is absolutely no reason to believe that health care is an exception to that rule," said Dr. Arnold Milstein, national health care thought leader for Mercer Human Resource Consulting in San Francisco.

Pay-for-performance programs are helping to create a much-needed overhaul of the health care system, said Joe Martingale, national leader for health care strategy at Watson Wyatt Worldwide in New York. What is lacking in the current health care system is an ability on the part of patients to evaluate the quality and price of health care providers, Mr. Martingale said. "But that's the direction we need to move," he said.

To reach that point, though, providers need to have an incentive to provide added quality, he said, and the bonuses meet this need.

The Bridges to Excellence program currently addresses diabetes treatment and physician office management; provisions for cardiac

care eventually will be added. The program will cover about 500,000 employees in three cities—Boston, Cincinnati and Louisville, Ky.

Participating employers will pay a doctor \$100 for every eligible diabetic patient treated if the doctor meets certain standards set by the National Committee for Quality Assurance and the American Diabetes Assn. These include such measures as providing regular foot exams and ensuring that patients take their medication and control their blood-sugar level.

Underlying pay-for-performance efforts is a growing realization among employers that traditional methods of controlling health care costs are not as effective as they once were. Rather than changing health plan design, some employers are seeking to alter how doctors and hospitals deliver care.

In addition, participating employers will highlight such physicians in their provider directories.

The incentive program "gives doctors an impetus to take a more-careful look at how they're caring for their diabetic patients," Ms. Delbanco said.

Because controlling a patient's diabetes is not normally a physician's role, the financial incentive is needed to motivate doctors to take on this task and improve patient care, Dr. Milstein said.

"If you don't do a little something extra, it won't get any better," he said.

The other part of the program

seeks to reduce administrative costs. Participating employers will pay physicians a yearly bonus of \$55 for each covered patient if they introduce certain office information systems and electronic care management tools to streamline the delivery of care.

Key to the program is the use of well-accepted diabetes treatment measures, which should reduce physicians' reluctance to implement them, said Francois de Brantes, program leader-health care initiatives at General Electric Co. in Fairfield, Conn., and one of the program's leaders.

In a similar program launched last year, five large New York employers paid a total of \$195,000 to 29 hospitals that implemented certain patient safety programs. While these payments did not cover each hospital's costs to implement the safety programs, it did provide some incentive to adopt them, said a spokeswoman for Empire Blue Cross & Blue Shield, one of the employers involved.

Although interest in pay-for-performance programs is taking hold, it is not yet widespread, Ms. Delbanco said.

For the movement to develop significant momentum, additional standards need to be established. Furthermore, more data must be collected about what an employer can expect to save from its investment in such programs, she said. As such data are developed, more employers will see the value of these programs.

Not everyone is sanguine, though, about the future growth of these programs.

Bill Sharon, senior vp at Aon Consulting Inc. in Tampa, Fla., said he hopes that the concept will catch on, but he's not optimistic it will happen any time soon.

"This is a slowly evolving process, and right now it's just a handful of employers on just a few conditions," he said.

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International

17

SARS warnings curb Toronto travel

By MEG FLETCHER

TORONTO—The Toronto business community's concern about a SARS outbreak reducing revenues and increasing expenses—losses for which insurance coverage is uncertain—was heightened last week when the World Health Organization issued an advisory against nonessential travel there.

On April 23, the WHO added Toronto along with China's Shangxi province and Beijing to the list of places that should not be visited for "unnecessary travel" because of a risk of exposure to severe acute respiratory syndrome, which is a pneumonia-like virus. Already on the list were Hong Kong and the Guangdong province of China.

Such sites "have a high magnitude of disease (and) a great risk of transmission locally outside of the usual health workers," according to David Heymann, the WHO's executive director of communicable diseases. In Toronto's case, there also is concern that at least one infected

person left the city and subsequently caused "a cluster of five cases" among health workers in another, unspecified, country.

The WHO's travel advisory will be re-examined in three weeks, which is twice the maximum incubation period for SARS.

But key Canadian government and health officials as well as the U.S. Centers for Disease Control and Prevention disagree that the advisory is necessary. "All Toronto cases have occurred in persons who have traveled to Asia or had contact with SARS cases in their household or in a health care setting," according to a statement by Toronto officials. As of late last week, Canada reported 327 cases, with 16 deaths; the WHO reported 4,649 cases worldwide, with 274 deaths.

Meanwhile, news of the outbreak has caused many conventions and bus tours to cancel visits to Toronto and has significantly reduced occupancy rates at local hotels, according to two risk managers.

"The epidemic that's going on in

Toronto is one of fear," spurred by "overblown" press reports, said Susan Meltzer, assistant vp-risk management for Sun Life Assurance Co. of Canada in Toronto.

Insurers are likely to deny claims

for SARS-related event cancellations, because "fear of contracting an illness is not sufficient cause to collect on an event-cancellation policy," said Robert P. Hartwig, se-

See SARS/page 20



PHOTO: GETTY/TOM SANDLER

A traveler at Toronto's Lester B. Pearson International Airport picks up a handbill about severe acute respiratory syndrome.

Many major U.K. companies don't meet minimum disclosure level: Survey

Compliance with Turnbull found lacking

By SARAH VEYSEY

Many of the United Kingdom's largest companies are "merely paying lip service" to risk management and corporate governance guidelines, a new report concludes.

A study of 219 of the FTSE 350 companies—the largest 350 publicly listed companies in the United Kingdom—found that 55% have failed to meet even the minimum expected disclosure called for in the 1999 Turnbull report on risk management and corporate governance, according to Simon Lowe, risk management services partner at auditor and management consultancy Grant Thornton in London.

The Turnbull report, which is in-

tended to encourage "best practices," says that publicly traded companies should report on the risks they face and outline their risk management strategies in their annual report and accounts state-

The Turnbull report called for risk management to become embedded in a company's culture.

ments for shareholders.

The Turnbull report also called on management boards to be fully aware of the risks the company faces and the steps being taken to minimize those exposures.

The Turnbull report, spurred by

events including the raiding of corporate pension funds by late publishing mogul Robert Maxwell in the early 1990s, called for risk management to become embedded in a company's culture.

But Grant Thornton's research found that while 53% of companies were aware of the need to "embed" risk management and internal control in the culture of their organization, just 19% explained in any detail in their annual statements how

they were ensuring that the "best practices" outlined by the report are being implemented throughout their organization, Mr. Lowe said.

Sixty-one percent of the 99 FTSE 100 companies studied reported that they included all types of risk—for example, operational as well as financial risk—in their management board's review of risk, the report revealed.

Among the remaining 250 FTSE-listed companies, that percentage dropped to 59%.

Grant Thornton also studied whether companies had summarized in their annual statements the processes applied by management boards and committees in review-

See TURNBULL/page 20

Aussies may see terror cover mandate



Property insurance buyers in some Australian cities, such as Sydney, would face an additional surcharge under a plan to provide terror coverage.

By MICHAEL BRADFORD

SYDNEY, Australia—A proposal that would require all Australian insurance buyers to help fund terrorism insurance coverage is causing some concern among risk managers Down Under.

If the Terrorism Insurance Bill passes in its current form, it would go into effect July 1 and require all commercial property policyholders in Australia to pay a levy to fund coverage that protects against acts of terrorism. Policyholders could avoid the levy—and the coverage—by self-insuring their property exposures.

The bill, which has cleared Australia's House of Representatives, last week was before a Senate com-

mittee.

The coverage differs from that mandated by the Terrorism Risk Insurance Act of 2002 in the United States. Under TRIA, policyholders can reject coverage for terrorist acts, and no payment is required unless coverage is purchased.

Australia's terrorism insurance would cover property losses as well as business interruption and third-party liability exposures related to the covered property. It also would cover chemical and biological attacks but would exclude losses from nuclear incidents; the U.S. law excludes nuclear, biological and chemical attacks.

Australian risk managers differ on whether the coverage should be re-

See TERROR/page 20

World Updates

Rate increases drive Beazley 2002 profit

Beazley Group P.L.C. said that its Lloyd's of London syndicate 623 recorded a profit of £22 million (\$35.4 million) for 2002, compared with a £17 million (\$24.7 million) loss in 2001. The multiline syndicate recorded gross written premiums of £438 million (\$705.1 million) in 2002, up 23.4%. Beazley said that it has seen average rate increases of 33% on renewal business in 2002.

Kiln goes back into the black

Lloyd's of London insurer Kiln P.L.C. reported profits of £5.9 million (\$9.5 million) in 2002, compared with a loss of £11.4 million (\$16.5 million) for 2001, which reflected Kiln's losses from the Sept. 11 terrorist attacks, among other factors. Kiln reported gross written premiums of £268.6 million (\$432.2 million) in 2002, down 2.5%.

Transport mutual holds line on rates

The International Transport Intermediaries Club Ltd. said that, for the eighth year in a row, it will not increase rates at its June 1 renewals. The London-based mutual insurer said that for the 2000 policy year, its most recent to close, it recorded a surplus of \$929,000.

Japan considers pension mandate

The Japanese health, labor and welfare ministry has proposed that part-time employees who work more than 20 hours a week and earn more than 650,000 yen (\$5,423) per year be required to enroll in an occupational pension plan. The rule change, which is part of proposed pension reforms, aims to boost membership in employer-sponsored pension plans in Japan.

Briefly noted

Audrey Zuck has been appointed an executive director in Willis Group Holdings Ltd.'s political and credit risks team in London. Ms. Zuck was formerly vp in the agency finance and insurance group at Banc of America Securities in Washington....John Kavanaugh has been appointed chairman of financial services company Heritage Group, which is based in London and Guernsey. Mr. Kavanaugh was formerly a deputy chairman of Aon U.K. Heritage provides captive management, among other services.

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LEGAL NOTICE

NOTICE OF TERMINATION OF SCHEME OF ARRANGEMENT

CHANCELLOR INSURANCE COMPANY LIMITED (subject to a scheme of arrangement)
 9 Saint Clare Street, London EC3N 1LQ
 (Incorporated in England and Wales under Companies Act 1948 to 1981 with Company Number 1639367)

NOTICE IS HEREBY GIVEN that, by a notice dated 11 April 2003 served on Chancellor Insurance Company Limited ("the Company"), at the Company's registered address, by the scheme administrators pursuant to clause 48.1.5 of the scheme of arrangement which became effective on 2 November 1994 (the "Original Scheme"), the Original Scheme was terminated.

Pursuant to a court order dated 9 April 2003 a new scheme of arrangement was sanctioned and became effective on 11 April 2003 (the "New Scheme"). Potential creditors of the Company should note that the key provision of the New Scheme is to introduce a cut-off known as the Final Claims Submission Date by which time all creditors must lodge their claim against the Company. The Final Claims Submission Date will be 11 August 2003, being 4 months from the date that the New Scheme became effective.

The Company will have no liability to any potential creditor who does not submit a claim form by the Final Claims Submission Date, and thereafter any such potential creditor will not be allowed to participate in the Scheme.

A copy of the Scheme and a copy of the long form explanatory statement required pursuant to section 426 of the Companies Act 1985 can be obtained on request from the Scheme Administrators at 180 Strand, London, WC2R 1WL or on the internet at www.deloitte.co.uk/chancellorinsurance.

Dated 11 April 2003

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LEGAL NOTICE

NOTICE OF BANKRUPTCY OF LLOYD'S NAMES

On January 30, 2003, Aubrey Linn Wilson, Sr., and Joan Burch Wilson, former Names at Lloyd's, filed a Chapter 7 bankruptcy, case # 03-50512-C, in the Bankruptcy Court for the Western District of Texas, San Antonio Division. Policyholders and other beneficiaries of policies insured or reinsured by those syndicates listed below who may have claims against Mr. or Mrs. Wilson should consult an attorney. Mr. Wilson, Lloyd's #016949K, participated during the years of account, 1977-1993 in syndicates 126, 127, 190, 122, 203, 206, 207, 209, 288, 428, 210, 212, 293, 925, 950, 960, 998, 546, 561, 718, 662, 317, 418, 437, 51, 861, 799, 1173, 1232, 1215, 1066, 1067, 1068. Mrs. Wilson, Lloyd's #029565X, participated during the years of account 1982-1992 in syndicates 206, 209, 288, 428, 662, 210, 122, 546, 598, 960, 925, 866, 330, 204, 204, 212, 219, 700, 701, 661, 1028, 503 and 37.

The Court has set a deadline of June 17, 2003, for the filing of Proofs of Claim. Failure to file a timely claim may lead to the claim being disallowed and to the discharge of any liability of the claim. Complaints to determine dischargeability of certain debts must be filed on or before May 13.

LEGAL NOTICE

LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
 SOUTHERN DISTRICT OF NEW YORK

In re

PETITION OF DAN YORAM SCHWARZMANN and MARK CHARLES BATTEN, as foreign representatives of

ASSURANTIEMAATSCHAPPIJ "DE ZEVEN PROVINCIËN" NV (also known as "THE SEVEN PROVINCES" INSURANCE COMPANY LIMITED);

"TRANSATLANTICA" HERVERZEKERING MAATSCHAPPIJ NV;

NATIONALE-NEDERLANDEN SCHADEVERZEKERING MAATSCHAPPIJ NV;

NATIONALE-NEDERLANDEN INTERNATIONALE SCHADEVERZEKERING NV (also known as NV THE NETHERLANDS INSURANCE COMPANY EST. 1845 LTD); and

MERCANTILE MUTUAL INSURANCE (AUSTRALIA) LIMITED,

Debtors in Foreign Proceedings.

In a Proceeding Under
 Section 304 of the
 Bankruptcy Code

Case No. 02-16430

ORDER GIVING FULL FORCE AND EFFECT TO THE SCHEME OF ARRANGEMENT IN THE UNITED STATES

This matter having come before this Court on the Petition dated December 23, 2002 (the "Petition") of Dan Yoram Schwarzmann and Mark Charles Batten (the "Petitioners") as the foreign representatives of Assurantiemaatschappij "De Zeven Provinciën" NV (also known as "The Seven Provinces" Insurance Company Limited), "Transatlantica" Herverzekering Maatschappij NV, Nationale-Nederlanden Schadeverzekering Maatschappij NV, Nationale-Nederlanden Internationale Schadeverzekering NV (also known as NV The Netherlands Insurance Company Est. 1845 Ltd), and Mercantile Mutual Insurance (Australia) Limited (collectively, the "Companies"), for entry of an order pursuant to Section 304 of Title 11 of the United States Bankruptcy Code (the "Bankruptcy Code") giving full force and effect in the United States to the Scheme of Arrangement dated October 28, 2002 (the "Scheme" or "Scheme of Arrangement") between the Companies and their respective Scheme Creditors (as defined in the Scheme) in respect of certain insurance, reinsurance and retrocession business, and upon this Court's Order of January 3, 2003 permitting service of the summons issued in this case by publication and specifying the form and manner of service of notice of the Petitioners' request for entry of this Order, and this Court having considered and viewed the Petition, and there being no answers or responses thereto, the Court finds and concludes as follows:

1. The Petitioners have demonstrated that:
 (a) the Companies are subject to "foreign proceedings" within the meaning of Sections 101 and 304 of the Bankruptcy Code; and
 (b) the Petitioners are the "foreign representatives" of the Companies within the meaning of Sections 101 and 304 of the Bankruptcy Code;
2. Pursuant to principles of international comity and Section 304, the Scheme of Arrangement shall be made binding and enforceable in the United States;
3. The interests of the public will be served by this Court granting the relief requested by the Petitioners; and
4. Venue is proper in this district pursuant to 28 U.S.C. Section 1410(c).

NOW, THEREFORE, it is ordered as follows:

ORDERED, that the Scheme of Arrangement (a copy of which is annexed hereto and made a part hereof) is hereby given full force and effect in the United States and is binding on and enforceable in accordance with its terms against Scheme Creditors in the United States; and it is further

ORDERED, that all persons and entities are hereby enjoined and restrained from taking any action that is inconsistent with the Scheme of Arrangement; and it is further

ORDERED, that all persons and entities are permanently enjoined and restrained from:

- (a) relinquishing or disposing property of the Companies or the proceeds of such property to third parties;
- (b) commencing or continuing any Proceedings (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) against the Companies or any of their property, except as otherwise provided in the Scheme;
- (c) enforcing any judicial, quasi-judicial, administrative or regulatory judgment, assessment or order or arbitration award and commencing or continuing any act or any action or other proceedings (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) to create, perfect or enforce any lien, set-off or other claim against the Companies or any of their property, except as otherwise permitted in the Scheme;
- (d) invoking, enforcing or relying on any statute, rule or requirement of federal, state or local law or regulation requiring the Companies to establish or post security in the form of a bond, letter of credit or otherwise as a condition of prosecuting or defending any proceeding (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceedings or process whatsoever), except as otherwise permitted in the Scheme; provided, however, that nothing in this Order shall in any respect affect any collateral security in existence at the effective date or replacement for such security; and it is further

ORDERED, that nothing in this Order shall in any respect prevent the continuation or commencement of proceedings against any insurer other than the Companies; and it is further

ORDERED, that the Petitioners are authorized to transfer to the Companies in England for distribution pursuant to the Scheme any property, monies or assets of the Companies located in the United States which the Petitioners have or may hereafter recover; and it is further

ORDERED, that this Court shall retain jurisdiction with respect to the enforcement, amendment or modification of this Order or request for any additional relief in this Section 304 proceeding and all adversary proceedings in connection herewith, properly commenced and within the jurisdiction of the United States Bankruptcy Court; and it is further

ORDERED, that no action taken by the Petitioners, their successors, agents, or representatives, or any of them, or their counsel, in preparing disseminating, applying for, implementing or otherwise acting in furtherance of the Scheme, the Order, this Section 304 case, any further order for additional relief in this Section 304 case, or any adversary proceedings in connection with this Section 304 case shall be deemed to constitute a waiver of the immunity afforded to the Petitioners, their successors, agents or representatives pursuant to Section 306 of the U.S. Bankruptcy Code; and it is further

ORDERED, that counsel for the Representatives shall cause the service of this Order (without a copy of the Scheme of Arrangement) as follows:

by United States mail, first class postage prepaid on or before April 21, 2003, upon the known parties in interest at the time of such service; and

by publication, one time, of notice of entry of this Order in Business Insurance magazine (United States), in The Financial Times (United Kingdom), in De Staatscourant (Holland), and in The Australian Financial Review (Australia) on or before May 5, 2003;

and it is further

ORDERED, that service pursuant to the foregoing paragraph should be good and sufficient service and adequate notice for all purposes.

Dated: New York, New York

March 25, 2003

ROBERT D. DRAIN United States Bankruptcy Judge

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Terror: Australians may see coverage mandate

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quired. While some organizations claim their chances of suffering a terrorist attack are remote and that they don't need the coverage, others, such as financial institutions, support the measure.

For the Assn. of Risk & Insurance Managers of Australasia Ltd., the compulsory nature of the coverage is an unwelcome feature in an otherwise welcome piece of legislation. While ARIMA's members don't oppose the use of a levy, they do object to imposing it on all property insurance policyholders.

Risk managers are being forced to purchase the insurance "whether terrorism is a real risk or not," said Brad Greer, president of ARIMA.

He said there are many risk managers with good programs in place designed to protect their organizations from terrorist incidents. Such risk managers don't see a need for the coverage and have little chance of ever filing a terrorism-related claim, according to Mr. Greer.

Under the proposal, insurers would write terrorism coverage to the same limits as provided in the underlying property policies. Insurers would bear the first \$10 million Australian (\$6.2 million) in claims, with each company subject to an annual retention of \$1 million Australian (\$615,271). That retention

could be reinsured in the commercial market.

The legislation also would create the Australian Reinsurance Pool Corp., into which insurers could cede their exposures above the retention. Premiums paid by insurers would fund a pool of around \$300

For the Assn. of Risk & Insurance Managers of Australasia Ltd., the compulsory nature of the coverage is an unwelcome feature in an otherwise welcome piece of legislation.

million Australian (\$184.6 million). Above that level, coverage would be provided by a bank line of credit of \$1 billion Australian (\$615.3 million) and a government-funded indemnity of \$9 billion Australian (\$5.54 billion), providing aggregate cover of up to \$10.3 billion Australian (\$6.34 billion).

The bill proposes that the levy initially would cost policyholders an amount equal to 2% of their property premiums plus a 10% surcharge for properties in the capital

cities of states and territories or 2% if the risk were to be located in other urban areas. Although the levy could be increased, it would be capped at 6% of premiums, 30% for the capital cities surcharge and 6% for other urban areas.

Insurance policies in Australia already carry additional charges for fire services, stamp duties and goods and services taxes.

Although many insurance buyers balk at the proposed requirement, risk managers at some of Australia's banks have a different perspective; as lenders, they want to make sure borrowers are adequately protected from terrorism risks.

David Bell, chief executive of the Australian Bankers' Assn. in Sydney, said in a statement last October that the plan "will provide certainty for loan security and servicing, project finance of large infrastructure and property projects and the funds management sectors which manage property portfolios."

Mr. Bell said he is "pleased that the federal government has acted, because there was a clear market failure after the Sept. 11 terrorist attack, when reinsurers progressively withdrew cover." The new program is important, he added, because terrorism coverage is practically nonexistent or is available only at "a price that far exceeds the per-

ceived cost of the risk."

Insurers are supporting the bill for the same reasons.

The Insurance Council of Australia said in a statement that not only did the Sept. 11 attacks impact the marketplace but that "the issue of terrorism insurance was brought even closer to home with the tragic events that occurred in Bali," referring to the October 2002 nightclub bombing on the Indonesian island, in which many Australian tourists were killed.

By spreading the insurance cost across all property policyholders, the proposal "will make cover more affordable and widely available," according to the council.

Lambros Lambrou, who heads market relationship strategy for Aon Risk Services Australia Ltd. in Sydney, said brokers are waiting for clarification on several aspects of the legislation, including the treatment of captives. "At the moment, there's still a fair amount of detail we're still waiting to hear on."

While the differences in the surcharges for capital cities and urban areas help differentiate the perceived terrorist risk for those areas, basing the surcharges on the underlying property rate could mean that less-risky terrorism exposures could, in some cases, pay more for coverage than

would a high-profile target, he explained. For example, a high-hazard manufacturing risk outside a capital city would face a lower surcharge rate than would an office building in a capital city, but the risk outside the city might pay a much higher underlying property rate on which the surcharge is calculated.

As for the compulsory nature of the bill, Mr. Lambrou said that without such a feature, it is unlikely that enough premium would be raised to fund the government reinsurance pool. Even so, he noted, some of the broker's clients undoubtedly will be unhappy about being asked to participate regardless of whether they feel they need the coverage. Earlier this month, Mr. Greer of ARIMA submitted testimony to the Senate committee studying the measure. In it, he pointed out that while the government has argued that making the levy compulsory would achieve diversification of risk, it may do the opposite.

That's because those who don't want the terrorism coverage may choose to self-insure or fund the risk in captives, he pointed out. "Consequently," he said, "they will not participate in insurance arrangements in Australia which will attract the levy."

Turnbull: Study finds lack of compliance

Continued from page 17

ing the effectiveness of internal controls. In ascertaining the level of disclosure on this topic, Grant Thornton considered, among other things, whether companies had reviewed specialist functions within the company, such as health and safety management, insurance, environmental coordination and legal and regulatory compliance.

While 77 of the 99 FTSE100 companies studied made "some disclosure," on the effectiveness of internal controls, only 58 of those made what Grant Thornton considered to be "good disclosure," Mr. Lowe noted. And among the remaining 120 FTSE 350 companies, 45 made some disclosure, and just six made a fuller disclosure, Mr. Lowe said, citing this as an area of concern.

Many companies, especially medium-size companies, "have a long way to go" to achieve Turnbull-compliant best practice, he noted.

It will be interesting to see how investors react to Grant Thornton's research and concerns, said David Gamble, executive director of the London-based Assn. of Insurance & Risk Managers. "If people aren't reporting on risks satisfactorily, then investors are not getting a clear view as to what is happening in the organization. And if they are not getting a clear view, then they are going to be less comfortable about putting money into that organization," he said.

"Obviously, from the risk management community, we see it as being part of our role to help the executives provide detailed risk reporting," Mr. Gamble noted.

While supportive of the recommendations of the Turnbull report, Steve Fowler, chief executive of the London-based Institute of Risk Management, noted that risk managers and chief executives of U.K. companies have to balance their efforts to comply with corporate governance guidelines with managing other risks facing their organizations. "If you're looking at the average medium-sized enterprise, they've got to look at corporate governance, but they've got to look at all the other aspects of risk management at the same time and try to keep everything on an even keel," he said. "And it is very difficult."

While corporate governance is important, Mr. Fowler noted, it plays little role in preventing many of the largest risk events seen in recent years—such as the Sept. 11, 2001, terrorist attacks or natural catastrophes.

"Risk management is about much, much more than corporate governance," he said.

An executive summary of the Grant Thornton report, "Corporate Governance in Practice or '...don't forget about Turnbull,'" is available at www.grantthornton.co.uk.

SARS: Fear hits Toronto travel

Continued from page 17

nior vp and chief economist of the New York-based Insurance Information Institute.

In addition, business interruption and extra-expense coverages require that there be a physical loss or damage from a covered peril, which does not include disease, Mr. Hartwig said.

One exception would be workers

compensation-type coverage for health care workers who contracted SARS as part of their job-related duties, according to a spokesman for Ontario's provincial Workplace Safety & Insurance Board.

Fear of having to voluntarily quarantine Sun Life workers who work at multiple Toronto locations caused the company to discourage workers from moving among work-

sites, Ms. Meltzer said. Thus far, no Sun Life employee has contracted the disease, she said.

Although ticket sales for the Toronto Blue Jays baseball team are down, league play continues. The Major League Baseball association's medical advisor, however, is recommending that visiting players restrict contact with individuals and large groups.

D&O: Hard market continuing

Continued from page 3

The hard D&O marketplace followed five years of annual premium decreases during the second half of the 1990s. The turnaround stemmed from a variety of factors, including increases in the costs of D&O lawsuits and more expensive reinsurance following the terrorist attacks of Sept. 11, 2001, the report states. The total capacity offered by D&O insurers in 2002 shrank to the 1998 level of \$1.50 billion, compared to 2000's all-time high of \$1.58 billion.

But the report notes that the continued high capacity "suggests that the firming of the D&O market—even the sharp increase seen by some sectors—does not signal a return to crisis conditions similar to those of the mid-1990s."

Despite market conditions, an overwhelming majority of the survey participants purchased D&O coverage in 2002—97% of the U.S. companies and 90% of their Cana-

dian counterparts. Biotechnology and pharmaceutical firms, technology firms and utilities had the highest prevalence of D&O coverage among U.S. businesses, while construction and real estate firms reported the lowest prevalence among for-profit businesses.

Mr. Larsen noted, however, that average policy limits for most asset size groups declined for the first time in eight years. For example, organizations with assets below \$100 million reported average D&O policy limits of \$5.2 million in the 2002 survey, down from \$6 million in the 2001 survey.

Among other findings:

- Employment practices liability claims represented the most significant increase in terms of incidence.

- The average indemnity paid to shareholder claimants reached an all-time high of \$23.35 million in the 2002 survey, compared with \$17.18 million in 2001 and \$9.62 million in 2000.

- American International Group Inc. and Chubb Corp. remained the largest primary D&O underwriters. AIG is the leader in terms of premium volume, while Chubb is the leader in policy count for U.S. policyholders.

- Chubb was the largest excess D&O underwriter in both policy count and premium volume for U.S. policyholders.

The survey was based on the responses of 2,187 U.S. participants with a median asset size of \$30 million and 88 Canadian participants.

Copies of Tillinghast-Towers Perrin's "2002 U.S. and Canadian D&O Liability Survey" cost \$300 for survey participants, \$480 for Risk & Insurance Management Society Inc. members that did not participate and \$600 for others. For more information, contact the Chicago office of Tillinghast-Towers Perrin at 312-609-9347 or mary.maze@tillinghast.com.

ADEA: High court to decide reverse discrimination case

Continued from page 4

the high court agreed to review the case.

"It's important because the combination of rising health care costs and the retirement of baby boomers is putting substantial pressure on employers to control costs," said Quentin Riegel, vp of litigation for the Washington-based National Assn. of Manufacturers. NAM filed an amicus brief with the high court seeking review of the appeals court decision.

"These kinds of questions relating to the benefits that are available to retirees will become more common, thus making the specific issue in this case more relevant, more important. It's something that needs to be resolved, because companies want to provide the best benefits they can for retirees. If the law prohibits that, they need to know in advance," Mr. Riegel said.

"It would be immensely confusing" if the Supreme Court upholds the 6th Circuit ruling, said Paul Siegel, a partner in the Woodbury, N.Y., office of the law firm of Jackson Lewis L.L.P. "There's a split in the circuits. The 1st and the 7th circuits have held that the ADEA does not preclude employers from

adopting policies that may favor older workers over younger ones," he said.

"Prior to the 6th Circuit ruling, employers assumed that ADEA did not prohibit providing more gener-

'Companies want to provide the best benefits they can for retirees. If the law prohibits that, they need to know in advance.'

Quentin Riegel
National Assn. of Manufacturers

ous benefits for older workers," based on a variety of factors, including the Older Workers Benefit Protection Act, said Bruce H. Schwartz, a partner in Jackson Lewis' White Plains, N.Y., office.

"For example, this supported early retirement incentive programs—specifically approved by the Older Workers Benefit Protection Act—benefits based on achieving a certain age, or benefits that become more valuable as a worker grows older—such as group health insur-

ance or group life insurance," Mr. Schwartz said. "If the Supreme Court upholds the 6th Circuit ruling, all of these programs would be open to question."

"The Supreme Court's acceptance of this case for review is key for employers, because a future ruling likely will have important consequences for employers, (human resources) professionals, and risk managers," said Gerald L. Maatman Jr., a partner in the Chicago law firm of Seyfarth Shaw.

"Should the Supreme Court interpret the ADEA to allow for 'reverse age discrimination' claims," Mr. Maatman said, "this will represent an expansive interpretation of the law with a concomitant impact on all types of age discrimination suits. Such a ruling also will force employers to rethink the manner in which employee benefit plans, reductions-in-force and early retirement programs are structured."

"The financial consequences of distinctions among employees over 40 will need to be recalibrated should the Supreme Court broaden the ADEA to reach those types of personnel issues," Mr. Maatman said.

Workers comp: New fund offers savings

Continued from page 1

in California ultimately to be less expensive than what it is now," said Theresa L. Muir, manager of workers compensation for Southern California Edison Co. in Rosemead, Calif.

The capital markets facility stems from a push by some employers to find a more economical way to provide guarantees for self-insured programs.

That push resulted in legislative changes last year that allowed the state's Security Fund to seek alternative ways to support unfunded workers comp liabilities.

Currently, the roughly 325 private-sector employers in California that self-insure their workers comp risks must participate in the Security Fund, a private nonprofit corporation that acts as a guaranty fund for self-insured workers comp liabilities.

All self-insured employers must post security deposits with the state based on their estimated annual workers comp liabilities. The minimum deposit is the greater of \$220,000 or 135% of an employer's estimated future liabilities.

Employers currently must post surety bonds, letters of credit, secu-

rities or cash with the Self Insurance Plans Division of the California Department of Industrial Relations. When employers default on their obligations, such as through bankruptcy, the state turns over their deposits to the Security Fund, which then pays the outstanding claims.

The Security Fund also has authority to assess all participating employers a maximum of 2% of their prior year's payments on new claims. Such an assessment currently would amount to about \$4.5 million. By law, the Security Fund's members are jointly liable for any shortfall in funds available to pay the obligations of defaulting employers.

The Security Fund currently has \$58 million unfunded liabilities. The shortfall resulted from the bankruptcy of surety providers and several self-insured employers (*BI*, Aug. 5, 2002).

Tapping capital markets

Legislation passed last year allows the Security Fund to adopt a new method of guaranteeing the payment of claims. The Security Fund

See **WORKERS COMP**/next page

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Workers comp: New California fund offers savings

Continued from previous page

now can assess participating employers based on their credit ratings and incurred liabilities.

Under this system, a composite fund from the assessment of most participating employers will replace the individual security deposits that self-insured employers currently post, said Mark Ashcraft, manager of the Self Insurance Plans Division and a trustee for the Security Fund.

Some employers will be excluded from this system, such as those with very low credit ratings, Mr. Ashcraft said.

The collective assessment will equal the roughly \$65 million that California's self-insured employers spent on funding their security deposits this year, said Ms. Muir, who is also chairwoman of the Self Insurers' Security Fund.

The assessment will be split three ways.

One portion will help pay down the Security Fund's existing short-

fall.

A second portion will be used to create a pool of funds to pay future obligations. As the size of the pool grows over several years, the assessments will be reduced, said Ms. Muir. The pool, estimated at \$35 million the first year, will also serve as a self-insured retention layer.

Finally, \$18 million of the assessment will be used to finance and administer an approximately \$4.6 billion hybrid capital markets and insurance mechanism, said Quentin Hills, managing director for MMC Enterprise Risk in San Francisco, who is structuring the deal.

The \$4.6 billion was calculated based on the amount of money that self-insured employers must post as security.

The mechanism is still being developed but likely will include a portfolio of blended workers compensation and credit risks that will be assumed by a pool of insurers,

Mr. Hills said.

The portfolio will consist of the combined risk of all employers that self-insure in California. Because the portfolio is so large, it will be split and sold to insurers in three tranches, each with a separate bond rating, Mr. Hills explained.

A portion of the \$18 million will cover the insurers' share for assuming the portfolio risk, somewhat like a premium paid by policyholders, Mr. Hills said. Contracts will have an annual renewal, and coverage will be triggered when an employer defaults on its workers comp liabilities.

The Security Fund hired MMC Enterprise Risk to find a more efficient way to guarantee self-insured claims, Ms. Muir said. MMC is now in the process of taking the transaction to market.

Highly rated insurers already have expressed interest in participating, Ms. Muir said.

Employers first looked into creat-

ing a different system more than two years ago, as they believed that the money they paid for surety bonds and other instruments was being lost to the market without any long-term benefit to them, Ms. Muir said.

Since then, capacity in the markets for surety bonds and letters of credit has contracted substantially. For most employers, the price for those instruments has increased 400% to 1,000% over the past three years, said Mark Reagan, chairman and CEO of the Willis Construction Practice at Willis North America Inc. in New York.

Pros and cons for employers

Some employers, however, say they object to being placed in a pool with employers that have lower credit ratings. One such employer is Federal Way, Wash.-based Weyerhaeuser Co.

But on the positive side, the new arrangement will free up \$10.5 mil-

lion in surety bonds that the wood products company now posts annually to guarantee claims for its employees working in California facilities, said Gary A. Baxter, the company's assistant treasurer and director of insurance. Weyerhaeuser will now be able to use those surety bonds for other corporate purposes.

Tim East, director of risk management for the Walt Disney Co. in Burbank, Calif., who is a trustee of the Security Fund, said the new system depends on placing the hybrid capital markets mechanism.

The new system would increase Disney's costs at first but would reduce them over the long haul. Disney's assessment would shrink as the pool grew and it would not have to bear the costs for employers that default, Mr. East said.

"Under the current situation, the insolvent employer declares bankruptcy and walks away from their liabilities, leaving us holding the bag," he said.

Asheville: Pharmacists help cut chronic care costs

Continued from page 1

tion, basic physical exams are conducted. These monthly sessions help the patients stay on track in controlling their disease. If the pharmacists find a health problem, they immediately schedule the patient an appointment with his or her physician.

This constant monitoring catches small problems before they become big ones. The result of maintaining better health is fewer hospitalizations, lower costs and reduced absenteeism.

To induce patients into the program, the city waived all copayments for the pharmacist visits, drugs for their disease and other supplies. For example, diabetic patients pay nothing for their insulin and also receive a machine that measures blood sugar levels. The city, which is self-insured, foots the entire bill.

The city pays the pharmacists an average of \$38 per visit, said John Miall Jr., director of risk management for Asheville, who is one of the founders of the project. "That's a pretty cheap office visit," he noted.

If a patient fails to stick with the program or misses too many meetings with the pharmacist, he or she is removed from the program and has to start paying copayments again, Mr. Miall said.

"Whether you need it or not, you go to your appointment," he said.

The savings have been considerable, according to recently published studies about the program.

The city has saved about \$2,000 in health care spending per year per patient in the diabetes program, said Barry Bunting, clinical manager of pharmacy at Mission St. Joseph's Health System in Asheville, and coordinator of the project.

On average, a patient with diabetes incurred \$7,082 in medical expenses in the year before entering

the program, Mr. Bunting said. This dropped 26% to \$5,210 in the first year of the program and fell 34% to \$4,651 for those in the program for five years.

In fact, the program was so promising from the start that the hospital adopted it in 1998 for its own employees, he said.

The big savings for Asheville have come from reduced hospital costs, according to Mr. Bunting. Because the patients with chronic diseases are kept healthier, they incur fewer emergency room visits and hospital stays, he said.

"The big losers in this whole scheme are the hospitals. Because the hospital is not admitting those patients" whose diseases are not controlled, said Dr. Paul Martin, medical director of health services for Asheville and the medical director of staff health services at Mission St. Joseph's.

The unique feature of paying for regular pharmacist visits helps patients with chronic problems maintain their health, said Bruce Kelly, senior consultant at Watson Wyatt Worldwide in Minneapolis.

"Our medical care system pays a premium for therapy and not for prevention or coaching very much," he said.

Asheville's Mr. Miall estimates that the city has saved \$4 for every \$1 it has spent on employees in the program. Besides the lower costs, the number of sick days for people in the program have dropped by more than 50%, he said. Patients in the program averaged more than 12 sick days in the year before entering the program and fewer than six while enrolled, he said.

Word of the program's success rapidly spread throughout the Asheville region.

"Several companies have either implemented that model for their own employee population or are planning to do it," said Michael

McManus, executive director of the WNC Health Coalition in Asheville.

"We look at it as a true pioneering effort by the city of Asheville," he said.

One area employer adopting the program is Blue Ridge Paper Products Inc. in nearby Canton, N.C., said Jessica Ellis, manager of disability programs for the paper products maker.

'The big losers in this whole scheme are the hospitals. Because the hospital is not admitting those patients' whose diseases are not controlled.'

*Dr. Paul Martin
Mission St. Joseph's Health System*

Blue Ridge launched its program in 2001 for workers in seven states, she said. To date, about 150 people have enrolled, she said.

"If it wasn't for the Asheville Project, I wouldn't have known where to start," she said.

The zero copayment, she said, has been the key in attracting people to the program, she said.

Two aspects of the project make it likely to succeed, said Dr. Arnold Milstein, national health care thought leader at Mercer Human Resource Consulting in San Francisco.

By using the pharmacists, which are an established health care network, the costs for starting and maintaining the program are much lower than traditional disease management programs, he said.

Also, because patients have face-to-face meetings with the same pharmacists, a trusting relationship develops. "You substantially increase the potential of the patient

taking to heart and adopting what the pharmacist advises," he said.

The pharmacists' role is seen as the key to the project's success, agreed Dr. Martin of Mission St. Joseph's.

"Pharmacists are ideal monitors," he said. They are well trained and geographically dispersed, he said. "It's convenient, it's accessible and it's an untapped resource."

Because of its success, the American Pharmacists Assn. Foundation has chosen the Asheville Project as a model for five pilot projects launched around the country earlier this year, said Dan Garrett, senior director of the foundation in Greensboro, N.C., and one of the founders of the Asheville Project.

The five pilot programs, which focus solely on diabetes patients, seek to replicate the Asheville Project with various employers. The pharmacists' group sees this as the first step in a wider introduction of the program, he said.

The pilot programs seek to determine the amount of money employers can save, the impact on employees' health and the best ways to administer the program, Mr. Garrett said. After the one-year pilots conclude, he said the foundation expects to be able to assist any employer in setting up its own program.

One of the employers in a pilot program, VF Corp., was attracted to the program because "the traditional ways of controlling health care costs are just not working anymore," said Debbie Arnold, manager of benefits planning at VF in Greensboro.

About 70 employees have already signed up for the program, she said. And while it's too early to determine any savings, the early responses from employees have been outstanding, she said.

To inform its employees of the new program, VF sent all employees

at the participating locations a special announcement last year. Other communications followed, leading to a December meeting where questions could be answered in person and people could enroll, Ms. Arnold said.

Whether Asheville's approach ever moves into the mainstream is anyone's guess. Mr. Miall predicted that it won't happen until health insurers and medical stop-loss insurers see the savings it can generate and widely promote it to their employer clients.

Mr. Kelly of Watson Wyatt agrees. Since most employers rely on their health insurer or a disease management vendor for this type of program, employers won't adopt it until these vendors offer it, he said.

But others are more optimistic. Mission St. Joseph's Dr. Martin said that other employers could easily adopt similar programs. "The basic premises can be replicated in a variety of settings," he said.

And Ms. Arnold of VF said that with health care costs skyrocketing, now is a great opportunity to present a unique health care program to senior management. "They are open to new ideas," she said.

ADVERTISER

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Late News

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Court ruling restores hospital's liability cap

Massachusetts' highest court has overturned a ruling stripping Brigham & Women's Hospital of its charitable status, thus limiting the facility's liability for malpractice under state law. The ruling reduces a \$4.1 million award against the hospital to \$20,000, in line with the state's liability cap for charitable organizations. The case arose from a medical malpractice suit involved missing documents relating to a 1986 birth. The lower court stripped the hospital of its liability cap protection, finding that, because the records were missing, the plaintiff could not identify other caregivers that would not be subject to the cap.



PHOTO: AP/WIDE WORLD

An April 6 storm destroyed this home in Tatum, Texas.

PCS puts April storm losses at \$1.2 billion

An unusually harsh April storm caused an estimated \$1.2 billion in insured property damage, according to the Insurance Services Office Inc.'s Property Claim Services unit. The violent weather ripped across 10 states April 4-8. Texas sustained the most damage, with an estimated \$885 million in insured property damage, according to the PCS estimate.

Hewitt to buy Northern Trust benefits unit

Hewitt Associates Inc. is acquiring

the retirement consulting and benefit administration business of Northern Trust Retirement Consulting L.L.C. Observers say that with just 200 clients and about \$75 million in revenues, Northern Trust's benefit administration and outsourcing business was too small to justify the major investments in technology benefit administrators have to make to provide services that clients seek. By contrast, roughly 65% of Hewitt's \$1.7 billion in revenues in 2002 was generated by outsourcing and administration services. Terms of the sale were not disclosed.

Gephardt proposes health care reform plan

All employers would be required to offer a health care plan and would receive a 60% refundable federal tax credit for the premium cost

under a sweeping health insurance reform proposal presented by Democratic presidential candidate Richard Gephardt.

The proposal would, he estimates, provide a tax cut of more than \$300 billion over a three-year period to employers that currently provide coverage. The package, whose costs Rep. Gephardt estimates at about \$700 billion over a three-year period, would be financed by repealing the tax cuts Congress passed in 2001.

Major quake forecast for Bay area

There is a nearly 2-in-3 chance that the San Francisco Bay area will suffer a major earthquake within 30 years, according to a government study. The study, prepared by the U.S. Geological Survey's Working Group on California Earthquake Probabilities, projected a 62% chance that an earthquake with a magnitude of 6.7 or greater would strike the area before 2032. A 6.7 magnitude quake struck the Northridge section of Los Angeles in



Mr. Gephardt

1994, killing 57 people and causing more than \$20 billion in damage.

AFIG members report record business

Members of the Assn. of Financial Guaranty Insurers reported a record volume of insurance written in 2002. The nine member companies insured \$431.2 billion in par value of securities, a 16% increase from 2001's record volume. The 2002 total reflects \$228.7 billion in U.S. and international asset-backed securities, a 5% increase over last year's record, plus \$202.5 billion of insured municipal bonds in both the domestic and international markets, a 33% increase over 2001. Insured penetration levels in muni bonds were close to 50%, according to the AFIG.

AIG, Berkshire Hathaway offer surety coverage

A surety facility that will write up to \$200 million per bond and \$600 million in the aggregate for large contractors has been formed by American International Group Inc. and Berkshire Hathaway Inc. The facility is available to contractors with a minimum net worth of \$25 million. AIG companies will underwrite the bonds, and Berkshire Hathaway unit National Indemnity Co. will reinsure the facility on a 50% quota-share basis.

AIG first-quarter profits drop slightly

American International Group Inc.



reported profits of \$1.95 billion for the first quarter of

2003, down 1.4% compared with the first quarter of last year. AIG attributed the decline chiefly to an increase in realized capital losses. AIG's property/casualty operations reported a 24.8% rise in operating profits, to \$1.32 billion. The insurer reported gross revenues of \$18.93 billion for the quarter, a 17.3% increase over the same period in 2002.

Willis reports revenue, profit growth

New business and higher rates at

Willis Group Holdings Ltd. resulted

in double-digit top- and bottom-line growth in the first quarter of 2003, the broker reported. Gross revenues increased by 23.1%, to \$555 million, in the first quarter, while net income rose 72.1% over the year-earlier period, to \$117 million.



Aetna posts \$330 million profit

Aetna Inc. reported profits of \$330 million for the first quarter of 2003, compared with a \$2.83 billion loss in the year-earlier period. The 2002 first-quarter loss stemmed in large part from a \$2.97 billion charge the insurer took because of a change in accounting rules with regard to goodwill. The Hartford, Conn.-based health insurer reported total revenues of \$4.5 billion for the first quarter, a 15.1% decline.

Briefly noted

The Department of Transportation has increased by two hours the required rest period for commercial truck drivers. Drivers must now rest for at least 10 hours between stints at the wheel. The longer rest period will reduce driver fatigue and help lower the number of trucking accidents and deaths, the DOT said....The Occupational Safety and Health Administration has unveiled an online "Evacuation Planning Matrix." The matrix, available at www.osha.gov/dep/evacmatrix, is designed to help employers plan for evacuations during workplace emergencies, including terrorist attacks.

Check out BusinessInsurance.com

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

Online Poll

[4/21 - 4/25]

Do you think the Supreme Court's recent ruling limiting the scale of punitive damage awards will lead to lower liability insurance rates?



22.5%

Yes

70.3%

No

7.2%

Do not know

BI Stock Index

[4/21 - 4/25]

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

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

BI Stock Index 1812.77 **-0.77**

Dow Jones 8306.35 **-0.38**

S&P 500 898.81 **0.59**

Largest gains

Sierra Health Services	32.67%
Gainsco Inc.	26.92%
PMA Capital Corp.	25.00%
SCOR	20.43%
Fairfax Financial Holdings	19.62%

Largest losses

UNUM Corp.	-19.93%
AFLAC Inc.	-10.96%
Arthur J. Gallagher	-5.48%
EMC Insurance Group	-5.21%
Baldwin & Lyons Inc.	-4.66%

Weekly change by market segment

Brokers	-0.42%
Insurers/Reinsurers	2.44%
Managed Care Organizations	2.31%

Source: CNET Investor (investor.cnet.com)

Gretna: City can't opt into ERISA

Continued from page 3

sion, Judge Livaudais wrote that "desire and compliance do not an ERISA plan make. A benefit plan does not choose whether to opt in or opt out of ERISA."

Congress "deliberately excluded governmental plans from the broad sweep of ERISA pre-emption of state laws," Judge Livaudais wrote.

Richard Tuschman, an attorney with Becker & Poliakoff in Fort Lauderdale, Fla., said: "This is an example of an employer trying its best to have an ERISA plan because ERISA, if it does apply," pre-empts state law and precludes such remedies as compensatory

damages for pain and suffering, economic losses and punitive damages.

Furthermore, "ERISA has a heightened standard of review," said Mr. Tuschman. A plaintiff in an ERISA fiduciary liability suit cannot prevail unless he or she can prove that the plan administrator acted in an arbitrary and capricious manner.

Mr. Tuschman said: "The most significant point is that, as the court pointed out, an employer cannot choose whether to opt in or opt out of ERISA. It's a question of law for the court, and not for the plan itself to choose. In this case, the court

found that this was a governmental plan notwithstanding the efforts of the plan to qualify under ERISA," he said.

Brian Ashe, an attorney with Seyfarth Shaw in San Francisco, said the decision "stands for the proposition that state employers cannot avail themselves of the protections of ERISA, even if their plans look and talk like an ERISA plan."

Furthermore, said Mr. Ashe, "once you're in state court instead of in federal court, you usually have a more plaintiff-friendly jury and you usually have a more plaintiff-friendly judge, and so it's a real

detriment for any employer to be in state court in these sorts of matters."

Louisiana's state court system is a more favorable venue for plaintiffs "even though the federal court is a couple of blocks up the street" from the state courthouse, said New Orleans-based solo practitioner J. Mac Morgan, who is one of Mr. Michel's attorneys.

Glen R. Michel vs. United Healthcare of Louisiana Inc. and the City of Gretna, U.S. District Court for the Eastern District of Louisiana, 03-CV-649.