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Airline liability pact faces snags in E.U. / 3

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May 10, 2004

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WTC policy disputes continue

Silverstein hit by Swiss Re setback; prepares for new phase of litigation

By DOUGLAS McLEOD

NEW YORK—Silverstein Properties Inc. is heading into the next phase of the World Trade Center property insurance litigation with a nearly unbroken string of courtroom losses and uncertain prospects against the 10 insurers remaining in the case.

A federal jury dealt Silverstein a second major blow last week, finding that the WTC property program's largest single insurer, Swiss Reinsurance Co., bound coverage on a policy form that treats the WTC's Sept. 11, 2001, destruction as a single event.

The decision followed an earlier verdict that nine other insurers were bound on the Willis Group Holdings Ltd. form, known as Wilprop. In all, insurers representing about $2.41 billion of the program's $3.55 billion limit have now been found to have agreed to the Wilprop form, obligating them to pay only a single limit.

A second phase of the litigation, expected to begin in August, will determine whether 10 insurers not bound on Wilprop—representing the remaining $1.13 billion in coverage—must pay for one occurrence or two. These insurers bound

See WTC/page 18

PHOTOS: EAP

Larry A. Silverstein, inset-left, and New York Gov. George E. Pataki visit the former site of the World Trade Center in lower Manhattan.

Buyers still frustrated by long waits for policies

By SALLY ROBERTS

Despite the pivotal role that slow policy issuance played in the World Trade Center coverage dispute, such delays continue to frustrate risk managers, prompting some to get tough with their insurers.

The WTC dispute arose largely because no final policy had been issued for the program before the Sept. 11, 2001, terrorist attacks, even though the coverage was placed by broker Willis Group Holdings Ltd. before the July 2001 closing of Silverstein Properties Inc.'s 99-year lease on the complex.

At the center of the coverage litigation was the issue of whether several insurers bound coverage on a form that would define the WTC's destruction as a single insured event or on a form that could allow for a double payout of the property program's $3.55 billion limit.

A jury determined that many of the program's insurers bound on the single-occurrence form, though

See POLICIES/page 18

Captive benefits plan gets tentative OK

By JERRY GEISEL

WASHINGTON—The Department of Labor has formally proposed that a major Swedish company be allowed to use a U.S. branch of its Ireland-domiciled captive to fund the benefit risks of the company's U.S. employees.

Under the proposed ruling, published in the May 3 Federal Register, Svenska Cellulosa Aktiebolaget—a paper, packaging and consumer products company better known as SCA—would be able use the recently formed U.S. Virgin Islands branch of its 13-year-old captive to fund benefit-related risks. The captive, SCA Re, would reinsure life insurance, accidental death and dismemberment, and long-term disability policies written by Aetna Inc. for SCA's U.S. employees.

If its application is approved—virtually a certainty after a public comment period—SCA would be the first non-U.S. employer to get Labor Department clearance to fund benefits through its captive. Departmental approval is required because such arrangements are normally prohibited under the Employee Retirement Income Security Act.

SCA is seeking to become the fourth company to fund benefit risks through a captive since the Labor Department in 1999 gave employers an alternative to a 20-year rule that had limited captive fund-

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International

E.U. BROKER RULES PROMPT CONCERNS

Begins on page 13

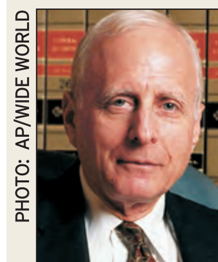
NEWSPAPER

Late News

Asbestos compromise talks break down

Talks aimed at crafting compromise asbestos litigation reform legislation have ended without agreement. The failure of the discussions, which were mediated by U.S. Appeals Court Judge Edward Becker in Philadelphia, likely dooms the chances of any asbestos accord in the current Congress. A measure that would have replaced the current litigation-based system for compensating victims of asbestos-related diseases with a no-fault national trust fund stalled in the Senate last month. Proponents and opponents of the measure agreed to make one more effort to reconcile their differences through mediation. The mediation effort lasted nearly two weeks before ending late Thursday.

PHOTO: AP/WIDE WORLD



Judge Becker

House to vote on FSA carry-overs

The House this week is expected to vote on legislation that would allow employees to carry forward up to $500 a year in unused health care flexible spending account balances. Alternatively, up to $500 in unused balances could be contributed to a health savings account, if the employer maintained one. The bill, which would modify the current "use-it-or-lose-it" requirement for FSAs, would encourage more employees to contribute to the accounts, said sponsor Rep. Jim McCrery, R-La.

N.Y. insurer must show prejudice in late notice

A medical malpractice insurer cannot deny coverage to a New York hospital on a claim that was nine months late without showing that the insurer was somehow prejudiced by the late notice, a New York Supreme Court judge has ruled. The ruling is considered a policyholder victory and counters a long trend among New York courts to adhere to a so-called "no-prejudice" exception.

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Airlines, E.C. may clash over liability notice rules

By DAVE LENCKUS

BRUSSELS, Belgium—As commercial airlines in Europe move to reduce crash-related litigation by voluntarily assuming strict liability for passengers harmed on international flights, the airlines may face a new legal battle with the European Commission over liability notice issues.

Complying with the notice rules, which are part of an E.C. directive but are not required by a new international treaty on airline liability, may not be possible, according to airline industry attorneys.

Late last month, 14 European nations and the European Commission notified the Montreal-based International Civil Aviation Organization that they had ratified the Montreal Convention, which is the unlimited liability treaty that ICAO hammered out in May 1999. The treaty becomes effective on June 28 for airlines based in those 14 countries. ICAO is the independent air transportation arm of the United Nations.

The convention's liability rules apply to the international flights operated by airlines based in countries that have ratified the treaty. Under E.C. rules, the convention's liability requirements also apply to domestic flights operated by airlines based in E.U. member nations.

In its filing, the Commission included a declaration establishing its authority to impose additional liability notice rules on airlines that operate within the European Union. A U.K. court in 1999 suspended enforcement of those rules unless E.U. countries voted to ratify the Montreal Convention. The Commission's rules take effect June 28 as well.

Attorney George N. Tompkins Jr., who represents the International Air Transport Assn., a group of about 240 airlines worldwide, said representatives of the Commission have informed him that it wants airlines to include with passengers' tickets an explanation of the new liability system.

In addition, the Commission wants all airlines operating within the European Union to provide passengers a standard explanation of airline liability, which includes air-

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Awareness lacking on how rule applies

Many Canadian employers not following privacy law

By GLORIA GONZALEZ

TORONTO—Many Canadian companies are still not in compliance with the country's federal privacy legislation, a fact that privacy experts say could expose them to several potential liabilities.

Since Jan. 1, 2004, Canadians' personal information has been protected by a law called the Personal Information Protection and Electronic Documents Act, which sets out the ground rules for the collection, use and disclosure of personal information in the course of commercial activities. It balances an individual's right to privacy with an organization's need for personal information for legitimate business purposes, according to the Office of the Privacy Commissioner of Canada.

Although Canadian companies were expected to be in accord with the legislation by Jan. 1, more than 43% of private-sector organizations have not yet taken actions toward compliance, including 5% who have not heard of PIPEDA, according to a survey conducted by the Toronto-based human resource consulting firm Morneau Sobeco.

A key reason for the lack of compliance is that risk managers are unsure what the legislation actually requires of their organizations, said Nowell Seaman, chair of RIMS Canada Council and manager, risk management and insurance services, at the University of Saskatchewan. "Most risk managers are generally familiar with PIPEDA, although many organizations are not yet sure how it affects them or whether or not it applies to them," Mr. Seaman said. "There have been concerns about how does this affect the way we do business and what liabilities are associated with failure to adhere to the new legislation."

PIPEDA identifies 10 principles of fair information practices that are often difficult to comply with, privacy experts say. The list includes appointing an individual or individuals responsible for compliance, identifying the reasons for collecting personal information and how it will be used and securing an individual's consent for the use of the information. While it may be easy

See CANADA/page 16

PHOTO: ZUMA

Gov. Arnold Schwarzenegger, right, signed reform legislation that California employers say will encourage integration of health care and make providers compete for workers comp business.

California comp law expected to integrate employee health care

By ROBERTO CENICEROS

California's newly adopted workers compensation reform law will help merge medical treatment for injuries and illnesses whether or not they are job-related, employers and vendors predict.

Provisions in the law also will boost the use of managed care practices and spur more medical providers to compete for workers compensation business, they add.

Gov. Arnold Schwarzenegger signed the law April 19.

One provision allows employers to indefinitely direct injured workers' medical care, from a current limit of 30 days, if they establish workers compensation medical provider networks beginning Jan. 1.

For years, many California employers have contracted for workers comp medical network services, doing so independently or through their insurers or other vendors.

But to gain indefinite control of employee care, the new law requires that networks include occupational and nonoccupational doctors "with a goal of" including at least 25% primarily nonoccupational practitioners, according to a Commission on Health and Safety and Workers' Compensation analysis of the law.

Provider networks must also meet some eligibility requirements and receive regulator authorization. But certain organizations, such as managed care companies regulated under California's Knox-Keene Act, automatically meet eligibility requirements, according to the law.

That stipulation, along with the requirement for workers comp networks to include nonoccupational doctors, points

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Inside Business Insurance

Comp fraud costing insurers, customers

Berkshire Hathaway Chairman Warren Buffett called workers comp fraud a costly problem for bother insurers and policyholders. Page 4

ISO files endorsements to limit terror cover

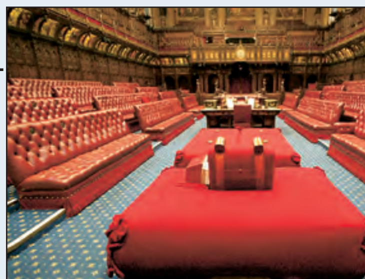
Preparing for the possibility that TRIA is not extended, ISO has filed optional endorsements. Page 4

Tort reform winning popular support, at least

In some good news, research shows that public support for class action litigation reform is increasing,writes Paul Winston. Page 4

An absurd application of insurance regulation

European risk managers should not be regulated as brokers, one of this week's editorials says. Page 8



U.K. employer owed duty of care to worker

The House of Lords, the highest U.K. court, upheld liability for British Steel in a case arguing causality of a worker's injury. Page 13

Online

- *Business Insurance* articles as well as trial documents from the World Trade Center insurance coverage trial.
- Searchable directories of all the listings of industry vendors found in *BI*'s Market Sourcebook.
- New Opinion Poll for readers: Does your organization mandate the use of arbitration to settle employment disputes?

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS.

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Mandatory arbitration losing appeal among employers

By JUDY GREENWALD

Fewer employers are turning to mandatory arbitration agreements to settle employment disputes, say many observers.

While many of the firms that have used mandatory arbitration over the past 10 years or so continue to favor that procedure, the approach is attracting relatively few new recruits among other employers, say observers.

The rising cost of arbitration proceedings, the inability to appeal arbitrators' decisions and the fear of alienating employees are reducing the appeal, say these observers.

But rather than go the litigation route, some employers are turning to other alternative dispute resolution methods, including mediation, observers say.

A key court decision in the mandatory arbitration arena was the U.S. Supreme Court's 2001 decision in *Circuit City Stores Inc. vs. Saint Clair Adams*, in which the court ruled federal law does not bar employers from requiring that employment disputes be settled outside the court.

Somewhat undercutting that decision, though, was the high court's 2002 ruling in *Equal Employment Opportunity Commission vs. Waffle House*, in which it held that the EEOC had the right to pursue "victim-specific" remedies for alleged violations of the Americans with Disabilities Act even though the alleged victim had signed an agreement to settle all employment disputes through arbitration.

Employees whose firms have mandatory arbitration agreements also still have the right to file complaints with their state human rights agencies.

Proponents of mandatory arbitration say it often costs less and is quicker than litigation and it places the decision in the hands of a dispassionate expert who may be less likely than a jury to be swayed by emotional considerations.

Rising costs

However, the costs are rising. "I think the original idea was to have a quicker and cheaper and stream-

See **ARBITRATION**/page 11

PHOTO: AP/WIDE WORLD

Berkshire Hathaway Chairman Warren Buffett, speaking at the company's annual meeting, cited insurance fraud as a costly problem for both insurers and policyholders.

Workers comp fraud threatening industry, Berkshire chairman says

By MARK A. HOFMANN

OMAHA—Every dollar spent combating insurance fraud results in more than $10 in savings, according to the chairman of Berkshire Hathaway Inc.

"There's plenty of fraud in various aspects of insurance," said Warren E. Buffett, the chairman of Omaha-based Berkshire Hathaway, during the company's annual meeting on May 1.

But ensuring continuity at the top of Berkshire Hathaway, rather than the business of insurance that makes up so much of the Omaha-based conglomerate's holdings, appeared to be greater concern to the 19,500 or so people attending the annual meeting in Omaha's new Qwest Center.

In fact, a shareholder asked Mr. Buffett if Microsoft Corp. Chairman Bill Gates would be tapped to head Berkshire Hathaway when Mr. Buffett, 73, decides to step down. While saying that Mr. Gates—a close friend and bridge-playing partner—could handle the job, Mr. Buffett said that "barring something terrible," the next chairman of Berkshire Hathaway would be a Berkshire Hathaway employee. Four current employees could fill his shoes, he said. Mr. Buffett did not give any hint as to who those four possible successors are.

Mr. Buffett's comments about fraud came in response to a shareholder question about fraud perpetrated by insurers upon policyholders.

Berkshire Hathaway owns several insurance operations, including General Reinsurance

See **BERKSHIRE**/page 17

ISO filings made in case TRIA expires

Endorsements would allow insurers to limit coverage

By MEG FLETCHER

JERSEY CITY, N.J.—The Insurance Services Office Inc. has taken initial steps to allow insurers to deny or modify terrorism coverage if the federal terrorism backstop program is not extended beyond its current Dec. 31, 2005, sunset.

ISO said it filed optional endorsements with regulators in every U.S. jurisdiction seeking their approval for insurers to limit coverage if the backstop program ends or if Congress modifies it to increase insurers' share of losses or risk of loss from terrorism.

The Terrorism Risk Insurance Act of 2002 created a federal coverage backstop—set to expire at the end of 2005—for losses from catastrophic acts of terrorism in the United States. Beginning in September 2004, insurers will start taking action on policies with effective dates of Jan. 1, 2005, and later, according to Jersey City, N.J.-based ISO. Some of those policies include terrorism coverage that extends beyond the law's current sunset, ISO said.

The optional endorsements "will help insurers and policyholders manage potential coverage problems posed by the Dec. 30, 2005, 'hard ending' of the federal backstop by providing critical tools needed now to make underwriting decisions on terrorism coverage in an uncertain post-TRIA environment," ISO said.

If Congress doesn't renew the existing backstop, the endorsements become applicable on Jan. 1, 2006, and would apply to losses on or after that date.

The endorsements provide several options to participating ISO insurers, including allowing them to exclude all terrorism-related losses or just those stemming from acts involving nuclear, biological or chemical causes.

In addition, the endorsements may provide coverage up to a sublimit that is less than the full policy limit.

Meanwhile, risk managers and others have until June 4 to comment on whether the Treasury Department should extend the "make available" provision of the Terrorism Risk Insurance Act beyond the end of 2004.

Hines symposium to address insurers' financial security

CHICAGO—Helping risk managers answer new questions and concerns about the financial strength and security of their insurers will be the focus of the 2004 Harold H. Hines Jr. Memorial Symposium in Chicago.

This year's symposium, "Insurer Security: Can You Pick a Survivor?" will be held May 20 at the Union League Club of Chicago.

The annual event is held in honor of the late Harold H. Hines Jr., who at the time of his death in 1984 served as president and chief executive officer of Rollins Burdick Hunter Co., now part of Aon Corp. The event is co-sponsored by *Business Insurance*, the Chicago Chapter of the Risk & Insurance Management Society Inc. and the Insurance School of Chicago.

At this year's symposium, a panel of experts will discuss how risk managers can determine the financial health of their insurance companies; what market forces are creating challenges for insurers; and how buyers, along with brokers and regulators, can spot potential problems, among other issues.

The panelists for this year's symposium are:

- Steven A. Coombs, president of Risk Resources Inc., a risk management consulting firm based in Elmhurst, Ill.
- Nathaniel S. Shapo, a partner in the insurance regulatory group of Sonnenschein, Nath & Rosenthal in Chicago, and a former Illinois insurance commissioner.
- Paul F. Sherbine, managing director in the market information group of Marsh Inc. in New York.

Paul Winston, editor of *Business Insurance*, will serve as moderator.

The symposium follows a question-and-answer format, and audience questions are encouraged throughout the program.

Registration for the event will be held from 2:30 p.m. to 3:00 p.m., and the program is scheduled for 3:00 p.m. to 4:30 p.m. A reception will follow. The Union League Club, located at 65 W. Jackson Blvd., requires business attire.

To receive a registration form by e-mail, please contact Carrie Brittain of *Business Insurance* at 312-649-5313 or *cbrittain@businessinsurance.com*.

SCA: Gets tentative approval

Continued from page 1

ing of benefits to those organizations whose captives took on a big chunk of third-party business.

The other employers to have received captive benefit funding approval from the Labor Department since that relaxation are Columbia Energy Group, Archer Daniels Midland Co. and International Paper Co.

More employers are expected to follow.

"A number of employers are seriously looking at this," said Ted Scallet, a principal with the Groom Law Group in Washington, which represents SCA.

"We are working with several clients that want to go ahead and do this," said Sofia Tesfazion, a former benefit manager at SCA and now a consultant with Towers Perrin in New York, which will provide actuarial services to SCA Re's Virgin Islands branch.

"This is a win-win situation for employers and employees," adds Mr. Scallet.

Indeed, benefit consultant Towers Perrin, based on the experience of its clients, pegs cost savings of captive benefit funding arrangements—compared to commercial insurance—at 15% to 25% for long-term disability coverage, 10% to 15% for group-term life insurance and 10% to 12% for medical stop-loss coverage.

Per Larsson, SCA's group risk manager in Stockholm, earlier said the funding arrangement should save money, over the long run, when compared with the cost of traditionally insuring the benefits.

Other advantages, Ms. Tesfazion said, include more control over the design of benefit plans and the handling of claims administration.

SCA for several years has funded the benefit risks of European employees through Dublin, Ireland-based SCA Re, which in 2002 generated $16.5 million in gross written premiums. SCA Re also funds property, business interruption and credit lines of business for its parent, which has about 40,000 employees in more than 40 countries and revenues of about $12 billion.

While risk and benefit experts for many years have discussed the advantages of funding benefits through captives—including cost savings and a broadening of business—it wasn't until 1999 that the arrangements became a realistic option for employers.

> **The fast-track process 'gives you a very clear road map as to what you need to do to get your application approved.'**
>
> *Mitchell Cole*
> *Towers Perrin*

That was when the Labor Department said it would be more flexible in evaluating captive benefit funding arrangements.

Until then, the department had said that such arrangements would have to be structured so that no more than 50% of the captive's business, including benefit risks, could be related to its parent. That was a test few employers wanted to meet, out of concern about the risks of taking on such a large block of third-party business.

In 1999, the Labor Department, while not abandoning the 50% test, said that meeting it no longer would be an absolute prerequisite to winning approval to fund benefits through captives.

Among other things, the department said it wanted employers to use top-rated primary insurers to write the policies, to boost benefits for plan participants and to use an independent fiduciary to see that all conditions were met.

Three employers—Columbia Energy, ADM and International Paper—have followed the Labor Department road map, with the department approving their applications.

Like the other employers, SCA is using a top-rated insurer, Aetna; is sweetening benefits for plan participants; and will use an independent fiduciary, U.S. Trust Co., a subsidiary of Charles Schwab Corp., to oversee the arrangement.

However, SCA's application did not qualify for a special fast-track approval process, which is available in situations where the department has approved two substantially similar applications in the last five years. Under that expedited review process, the Labor Department must give its initial decision within 45 days of receiving an application and a final decision about 30 days after that.

SCA was not eligible for the fast-track process because at the time it submitted its application, its fronting insurer, Aetna, was rated A- by A.M. Best Co. Best has since upgraded Aetna to A.

International Paper was the first employer with a captive benefit arrangement to qualify for the fast-track procedure; it cited the approved applications of Columbia Energy and ADM.

The fast-track process "gives you a very clear road map as to what you need to do to get your application approved," said Mitchell Cole, a Towers Perrin principal in New York. Mr. Cole said he is working with several employers with benefit captive proposals that intend to utilize this approach with the next few months.

Groom Law Group's Mr. Scallet said it is not surprising that employer interest in captive benefit arrangements has only recently started to swell.

Even if the advantages are clear, it takes time for an idea to percolate to the ranks of senior corporate management, who must give their approval to such an arrangement, he said.

Seeking the extraordinary

BI solicits nominations for 40 under 40

CHICAGO—*Business Insurance* is seeking nominations for its "40 Under 40: People to Watch" feature, a roundup of men and women who are doing extraordinary work in the commercial insurance industry before celebrating a 40th birthday.

Anyone working in the commercial insurance industry serving the buyers of risk and benefit management services, and whose birthdate falls after Oct. 4, 1964, is eligible for consideration. Candidates may nominate themselves or may be nominated by someone else.

There is no formal nomination form. Simply send a 250- to 300-word statement detailing the nominee's qualifications to: 40 under 40, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Please include a resume, if possible, and be sure to state the candidate's date of birth.

Nominations also may be e-mailed to *biweb@business-insurance.com*, as long as "40 under 40" is in the subject line.

The deadline for nominations is Aug. 2. Winners will be featured in the Oct. 4 issue of *Business Insurance* and on *www.businessinsurance.com*.

Paul Winston

Public firmly in tort reform camp

After repeated setbacks in the drive for tort reform at the federal level—from med mal reform, to asbestos reform to class action reform—folks might start to wonder if it is they, and not lawmakers, who are out of step with what the public wants and needs.

Stop doubting yourselves and buck up! New research shows you are not alone, after all.

The Insurance Research Council, the same folks who last year found that one-third of consumers think it's OK to defraud their insurance companies, now has researched public attitudes toward tort reform.

And—surprise!—while many think it's OK to pad a claim, the majority think there is way too much litigation in our society. What a relief that the public recognizes the need for some boundaries.

Paul Winston

No doubt with insurance costs rising in recent years, folks have begun to make the connection that litigiousness and large jury awards affect their premiums.

The Malvern, Pa.-based IRC's latest Public Attitudes Monitor (*www.ircweb.org*) found that the majority of respondents recognize that litigation is on the upswing. Eighty percent said people today are more likely to sue for personal injury than in the past, while 77% agreed that the size of damage awards today is larger than in the past.

In addition, half of respondents said that pain-and-suffering awards in personal-injury lawsuits have become "too large," and two out of five respondents feel that awards in class action lawsuits are "too high," according to the IRC.

The IRC found that a growing number of respondents believe class action reform is needed.

The survey showed 78% of respondents somewhat or strongly agrees that reform of the class action system is needed, up from 70% in 2000.

The IRC also found wide support for a variety of class action reform measures. The most popular reform, cited by 86% as an excellent or good idea, is making it easier for class action members to understand their rights. Eighty-two percent support limiting attorneys fees; 73% support sanctions against attorneys who file frivolous lawsuits; and 53% support requiring nationwide class action suits to be heard in federal courts.

"These findings suggest that while most Americans appreciate the social benefits of the civil justice system, they also recognize that inefficiencies in the current system, reflected in matters such as out-of-control tort costs and excessive payments to attorneys, ultimately penalize businesses and consumers," Elizabeth A. Sprinkel, senior vp of the IRC, said in a release accompanying the study, which was released last month. "The public clearly supports reforms to restore the system to more balanced standards, reducing pressure on the economy while still protecting consumers."

So if the majority of the public supports class action reform, insurers and businesses support reform, and many lawmakers support reform, why are reform efforts stalled in Congress? (That's a rhetorical question, by the way: I know how to spell "lawyers.")

Keeping customers at arm's length

Why do companies outsource various business functions?

A main reason is that they regard such functions as operations that they do not do especially well and that are not essential to their business. Also, many know that to perform better in one of these noncore functions would require more resources and attention than they are willing to divert from their main business purposes.

So a widget manufacturer may decide that investing in the refinement and manufacture of state-of-the-art widgets is a better use of capital than, for example, maintaining a large human resources department or making grilled cheese sandwiches in a company cafeteria.

What, then, is one to make of a press release I received the other day touting the benefits to insurance companies of "outsourcing customer relationship management"?

I don't think the point of outsourcing is to keep your customers at arm's length. Furthermore, does an insurer really want to admit that keeping customers happy is something it doesn't do well, or regards as irrelevant to its main business?

Outsourcing back-office functions that are critical to keeping the operation running but are out of the public eye may make sense to some. But when you have to hire someone else to run the front office, what's the point? Might as well revisit your mission statement and get into the business of making grilled cheese for other companies.

Here's hoping that no insurers buy into this management snake oil, for their policyholders' sake.

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

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AMERICAN ABM BUSINESS MEDIA

Editorial

Clarify broker regulations

IT SEEMS ABSURD that regulations designed to protect consumers from rogue operators should actually be imposed on the consumers themselves.

Yet that is what could happen under certain interpretations of the European Union's insurance broker regulations that are due to come into force next year.

The regulations, which were designed to harmonize the regulation of brokers throughout the European Union, require that intermediaries of insurance be licensed to ensure sufficient oversight of their activities. That, of course, is an admirable and necessary goal as the European Union evolves into a more cohesive whole.

The problem is that some regulators, such as the Financial Services Authority in the United Kingdom, are refusing to say whether some risk managers should also be regulated under the legislation.

The sticking point appears to be the status of risk managers that arrange the insurance coverage for subsidiary companies of their corporations. It might be arguable that companies—such as many in Germany—that set up separate companies as so-called "captive brokers" to arrange their corporate and group insurance should be included in the regulatory regime, but it's a step too far to say that risk managers ought to be included as well.

The risk managers, who will likely use regulated brokers to place the risks, are placing coverage for a corporate entity and all its constituent parts. They are not soliciting business from third parties, and their actions are "regulated" by their own management and any legal requirements pertaining to mandatory insurance coverage.

What exacerbates the problem is regulators' reluctance to tell risk managers outright whether they need to comply with regulations. Instead, they say that all parties should study the regulations and make up their own minds as to whether they need to be licensed.

Someone, be it a regulator in Brussels or the individual countries, needs to make a call on this issue and remove the threat of an unnecessary layer of red tape tying up risk managers' time.

Mediation deserves a try

TIMES CHANGE, and so do the techniques needed to deal with employment issues.

Take the issue of mandatory arbitration agreements as a means of settling employment disputes. Such agreements have been popular for years, but as we report on page 4, the pacts, while still popular among employers that already have them in place, are drawing few new adherents. That's in part because even though such arrangements generally remain less costly than litigation when it comes to settling employment disputes, the costs associated with the agreements are rising. While some employers viewed arbitration agreements as a sort of silver bullet, the agreements can look somewhat tarnished under certain circumstances.

That's why we're heartened by the apparent movement of some employers toward mediation as a way to settle employment disputes. Mediation and arbitration each have their own strengths and weaknesses. Employers have learned that both approaches offer the potential of saving time and money while protecting the interests of employer and employee alike.

No system is perfect, and occasions arise when disputes should go to the courts. But any equitable system that can keep disputes out of the courtroom at a reasonable cost deserves a try. The fact that an increasing number of employers are giving mediation a try can only be taken as a welcome development in the never-ending effort to hold litigation costs in check.

Schillerstrom

Letters to the Editor

Contingent commissions fundamental in industry

To the editor: Contingency arrangements for brokers and agents across the United States are fundamental in our insurance distribution system. Typically there are two types of measurements: those based upon pure growth and those based upon profitability and in many cases, the arrangements have both components.

Let's look at how these incentives benefit the consumer.

- The Growth Component:

Brokers and agents, for the most part, have a finite number of insurers they contract with on a direct basis. These insurers each have their own specific classes of business they define as their target market segment. These insurers create a growth reward to highlight their products and services. A broker/agent will always look to their contracted insurers first (with or without contingency incen-

See LETTERS/page 16

And the beats go on...

In an effort to ensure continuing timely coverage of risk management, insurance and employee benefit-related news, *Business Insurance* has formalized a list of its reporters' assigned beats. This list is not intended to be exclusive but rather to represent core subject areas of importance to *BI* readers. *BI* welcomes ideas and tips from readers on these and other areas. Following is a list of the beats and the principal reporters for each:

Agents/brokers: Sally Roberts.
Asian markets: Michael Bradford.
Aviation/space risks: Peta Miller.
Benefits—health care and ancillary benefits: Joanne Wojcik.
Benefits—retirement savings/pensions: Jerry Geisel.
Canada—risk management and benefits: Gloria Gonzalez.
Captives/alternative risk transfer: Michael Bradford.
Claims management: Meg Fletcher.
E.U. regulatory/legislative: Sarah Veysey.
Employment practices: Judy Greenwald.
Environmental risk management: Sally Roberts.
European benefits management: Sarah Veysey.
European industry operations: London bureau.
European public entity risks: Carolyn Aldred.
European reinsurance: Sarah Veysey.
European risk management: Peta Miller.
Federal regulation/legislation—benefits: Jerry Geisel.
Federal regulation/legislation—risk management: Mark A. Hofmann.
Health care industry operations: Gloria Gonzalez.
Inland marine/transportation: Michael Bradford.
Insurance coverage litigation: Douglas McLeod.
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Regulation of insurance: Meg Fletcher.
Reinsurance: Judy Greenwald.
Risk management profession: Dave Lenckus.
Risk securitization/capital markets risk financing: Carolyn Aldred.
Runoffs/receiverships: Douglas McLeod.
Safety/ergonomics: Meg Fletcher.
Surplus lines/wholesalers: Roberto Ceniceros.
Tort reform: Mark A. Hofmann
Work/life benefits and EAPs: Sally Roberts.
Workers compensation: Roberto Ceniceros.

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Back up cyber risk submission with key data

Underwriters want to see documentation of computer system security plans

By Brad Gow

After five years of relatively modest growth, the demand for cyber risk insurance is now steadily accelerating as insurance buyers realize that network-based perils constitute a significant threat to corporate balance sheets.

Brokers and risk managers looking for cyber risk coverage now have the responsibility for presenting their companies' network operations to underwriters, focusing on exposures such as network interruptions, malicious code, privacy breaches and—more commonly—copyright and media perils.

Unlike other, more established lines of business, there are no generally acknowledged standards for a good cyber risk underwriting submission. Presenting your company in the most favorable light requires a bit of effort, pulling together information from a variety of areas within your organization, including information technology, legal and human resources.

So what are network risk underwriters looking for, and what key pieces of documentation should you have?

● Formal management responsibility and standards.

First and foremost, a company must demonstrate that the responsibility to maintain a secure network environment is "owned" by a senior individual within the organization. Unless responsibility is formally assigned, network security will never be considered a priority. Network security policies and procedures should be published and communicated to all staff. Audits and testing should be completed at least twice a year by either an internal team or a competent third party.

Key documentation: written network security policies and procedures, security audit schedules, security audit reports.

● Physical network security controls.

The company needs to demonstrate that the physical environment is robust enough to keep the bad guys out. Along with the basics such as monitored entry/exit points and magnetic access cards for employees, key information technology facilities such as data centers and server rooms should have strong perimeter authentication controls. Physical security should be layered, and staff should know whom to call in the event of suspicious activity.

Key documentation: physical security policies and guidelines, lists of perimeter and internal security elements in place.

● Logical network security controls.

The presence of equipment designed to protect the integrity and security of the organization's computer network should be documented and demonstrated. At a minimum, this should include proxies, filters and firewalls to keep unauthorized intruders from accessing the network using the Internet, antivirus software to keep viruses and other malicious code at bay, and intrusion-detection software to identify potential hackers and internal abuse.

In the event that medical, financial or other nonpublic, personally identifiable information is transmitted via the Internet or stored in databases, Triple DES—or "data encryption standard"—and/or 128-bit minimum DES should be enforced. For networks with a large number of users, password management software should be in place, and systems and security logs should also be activated on key servers and networking equipment.

Key documentation: network architecture diagrams, firewall and intrusion-detection software make and model information, antivirus vendor information, and a copy of the policies and procedures in place to ensure that new equipment is properly configured and tested before it is connected to the network.

A company should be prepared to demonstrate that formal plans are in place not only to protect critical data but also to ensure that network availability is maintained in the event of a natural disaster, virus outbreak or denial-of-service attack.

● Change management controls.

A "softer" security function requiring consistent communication between the human resources and information technology departments, proper change management controls include policies and procedures intended to ensure that network-access rights for employees who have resigned or been terminated are revoked. There should also be assurance that authentication and facility-access cards are collected during exit interviews.

Key documentation: written employee resignation and termination guidelines, incorporating both the HR and IT functions.

● Internet content controls.

Cyber insurance applicants must be able to document written controls of the posting of information to the Internet. Any content posted should go through a formal process that includes copyright and trademark clearances, compliance with rule sets around the use of Internet links, the use of framing technology, and compliance with corporate or regulatory privacy requirements.

Key documentation: formal policies and procedures for the posting of content on company sites, posted privacy policies and posted user agreements.

● Disaster recovery and business continuity planning.

A company should be prepared to demonstrate that formal plans are in place not only to protect critical data but also to ensure that network availability is maintained in the event of a natural disaster, virus outbreak or denial-of-service attack. Elements include data backup and recovery testing, redundant/mirrored applications and connections, and periodically tested and personnel plans to ensure that the human element is addressed.

Key documentation: disaster recovery and business continuity planning reports and outlines; recent DR reports with stated objectives, findings and "lessons learned"; contracts for redundant/mirrored sites.

The bottom line is that network risk underwriters want to know that security is built into a company's culture. While the applications for the better network risk programs include questions in each of these areas, companies providing documentation proving that they "walk the walk" can be eligible for significant premium discounts, lower self-insured retentions and broader coverage options.

Brad Gow is vp-professional risk at ACE USA in Philadelphia.

Injury while on call not compensable

Legal Briefs

An employee's injury, which occurred when he was attacked by unknown assailants while walking home from a bowling alley while "on call," did not occur during the course of employment so as to entitle him to workers compensation benefits, ruled the Commonwealth Court of Pennsylvania.

David Sekulski worked as a maintenance man for Indy Associates, the owner of an apartment building. Every other week, he was required to be on call, which called for him to carry a beeper and remain within 15 minutes of the property so he could promptly respond to any page.

In December 1998, Mr. Sekulski was beaten and robbed while walking home from a bar in a bowling alley. He was on call at the time. Due to the attack, he could not remember if he had been paged while at the bowling alley or was responding to a page. There was no evidence, in fact, that he had been paged at that time. Mr. Sekulski filed for, but was denied, workers compensation benefits.

On appeal, he argued that he was furthering the affairs of his employer simply by being on call, carrying a pager and remaining within 15 minutes of the building. The court concluded that an on call, nontraveling employee such as Mr. Sekulski, limited to carrying a pager and remaining in the area in order to respond timely to work communications, is not considered to have sustained an injury in the course of employment unless he is engaged in work-related activities at the time of the injury. Thus, the court agreed Mr. Sekulski was not entitled to benefits.

Sekulski vs. W.C.A.B. (Indy Associates), Commonwealth Court of Pennsylvania, July 31, 2003 (BI/04/F.-$10)

No coverage for gunshot injury

An employee's injury, sustained when he was on a smoking break and was accidentally shot by a co-employee's gun, did not "arise out of" his employment and therefore was not compensable under the Workers Compensation Act, according to the Supreme Court of South Carolina.

While working as a paramedic, Richard Dukes and his co-worker took a smoke break. Mr. Dukes did not need to clock out for such breaks and received compensation for them. While on break, Mr. Dukes' co-worker went to her car for a handgun to show to Mr. Dukes. She handed the pistol to Mr. Dukes, who examined it and gave it back to her. The gun then accidentally discharged, shooting Mr. Dukes in his upper thigh. Mr. Dukes applied for workers compensation benefits. The compensation commission denied his claim; an appellate panel reversed the decision, finding that Mr. Dukes suffered a compensable injury during "down time," which was part of his job. Both a trial court and court of appeals affirmed the award. The employer appealed.

The appellate court said that Mr. Dukes was injured by a gun that was not naturally found on his employer's premises and was in no way connected to his employer's business. Therefore, the court found that Mr. Dukes' injury did not "arise out of" his employment because there was no nexus connecting his job as a paramedic to his colleague's handgun that they were examining during a smoke break. The lower court decisions were reversed.

Dukes vs. Rural Metro Corp., Supreme Court of South Carolina, Oct. 13, 2003 (BI/02/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, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806. Provide the listed number for each opinion ordered.

How to submit a Perspectives article

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● All articles are to be accompanied by a photograph and brief biography of the author.

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

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Arbitration: Employers realizing it's not a panacea

Continued from page 4

lined way of having disputes resolved," said D. Gregory Valenza, an attorney with Jackson Lewis in San Francisco. "But what the courts have done is to say, at least in discrimination cases, arbitration has to look very much like litigation." That means, Mr. Valenza said, the cases must have a certain amount of discovery and can place no limitation on remedies, with the cost of the arbitration borne by employers well.

As a result, fewer employers are turning to arbitration for the first time, say many observers. While a number of employers initially moved toward requiring arbitration, "I think that the trend has slowed," said Michael Cleveland, an attorney with Vedder, Price Kaufman & Kammholz in Chicago. "Most employers that were thinking about it have made that call and have either done it or not," he said.

'I think the more successful examples of implementation of mandatory arbitration are in circumstances where it's well thought out in advance and effectively communicated in a positive way to employees.'
Michael D. Karpeles
Goldberg Kohn

Robert Meade, Syracuse, N.Y.-based senior vp with the American Arbitration Assn., said that while "the 600 or so companies that I've worked with over the past 10 years are, by and large, pleased" with their mandatory arbitration programs, "the number of companies coming to us with new programs has kind of fallen off." Mr. Meade said he believes that those companies that might have been inclined to have such programs have put them in place already.

Robert Nobile, an employer attorney with Seyfarth Shaw in New York, said, "I think what a lot of employers are realizing is that arbitration's not a panacea. A lot of employers have opted into, or implemented, arbitration programs thinking they would be able to save money in terms of litigation expenses" as well as avoid adverse publicity. "The reality, quite frankly," he said, "is that there have been a number of fairly significant arbitrators' awards," which, unlike court decisions, generally cannot be appealed.

Steve Bokat, executive vp of the National Chamber Litigation Center Inc. in Washington, which handles litigation for the U.S. Chamber of Commerce, said that those who have not already established plans "may feel it's just more hassle than they want to tackle." They "just don't want to deal with all the litigation over whether they can do it," he said.

Examine the issues

While initially there was a strong trend toward mandatory arbitration, driven mostly by the fear of runaway jury verdicts, "I think now there's a much more mature examination of the issues," said Mark Dichter, an employer attorney with Morgan, Lewis & Bockius in Washington.

But most, if not all, of those who have already introduced mandatory arbitration programs remain committed to them, say observers. For instance, Circuit City, which has been involved in several other court cases over its mandatory arbitration program in addition to the *Adams* case, has no plans to change its policy. "Arbitration is still less expensive than a jury. It also tends to be quick," said a spokesman. "We feel it's an effective policy for both the associates and the company."

Frank Jackson, assistant general counsel at Detroit-based Blue Cross & Blue Shield of Michigan, which has a mandatory arbitration program for termination disputes, said, "It works. It's faster, it's cheaper and there's less of a threat of a runaway jury."

The decision whether to use mandatory arbitration can depend on where an employer is located, say observers. In certain states such as California, "where the courts seem to be much tougher in analyzing mandatory arbitration agreements and subjecting them to significant scrutiny, employers may be somewhat deterred from using mandatory arbitration," said Michael D. Karpeles, an attorney with Goldberg Kohn in Chicago.

Nonetheless, Mr. Karpeles said, he thinks employers are still "considering their options" in jurisdictions such as the Seventh Circuit of the U.S. Court of Appeals, which covers Illinois, Indiana and Wisconsin and is considered somewhat pro-employer.

He added, "I think the more successful examples of implementation of mandatory arbitration are in circumstances where it's well thought out in advance and effectively communicated in a positive way to employees."

In addition to the jurisdiction, "you have to look at the employer's history of litigation" in considering whether to introduce mandatory arbitration agreements, said Jackson Lewis' Mr. Valenza. If there has not

See ARBITRATION/page 12

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Commentary

A fantasy league of risk managers

Like a lot of people around the country with apparently too much time on their hands, I have found a way to waste some of it by participating in a fantasy baseball league.

For those unfamiliar with the fantasy league concept, it involves assembling a virtual team of real-life players and competing against other managers, based on the performance of each team's roster. Players are selected through a draft, with the top-rated players in the greatest demand, while the less productive players are picked in later rounds to fill out fantasy managers' lineups.

During the course of the season, you can make trades with other teams, pick up available players and drop others from your roster. Essentially, it lets a person like me who will never manage a Major League team get the thrill—without the accompanying ulcers—of doing so.

Rodd Zolkos

It's actually kind of a cool thing. For a Midwesterner and a Cubs fan like me, it's a way to become more familiar with players on teams to which I used to pay little attention—those in the American League West, for example. This season, I'm keenly aware of the fortunes of the Oakland Athletics, or at least those of pitcher Mark Mulder and third baseman Eric Chavez.

Actually, that reflects one criticism some have of the fantasy sports trend: that it drives participants to care only about the stats of individual players, rather than the teams for which they play. Nonsense. Who wouldn't want to know what the Expos' shortstop is hitting in home games played in Montreal vs. his average for home games played in Puerto Rico?

As with so many things, you can waste about as much time as you want on your fantasy team. Some fantasy league managers do most of their fiddling with their team at the start of the week, and then let things kind of go on autopilot.

At the opposite extreme, there's the type of manager who seems to be using the fantasy season as an audition for a Major League Baseball front-office job. Wheeling and dealing relentlessly, they'll burn the midnight oil poring over statistics, scanning the rows of agate in The Sporting News in hope of gaining any possible advantage.

After a few fitful hours' sleep, they'll fire up the computer in the predawn gloom to continue the search for that available player who's still an unknown to the other managers in the league, but is clearly on the cusp of glory. Maybe it's a youngster fresh from the minor leagues but destined to burn up the majors as he seizes the opportunity afforded by an injury call-up. Convinced this player's the one, the anxious manager adds him to the roster.

Later, as midnight approaches once again and the manager's genius is betrayed by that evening's O for 4, it's time to drop that morning's acquisition and seek out the next hidden gem.

The world of fantasy sports isn't limited to baseball, of course. There are fantasy leagues for all sorts of things—football, hockey, auto racing, golf. Some members of the *BI* staff on both sides of the Atlantic have participated in a fantasy league based on English football, or, as we call it, soccer.

So, having found fantasy baseball so engaging, and with apparently just about anything lending itself to the fantasy format, I found myself thinking about what else might pose an interesting challenge. How about fantasy risk management?

I may never be the risk manager of a major corporation, but I could get the chance to try my hand at it in a fantasy risk management league. As I envision the competition, each participant would be assigned the fantasy equivalent of a real business and a risk management budget.

Keys to success would seem to be how well the fantasy risk manager assesses his organization's exposures, and how he or she chooses to use the risk management budget. Players can allocate the budget however they choose, spending it on such things as loss control, purchasing insurance (with coverage for better-quality companies costing more than policies from those with a murky future), consulting services or travel to captive board meetings in Winstonia.

I haven't worked out all the details on scoring, but I see it being based on how the fantasy risk management program would perform in the face of events the real-life company experiences.

Once risk management makes the leap to fantasy sports, there seems only one logical next step: bobbleheads. Imagine owning the entire set of Risk Manager of the Year bobbles. And nodding figures of insurance industry execs could also be a hot commodity. They'd sure make great RIMS giveaways.

Senior Editor Rodd Zolkos can be reached at rzolkos@businessinsurance.com.

Arbitration: Options investigated

Continued from previous page

been a lot of litigation, it "may not be worth imposing, from a cost and employee relations standpoint, because employees get upset when arbitration agreements are imposed, so they do have to look at their particular situation," he said.

"People are still considering it very carefully and are opting for it," although this varies geographically and by type of company, said Richard Jeydel, secretary and general counsel for New York-based Kanematsu USA Inc., a trading company.

"The major providers like AAA use a due process protocol to make sure that the arbitration agreements that are going to be administered by them ... are fair and in compliance with recent court decisions. For employers who wanted to stack the deck, there may very well be a reluctance to use arbitration because you can't do that any more with reputable providers," said Mr. Jeydel.

Mediation an alternative

Instead, some employers are turning to mediation, say observers. Available programs include one run by the U.S. Equal Employment Opportunity Commission. Last month, the EEOC announced a $600,000 settlement as the result of mediation proceedings in a case brought by an HIV-positive aerialist against Montreal-based Cirque Du Soleil (U.S.) Inc. (*BI,* May 3, 2004). A 2000 survey of the EEOC's program found that 91% of the parties that brought charges and 96% of respondents would be willing to participate in the mediation program again if they were a party to an EEOC charge.

"I think employers realize, upon further reflection, (mandatory arbitration) is not a silver bullet and there are other alternatives that should be explored in the field of alternative dispute resolution" and the EEOC process is one of them, said Ann M. Longmore, senior vp and product manager for Willis of New York, Inc.

"There are a lot of companies that are moving away from arbitration and choosing mediation as an alternative forum," said Mr. Nobile, who recommends it to his clients. It is not binding, it is voluntary, it has a resolution rate of more than 90%, and if the dispute is not resolved, parties still have the option to sue. "You don't have to worry about getting stuck with a bad decision from an arbitrator that you can't appeal," he said.

Bob Bradshaw, vp, human resources, for Holtsville, N.Y.-based Symbol Technologies, Inc., which has had a mediation program for several years, said, "We felt mediation was more conducive to the relationship that we maintain with our employees."

The process normally takes a day, he explained. "The mediator does a little bit of shuttle diplomacy, in and out of the room, and at the end of the day, we're normally able to resolve the matter," he said.

When it was first introduced, Mr. Bradshaw said, there was some concern "people would be going out and mediating everything under the sun" because the entire program's costs are borne by Symbol. "It never happened. There was no increase in issues after the program was launched," he said.

Mr. Jeydel said, "Most in-house people I've spoken to" use a stepped or staged system. At Kanematsu, for instance, employees are required "to attempt to mediate any disputes they may have, and if this mediation does not result in a settlement, then to use arbitration," he said.

Mr. Jeydel noted that, in the period since Kanematsu's program was first fully rolled out, which was subsequent to the Supreme Court's *Circuit City* decision, no dispute has reached the arbitration stage. "We've had pretty good luck with mediation," he said.

"Be sure that you return it."

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New E.U. directive to regulate insurance intermediaries may subject U.K. risk managers to FSA oversight

Will British buyers need licenses?

By CAROLYN ALDRED

BRUSSELS, Belgium—A directive designed to harmonize the oversight of insurance intermediaries throughout the European Union could also result in the regulation of some insurance buyers.

In the United Kingdom, discussions are continuing among brokers, risk managers, the government and the regulatory authorities as to whether or how British risk managers would be affected by the new E.U. directive.

In Germany, so-called captive brokers, which are in-house units that arrange insurance for the operations of their large industrial parents, would have to seek a license and be regulated as a result of the directive (see related story, page 14).

PHOTO: AFP

The flags of European Union nations fly in front of the European Parliament in Strasbourg, France.

The E.U. Insurance Mediation Directive, which has been in the works for over a decade, will take effect in all member counties on Jan. 14, 2005. To be in compliance with the new directive, each broker and other intermediary must submit an application for an E.U. license by July 13, 2004. After that effective date, carrying out the activities regulated by the directive without a license would be a criminal offense.

Regulatory authorities in all E.U. countries will be appointed to oversee the activities of insurance intermediaries in their jurisdiction.

In the United Kingdom, for example, the Financial Services Authority will "regulate the activities of introducing, proposing or carrying out other work preparatory to the conclusion of contracts of insurance, or of concluding such contracts, or of assisting in the administration and performance of such contracts, in particular in the event of a claim."

Risk managers fear that wording could encompass some of their activities putting them at risk.

The Assn. of Insurance & Risk Managers has held discussions with the Treasury and the FSA to seek an exemption for risk mangers and corporate insurance buyers, said David Gamble, executive director of AIRMIC. He said those talks are continuing.

"This is a hugely important issue for AIRMIC members. Being regulated under the directive would entail a large amount of work for risk managers," he said.

AIRMIC and the London Market Insurance Brokers Committee have jointly sent a letter to the FSA outlining why, in their legal opinion, risk and insurance managers should be exempt from the directive.

The E.U. directive and the U.K. regulations that implement it do not specifically exclude intracompany transactions, in which a risk manager may place insurance for corporate affiliates, said Mr. Gamble.

For many FSA regulations, which are designed to protect the customer, intracompany transactions are exempted, but they are not in this case, said David Hough, executive director of the LMIBC.

"We and AIRMIC are arguing, however, that risk and insurance buyers are not arranging insurance as a separate business activity or profit center within a group and should be excluded from regulation," said Mr. Hough.

The FSA does not, though, appear inclined to change the current regulations.

A spokesman from the FSA stated that detailed guidelines on the directive have been publicized and now each organization or individual must make a judgment as to whether to register in July or face the risk of their actions being found not in compliance.

"We are governed by the directive and the reg-

See **DIRECTIVE**/next page

Reinsurer to pay HIH liquidator to settle charges over contracts

By ELIZABETH FRY

SYDNEY—GeneralCologne Re Australia Ltd. will pay $27.2 million Australian ($19.9 million) to the liquidator of HIH Insurance Ltd. to settle charges that reinsurance contracts it wrote were designed to hide the true financial condition of a troubled insurer that HIH later acquired.

GeneralCologne Re, which admitted no wrongdoing in settling the "enforcement undertaking," also must have senior executives attend an ethics training program, while several executives also will be barred from holding financial services licenses or managing Australian public companies, according to a statement from the Australian Securities and Investment Commission.

The agreement with the ASIC stems from an Australian Royal Commission's investigation into HIH's 2000 collapse. That collapse has been blamed, in part, on its acquisition of FAI Insurance Ltd., which later became insolvent.

FAI had bought $65 million Australian ($47.6 million) in reinsurance coverage from GeneralCologne Re to boost its June 30, 1998, financial results. But testimony before the Royal Commission indicated that a "side letter" was signed, in which FAI agreed not to make any claims on the policy, so no actual transfer of risk occurred.

The transaction was essentially a loan disguised as reinsurance, the commission concluded. But because reinsurance is accounted for as an asset, the deal allowed FAI to post an $8.2 million Australian ($6.0 million) profit for the 1998 fiscal year, rather than a $50 million Australian ($36.6 million) loss. HIH bought FAI the following year.

Australia Supreme Court Justice Neville Owen, who headed the Royal Commission, stated that using reinsurance contracts to smooth financial results is allowed only if there is a transfer of risk to the reinsurer.

William A. Thiele, senior vp of General Re Corp., the U.S. parent of GeneralCologne Re Australia, said that the $27.2 million Australian payment to the HIH liquidator was not an admission of liability. The company is "committed to the highest ethical standards" and has "co-operated fully" with the ASIC investigation, he said.

An Australia–based spokesman for GeneralCologne Re Australia said "that this issue of the side letters is a complex one which cannot be dealt with in a brief comment. Evidence led before the Royal Commission makes it clear that the purpose of the side letters was not to negate, nor did it in fact negate, the risk."

Simon Longstaff, executive director of the St. James Ethical Centre, which will oversee the ethics training, said, "In cases like this, it is quite possible that a company, while maintaining that it has done nothing wrong might conclude that it is better to cooperate with the regulator than incur an additional cost—even if the cost is a reputational one."

PHOTO: THE TIMES

The House of Lords ruled April 29 that British Steel's duty of care extended beyond just the physical consequences following an accident.

Compensation due worker for psychiatric symptoms of injury

By CAROLYN ALDRED

LONDON—An employee who suffered physical and psychiatric injuries as a result of anger about an injury at work should be compensated by his former employer, the House of Lords ruled.

In a judgment that is likely to be closely examined by U.K. personal injury and defense lawyers, the House of Lords upheld damages of £498,221 ($896,798) plus interest awarded to Christopher Simmons, a former employee of London-based British Steel P.L.C., rejecting an appeal by the steelmaker.

Mr. Simmons had sustained a head injury on May 13, 1996, while working at a steelworks in Cambuslang, Scotland. The steel company was held responsible and was ordered to pay him

See **AWARD**/page 16

World Updates

FSA floats capital rules for Lloyd's companies

The United Kingdom's insurance regulator has proposed new risk-based capital rules for business written at Lloyd's of London. Under the Financial Services Authority's proposed rules, slated for introduction next year, Lloyd's managing agents would have to assess the financial resources needed to support the risks stemming from the insurance operations they manage, among other requirements. The FSA is seeking public comments on the rules until July 30. They are available at *www.fsa.gov.uk/pubs/cp/04_07/index.html*.

Safety compliance pays off: Employers

The majority of U.K. employers believe that health and safety requirements benefit their companies financially, though many say compensation claims are too high, a survey shows. The survey, conducted by the Health and Safety Executive and Mori Social Research Institute, both of London, surveyed 500 employers on their attitudes toward workplace health and safety. About 60% reported that complying with health and safety requirements saves money long-term. However, 43% "strongly agreed" that "health and safety compensation claims have gone too far," while another 27% "agreed."

Accounting rules unlikely to affect ratings: Fitch

New accounting standards for E.U. insurance companies are unlikely to affect insurers' ratings, though they may prompt changes in the products companies offer, according to Fitch Ratings in London. In a report, Fitch said that while the International Accounting Standards Board rules have drawn fire from some insurers over concerns that they will bring greater financial volatility, the rules are not likely to result in direct changes to Fitch's ratings of insurers. But Andrew Murray, associate director-insurance at Fitch in London and co-author of the report, said the standards will require companies to more closely match their assets and liabilities at present-day values, and this may lead some insurers to alter the coverages they offer.

Zurich appoints CEO for U.K. nonlife business

Ian Stuart has been appointed chief executive officer of Zurich Financial Services Group's nonlife insurance business in the United Kingdom, succeeding Geoff Riddell, who has been appointed CEO of Zurich's global corporate customer business. Mr. Stuart was previously managing director and CEO of the nonlife business of Zurich's Eagle Star unit, and he will continue to oversee Eagle Star's nonlife business in Ireland until a successor is found.

Directive: Licenses?

Continued from previous page

ulations. We are aware that there are issues at the margins, including whether risk managers need to be authorized. It's a judgment individuals have to make and one that may need to be settled through the court process," said the spokesman.

The issue is of concern to risk managers, who would like more clarification in the regulation, said Richard Reddaway, risk and insurance manager for Brentford, Middlesex-based GlaxoSmithKline P.L.C.

"We are aware of the issue because Marsh, our broker, has written to us to advise us that we need to be registered by July 14, if we are seeking registration," said Howard Palmer, insurance and risk manager for Newbury, Berkshire-based Vodaphone P.L.C.

"But we have had no information from the FSA and no indication from them as to whether the regulation applies to us," he said.

"It is an issue we are looking into, and we are trying to find out what the implications are," said Mr. Palmer, noting that it seems absurd for a multinational corporation such as Vodaphone to be regulated by the FSA for its efforts to arrange insurance for its worldwide companies.

Mr. Gamble pointed out that AIRMIC's legal opinion on the matter, which was published on its members' Web site, already had attracted more than 1,000 hits.

Brokers, meanwhile, are alerting their corporate clients to the issue.

In addition to Marsh Ltd., London-based Jardine Lloyd Thompson Group P.L.C. is writing to risk and insurance managers.

According to JLT, individuals who might fall under the regulation include insurance buyers acting to place coverage for other companies in their own organization and partners in joint ventures arranging insurance contracts that also cover other named interests.

JLT also believes that the directive could impact the construction sector, where some deals, including public-private partnerships, require complex insurance arrangements covering multiple entities.

According to JLT, a company that carries out a regulated activity may have to become directly licensed by the FSA or become an appointed representative of a licensed firm. The firm, which could be a broker or insurer, would have full responsibility for ensuring the appointed representative complies with the FSA requirements. There would need to be a written contract between the appointed representative and the principal, according to JLT.

JLT, though, has decided not to appoint representatives "except in exceptional circumstances," the company said in a statement last week.

"We believe that firms who carry on these activities are likely to be better off being regulated directly by the FSA. Authorized firms and potential appointed representatives will need to carefully consider the affects of AR supervision arrangements and the impact they have on client relationships," said Bobby Deegan, JLT's group director of compliance.

German in-house brokers subject to E.U. directive

BRUSSELS, Belgium—German companies' captive brokers will have to apply for licenses under a new European Union directive aimed at harmonizing the regulation of intermediaries.

The E.U. Insurance Mediation Directive takes effect Jan. 14, 2005, but requires intermediaries to apply for their E.U. licenses six months earlier—by July 13, 2004 (see related story).

Ralf Oelssner, director of corporate insurance for Koln-based Lufthansa A.G. and president of the German Insurance Buyers Assn., noted that many large German companies have created so-called "captive brokers" or "in-house brokerage arms" to handle their insurance purchasing and placement needs.

If the captive broker is a separate legal entity, which is not uncommon, and arranges insurance for other subsidiaries within an organization, it will need to be registered, he said.

Risk and insurance managers who undertake these activities for their companies but are not employed by a separate legal entity, though, will not fall under the legislation, Mr. Oelssner said.

Johannes Fischer, president of the Mainz-based German Captive Brokers Assn., or Bundesverband Firmenverbundener Versicherungsvermittler, confirmed that captive brokers had been unable to obtain special exemption from the intermediary directive for in-house brokers.

"Our members will be treated the same as third-party brokers," he said, noting that the regulations "will not have a serious impact on our members."

According to Mr. Fischer, there are more than 250 captive brokers for companies in Germany.

—By Carolyn Aldred

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2nd Avenue Subway - Phase I

The Metropolitan Transportation Authority's Risk and Insurance Management Department is soliciting Requests for Proposals (RFPs) from qualified brokers/agents to provide Program Administrative and Insurance Marketing Services for an MTA Capital Construction Company Owner Controlled Insurance Program (OCIP) for Second Avenue Subway - Phase I.

Brokers/Agents must demonstrate:

(1) a clear understanding of the objectives and constraints of an OCIP;
(2) experience as Broker of Record handling OCIPs in the transportation industry, with construction values of at least $250 Million for an individual OCIP program;
(3) principal staffing in a location readily and easily accessible to MTA Service Area and
(4) commitment, capability and experience of key personnel proposed to manage these programs.

The OCIP will require a DBE goal participation. The DBE goal is to be determined.

The contract term of the OCIP is eight years. Information concerning the projects to be included in this OCIP will be available on or about May 10, 2004. Please fax request for an RFP to 212-878-1203. Responses to the RFP are due by 11:00 AM on July 16, 2004. Please submit ten (10) copies to **Ms. Lauren Gregory, Esq., ARM, Director, MTA Risk and Insurance Management Department, 347 Madison Avenue, (341/18), New York, N.Y. 10017**

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Award: Firm owed worker duty of care

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£3,573 ($6,431).

However, shortly after the injury, Mr. Simmons, who had allegedly warned his employer of the dangers that caused the accident, became very angry that the avoidable accident had occurred.

His anger caused a pre-existing skin condition, psoriasis, to flare up, as a result of which he was unable to return to work. A lengthy absence from work increased his anger with his employers and led to a severe depressive illness. These injuries proved more severe and costly than the original blow to the head.

Mr. Simmons' claim for compensation of these illnesses was initially rejected for failing to demonstrate a causal link between the accident and the injuries arising from his mental state. An appellate court reversed that decision, though, finding that all of the resulting injuries and illnesses stemmed from the accident.

British Steel appealed, arguing that it did not dispute Mr. Simmons' illnesses were a consequence of the accident but, rather, that they were not foreseeable and, therefore, not the responsibility of the employer.

The Law Lords—while taking issue with the appellate court's reasoning—upheld British Steel's liability.

The Law Lords held that the duty of care owed by the employer extended to treating the psychiatric symptoms as well as the physical consequences following an accident. Because there was a causal connection between the anger that led to Mr. Simmons' skin condition and depression and the original accident, the employer was found liable, according to the April 29 ruling.

The House of Lords' ruling not only is binding in Scottish law but also will be persuasive in England and Wales, according to legal sources close to the case, who noted that the ruling likely will be cited by plaintiff lawyers in future cases involving illnesses linked to workplace injuries.

"It is rather a difficult judgment to understand, and it is difficult to see how it will be interpreted," said Claire Davidson, an associate with the Edinburgh-based law firm of Simpson & Marwick, which represented British Steel.

Simmons vs. British Steel P.L.C., House of Lords, April 29, 2004; Session 2003-04 [2004] UKHL 20

Privacy: Compliance level low

Continued from page 3
to name someone to be held accountable, it is much more difficult to make sure all employees are aware of and are complying with policy regulations, said Linda Drysdale, leader of the Canadian privacy practice for PricewaterhouseCoopers L.L.P.

"There's a training component that a lot of organizations are struggling with," she said.

Companies are also struggling with one principle that dictates individuals must be able to access their personal information and must be able to challenge the accuracy and completeness of it. An organization must respond to such a request within 30 days, which is often problematic because it may have multiple databases and staff may be unsure where the information is and how to access it, she said.

"When we have full access requests by a customer, it can be somewhat challenging to pull that together," said David Elder, assistant general counsel for regulatory law for Bell Canada and the company's privacy policy expert.

PIPEDA has been coming into effect in stages. Since Jan. 1, 2001, the act has applied to personal information collected about customers and employees in federally regulated industries such as banking, telecommunication and transportation. It has also applied to information transported across provincial and territorial boundaries. Yet even the federally regulated private sector has not achieved full compliance despite provisions of the act being applicable to them since 2001; only 78% of these respondents are in compliance, according to the Morneau Sobeco survey.

Montreal-based Bell Canada has been in full compliance with PIPEDA since 2001, but Mr. Elder said the company constantly tweaks its processes and policies to deal with any new issues that arise. "In a sense, you're never really done," he said.

The company collects personal information to provide services for its customers and manage its business operations. The company also said it shares information among Bell companies, but customers can opt out via e-mail or telephone.

Since Jan. 1, 2004, PIPEDA applied to all personal information collected, used or disclosed in the course of commercial activities by all private-sector organizations except in provinces that have enacted legislation deemed to be substantially similar to the federal law. To date, Quebec is the only province with legislation that has been deemed substantially similar, although British Columbia and Alberta have their own privacy standards that should be approved soon, according to a spokeswoman for the federal privacy commissioner.

The impetus for passage of PIPEDA was a directive issued by the European Union in 1995 that established minimum privacy regulations and precluded members from transferring information across borders to countries that did not have minimum regulations. The need to comply with the E.U. directive led to development of the Safe Harbor provisions in the United States and PIPEDA in Canada, privacy experts say.

PIPEDA aims to alleviate concerns about the collection and use of personal information by allowing customers to manage that information. For example, if a company needs an individual's information for one purpose, then the customer can limit the use of information to just that purpose.

Employees working in the federally regulated sector or in certain territories covered by PIPEDA have the same rights to privacy as customers, but PIPEDA does not extend protection of personal information to employees in the nonregulated commercial sector. Many companies are applying the same privacy standards to the personal information of their employees, though, because some provinces do include all employees and because it may be difficult to convince employees that their information should not be afforded the same protection as customer information, said Robert Parker, a partner with Deloitte & Touche L.L.P.'s enterprise risk practice and a privacy expert who is based in Toronto.

In order to achieve compliance, companies must assess all occurrences of the collection and use of personal information within the organization and use this analysis to formulate a policy on how to treat this information. If companies are simply collecting personal information for payroll and benefit purposes, then merely achieving more transparency in their privacy policies should be sufficient, Ms. Drysdale said. Companies, though, that extend the use of personal information for practices such as the inclusion of birthdays or photos in company newsletters must now obtain consent. "It seems like a trivial example, but people can be really sensitive about these things," she said.

Two key examples of extended use of personal data are the use of personal credit card information in expense reports and information in resumes submitted for vacant positions. Companies must secure consent to use this information and establish procedures to deal with the information when it is no longer needed, such as destroying resumes after a position has been filled.

Organizations must also develop policies on how they share personal information with third parties such as pension plan administrators because accountability for violations of the privacy standards rests with the organization that collects the information. One way to ensure that business partners comply with privacy regulations is to contractually bind them to the organization's privacy policy, Mr. Parker noted.

As difficult as the compliance process may be, risk managers have to address the issues in order to minimize their exposures, Mr. Parker said. "I don't think enough of them are taking enough interest in it," he said. "Risk managers should clearly be taking a role in making sure the organization has addressed that risk along with other risks."

A key risk is the possibility that customers will cease doing business with the company if it does not have a solid privacy policy in place or if there is a privacy security breach. Another risk is what Mr. Parker refers to as a "privacy blowout"—the cost of containing the damage stemming from an unauthorized release or use of personal information. These costs have been estimated at about $50,000 for small businesses and $1 million for large businesses. There is also the potential that companies could be sued by individuals or by the office of the privacy commissioner for any unauthorized release or use of personal information.

Although the survey shows companies have not achieved full compliance yet, anecdotal evidence indicates that they are making legitimate efforts to comply with PIPEDA, Mr. Parker said. "I think it will take awhile, but I think the high-risk areas will be addressed," he said.

Letters to the Editor

Continued from page 8
tives). If a match exists between the insurer and the insured, everyone in the transaction benefits, especially the consumer.

In many cases, the insurer has specialized programs with broader coverage and very competitive pricing because they have targeted this class of business. Insurance being a complicated commodity, a broker/agent benefits its client by having a strong direct relationship with the insurer in terms of negotiations, handling the details of the transactions and in terms of difficult claims situations that are not always black and white. Brokers and agents that are given an opportunity to be part of a contingency arrangement can count on good customer service, access to the insurers' many resources, and having a part in the overall financial stability of that insurer.

- The Profit Component:

Insurers want to write business profitably and they rely upon their brokers/agents to bring them risks that are well-managed and with good loss experience, and consumers who understand the importance of their insurance program. Since the brokers/agents are the "eyes and ears" for the insurers, there is a reward system when the job is done right.

The consumer benefits by having their insurance contracts with financially sound companies and by receiving better-than-average pricing as an experience-rated risk. In addition, as insurers produce profits, the market cycle turns downward whereby prices are reduced as more insurers compete for more market share.

Technically, brokers represent the client and agents represent the insurer, but in the real world, it's actually a delicate balance. Consumers have the freedom to change their broker/agent at any time and can solicit bids from several firms. I'm confident brokers/agents work hard for their clients' benefit and for the good of the insurance industry. In firms whose intentions are questionable, professionalism and capitalism will ultimately correct those situations.

Christine Sadofsky
President
Ventura Insurance Brokerage Inc.
New York

Deadline approaching for annual *BI* directory of consumer-driven plans

Business Insurance will publish its online Directory of Consumer-Driven Health Care Plans in conjunction with the June 28 issue. The issue will include a Spotlight report on consumer-driven health care and a ranking of 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 28.

The online directory will be available to subscribers on *www.businessinsurance.com* and will be included in *BI*'s 2004/2005 Market Sourcebook, a special printed compilation of all 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; companies must report the number of employer/institutional clients and total number of lives covered to be ranked.

Consumer-driven health plans are defined as coverage arrangements involving health spending accounts or health reimbursement arrangements, network and benefit selection, or customized benefit combinations. Companies that provide only flexible spending accounts or health saving reimbursement accounts administration are not eligible.

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 from the Directories area of *www.businessinsurance.com.*

Comp: Employers welcome law

Continued from page 3

to support for integrating all employee health care, said John Ireland, business manager for occupational health for Kaiser Permanente in Oakland, Calif.

"There seems to be some movement afoot encouraged by this legislation that draws more closely together health care with workers compensation medical care," Mr. Ireland said. "It looks to us as if those who made the law believe there is an advantage of having the same provider regardless of why or where a person becomes injured or ill."

Some employers already have been moving toward implementing such "24-hour" care, but the new law could help employers gain greater benefits, said Bill Zachry, vp of corporate workers compensation for Pleasanton, Calif.-based Safeway Inc.

Two years ago, for example, the Safeway grocery store chain contracted with Kaiser for workers compensation medical treatment, Mr. Zachry said. Safeway did so, in part, because Kaiser excels at applying established treatment guidelines, he said. Such guidelines eliminate the unnecessary procedures performed by some medical providers and produce favorable results, Mr. Zachry added.

Additionally, Safeway, through a union health and welfare trust fund, pays for employees to obtain health plan coverage from Kaiser. Therefore, many Safeway employees already trust turning to Kaiser for health care, he said.

The new law could further help Safeway, Mr. Zachry said. Because of medical control provisions in the new law, Kaiser has told him that it may now be possible to provide occupational care on a capitated basis.

"That is a revolutionary change," Mr. Zachry said.

A Kaiser spokeswoman confirmed that the health plan would consider the pricing change. She added that the arrangement would be a natural fit for the health plan because it already provides the nonoccupational care on a capitated basis.

> **Providing high-quality health care to injured employees is important because it 'gets them back faster, they are more productive and they are happier.'**
>
> *Bill Zachry*
> *Safeway Inc.*

While capitation can produce cost benefits for purchasers, many observers say a bigger benefit of the new law is the ability of employers and insurers to direct employees to the best-quality providers. That will help injured employees recover and return to work sooner.

"High-quality care is really what we want to provide to our employees," Safeway's Mr. Zachry said. "That is so important because high-quality care gets them back faster, they are more productive and they are happier."

While many California employers already contract with provider networks for workers compensation care, only 50% to 60% of their total workers comp treatment comes from those networks, said Tim Hoops, general manager of workers compensation managed care services for Wellpoint in Anaheim, Calif.

That's because employers can direct care for only 30 days. But allowing them to control care indefinitely means that more than 90% of their employees' treatment will come from provider networks," Mr. Hoops estimated.

Without the ability to control medical care in California, it has been difficult to apply managed care principals that provide injured workers with appropriate care, Mr. Hoops said. "This legislation will give employers exactly that," he said.

Meanwhile, several market observers say they expect to see growth in medical doctors and clinics forming into networks to care for injured workers.

Market forces eventually will weed out networks and providers that fail to produce "the best-quality care at the most reasonable price," predicted Bill Poland, executive vp for Torrance, Calif.-based Keenan & Associates.

For now, though, Mr. Poland and other workers compensation service vendors say they see increased opportunity.

Employers will need their help, they say, ensuring that they contract with medical providers that understand work-related injuries and the complexities of workers comp claims while producing good results that return employees to work.

Nationwide, there are examples of failures when doctor networks have tried to migrate from treating only health plan patients to also treating workers compensation cases, said Kathryn M. Tazic, senior vp national workers compensation practice lead in Chicago for Sedgwick Claims Management Services Inc.

"We are hoping to use this as an opportunity to focus our employers on getting the correct medical care, because we know that just because (doctors) are in a network doesn't necessarily mean they are getting better outcomes," Ms. Tazic said.

Berkshire: Comp fraud costly

Continued from page 4

Corp., Berkshire Hathaway Reinsurance, GEICO and some small, specialized property/casualty insurance companies.

The shareholder said he had evidence that a workers compensation insurer had greatly inflated the costs of its payouts of individual claims in reports to state insurance regulators, which resulted in higher costs for policyholders. He called it "a scandal I believe is far greater" than anything else that had been discussed at the meeting, though he did not name the insurer.

The shareholder added that he was concerned that workers compensation insurers would attempt "to pull the same stunt" on labor-intensive Berkshire Hathaway units such as Dairy Queen. "Are your managers attuned to this?" he asked Mr. Buffett.

Mr. Buffett responded by saying that fraud existed across all lines of insurance and that Berkshire Hathaway found that it saved more than $10 for each dollar the company spent in fraud detection.

Mr. Buffet added that Berkshire Hathaway owns a small direct workers compensation insurer called Cypress Insurance Co. that writes in California and that Gen Re reinsures workers compensation insurers.

He called workers compensation situation in California particularly bad, calling it a "blood bath" for insurers. He said that insurers had been the targets of a considerable amount of fraud.

Charles Munger, Berkshire Hathaway's vice chairman, said that insurers that suffered fraud-related losses might indeed try to lay the losses off on policyholders. But he said that dishonest claimants, lawyers and physicians are far more common sources of fraud than insurers.

Unlike some previous meetings, Berkshire Hathaway's individual insurance operations did not stir much shareholder comment this year. That might reflect the improved performance of Berkshire Hathaway's once-troubled Gen Re unit.

In fact, in his annual letter to shareholders, Mr. Buffett said in March that Gen Re is "fixed" after years of having been a corporate "problem child."

In the letter, which accompanied Berkshire Hathaway's annual report, Mr. Buffett noted that Berkshire Hathaway's insurance units posted a pretax underwriting gain of $1.71 billion in 2003, compared with a $398 pretax underwriting loss in 2002. Gen Re's results alone improved to a $145 million pretax underwriting gain last year from a $1.39 billion underwriting loss in 2002.

Berkshire Hathaway acquired Gen Re in 1998.

Mr. Buffett used the letter to praise the managers of all of Berkshire Hathaway's insurance units as being "truly exceptional."

Net earnings for Berkshire Hathaway as a whole grew to $8.151 billion in 2003 from $4.286 billion in 2002.

Aviation: Liability

Continued from page 3

line liability for flight delays and baggage problems, noted John Balfour, another IATA attorney.

The convention suggests, but does not require, that airlines provide such notice, and airlines do not want to do so, said Mr. Tompkins, who helped draft the convention. Airlines believe that the notice would be of little value, because they do not believe passengers would read it and that it would make tickets bulky, said Mr. Tompkins, who is with Schnader Harrison Segal & Lewis L.L.P. in New York. In addition, airlines point out that they are assuming full liability rather than trying to avoid liability, he noted.

On a pragmatic level, complying with the E.C. notice requirements may be impossible, according to Mr. Balfour, who is with Beaumont & Son in London.

First, airlines do not have control over agents, through which most tickets are sold, Mr. Balfour said.

Second, to date, 52 nations have ratified the convention, he noted. That means many airlines operating within the European Union are not bound by the convention, since they are based in nations that have not signed the treaty. So, airlines do not understand how they can devise a standard liability notice when airlines continue to operate under varying liability systems, he said.

IATA may challenge the Commission's liability notice requirement in court in an effort to prevent if from taking effect, Mr. Balfour said. Alternatively, IATA may wait to challenge the directive until an E.U. member nation attempts to penalize a carrier for failing to comply with the directive, he said.

Referring to the notice directive, a representative for the European Union said: "It is a measure of information so that people can make important choices and also know what they are entitled to."

Under the new convention, an airline is strictly liable for 100,000 special drawing rights per passenger harmed or killed aboard an international flight. The airline could be held liable for unlimited damages beyond that if it cannot show either that it was not negligent or that a third party was responsible for the accident. An SDR is an instrument made up of a basket of currencies.

The 13 E.U. nations that just ratified the treaty are Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Spain, Sweden and the United Kingdom. Norway, which is not a member of the European Union, also ratified the convention. The other two E.U. nations, Greece and Portugal, ratified the convention in 2002 and 2003, respectively.

Sarah Veysey in London contributed to this report.

Comings & Goings

Insurers:

Cincinnati-based Great American Insurance Group has named **Keith A. Jensen** as executive vp, and he will continue to serve as chief financial officer of the company. Before his promotion, Mr. Jensen was a senior vp.

Mutual of America Life Insurance Co. has appointed **Kathryn Lu** to the position of senior vp. She will continue as associate general counsel. Previously, Ms. Lu was vp of the New York-based insurer.

ACE USA, based in Philadelphia, has named **Dennis Crosby** as senior vp and regional executive for the Southeast region. Previously, Mr. Crosby was president-commercial middle market at The St. Paul Cos. Inc.

Mark Pfaff has been named senior vp of Northeastern agencies for New York Life Insurance Co. Before his promotion, Mr. Pfaff was a managing partner for the New York-based insurer.

Brokers:

Barry Duffin has been named operations director of the Select Business Unit of London-based Heath Lambert Group. Previously, Mr. Duffin was project manager with A-Plan Insurance Group.

Daytona Beach, Fla.-based Brown & Brown Inc. has named **Cory T. Walker** senior vp, treasurer and chief financial officer. Previously, he was a vp.

Reinsurance:

Global P&C Re, a unit of GE's Employers Reinsurance Corp. has named **William E. Donnell** as head of the global casualty team. Before joining the Overland Park, Kan.-based company, Mr. Donnell was president of P&C Select.

Hamilton, Bermuda-based XL Capital Ltd. has named **James McNichols** as global chief actuary. Before his promotion, Mr. McNichols was executive vp and chief operating officer of XL Financial Assurance Ltd.

Other suppliers:

PERFORMAX, a Baltimore-based administrator of self-funded employee health benefit plans, has named **John L. Hauer** as senior vp, operations. Previously, Mr. Hauer was vp of third-party administrator operations at CareFirst BlueCross & BlueShield.

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WTC: Silverstein prepares for next phase of litigation

Continued from page 1

themselves on a variety of policy forms, some of which contained occurrence definitions and some of which did not.

Even if it prevails against all of the remaining insurers, Silverstein, the WTC's leaseholder, would recover no more than $4.68 billion. This is far less than the $7 billion that Larry A. Silverstein, the leaseholder's principal, has said he needs from insurers to rebuild on the site.

Silverstein's legal setbacks have already raised doubts about the financing for four of the five office towers proposed for the site. Only the planned 1,776-foot Freedom Tower currently has financing. The loss of insurance proceeds has also prompted speculation that Silverstein's role in the rebuilding effort could be reduced and that the developer and The Port Authority of New York & New Jersey, the WTC's owner, may be more inclined to settle with the remaining insurers.

A Port Authority spokesman said settlement "is not an issue for us to decide" and that any settlement will be up to Silverstein. "We fully expect to continue our partnership," the spokesman said.

Silverstein representatives declined to comment on the settlement question, but Mr. Silverstein last week sounded ready to continue the fight.

"A defeat in the courtroom is not a defeat for rebuilding," he said in a statement issued after the Swiss Re verdict. "We are ready to move on to the second phase of the trial... We feel the evidence is strongly in our favor and look forward to our next day in court."

The coverage battle, launched by Swiss Re in October 2001, stemmed from the fact that no final policy was issued on the WTC complex before the Sept. 11 terrorist attacks, despite Willis having placed the coverage almost two months earlier in time for the closing of the WTC lease deal.

Several of the property program's insurers maintained that they bound coverage on the Wilprop form that Willis provided with its underwriting submission. Silverstein countered that Willis was shifting the program to a Travelers Property Casualty Corp. form and that insurers either knew about the change or had waived their right to agree. The Travelers form would treat the loss as two occurrences, entitling Silverstein to two policy limits, the leaseholder contended.

After 10 weeks of trial and two weeks of deliberations, the jury on April 29 returned a partial verdict in favor of nine insurers accounting for $1.06 billion of the program's limit. Initially deadlocked on Swiss Re, which wrote $877.5 million of the limit, jurors continued deliberating and last week found that it, too, bound coverage on the Wilprop form.

Swiss Re representatives expressed relief with the verdict.

"Swiss Re was the engine behind all of this," said Barry Ostrager, a lawyer with Simpson, Thacher & Bartlett in New York, which represented Zurich-based Swiss Re. "We didn't want the train to leave with us in the station."

The jury also found that three insurers representing $176 million of the program's limit—Royal Specialty Underwriting Inc., Twin City Fire Insurance Co. and Zurich American Insurance Co.—are not bound on Wilprop.

Those three now join seven other insurers in the second phase of the litigation, which will determine whether the policy forms governing their participation treat the loss as one event or two.

Silverstein and the three insurers are expected to file motions to set aside the verdict, and may later appeal. It is unclear whether U.S. District Judge Michael B. Mukasey will allow an appeal before the conclusion of the next phase of the litigation, though.

The facts surrounding the participations of the 10 insurers in phase two vary widely.

Travelers, with $210.6 million of the program limit, bound coverage on its own form, which contains no definition of "occurrence."

Silverstein has argued that under New York law and industry custom and usage, the Travelers form would treat the loss as two occurrences.

Travelers has noted, though, that Willis officials compared the Travelers and Wilprop forms in mid-July 2001 and submitted a list of more than 76 differences as a starting point in negotiating changes to the Travelers form.

The list did not point out the form's lack of an occurrence definition. Nevertheless, Travelers is expected to argue that the parties' intent was to bring the Travelers policy as much into line with the Wilprop form as possible, and, therefore, that the Wilprop form's occurrence definition should apply.

Wilprop defines an occurrence as "all losses or damages that are attributable directly or indirectly to one cause or to one series of similar causes." A previous court ruling found that the destruction of the WTC should be deemed one insured event under the Wilprop wording.

Other phase-two insurers have slightly different stories:

- Allianz A.G., which wrote $77.9 million of the WTC risk on a direct basis and $354.7 million as a fronting insurer for SCOR S.A., issued its own policies to Silverstein before the Sept. 11 attacks.

Those policies define "occurrence" as "one loss, disaster or casualty, or series of losses, disasters or casualties, arising out of one event."

A federal court in 2003 found that the term "event" is as ambiguous as the undefined term "occur-

See WTC/next page

WTC archive, resources at *BI.com*

To help readers stay informed of insurance and risk management developments arising from the Sept. 11, 2001, terrorist attacks, especially the ongoing World Trade Center insurance coverage litigation, we have compiled online a collection of *Business Insurance* articles and additional resources.

An archive of stories and documents related to the 9/11 attacks is available at *www.businessinsurance.com*. The archive will be updated as new information becomes available.

Policies: Buyers still frustrated by long delays

Continued from page 1

the coverage terms of several other insurers remain to be determined in another phase of litigation.

Risk managers note that even though the coverage trial drew national attention, little has changed in the two years since the dispute began, and the lack of timely policy issuance remains a frustration.

"World Trade Center or not, it's a sore point," said Mike Becker, treasurer of Rogers Group Inc., a Nashville, Tenn.-based crushed stone producer and highway construction company.

"You can try to be as demanding as you can, and it just does not seem to make any darn difference in the process. It kind of takes as long as it takes. It's a source of frustration for me, for sure," he said.

"We had our renewal on March 31 and, no, I don't have my policies in my hand yet," Mr. Becker said.

"To me, a lesson out of 9/11 both for risk managers and for carriers is that had the policies been issued...who knows if this litigation would have been necessary," said Jeff Strege, director of risk finance and claims for Advance Auto Parts Inc. in Roanoke, Va.

"There's a win-win for carriers, risk management professionals and brokers when policies are issued timely, because then it is all in black and white and the 'i's are dotted and the 't's are crossed, and everybody knows the terms and conditions of coverage," he said. "With regard to the World Trade Center, I think it's extraordinarily embarrassing for the whole industry," said Dean Reynolds, senior director of risk management for Freedom Communications Inc. in Irvine, Calif.

"Disputes about how coverage should be interpreted, frankly, are pretty common, especially if you've had a large claim," Mr. Reynolds said. That there was a major dispute "about which policy language applies 60 days after the binding is just astonishing, and that's embarrassing," he said.

"If I went to my board and said, 'I don't know what I bought,' it would be what I call a 'CLM'—a career-limiting moment," Mr. Reynolds said.

Some risk managers are taking the matter into their own hands.

"Since 1998, I have basically told insurers that I will not pay for policies unless they are delivered," said Susan Meltzer, assistant vp-insurance and risk management for Sun Life Financial in Toronto. "I actually in my underwriting submissions put a formal statement about that."

That strategy has reduced Ms. Meltzer's waiting time for insurance policies to 30 days from an average of about six months, she said.

"That's all (risk managers) can do," Ms. Meltzer said. But many buyers "seem to be too afraid of getting a cancellation clause, because (policies) can be canceled for nonpayment of premium. So there's a risk," she said.

"But I put the underwriter's reputation on the line and say, 'If I get a cancellation notice, do you really want me to send this to the CEO of your company?'" said Ms. Meltzer, noting that she has yet to receive such a notice since she began threatening to withhold premiums.

> **'To me, a lesson out of 9/11 both for risk managers and for carriers is that had the policies been issued... who knows if this litigation would have been necessary.'**
>
> *Jeff Strege*
> *Advance Auto Parts Inc.*

Mr. Reynolds of Freedom Communications has used a similar approach with his insurers.

"I told them that if they can issue me the invoice, they can issue the policy," Mr. Reynolds said, noting that he's willing to withhold full premium payment, if necessary.

"I used to be a broker; I understand the insurance company position that they'd like to make sure the insurance coverage is there and that there's money collected, but I'm willing to pay 20% down within 10 to 20 days of binding and then pay the balance when they deliver the policy," he said.

Mr. Reynolds used this tactic with his December workers compensation renewal, and "it worked beautifully. I got everything within 30 days."

He is still awaiting the actual policies from his April 1 property and general liability renewals. But he said he paid deposits—rather than the full premium—and will make a final payment when the policies are received.

Rather than withhold premiums, Jeff Vernor, director of operational risk processes at the United Services Automobile Assn. in San Antonio, sets specific expectations with his brokers and underwriters about the timeliness and accuracy of his insurance policies.

Those expectations are set forth in one of 39 guidelines developed by the Risk & Insurance Management Society Inc. as part of its Quality Improvement Process initiative.

"I do think that the QIP can be a solution in this regard, because the whole purpose of the process if for all the parties to define collectively what they think quality is," said Mr. Vernor, who is vice chairman of the RIMS Quality Advisory Council.

When it comes to the issuance of timely and accurate insurance policies, "quality is pretty straightforward," he said. "You decide what timeline is appropriate, set the target and then measure against it."

Mr. Vernor, who is in his third year of using the guidelines with USAA's brokers and underwriters, said that he's seen an improvement each year in how promptly he receives his policies.

On one major program, for example, the policy was issued the same day it was bound, he said. And "on one of our most difficult programs, which has the most layers, we've cut the time in half."

Mr. Vernor said that his underwriters have welcomed the guidelines. "They're particularly open to the recognition that it is a quality effort that needs to be managed by all parties," he said.

"Once that recognition has been communicated—rather than just putting all the responsibility on the carriers themselves—they are more willing to say, 'You know what, we can do this and do it in this many days,'" he said.

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Late News

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That exception has allowed insurers to deny coverage without having to demonstrate that the insurer was prejudiced by the late filing.

Workers comp insurers post improved results

Workers compensation insurers experienced a calendar-year 2003 combined ratio of 108%, which is a 3-point improvement over 2002, according to a preliminary estimate by the National Council of Compensation Insurers. The estimate marks two consecutive years of improvement. Yet the NCCI's outlook for the workers comp industry remains "cautionary." Areas of market concern include low investment returns, continued increases in indemnity and medical costs, and terrorism exposures, the NCCI said.

AIG increases capacity for excess casualty line

AIG Excess Casualty, a unit of American International Group Inc., has introduced an excess casualty product that will offer an additional $25 million in capacity to policyholders that purchase lead commercial umbrella coverage from AIG. The product, AIG ExcessPrime, provides an excess layer that is intended to sit excess of $50 million. An automatic quote will be offered to AIG-led excess programs that exceed $100 million in limits.

Florida OKs changes to workers comp JUA

Florida lawmakers have passed legislation that would restructure the state's workers compensation market of last resort. H.B. 1251, sponsored by Rep. Kim Berfield, R-Clearwater, changes the structure of the state's Joint Underwriting Assn. to base participants' premiums on loss experience rather than size. The bill would set up three rating tiers based on loss experience; currently, companies are placed in one of four tiers, depending on their size. Employers placed in the highest-risk tier must immediately pay "actuarially sound" rates for their coverage, and companies in other tiers would have pay the actuarially sound rates after Jan. 1, 2007.

PHOTO: AP/WIDE WORLD

Rep. Berfield

OneBeacon forms E&S property unit

OneBeacon Insurance Group L.L.C. is entering the excess and surplus lines property business through the launch of its OneBeacon Specialty Property division. The new specialty property unit expects to begin writing business this month through its San Francisco headquarters and satellite offices in northern New Jersey, Dallas and Lenexa, Kan. OneBeacon's property coverage will be provided primarily through surplus lines wholesalers.

Mellon, Lumenos to offer integrated HSA

Mellon's Human Resources & Investor Solutions has entered into an alliance with Lumenos, a major player in the consumer-driven health care market, to offer an integrated health savings account product that will combine administration of both the health coverage and financial components of an HSA program. The integrated HSA product includes financial services—such as checking and debit cards to pay for qualified medical expenses out of HSAs, an investment account and Internal Revenue Service-required tax reporting—as well as health plan services, such as claims administration, customer service, online health tools, employee education and enrollment.

Briefly noted

Tennessee recently became the sixth state this year to enact legislation **protecting makers and sellers of food from lawsuits** seeking to hold them liable for the health problems—including obesity—of those who overeat....The **Interstate Insurance Product Regulation Compact** is gaining momentum after adoption by five states—Colorado, Iowa, Utah, Virginia and West Virginia. Another 25 states have either introduced bills seeking legislative adoption, or are planning to do so, according to the National Assn. of Insurance Commissioners. The compact aims to create uniform national product standards and provide a central point of filing for insurers....Scott D. Moore, president and chief executive officer of New York-based PartnerRe U.S., was elected chair of the Washington-based **Reinsurance Assn. of America.** John P. Phelan, chairman and CEO of Princeton, N.J.-based American Re-Insurance Co., was elected vice chair, while Andreas Beerli, Armonk, N.Y.-based chief executive officer, Americas Division, and executive board member of Swiss Reinsurance Co., was elected the secretary-treasurer of the organization.

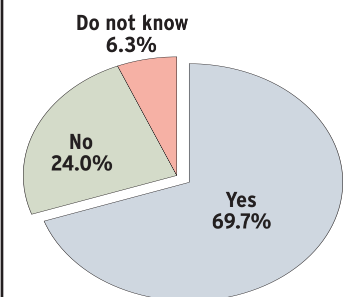
Check out BusinessInsurance.com

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

[5/3-5/7]

Should the practice of insurers paying contingent commissions to brokers for commercial insurance placements be phased out?



WTC: Heads for next phase of litigation

Continued from previous page

rence" in the Travelers form and denied Allianz's request for a ruling that it is liable for only one loss.

Allianz, however, will argue in phase two that the meaning of "event" is similar to that of "cause" in the Wilprop definition, and that Allianz intended to have an aggregating definition of occurrence similar to Wilprop's, said John B. Massopust, an Allianz lawyer with Zelle, Hofmann, Voelbel, Mason & Gette in Minneapolis.

- Industrial Risk Insurers, which wrote $237.2 million of the program, issued a binder that specifically incorporated its own policy form. That form defines occurrence as "the sum total of all loss or damage insured against arising out of or caused by one event."

The IRI policy, like Wilprop, should treat the entire WTC loss as one event, an IRI spokesman suggested. "The intent of the parties in the overall insurance program was to have a single-occurrence definition," he said.

- Royal Specialty, which wrote $127.8 million of the total limit, issued binders that referred to a standard form developed by the Insurance Services Office Inc. The ISO form does not define occurrence.
- TIG Insurance Co., which wrote $9.1 million of the program, issued its quote "subject to TIG forms and endorsements pending receipt and review of primary policies &/or manuscript form." The quote does not specify which TIG form applies; some have an occurrence definition, while others do not.

Silverstein will argue that several of these insurers' forms are the "functional equivalent" of the Travelers form and treat the WTC loss as two events, said Marc Wolinsky, a lawyer with Wachtell, Lipton, Rosen & Katz, representing the leaseholder.

Silverstein's loss in the first round of litigation, meanwhile, has revived speculation about Willis' potential exposure to a professional negligence claim over the WTC placement.

The developer said in 2002 that it had "no intention" of pursuing such a claim. Willis officials have worked closely with Silverstein throughout the litigation, and Willis executives spent days on the witness stand attempting to bolster the leaseholder's case.

Mr. Wolinsky said, though, that there were "no deals with Willis" to win the broker's support.

In its own Securities and Exchange Commission filings, Willis has warned about potential claims stemming from "our placement of property and casualty insurance for a number of entities which were directly impacted" by the terrorist attacks.

Silverstein, though, would have a tough time proving that Willis was negligent in not getting policy wording agreed upon before the attacks, one lawyer familiar with the case said. Evidence showed that Willis was working hard to do just that, he said. Silverstein would also have to show that the broker's alleged failures were responsible for the leaseholder's inability to recover two policy limits under the Travelers form.

"They basically would have to relitigate the whole issue," he said.

BI Stock Index

[5/3 - 5/7]

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

Index	Value	Change
BI Stock Index	2223.46	-2.14
Dow Jones	10117.30	-1.06
S&P 500	1098.70	-0.78

Largest gains

Company	Change
Trenwick Group Ltd.	50.00%
Penn-America Group Inc.	16.65%
United Fire & Casualty	12.12%
Navigators Group	9.54%
ProAssurance	5.60%

Largest losses

Company	Change
EMC Insurance Group Ltd.	-14.28%
Health Net Inc.	-8.02%
UNUM Corp.	-7.27%
Philadelphia Consolidated	-6.75%
NYMagic Inc.	-5.98%

Weekly change by market segment

Segment	Change
Brokers	-2.17%
Insurers/Reinsurers	-0.57%
Managed Care Organizations	-0.95%

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

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