HMOs likely to continue cycle of cost shifting / 2

Texas courts mixed on pollution exclusions / 3

Business Insurance®
www.businessinsurance.com
May 20, 2002

$4

HRH to buy Hobbs Group

Purchase will expand broker's large-account capabilities

By SALLY ROBERTS

GLEN ALLEN, Va.—Risk managers who are not familiar with Hilb, Rogal & Hamilton Co. soon might be.

The Glen Allen, Va.-based agency, which traditionally has targeted middle-market accounts with no full-time risk managers, will pay up to $274 million in cash and stock to boost its presence among larger clients with the acquisition of Atlanta-based broker Hobbs Group L.L.C.

Hobbs Group, which ranked as the 17th-largest broker of U.S business in 2001 with $86.2 million in 2000 brokerage revenues, derives 70% of its revenue from large accounts—those that pay at least $100,000 in commission and fees.

With the addition of privately held Hobbs, HRH not only extends its reach into the large-account market, but it also will boost its scale among the world's largest brokers.

Based on 2000 brokerage revenues of $260.3 million, HRH was the world's 10th-largest broker, according to *Business Insurance's* ranking for that year. HRH reported 2001 gross revenues, which include investment income, of $330.3 million, up 26% from the previous year.

Paired with Hobbs' reported $95.2 million in gross revenues for 2001, the company would have had $425.5 million in gross revenues and 3,120 employees if they had been combined in 2001.

BROKERS' SNAPSHOT

Revenues in millions of dollars

	HRH	Hobbs Group	Combined
2001 Gross revenues	$330.3	$95.2	$425.5
Employees	2,700	420	3,120

Source: SEC filings

"The biggest single opportunity in the distribution system today…is in the upper middle market and smaller risk management account market," said Andrew L. Rogal, chairman and chief executive officer of HRH. "That particular marketplace is rich in prospects and is terribly underserviced."

He noted that as a result of the brokerage consolidation movement of the 1990s—which produced powerhouses Marsh & McLennan Cos. Inc. and Aon Corp.—the upper middle market was left with fewer choices in brokers and reduced service.

"That business at the very top tier of the middle market has become a commoditized situa-

See HRH/page 22

Startup buys LaSalle Re property cat book

Endurance's stature grows with acquisition

By GAVIN SOUTER

HAMILTON, Bermuda—New Bermuda reinsurer Endurance Specialty Insurance Ltd. is poised to become a much larger player in the property catastrophe reinsurance market with the purchase of LaSalle Reinsurance Ltd.'s book of business from Trenwick Group Ltd.

LaSalle Re's book will be added to Endurance's $250 million in gross premiums written since December.

Kenneth J. LeStrange
Endurance Specialty

In a deal that sees one of the recent Bermuda startups swallowing up one of the companies formed during the property capacity crunch of the early 1990s, Endurance will take over much of the business and most of the staff of LaSalle Re. Endurance will not assume the Trenwick unit's existing liabilities.

The sale, structured as a reinsurance deal, will allow Trenwick to concentrate on noncatastrophe property/casualty reinsurance, which it had almost exclusively focused on prior to its purchase of LaSalle Re in 2000 in a more than $400 million deal. With the addition of LaSalle Re's business, Hamilton, Bermuda-based Endurance will quickly establish itself in the expanding Bermuda market, analysts note.

"It gives Endurance an established book of business, and it allows Trenwick to take the money and play in their own ball game," said Ira Zuckerman, an insurance analyst at Nutmeg Securities in Fairfield, Conn.

LaSalle Re had $133 million of premiums in force in 2001 and about $60 million in net un-

See ENDURANCE/page 23

COBRA subsidy bill to see vote

Benefit experts wary

By JERRY GEISEL

WASHINGTON—Congress may impose a COBRA health care mandate on employers without providing guidance on how companies are to comply with the law before it goes into effect.

Health care assistance provisions tucked into legislation expediting the ability of the executive branch to negotiate trade agreements would be a boon to employees who have lost their jobs because of foreign competition.

Under H.R. 3009, which is poised for a Senate vote, eligible displaced workers would pay 32% of the cost of COBRA coverage, while the federal government would cover the cost of 70% of the premiums. Currently, a beneficiary must pay the entire COBRA premium, which is 102% of his or her former employer's group rate.

The federal assistance called for in the legisla-

See COBRA/page 22

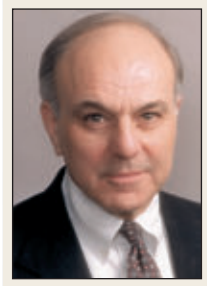
Late News

St. Paul discloses asbestos claim exposure

A claim by a former distributor and installer of asbestos products has prompted The St. Paul Cos. Inc. to disclose what it calls its "largest known asbestos exposure" to shareholders. In a Securities and Exchange Commission filing, St. Paul said that Western MacArthur Co.–a California building products distributor that acquired certain assets of Western Asbestos Co. in 1967–has asserted rights to coverage for asbestos-related injury claims. USF&G Co., which St. Paul bought in 1998, underwrote policies for Western Asbestos prior to 1961, the insurer said in its filings. In the SEC filing, the insurer said, "We do not believe that the total amounts that we and our subsidiaries will ultimately have to pay in all of these lawsuits will have a material effect on our liquidity or overall financial position."

Group faults report on cash balance plans

An employer lobbying group is asking the Labor Department to withdraw as "flawed" and "wrong" a recent report that concluded that employees covered by cash balance pension plans are being denied millions of dollars in benefits to which they are entitled. The report, issued by the department's Office of Inspector General, said it found underpayments of benefits to employees terminating employment before retirement in 13 of the 60 plans it audited. Extrapolating the findings, the OIG said participants leaving cash balance plans may be underpaid by $85 million to $199 million annually (*BI*, May 13). But Mark Ugoretz, president of the ERISA Industry Committee in Washington, said the report's finding is based on a 1996 Internal Revenue Service notice–which never was formally proposed–theorizing how benefits should be valued when an employee takes a lump-sum distribution.



Mr. Ugoretz

See LATE NEWS/next page

International

U.K. REVISITING RAIL SAFETY

Begins on page 17

Inside

Departments

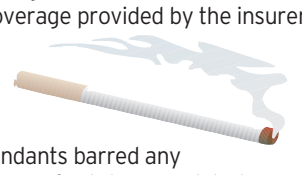
REPORTING WEEKLY ON CORPORATE RISK, EMPLOYEE BENEFIT AND MANAGED HEALTH CARE NEWS

Business Insurance (ISSN 0007-6864) Vol. 36, No. 20, is published weekly by Crain Communications Inc., 360 N. Michigan Ave., Chicago, IL 60601-3806. Periodicals postage is paid at Chicago and at additional mailing offices. POSTMASTER: Send address changes to Business Insurance Circulation Department, 1155 Gratiot Avenue, Detroit MI 48207-2912. $4 a copy and $97 a year in the U.S. $130 in Canada and Mexico (includes GST). All other countries $230 a year (includes expedited air delivery). Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 0293512, GST No. 136760444, Printed in U.S.A.

CONTINUED FROM PAGE ONE

Liggett loses bid for tobacco defense

Insurers scored a victory in a Delaware Supreme Court ruling last week that held they are not required to fund a defense for tobacco manufacturer Liggett Group Inc. in smoking-related lawsuits. Exclusions in coverage provided by the insurer



defendants barred any coverage for tobacco-related illnesses, the court said. Liggett sued 33 of its insurers in January 2000, seeking defense coverage for hundreds of liability suits (*BI*, Feb. 14, 2000). The state Supreme Court also rejected Liggett arguments that coverage existed under a separate media special perils policy. Among the insurers were ACE Property & Casualty Insurance Co.; Continental Casualty Co.; Hartford Accident & Indemnity Co.; National Union Fire Insurance Co. of Pittsburgh, Pa.; Royal Insurance Co. of America; and Zurich-American Insurance Co.

Insurers funding sweepstakes settlement

Simon Marketing Inc. says its professional liability insurers will fund the settlement of a class-action suit against McDonald's Corp. in connection with a sweepstakes promotion. The settlement includes a release of consumer claims against Simon and its employees, agents and vendors in connection with promotions run from Jan. 1, 1979, through Dec. 31, 2001. In August 2001, McDonald's severed ties with Los Angeles-based Simon after alleging that a Simon employee stole more than $20 million of winning game pieces for McDonald's promotional

games over a number of years. Simon's professional liability insurers are funding the settlement—terms of which were not disclosed—because Oak Brook, Ill.-based McDonald's was named as an additional insured, a Securities and Exchange Commission filing shows. The insurers were not identified.

Late News

Law Lords open door for asbestos claimants

Victims of mesothelioma who have worked for two or more employers can seek compensation without first having to prove where they contracted the disease, the House of Lords has ruled. The decision overturns a controversial Court of Appeal judgment. The House of Lords ruling in *Fairchild vs. Dovener, Wassingtons and Leeds City Council* clears the way for hundreds of mesothelioma sufferers and their relatives to seek compensation from former employers. The Union of Construction Allied Trades and Technicians, whose member Arthur Fairchild died in 1996 after being exposed to asbestos in two workplaces, estimates that the judgment will cost insurers more than £6 billion ($8.91 billion). But John Parker, head of general insurance at the Assn. of British Insurers in London, described the union estimate as "wildly out of line with reality."

Law firm to settle BFA investor claims

A Phoenix law firm and its insurer have agreed to pay $21 million to settle investor claims stemming from the firm's representation of the failed Baptist Foundation of Arizona. Jennings, Strouss & Salmon represented BFA when the foundation's assets were severely depleted. Several foundation officials have pleaded guilty to fraud charges, and others are awaiting trial. The law firm did not admit wrongdoing in the settlement. An undisclosed insurer will pay the $21 million minus a deductible and the law firm's legal costs, Jennings, Strouss said. BFA, which marketed investments and retirement accounts, filed for bankruptcy in 1999, with liabilities of $650 million and assets of $290 million. Chicago-based accounting firm Arthur Andersen agreed to pay BFA investors $217 million to settle

PHOTO: AP/WIDE WORLD

Arizona Corporate Commission Chairman William Mundell approved the BFA settlement.

negligence allegations stemming from its audit of the foundation.

RSA to sell Benelux units

Multiline insurer Royal & SunAlliance Insurance Group P.L.C. is selling its Benelux subsidiaries to Netherlands-based Achmea Holding N.V. for £77 million ($112.7 million) in cash. The two units, Royal & SunAlliance Schadeverzekering N.V. and Royal & SunAlliance Levensverzekering, in 2001 generated premiums of 120 million euros ($109.7 million) for nonlife business and 52 million euros ($47.5 million) for life business, a spokeswoman said. The units are based in Brussels, Belgium; Amsterdam, Netherlands; and Luxembourg. London-based RSA said that it would continue to provide insurance to its multinational clients in Belgium, but that this coverage would be written out of the United Kingdom.

Briefly noted

Aetna Inc. has promoted Ronald A. Williams to president. Effective May 27, he will be responsible for Aetna's health care business and group insurance, large-case pensions and disability and long-term care business. Mr. Williams, who joined Aetna in March 2001, is executive vp in charge of health care business. Dr. John Rowe, Aetna's current president, chairman and CEO, will remain chairman and CEO....Munich, Germany-based **Allianz A.G. Holding's** first-quarter net income more than doubled, to 1.9 billion euros ($1.72 billion) from 705 million euros ($636.6 million) a year earlier. Allianz said much of the increase was due to one-time gains from the recent sale of part of its stake in Munich Reinsurance Co. The insurer's first-quarter gross premiums increased 10.6% to 22.8 billion euros ($20.59 billion), and property/casualty premiums grew 6.7% to 13.9 billion euros ($12.55 billion).

Check out Businessinsurance.com

To get breaking news as it occurs, visit *Business Insurance*'s free online Daily News, at *www.businessinsurance.com.* Sign up for your daily e-mail of breaking news.

All the material in the Late News column, as well as other content in this week's issue, is generated from daily news postings that appeared on the Web site in the previous week.

Managed care rates expected to stay up into 2003

HMO cost-shifting to continue

By JUDY GREENWALD

The double-digit rate increases that produced higher first-quarter earnings for managed care organizations are expected to continue for employers through at least 2003.

Rate hikes will continue unabated, analysts say, because of high medical cost trends and the growing clout of providers to demand higher fees, among other factors. As a consequence, some analysts predict more employers will be forced to shift rising costs to employees.

"There's going to be an extended period here, probably 18 months or more, when prices are going to be quite strong," said Michael LeConey, an analyst with Gilford Securities in New York. Current estimates call for price hikes averaging 14% to16% this year, he said.

"I don't think there's going to be any question they'll be at the high end—and maybe more—when the year's over," he said.

Helped by the rate hikes, most managed care firms reported strong first-quarter results. But at least two companies—Santa Ana, Calif.-based PacifiCare Health Systems Inc. and Hartford, Conn.-based Aetna Inc.—saw their earnings decline because of Financial Accounting Standard No. 142. FAS 142 requires a company to set a value on its goodwill assets, record any impairment in that value and take a corresponding charge against shareholders' equity for any decline.

"The No. 1 challenge continues to be the rising medical cost inflation, driven primarily by a rapidly aging population, but for the most part in the first quarter, companies have been able to more than offset these rising costs through premium increases and operating efficien-

See RESULTS/page 20

HMO FIRST-QUARTER RESULTS

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

Company	2002 Net income	Percent Increase (Decrease)
Kaiser Permanente	$297.0	90.4
Humana Inc.	46.8	75.5
WellPoint Health Networks	141.1	46.2
Anthem Inc.*	99.8	41.4
UnitedHealth Group	295.0	39.2
Health Net Inc.	49.8	17.4
Trigon Healthcare Inc.*	35.2	8.8
Oxford Health Plans Inc.	71.4	5.7
CIGNA Corp.	275.0	(1.8)
Aetna Inc.	(2,827.7)	NM
PacifiCare Health Systems Inc.	(858.8)	NM

* Merger agreement announced between Anthem and Trigon NM=not meaningful
Source: Company reports

Texas courts issue mixed rulings on exclusions

By DAVE LENCKUS

SAN ANTONIO—Texas appellate courts have handed coverage victories to insurers and policyholders in two unusual rulings on the absolute and the sudden and accidental pollution exclusions.

A state appellate court in San Antonio unanimously ruled late last month that the absolute pollution exclusion bars coverage when any dispersed substance causes bodily injury, even if the environment was not contaminated and the substance was a commercial product that was used appropriately.

Another state appellate court earlier this month ruled that the sudden and accidental pollution exclusion does not bar coverage for personal injury claims, such as emotional distress and even various bodily injuries.

In the absolute pollution exclusion case, a worker for odor abatement specialist Bio Zapp Laboratories Inc. of San Antonio nearly died after spraying a Bio Zapp deodorizing product in a smoke-damaged airplane during a hull restoration project.

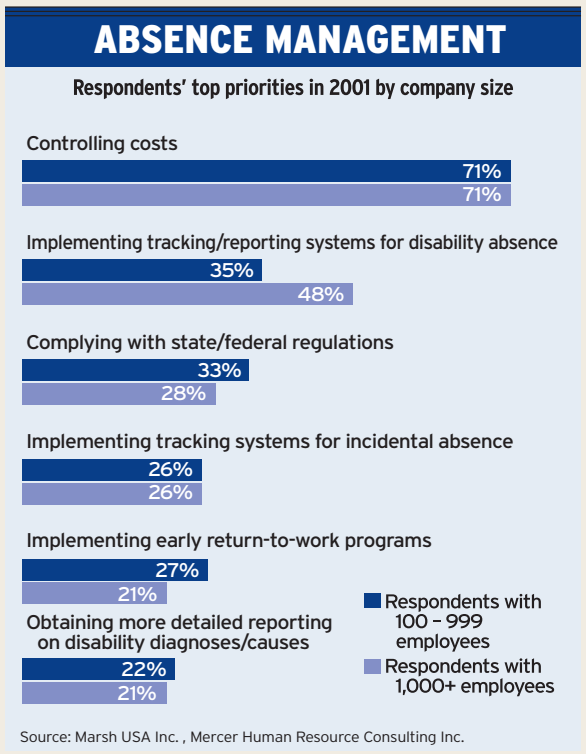
The worker, Milton Zaiontz, sued Bio Zapp—which had opted out of the state's workers compensation system—and the company's president for negligently preparing a material safety data sheet on the product. The safety sheet did not include proper ventilation instructions, Mr. Zaiontz alleged. A jury agreed and ordered the defendants to pay him $1 million.

Mr. Zaiontz and his wife sued Bio Zapp's general liability insurers, Trinity Universal Insurance Co. and Texas Pacific Indemnity Co., after they invoked their absolute pollution exclusions and refused to cover the jury award. In a summary judgment, a trial court ruled that the exclusion did not bar coverage, though the court ruled for the insurers on other grounds.

In overturning the lower court's decision on the pollution exclusion, the appellate court on April 30 said it was bound by a 1995 state Supreme Court ruling in a case involving an identical exclusion and a similar policyholder argument that the exclusion is ambiguous. The 1995 case, however, involved a construction accident that released a toxic cloud over a city.

The appeals court also rejected the plaintiff's argument that the absolute pollution exclusion does not apply because the deodorizing spray did not migrate from its intended location. The court refused to adopt that reasoning, applied in 1994 by another Texas appellate court, because the earlier case involved the sudden and accidental pollution exclusion.

See TEXAS/page 19



Employers surveyed

Cost of absence a present worry

By MARK A. HOFMANN

Controlling rising costs stands at the top of employers' concerns about their time-off and disability programs, a new study finds.

Nearly three-quarters—71%—of employers surveyed said that cost control is one of their top absence management priorities, according to the "2001 Survey on Employers' Time-Off and Disability Programs," conducted jointly by Mercer Human Resource Consulting and Marsh Inc.

"The key question employers seemed to be wrestling with in 2001 was how to minimize costs while maximizing the value of time-off and disability programs," according to the survey. "Employers are unlikely to substantially reduce their scheduled time-off benefits, which are highly prized by employees. But, faced with continued pressure to control costs, they are looking for new opportunities to wring some of the costs out of unscheduled absences and disabilities," it states.

"Awareness of the costs has increased, and employers feel that they can make a difference by the way they establish their benefit programs and also by how they manage absences," said Dr. William Craig. Dr. Craig is a Chicago-based Mercer consultant who co-wrote the report with Philadelphia-based consultant George Faulkner. The survey was based on the responses collected from 476 employers in mid-September 2001.

According to the report, absences of all sorts account

See ABSENCE/page 6

Open rating overhaul proposed

California comp bill would add minimum rate rule

By ROBERTO CENICEROS

SACRAMENTO, Calif.—A legislative proposal to stabilize California's troubled workers compensation market would increase regulatory scrutiny of the workers comp rates that insurers can charge employers.

The California Department of Insurance insists that the measure, which would introduce minimum rate requirements for workers comp insurance only, would not scrap the state's open rating system. But insurers say employers would suffer because the proposal would remove insurers' ability to offer premium discounts to companies that institute safety programs.

Open rating, which was implemented in California seven years ago, essentially allows insurers to set prices without having to adhere to a minimum rate set by state regulators. But under A.B. 1985, the Department of Insurance could determine a minimum rate that each insurer could charge employers. Insurers could offer a price below that rate only if they provide data that a specific employer warrants the lower price.

Some insurer critics of the measure complain that the minimum rate requirements would effectively prevent insurers from rewarding with lower premiums those employers that implement good loss control programs. The bill's backers, however, maintain that the change is needed to help make up for years of widespread market-share underwriting brought about by open rating.

Such underwriting, they say, has led to inadequate pricing and has contributed to financial troubles—including insolvencies—at many of the state's workers comp insurers. Analysts have said that, while insurers generally have been raising rates and loss costs are improving, some insurers continue to price for market share.

Larry White, senior staff counsel for the California Department of Insurance, said that California's "radically deregulated" market faces serious problems because there currently is no requirement that workers comp rates must be adequate to meet an insurer's losses and expenses.

A.B. 1985, which was introduced by Assemblyman Thomas M. Calderon, D-Montebello, was approved by the Assembly Appropriations Committee and is headed for a floor vote. State regulators maintain that the measure would allow them to stabilize rates, which they say would help attract more insurers to California's shrinking market for workers comp.

"The workers compensation market is not in very good

See CALIFORNIA/page 21

Successful companies attack health care costs: Survey

Cost controllers meet goals

By MICHAEL PRINCE

Companies that are successful financially are also more likely than others to be taking an aggressive and multipronged approach to controlling health care spending, a new survey finds.

Such an approach becomes more important as rising health care costs and weak economic conditions threaten to erode companies' profitability, the survey's authors say.

"Employers must be engaged in managing their health care costs as aggressively as they can," said Helen Darling, president of the Washington Business Group on Health in Washington, which is co-sponsoring the annual survey with Watson Wyatt Worldwide.

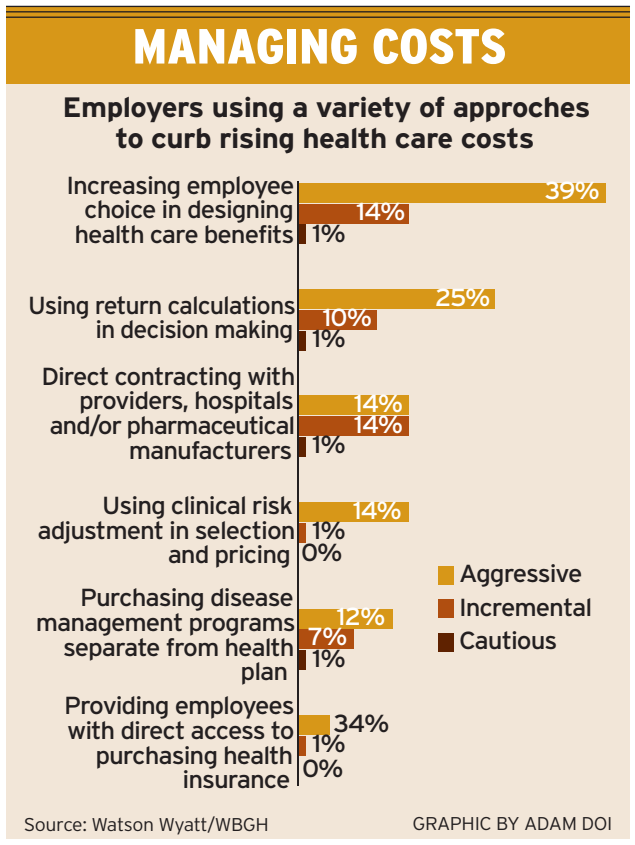
"It's a contact sport. You can't just sit back, make a few changes and be successful," she added.

Employers that manage their health care costs aggressively are almost twice as likely to be ones that are "successful," according to the survey, which defined success as meeting or exceeding financial goals and "significantly beating the average" in terms of health care cost increases.

In the survey of 500 large employers, only 18% of respondents were seen as aggressive managers, meaning they have adopted six or more health care cost control strategies. Of the remainder, 50% were identified as cautious, meaning they have adopted two or fewer health care cost control strategies, and 32% were deemed incrementalists, with three to five cost control strategies.

However, though in the minority, 31% of the aggressive em-

See COST CONTROL/page 20



Panel reacts to hard market reaction

By RODD ZOLKOS

CHICAGO—Whether price levels in the current hard insurance market are justified appears to be a matter of perspective, according to one recent panel of insurance and risk management executives.

Speaking at the 2002 Harold H. Hines Jr. Memorial Symposium, held May 9 in Chicago, the panelists discussed the current state of the insurance market and speculated about its future.

Asked whether current pricing was justified, David Mair, associate director for risk management for the United States Olympic Committee in Colorado Springs, Colo., answered, "Hell no."

"I think there are some significant overreactions in the marketplace at the moment, and there's a great deal of what I would characterize as 'take it or leave it' underwriting," said Mr. Mair, who also was the 2001-2002 president of the Risk & Insurance Management Society Inc.

On the other side of the fence, Richard G.M. Marko, senior vp of National Markets at Liberty Mutual Insurance Co. in Boston, said: "We have a very tough business; we have an awful lot of things working against us simultaneously. Do I think (the market is) hard enough? Hell no."

Mr. Marko said that from 1994 to 1999, insurance rates decreased by about 50%. Now, after two straight years of increasing rates, about half of that decrease has been made up, he said.

He cited a lengthy list of factors affecting current insurance pricing, including "rampant" medical cost inflation, new recognition of concentrations of workers compensation risk, a continuing increase in the number of covered lives and value of property in catastrophe-exposed areas, ongoing asbestos issues and numerous large losses in recent years.

Add to all of those a weak economy, and the factors combine in a sort of "perfect storm" for a hard market, Mr. Marko said. And Sept. 11 "exacerbated the situation," he noted.

"But, when you look at the different lines of business, it's not all going in the same direction," Mr. Marko said. "There are some areas that are very hard, and there are some areas that aren't hard enough yet."

J. Patrick Gallagher Jr., president and chief executive officer of brokerage Arthur J. Gallagher & Co. in Itasca, Ill., said he thinks it's important to bear in mind that the market was hardening before Sept. 11. Current market conditions are "a different kind of hardening" than what has been seen in the past, he said.

Rate increases in the current mar-

See HINES/page 16

Hines panelists


Mr. Gallagher


Mr. Lohmann


Mr. Mair


Mr. Marko

Absence: Eye on costs

Continued from page 3

for about 14.6% of payroll costs. Scheduled absences such as vacation and holidays amount to 10.2% of payroll costs, while unscheduled absences such as sick days, disability and workers compensation-related absences account for the remaining 4.4%. This represented a slight increase over the percentage reported in the initial survey, which was released in February 2000. In that survey, employers reported that absences of all kinds amounted to 14.3% of payroll costs, with unscheduled absences accounting for 3.9% of payroll.

After cost control, employers' greatest priority was implementing tracking and reporting systems for employee absences.

The survey found a disparity, though, between this issue's prominence among employers with at least 1,000 employees and their smaller counterparts. Forty-eight percent of the larger employers pointed to such systems as a priority, but only 35% of the smaller employers did so.

Complying with state and federal regulations ranked third overall among absence management priorities—cited by 28% of larger employers and 33% of smaller ones.

"The surprise is how much more important developing tracking and reporting systems has become this year compared to a year before," said Dr. Craig.

In the 2001 survey, 37% of large employers cited such systems as a top priority, while only 27% of the smaller ones did.

Making sure absence management efforts comply with the requirements of the federal Family and Medical Leave Act of 1993 is another concern of employers. Dr. Craig pointed out that the complexity of meeting the law's strictures is leading employers to look outside their offices for assistance.

Human resources departments and supervisors have found meeting the law's demands "a huge headache," he said.

"In terms of the FMLA, what we're seeing is a lot of increased interest in outsourcing the administrative function. They want to be in compliance with the rules, and those are complicated and take a lot of time. Vendors have developed software systems with automatic features so they can efficiently meet the client's requirements," he said.

The outside providers include an employer's insurers or TPA, said Dr. Craig, who pointed out that some employers rely on special FMLA administrators.

According to the report, only 8% of the respondents outsourced at least some of their FMLA cases in 2001. But that was four times greater than the percentage of employers who reported outsourcing in the 2000 survey. And the new survey points out that the trend seems likely to grow even stronger, particularly among large employers. In fact, about two out of five employers with 10,000 or more employees reported that they "are considering the outsourcing option," the report says.

Single copies of "2001 Survey on Employers' Time-Off and Disability Programs" cost $200 and may be purchased through www.imercer.com or by calling 800-333-3070.

Commentary

Insurance fiction underwritten

I recently read a novel that had a most unusual main character.

John Walker gets launched on a totally improbable adventure because he had a brief affair with a colleague who's now disappeared. There's a bunch of high-tech wizardry, a quirky new love interest and a rapidly growing heap of bodies before a pretty fantastic climax.

The fact that all this stuff happens to the main character in my vacation reading isn't what makes the guy unusual. What makes Walker unusual is his job—he's described as an insurance data analyst for a California insurance company.

In short, he sounds sort of like an actuary. So, in Thomas Perry's "Death Benefits," we've got a guy who's sort of like an actuary dodging bullets in the pursuit of truth and ill-gotten gains.

Mark A. Hofmann

The mere presence of insurance professional in pop fiction—or literature of any kind—is, in and of itself, noteworthy. Whereas fictional cops, robbers, Wall Street operatives, politicians and even journalists get lead roles all out of proportion to their actual numbers in the general population, the ranks of fictional insurance professionals are pretty slim.

After all, according to the Insurance Information Institute's 2002 Fact Book, federal data shows that all forms of insurance—including pet insurance—provided employment for about 2.3 million Americans. I'm pretty sure that's more people than make their living as detectives, Wall Street operatives or journalists.

You wouldn't know it from a quick survey of popular culture, though. Odds are that James M. Cain's masterwork, "Double Indemnity," published in 1936, is still the best-known work of fiction—other than some bogus contracts—involving the business of insurance. And the mere fact that a work that appeared more than 60 years ago is the best known of its kind shows just how scarce the competition is.

Back in 1998, I wrote in a review of a novel called "Armadillo" that insurance professionals seemed to be enjoying a higher fictional profile. I was wrong, though I stand by my contention that William Boyd's "Armadillo" is one of the most intriguing fictional treatments of insurance ever written.

To bolster my case back then, I cited the dogged claims supervisor Dennis Reedy in Carl Hiaasen's hilarious novel of insurance fraud gone awry, "Stormy Weather." Grasping more than a bit, I also noted that Jake Lassiter—the football player turned lawyer in Paul Levine's "Flesh & Bones"—got mistaken for a risk manager in one of his investigations.

After that, however, no notable insurance characters appeared on the literary horizon. Lloyd's underwriters do appear in Bruce Alexander's novels about Sir John Fielding's fight against crime in 18th-century London, but they're supporting characters. And there was Jack Wade, the ex-cop/surfer turned fire investigator in Don Winslow's "California Fire & Life," but he's extremely unlike any insurance professional you're likely to meet.

The pickings are even slimmer in the world of music lyrics; though, admittedly, in the world of rock, you can't expect insurance to rank up there with teenage lust and high school nihilism. I must note, however, that the incomparable Warren Zevon actually refers to "workman's comp" in the aptly titled "Mr. Bad Example" on his 1991 album of the same name.

Even though insurance rock-n-roll is even more scarce than insurance fiction, it's not like the material isn't out there for someone who wants to be the John Grisham of the insurance literary world.

There's been a colorful-enough run of rogues stretching all the way to Martin Frankel to serve as the models for shelves of potential bestsellers. I'm sure there are some dusty claims files hiding stories that would strike Don DeLillo as unbelievable. And, more prosaically, a few insurance corporate histories—and maybe a family feud or two—would have some potential in the right hands as well.

But it hasn't happened, and I'm not holding my breath—or volunteering to fill the void. Until the reading public tires of manipulative lawyers, obsessed cops and tattered journalists as protagonists who stumble into incredible webs of conspiracy, I think it's safe to assume that insurance is just going to be one of those subjects in which art definitely doesn't imitate life.

Senior Editor Mark A. Hofmann's commentary appears periodically in Business Insurance and on www.businessinsurance.com. He can be reached at by e-mail at mhofmann@crain.com.

www.swissre.com

For most people the horizon is as far as they can see. But for us it represents the threshold to an unseen world of new opportunities. As one of the world's foremost managers of capital and risk, we are constantly searching for solutions that lie beyond the obvious. With financial and intellectual reservoirs of great depth and breadth to draw from, we combine insight, knowledge and original thinking to create new opportunities. We do it for ourselves. We can do it for you.

Solutions beyond the obvious.

Swiss Re

Business Insurance

Vice President/Publisher: Martin J. Ross III (New York)

Editor: Paul D. Winston (*Chicago*)
Editor-at-Large: Jerry Geisel (*Washington*)
Managing Editor: Regis J. Coccia (*Chicago*)
Assistant Managing Editor - Graphics: Kathy L. Barnes (*Chicago*)
Assistant Managing Editor - News: Gavin Souter (*New York*)
Senior Editors: Meg Fletcher, A.R.M. (*Chicago*); Judy Greenwald (*San Jose*); Mark A. Hofmann (*Washington*); Dave Lenckus (*Tucson*); Douglas McLeod (*New York*); Edwin Unsworth (*France*); Joanne Wojcik (*Denver*); Rodd Zolkos (*Chicago*)
Bureau Chief: Roberto Ceniceros (*Los Angeles*)
Associate Editors: Michael Bradford (*New Orleans*); Michael Prince (*New York*); Sally Roberts (*Denver*); Sarah Veysey (*London*)
Copy Desk Chief: Matt Scroggins (*Chicago*)
Copy Editors: Mary B. Nick (*Chicago*); Joe Walker (*Chicago*)
Directory Editor: Kevin P. Edison (*Chicago*)
Assistant Directory Editor: Carrie A. Brittain (*Chicago*)
Assistant Graphics/Online Editor: Amy R. Kepka (*Overland Park*)
Executive Assistant / Reprint Manager: Karen Brown Tucker (*Chicago*)
Editorial Cartoonist: Roger Schillerstrom (*Chicago*)

Advertising Director: Kenneth F. Luker Jr. (*New York*)
Midwest Advertising Manager: Robert L. Niesse (*Chicago*)
District Managers: Chris Crain (*New York*); Lori Lieberman (*Los Angeles*); Robert B. Murray (*New York*) ; John L. Phillips (*Chicago*); Jennifer Powers (*Boston*)
Classified Advertising Manager: Irais Amleshi (*Chicago*)
Assistant to the Publisher: Pat Ghazvini (*New York*)
Advertising Traffic: Stephanie Cress (*New York*)
Production Manager: J. Thomas Janka (*Chicago*)

Director of Communications: Ronnie I. Drachman (*New York*)
Promotion Coordinator: Barbara O'Brien (*New York*)
Promotion Manager: Michael Ambrosio (*New York*)

EDITORIAL: Chicago: 312-649-5200; Denver: 303-698-7601; London: 207-457-1400; Los Angeles: 323-370-2455; New Orleans: 504-364-1908; New York: 212-210-0100; San Jose: 408-774-1500; Tucson: 520-579-1937; Washington: 202-662-7200
ADVERTISING: Boston: 617-292-4856; Chicago: 312-649-5276; New York: 212-210-0133; Los Angeles: 323-370-2456
COMMUNICATIONS: New York: 212-210-0132
SUBSCRIPTIONS: Detroit: 888-446-1422

Business Insurance is published by Crain Communications Inc.

Chairman: Keith E. Crain
President: Rance Crain
Secretary: Merrilee Crain
Treasurer: Mary Kay Crain
Executive Vice President/Operations: William A. Morrow
Senior Vice President/Group Publisher: Gloria Scoby
Group Vice President/Technology, Circulation, Manufacturing: Robert C. Adams
Corporate Circulation Director: Maxx MacConnachie
Corporate Director/Production & Manufacturing: Dave Kamis

G.D. Crain Jr. Founder (1885-1973)
Mrs. G.D. Crain Jr. Chairman (1911-1996)
S.R. Bernstein Chairman-executive committee (1907-1993)

Published weekly at 360 N. Michigan Ave., Chicago, Ill. 60601-3806, Fax: 312-280-3174, E-mail: *biweb@crain.com*. Offices: 711 Third Ave., New York, N.Y. 10017-5806, Fax: 212-210-0704, CRAIN COM NYK; 473 Fairfield Ave., Gretna, La. 70056, Fax: 504-364-1337; Suite 814, National Press Building, Washington, D.C. 20045-1801, Fax: 202-638-3155; 6500 Wilshire Blvd., Suite 2300, Los Angeles, Calif. 90048- 4947, Fax: 323-655-8157; 967 Bermuda Court, Sunnyvale, Calif. 94086-6750, Fax: 408-774-1155; New Garden House, 78 Hatton Garden, London EC1N 8LD England, Fax: 207-457-1440; 4 Grande Rue, 49140 Jarze, France; 8157 N. Torrey Place, Tucson, Ariz. 85743, Fax: 520-579-3476; 777 E. Speer Blvd., Denver, Colo. 80203-4214; Fax: 303-733-2244; 11133 W. 108th St.,Overland Park, Kan. 66210, Fax: 312-280-3174. $4 a copy and $97 a year in the U.S., $130 in Canada and Mexico (includes GST). All other countries, $230 a year (includes expedited air delivery). Don Mierendorf, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, *Business Insurance*, 1155 Gratiot Ave., Detroit, Mich. 48207-2912, Phone: 888-446-1422 or 313-446-0450, Fax: 313-446-6777. Microfilm copies available: University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48013. Microfiche copies: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For reprints or reprint permission: Karen Brown Tucker, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806, 312-649-5319, Fax: 312-280-3174.

To subscribe, call 888-446-1422, or 313-446-0450 outside the United States.
www.businessinsurance.com

Editorial

Congress should hold off on plan to subsidize COBRA

WHEN IT COMES to COBRA legislation, we hope Congress doesn't make the same mistake twice.

The Senate now is considering a proposal to subsidize COBRA benefits for certain eligible employees that sets bad public policy and requires more consideration. If it passes as is, employers would be faced with some of the same confusion and costs they encountered with the original health care coverage continuation law.

Sixteen years have passed, but veteran benefit managers likely have not forgotten the nightmare that resulted when Congress in 1986 passed the Consolidated Omnibus Budget Reconciliation Act.

With little warning and no public discussion, legislators, as part of a broad budget bill, included a provision requiring employers for the first time to extend their group health plans to millions of people who no longer had any direct connection to them.

By paying a premium equal to 102% of the group rate, employees terminating their employment—as well as their dependents—could continue for a limited period the coverage they otherwise would have lost.

Complying with that new benefit mandate was enormously difficult for employers, with companies forced to start from scratch in setting up systems to notify beneficiaries and track of premium payments.

That task wasn't made any easier by the fact that Congress gave many companies just a few months to comply with the new mandate. Employers' burden was enlarged by a total lack of guidance from regulators.

No one knows exactly how much money employers initially spent trying to comply with COBRA, but the amount was astronomical.

Now, showing that they have learned nothing from the past, some members of Congress are proposing the same sort of thing, albeit on a smaller scale.

As we report on page 1, two influential members of the Senate Finance Committee—Chairman Max Baucus, D-Mont., and Charles Grassley, R-Iowa, the committee's ranking minority member—have proposed an amendment to a massive trade bill that would provide federal subsidies of COBRA premiums to employees who have lost their jobs due to foreign competition. Under their plan, the government would pay 70% of the premium, leaving it to the beneficiary to pay the remaining 32% portion.

The amendment stipulates that employers would front the cost of this new subsidy, but does not spell out how employers would obtain reimbursement from the government. The amendment calls for the Treasury Department to sort that out.

The chief problem with this is that, if the measure is enacted, the COBRA subsidy provision would go into effect immediately, but it could be considerably longer before rules are developed for this process.

For example, it took Treasury 13 years to develop final regulations for the original COBRA law. In addition, despite the emergence in the mid-1980s and subsequent growth of cash balance pension plans, Treasury has yet to propose guidance on many key issues related to the operation of such plans.

If the past is any indication, therefore, the likely result of the COBRA subsidy would be mass confusion and uncertainty among employers.

At a minimum, if Congress accepts this amendment, it either needs to spell out how reimbursement would work or delay the mandate's effective date until Treasury provides the needed guidance.

Such concerns aside, we question whether government COBRA subsidies for workers who have lost their jobs to foreign competition are warranted.

There is no question that those individuals would very much welcome federal financial assistance to help pay COBRA premiums, the cost of which can be staggering. But why are these individuals being singled out for federal assistance? What makes an employee who has lost his or her job due to foreign competition more deserving of a federal COBRA premium subsidy than any other worker who has lost a job?

That's a question that taxpayers—who would be picking up the tab, after all—deserve to have answered.

If Congress does accept this amendment, it would be only a matter of time before other legislators would seek to extend the assistance to other groups. Indeed, some senators already have been pressing for federal health care premium subsidies for retired steelworkers.

Given what is at stake, we would hope that Congress thinks this proposal out long and carefully, with ample time for public input, before taking action.

Schillerstrom

Letters to the Editor

Facts call for expansion of Risk Retention Act

To the editor: This letter is in response to the letter Charles A. McAlear wrote in the May 6 issue. Mr. McAlear's letter is long on opinion and short on facts.

Here are the facts:

According to the Risk Retention Reporter, of the 142 risk retention groups that have been formed since 1986, only 15 have become insolvent. Twelve of the 15 RRGs that failed were formed between 1987 and 1989, and their failure, at least in part, can be attributed to the newness of the Liability Risk Retention Act and the fact that regulators had not yet adapted to the new regulatory requirements of the federal law. This rate of failure is comparable to an unpublished A.M. Best Co. insolvency study for the period 1992-2001, which shows that a little less than 1% of the 3,000 property/casualty insurers tracked by Best became insolvent. Sixty percent of RRGs are too small to be rated by Best. Of those that are rated, all have a B+ rating or higher. Eighteen RRGs are rated A- or A.

In regard to those RRGs that ceased to operate (primarily due to the soft market of the 1990s), the statistics are not so easy to retrieve because, of course, there are numerous state domiciles for RRGs. However, the experience of Vermont is instructive.

According to the records of the Department of Insurance, Vermont has licensed 64 RRGs. Forty are in operation today. Out of the 24 that are not in operation today, about half were never capitalized or never commenced operations. Of the remaining 12 that operated and then ceased operating, nine did so without formal regulatory action through orderly runoff, loss portfolio transfer, novation, etc. In the three cases involving formal liquidation or receivership, funding was provided either by a reinsurer dropping down to assume the reserves or by a third party such as a guarantor. No policyholder of a Vermont RRG has ever failed to receive a claim payment due to insolvency.

One of the principal supporters of the effort to expand coverage available under the LRRA is the Consumer Federation of America. Their stamp of approval after a critical review is strong evidence that the interests of the consumer will be enhanced by expansion of the LRRA.

Robert H. Myers Jr.
Special Counsel
National Risk Retention Assn.
Minneapolis

Online Commentary

Visit the Commentary section of www.businessinsurance.com to read the latest commentaries by Business Insurance editorial staff members as well as contributors Dr. George L. Head and Myron Picoult.

Business Insurance **welcomes letters to the editor. The section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Please send your letters to: Letters to the Editor, *Business Insurance*, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; fax: 312-280-3174; e-mail: *pwinston@crain.com***

Freedom

The new Aetna believes that people should be free to choose the coverage that is best for them. Aetna HealthFund offers a new choice. It provides the comprehensive coverage

to choose.

of a traditional health plan, plus an employer-paid health savings account which allows members to choose the services they want. They can see any doctor. Go to any

America was built on it.

hospital. In or out-of-network. And any unused dollars in the fund can be carried over to provide additional plan coverage the following year. Aetna is the first full-service

So is our new

health insurer to offer a plan like it.
New options and innovations for you
and your customers. That's the new Aetna.

Aetna HealthFund.™

Aetna™

Turning Promise into Practice™

Health • Dental • Disability • Life • Long-Term Care

www.aetna.com

Ask a Risk Manager

World class principles aid in success

Q: Many people talk about "world-class risk management," but it seems few can agree on a definition. How would you define it?

A: With the understanding that it's probably not that important for everyone to agree on a specific definition as much as to follow the general principles involved, let me try to define "world class" generically in a way that many of us can identify with and adopt. The successful deployment of the concept can move us forward with our bosses, senior management, governance and ourselves. It can give us more impact and ultimately make us more successful, no matter how our jobs are defined or how we view risk management as a discipline.

We can agree at the start that "world class" will mean many different things to different people. At its core, the term implies quality in our work. The Quality Improvement Guidelines being introduced by the Risk & Insurance Management Society Inc. in partnership with significant industry groups places some very thoughtful parameters around what quality in our industry should mean. But there's more to world-class risk management than quality.

I think one question to consider is "How do we get from 'very good' to 'even better?'" While there is no magic bullet, there are ways you can improve the likelihood that others will perceive you as operating at a high-quality level of performance:

- **Be continuously innovative.** This requires always looking at process and practice and asking yourself how you can solve problems in new and even completely different ways.
- **Employ widespread and acknowledged "best practices."** Regularly scan the landscape of your industry and related industries to find out who's doing things most efficiently and effectively, measured by the results they achieve.
- **Build your team into well-trained subject matter experts.** Your team members should have a confluence of skills that go beyond technical wizardry to include highly effective influencing, interaction and communication skills. This ensures that the image of risk management is regularly being enhanced among key customers and business partners.

Mr. Mandel

- **Ensure high efficiency among staff**. Like it or not, risk management is usually a cost center staff function and therefore must be viewed as efficiently using the resources allocated to it.
- **Aim for continuously declining output error.** At one time I would have said you should be error-free in the work that you do, but I think we all need to acknowledge our humanity and recognize that, in this life, we will never be perfect. But, in the spirit of continuous improvement, we can always reduce our error rate, whether small or large.
- **Focus on improving and enhancing the customer experience.** To improve customer satisfaction, you should develop a means of formally or informally scoring satisfaction. Without such measures, you just might not become aware of a problem until it brings you and your team down.
- **Target the top quartile in cost of risk**. Regardless of what formula you use to measure it, cost of risk is one of the fundamental metrics that determines the extent of our success. Utilize the many sources of benchmark data available—the RIMS Benchmark Survey being one—to compare yourself to other like organizations and employ the processes and practices that will improve your ranking.
- **Regularly make measurable and significant contributions to stakeholder value**. "Value added" may be an overused term, but I think world-class risk management requires that you add value to survive, and you must add significant and measurable value to thrive and wear a world-class label. This value can come in many forms, be it cost reduction, new revenue exploitation, customer satisfaction or cutting-edge approaches to new and old problems.

There are a couple of ways to determine if you are attaining world-class status as the result of employing the eight strategies described above.

First, you'll know that you're a world-class operation when risk management is recognized as a core competency within your firm. You'll know this is true when risk-related issues are built into your strategic and operational planning processes and you are called upon to provide your input and perspective to management on risk, when these discussions are undertaken.

Second, you'll know you're there when you've achieved what I call enterprisewide respect. Some ways to determine if you have this respect include such simple things as who and how often you are called upon to help the organization solve difficult problems, even those that only peripherally involve risk considerations. But also I believe that integrity and trustworthiness are central to this concept of respect. I assure you, though, that if you practice these principles and are plugged in to senior management, you will know unequivocally if you've achieved this respect or not.

Whether you call it "world class" or something else entirely, the point is we can all improve, and excellence in our work should always be our target. Employing this broad goal and using these basic quality principles will at least move you forward in your daily endeavors.

Ask A Risk Manager, Ask A Benefits Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

This month's column on risk management issues was written by Christopher E. Mandel, assistant vp-enterprise risk management at USAA Group in San Antonio and president of the Risk & Insurance Management Society Inc.

Dennis J. Nirtaut, managing director of compensation and benefits for Arthur Andersen L.L.P. in Chicago, answers questions on employee benefit plans. William J. Miner, an actuary with Watson Wyatt Worldwide in Chicago, answers actuarial questions on benefits issues. And Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore., answers actuarial questions in the casualty field.

Address your questions to ASK, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Damages under ERISA limited by plan terms

Claims for extra-contractual damages may not be recovered under the Employee Retirement Income Security Act, according to the 1st U.S. Circuit Court of Appeals.

The case in question stemmed from allegations that Borden Inc. improperly terminated a group of retired workers from Borden's Total Family Protection Plan of life, health, dental and disability insurance. The dispute was over the proper remedy for those retirees. Borden contended that they were due only reinstatement in the plan and reimbursement for expenses incurred that would have been covered by the plan. The trial court ruled for Borden.

On appeal, the workers argued that the trial court remedy was inadequate and that they were entitled to additional equitable relief under ERISA. The court said the plan expressly precluded reimbursement under its coordination of benefits provision when a claimant's bills are paid by a collateral source. The court said the trial court ruled properly that a claimant whose medical bills have been paid collaterally cannot demand that the plan reimburse the claimant for those bills. The court also said the trial court correctly applied that law by limiting relief to the reinstated workers to the benefits due under the plan.

Larocca vs. Borden Inc., 1st U.S. Circuit Court of Appeals, Jan. 8, 2002 (*BI*/05/Ju.-$10)

Legal Briefs

Ambiguous wording favors policyholder

The Colorado Court of Appeals ruled that the designation of the named insured in an insurance policy was ambiguous and that the policyholder was entitled to disputed coverage.

In 1995, Mid-Century Insurance Co. issued an insurance policy that identified the named insured as "Rafael Sanchez DC Concrete Management" and contained a printed legend stating: "The named insured is an individual unless otherwise stated." While the policy form included boxes for indicating that the named insured was a business entity, such as a corporation, no boxes were checked.

In September 1995, Mid-Century received a proof of loss form for items allegedly stolen from a job site. The form indicated that the insured was "Rafael-D.C. Concrete Mgmt.," and was signed by Rafael Sanchez. The total claim was for $264,526. Subsequently, the corporation and Mr. Sanchez sued Mid-Century, asserting that the insurer had improperly failed to act on the insurance claim. Although a jury awarded the corporation damages for breach of contract, the trial judge found in favor of the insurer, concluding that the corporation was not insured under the policy.

The appellate court said that the designation of the named insured in the policy here was unclear. From the language "Rafael Sanchez DC Concrete Management," the court said, "one cannot tell whether there is one named insured or two." The court said the policy language was ambiguous, so the language should be construed in favor of the insured. The trial court decision was reversed.

D.C. Concrete Management vs. Mid-Century, Colorado Court of Appeals, Sept. 13, 2001 (*BI*/03/Ju.-$10)

Comp law bars suits for loss of consortium

Minor children whose fathers were killed at work are barred from seeking damages for loss of parental consortium by the exclusive remedy provision of the Workers' Compensation Act, according to the Court of Appeals of Kentucky.

In April 1998, Stephen Hardin was killed while acting within the scope of his employment with Action Graphics Inc. In November of that year, Marion T. Gray, a construction worker employed by Phillips Brothers of Hardin County Inc., was also killed while at work. Both men had elected coverage under the act.

A minor son survived each man, and each dependent, through a guardian, filed a negligence action against his father's employer seeking damages for loss of parental consortium. The trial court dismissed both suits.

On appeal, the guardians argued that a claim for loss of parental consortium is distinct from those claims contemplated by the exclusive remedy provision of the act. The court said the act was unambiguous and left no room for exception to the rule that one may not recover for loss of consortium where an injured employee has elected coverage under the act. The trial court decision was affirmed.

Hardin vs. Action Graphics Inc. Court of Appeals of Kentucky, Jan. 12, 2001 (BI/04/-Ju.-$10)

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

The importer took a risk purchasing the water wings.

The marine cargo company took a risk shipping the water wings.

The retail distributor took a risk buying the water wings.

The store manager took a risk selling the water wings.

Katie took a risk jumping into the deep end for the first time.

And Marsh solved all these risks.

MMC Marsh & McLennan Companies

www.marsh.com

MARSH

The world's #1 risk specialist℠

Marsh is the risk and insurance unit of Marsh & McLennan Companies

Making employees health care consumers

Consumer-driven health plans cut employer costs

By MEG FLETCHER

CHICAGO—Employers can take several steps to help employees become more sophisticated consumers of health care, said benefits expert Wendy S. Rhodes.

Ms. Rhodes, principal and communication practice leader with Hewitt Associates L.L.C. in Lincolnshire, Ill., said employers should take the steps she outlines because the need for "consumer-driven plans" has never been greater.

The financial burden of providing benefits is a prime motivator for employers, Ms. Rhodes told attendees at a one-day conference, "Health Benefits Ahead: Are Consumers Ready to Take the Wheel?"

The conference, held earlier this month in Chicago, was sponsored by Aetna Inc.

According to a 2001 Hewitt survey, employers expect overall health care costs to increase 13% to 14% annually, though the average employer can afford increases of only up to 8%, Ms. Rhodes said. After five years, there could be as much as a 37% gap between the increases employers predict and those they anticipate being able to afford, she said.

In an effort to close that gap, employers typically have adopted a variety of measures, including raising employee premiums, adding more cost-sharing to plan designs, switching plans, adopting new delivery systems and implementing disease management programs. These traditional measures have not been effective, though, and "the time is ripe for a new approach," Ms. Rhodes said.

She urges employers to adopt "consumer-driven plans" that reduce costs by providing "reality-based" health benefits and by giving employees "skin in the game"—making them financial stakeholders—so they will choose and use benefits in a cost-effective manner.

"The more engaged your employees are, the more you can save dollars," Ms. Rhodes said. The idea, she said, is to extend employees' savvy consumer shopping behavior, which they now apply to buying cars and houses, to the purchase of health care.

'For the most part, consumers understand their health care benefits fairly well, including how to choose and access them.'

Hewitt Associates

Employees could use more education in this area, according to the Hewitt survey.

The survey found that, "for the most part, consumers understand their health care benefits fairly well, including how to choose and access them."

Those activities include understanding how to enroll in a health plan, manage one's health, choose the best health plan to meet individual needs, use wellness programs, make a plan selection and how health care fits into overall compensation.

The least understood area, though, is "how to efficiently navigate the health care delivery system," Ms. Rhodes said. That is particularly true when an employee has to obtain the services of a specialist, for example.

Employers that want to succeed in developing consumer-driven health plans must take several steps to inspire their employees, Ms. Rhodes said. These include helping employees understand the health care environment, creating a demand for new benefits options, leading employees through the buying processes and promoting the use of decision-support tools and resources.

A successful program requires an employer to educate its employees, making sure to coordinate the messages it provides to employees with its plan design and delivery; and ease the transition to consumer-driven plans with such decision-support tools as health plan comparison charts, lists of area providers and benefits expense calculators.

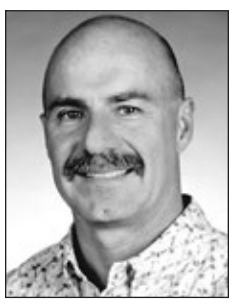
But Ms. Rhodes added that employees have responsibilities, too. They must be accountable, hold a financial stake and determine which options best fit their needs by using the decision-support tools made available to them.

In developing this new approach, employers must set goals, coordinate strategies, present the program to employees—after testing materials on a small group—and continuously measure all of the outcomes. Employees, meanwhile, must assess needs, take the necessary actions and use the plans.

Ms. Rhodes said that the development of a consumer-driven health plan that changes employee behavior is a challenging but achievable task.

Comings & Goings Industry

Mr. Glaser



Mr. Braig

Dr. Book

Brokers:

Joseph P. Flanagan has been named president of Hub International Ltd.'s Chicago-based broker unit Mack and Parker Inc., and **Richard J. Palleschi** has been named president and chief executive officer of The McCarthy Cos., a division of Hub in Wilmington, Mass.

Mr. Flanagan joined Hub and Mack and Parker in June 2001 along with his firm, J.P. Flanagan Corp., which was merged into Hub in January 2002.

Mr. Palleschi previously was executive vp and chief operating officer of the McCarthy Cos.

Patrick Veale has been named president of Boston-based broker William Gallagher Associates. Mr. Veale, formerly a principal of the company, has been with WGA since 1994. He succeeds **Philip J. Edmundson**, who will remain with WGA as CEO.

Insurers:

American International Group Inc. has made several executive appointments:

- **Daniel Glaser** has been named regional president of the U.K./Ireland Division of American International Underwriters and managing director of AIG Europe (U.K.) Ltd. He had been executive vp of AIG's Domestic Brokerage Group, responsible for field operations and market segments.
- **Mark Willis**, who has been AIG's Chicago-based senior executive-Midwest, will succeed Mr. Glaser in New York.
- **Kevin Hogan** has been named COO of AIU and will retain his responsibilities as president of AIG's Worldwide Accident and Health Division.
- **Hamilton C. Da Silva** has been appointed vp of foreign general insurance and CEO of AIG's Latin American Region, with responsibility for all of the insurer's operations in the region. Mr. Da Silva had been president of AIU's Latin American Division.
- **Gustavo Covacevich** has been named deputy CEO in New York of AIG's Latin American Region. He previously had responsibility for international pension operations in the AIG life companies.

Robert Walton has been named regional executive for the Southwest and Northwest regions of Zurich North America's Middle Markets Business Unit. Mr. Walton will be based in the insurer's Glendale, Calif., office.

Eric Parsons was named president and COO of StanCorp Financial Group Inc. of Portland, Ore., and its largest subsidiary, Standard Insurance Co. **Doug Maines** was appointed executive vp of StanCorp and president of the Employee Benefits-Insurance Division of Standard. Mr. Parsons had served as chief financial officer, a post he will retain until a replacement is found. Mr. Maines had been senior vp in the Employee Benefits-Insurance Division.

Surplus lines:

Carolyn Vaughan has been named senior vp and COO of Kenneth I. Tobey Inc., a Seattle-based managing general agency. She had been vp of operations.

Bill Braig has joined Swett & Crawford Group's Honolulu office as senior vp and branch manager. Before joining Swett, a subsidiary of Aon Corp., Mr. Braig was senior vp at Hull & Co.

Managed care:

Dr. Eric Book has joined Blue Shield of California in San Francisco as chief medical officer and senior vp. Dr. Book replaces **Dr. Jeffrey Rideout**, who has become president of the California Physicians' Service Foundation, a charitable foundation associated with Blue Shield of California. Before joining Blue Shield, Dr. Book was chief medical officer of Wellmark Blue Cross & Blue Shield.

Sidney L. Meyer has been named executive vp and COO of Atlantis Health Plan Inc., a physician-owned health insurance company based in New York. Mr. Meyer had been executive vp and general counsel of managed care company MultiPlan Inc.

Comings & Goings Buyers

Larry Y. Bush has been named executive director of the Intergovernmental Risk Management Agency, a public entity risk pool and risk management agency in Oakbrook Terrace, Ill.

Mr. Bush will replace Sal M. Bianchi, who is retiring June 1.

He joins IRMA from the Pace Suburban Bus Division of the Regional Transportation Authority of Metro Chicago.

Mr. Bush earned a bachelor of arts degree in political science from the University of Illinois in Champaign-Urbana and a master of urban studies degree from the University of Chicago.

He holds the Chartered Property & Casualty Underwriter designation and is an officer in the Chicago chapter of the Risk & Insurance Management Society Inc.

***

John Clifford has been named senior vp of human resources at The St. Paul Cos. Inc. in St. Paul, Minn.

Mr. Clifford replaces **David Nachbar**, who left the company. He reports to John MacColl, vp and general counsel at the St. Paul, Minn.-based insurer.

Mr. Clifford joined St. Paul in 1984 as a compensation analyst and was later promoted to compensation manager and to compensation and benefits officer. In 1999, he was named vp-compensation and benefits.

He holds a bachelor of arts degree in economics from Carleton College in Northfield, Minn., and a master of public policy administration from the University of Missouri in St. Louis.

***

Tom Wronski and **Peter Burd** have been promoted to vps-insurance and risk management at FMR Corp., better known as Fidelity Investments.

Both report to Judy Lindenmayer, vp-insurance and risk management for the Boston-based financial services company.

Mr. Wronski joined Fidelity in 1994 after working for more than seven years at Digital Equipment Corp. in Maynard, Mass.

He earned a bachelor of science in business administration from the University of Massachusetts in Lowell, Mass., and a master of business administration from Rivier College in Nashua, N.H. He holds the Associate in Risk Management designation from the Insurance Institute of America.

Mr. Burd spent seven years at Amerada Hess Corp. in Woodbridge, N.J., before joining FMR in 1995.

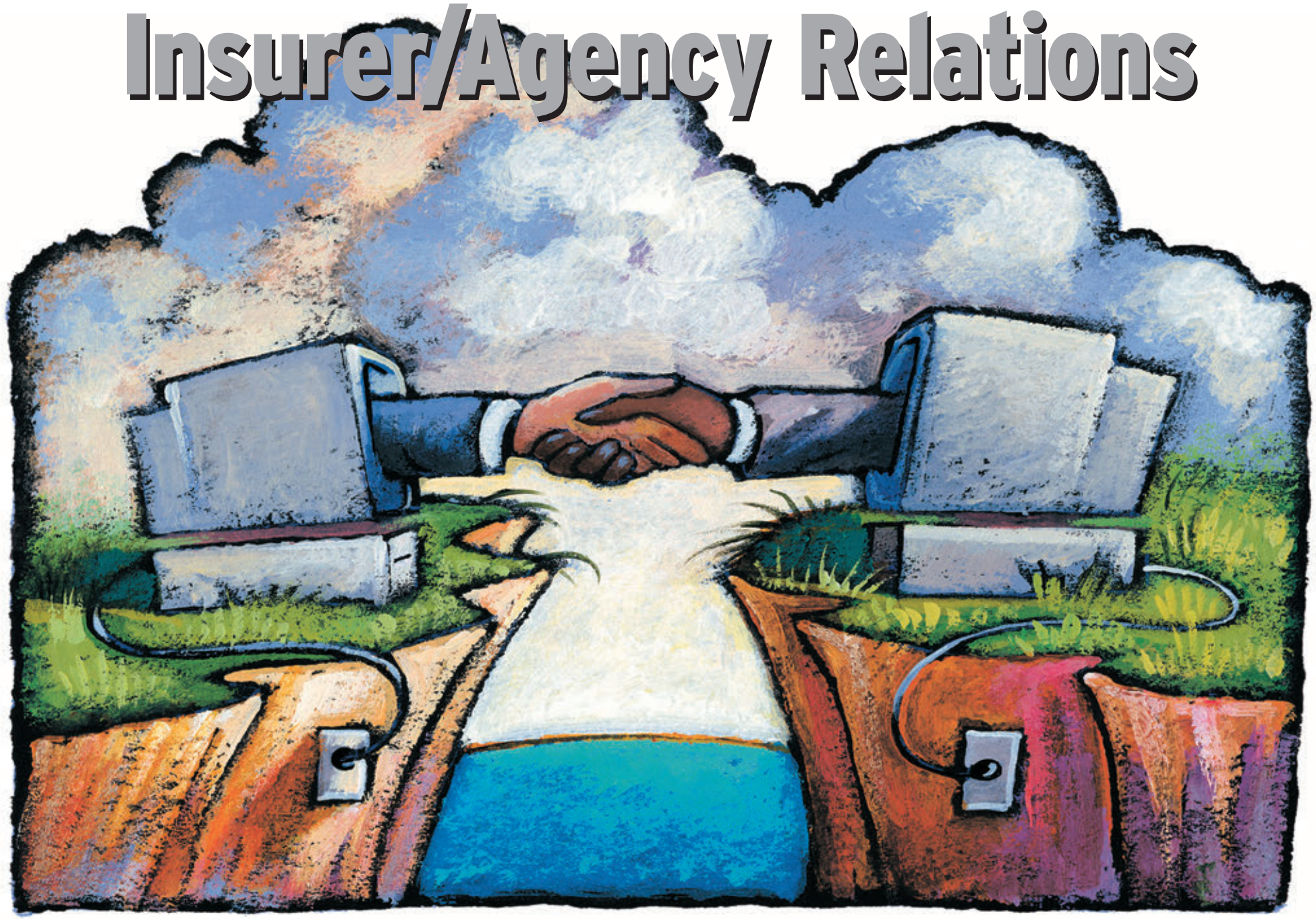
He earned a bachelor of arts in economics from Lafayette College in Easton, Pa. He also holds the Associate in Risk Management designation.

We'd like to report on staff changes in your risk management, safety and employee benefits departments. Contact Michael Bradford, Business Insurance, 473 Fairfield Ave., Gretna, La. 70056; phone: 504-364-1908; fax: 504-364-1337; e-mail: mbradford@crain.com.

INSURER TOPICS

A MONTHLY EDITORIAL SECTION SENT EXCLUSIVELY TO INSURERS AND REINSURERS

Insurer/Agency Relations



Services helping link insurers with agents that have profitable business

Market finders making connections

By JOANNE WOJCIK

The tight insurance market, which has severed many of the long-term ties between insurers and retail agents, has spawned a new breed of entrepreneur: the market finder.

A market-finding consultant is similar to a matchmaker, but a market finder, instead of arranging marriages of suitable partners, arranges contracts between agents and insurers that are mutually advantageous.

A handful of these market-finding consultants come in "analog" form—they are human beings who interview agents in person to determine their needs and then set out to find appropriate markets.

But a growing number of market finders come in "digital" form. These operations are Internet-based clearinghouses to which agents and insurers both subscribe. Agents post queries seeking markets for specific lines of coverage, and insurers respond to those they like.

Agency consultants say the number of digital market finders is growing because there's less stigma associated with using an online service to secure markets than there is in using the services of a live person. Plus, they note that online services are virtually anonymous.

"This is an end of the business done under confidentiality agreements. Owners wouldn't want it known that they had to retain someone else to get them a market," acknowledged Andrew J. Barile, a market finder. Mr. Barile is the president and chief executive officer of Andrew Barile Consulting Corp. Inc., an insurance and reinsurance consulting firm in Rancho Santa Fe, Calif. Still, Mr. Barile said he currently has about 20 clients for his "analog" market-finding services, a number that is up 50% from just six months ago. "It's a growing area of business," he said.

During the soft market, it was mostly agents with poor reputations who sought out the services of market finders, according to Chris Burand, the president of Burand & Associates L.L.C. in Pueblo, Colo., an agency consulting firm.

But "that's less the case now, because market conditions are so intense," Mr. Burand said. "Lots of good agents need help now."

He added that the use of market-finding assistance has become more prevalent among agencies that write program business, for which markets are becoming increasingly scarce.

"There's a philosophical change in the attitude of insurers," Mr. Barile agreed. They're no longer accepting business from small producers that cannot meet a minimum threshold of premium production, such as $10 million annually, he said. And because insurers had underpriced the business for so long, they no longer are accepting what they consider to be unprofitable business, he added.

"If you have a book that historically runs at a 70% loss ratio and you're looking at A.M. Best's and find companies with 30% and 40% expense ratios, you can't bring them your business, because the more they write, the more money they lose," Mr. Barile explained. "A business relationship requires mutual respect. You have to constantly prove you're making money for the carrier."

As a market finder, Mr. Barile acts as an agency's advocate. He prepares a profile of the agency—including such information as its loss history, lines of business sold and producer experience—that he shares with insurers he thinks might make good matches. If contract negotiations are required, he handles them. If letters of reference are needed from prior insurers, especially in cases in which insurers dropped agencies because their production levels were too low but the business was still profitable, Mr. Barile obtains them.

Mr. Barile said that though he charges a fee for his services, that fee is often much less than an agency might spent doing

See MARKET/next page

INSURER TOPICS

Market: Services help connect insurers, books of business

Continued from previous page
all of this legwork on its own. He explained that market finders also can steer agents away from insurer markets that have no interest in appointing them and steer them toward more appropriate partners.

"I want to stop agents from recklessly spending money visiting companies that will never write their program or appoint them," Mr. Barile said.

"It's amazing to me how disconnected agents are with regard to markets," said Larry Neilson, co-founder and president of National Marketing Services in Laguna Hills, Calif., a telemarketing firm specializing in insurance telemarketing. About two years ago, NMS launched an online market-finding service called Programbus-iness.com.

The agents, Mr. Neilson said, "operate in their own universe. With the extended soft market, they didn't have to pay attention to markets; they just had a relationship with the local wholesaler. But now, that wholesaler may not have a solution for them."

As a result, he said, there is a need today for a third party to act as a matchmaker for jilted agents.

Programbusiness.com is one of the "digital" market finders, providing an online trading floor on which agents, brokers, managing general agents and wholesalers can post their books of business without charge. Insurers, which pay to advertise on the site, then "shop" among the books and select those they find attractive. A type of courtship ensues, and there is usually an additional exchange of information until the agent secures the market.

Insurers also use the service to seek out new distributors of their products, Mr. Neilson said.

"We found that MGAs and carriers were always looking for agents," he said. "If you own a storefront on Programbusiness.com, you can actively market to our database."

That database consists of more than 18,000 independent agents and brokers, he said.

On the other side of the United States, the newly launched Target Markets Program Administrators Assn. is providing market-finding services as part of its membership benefits, according to Ray Scotto, Target Markets' executive director based in Wilmington, Del.

Like Programbusiness.com, Target Markets has a Web-based program that enables its agent and broker members to submit specific program information to all of its insurer partners electronically, Mr. Scotto explained.

"We are partnering with carriers that have a program focus and are interested in access to our members," he said. Among Target Markets' participating insurers are Markel Corp., American International Group Inc., Clarendon Insurance Co., XL Capital Ltd. and Old United Casualty Co.

'Carriers have been deluged with agents seeking coverage for programs. We ensure the information they submit is...what the carrier wants or needs.'

Ray Scotto
Target Markets Program Administrators Assn.

Before he launched Target Markets in partnership with reinsurance broker Benfield Blanch, Mr. Scotto, who was formerly with MGA Rockwood Programs, conducted market research to establish that there was a need for such a service.

"Carriers have been deluged with agents seeking coverage for programs," Mr. Scotto said. "We ensure the information they submit is complete and is the information the carrier wants or needs." As for the producer, "our members get access to markets they normally would not have on their own," he said.

While the market-finding service is free to members, insurers pay to "shop" Target Markets' database of agencies.

The initial membership fee is $1,000 for individuals and $2,500 for agencies. Because the site became operational only in January, the amount that will be charged in annual membership renewal fees for producers has not yet been determined, Mr. Scotto said. Additional operational logistics will be determined at the association's annual meeting this fall, he explained.

While digital market finders such as Programbusiness.com and Target Markets would seem to be in competition with firms such as Mr. Barile's, which do the legwork in person, Mr. Neilson said that is not the case. Some agents, he said, need individualized assistance, something online services don't provide.

"There's a place for expertise like Andrew Barile's," Mr. Neilson said. "If you're an independent agent in Anywhere, U.S.A., and you don't know who the best match is, you need a third party to act as a go-between."

"Andrew Barile is the next level up. He holds hands," he said.

As one of the leading reinsurers, we provide strength and stability in the ever-changing business environment. Combine this with our consistent A+ rating from A.M. Best, and it's no wonder our customers feel so protected.

www.gmacre.com 1-800-380-4055

GMAC RE

INSURER TOPICS

Many agents frustrated by co-branding programs

By SALLY ROBERTS

Advertising and marketing a certain insurance product is an expensive undertaking for any agent or broker. But, with help from an insurer, much of the cost can be alleviated through a cooperative advertising campaign.

For years, insurers have offered agents assistance in advertising and marketing their products to customers—typically providing up to 50% of the cost, up to a specific dollar limit. Under these programs, the insurer's logo is placed alongside the agent's or broker's logo.

'What a lot of agencies want is for the company to support their marketing efforts. They want to do it their way with their name up front.'

Kimberly Paterson
Creative Insurance Marketing Co.

But while the concept seems simple enough, when it comes to satisfaction with their insurers, independent agents are least satisfied with cooperative advertising efforts, according to an Independent Insurance Agents & Brokers of America study.

Marketing experts say, among other gripes, that agents are frustrated with the lack of assistance they receive from insurers when they attempt to co-brand an advertising program.

At the same time, experts and agents point out that much of the frustration surrounding cooperative advertising lies in the fact that many agents don't ask their insurers for it.

Those that do and successfully co-brand an advertising program, however, are seeing a nice return on their investment.

According to the Big I's 2000 Agency Universe Study, which is conducted every four years, of the nearly 3,000 independent agents surveyed, 20% gave their No. 1 small commercial lines insurer a six or seven on a seven-point scale in a satisfaction survey when asked about cooperative advertising. Only 16% gave their No. 1 medium-size and large commercial lines insurers a six or seven. And in ranking their overall satisfaction with their No. 1 personal lines insurer, 26% of the agents gave their insurer a six or seven when it came to cooperative advertising.

Although agents generally are not satisfied with cooperative advertising, it does not play a big factor in determining overall satisfaction with insurers, the study points out. Such issues as making it easy for customer service representatives to write business and insurers' underwriting flexibility have more critical importance to overall satisfaction, the study said.

While cooperative advertising may not be that important when it comes to overall satisfaction, agents are frustrated, experts say.

"They don't feel they are able to work with their companies to co-brand their advertising to clients," said Madelyn H. Flannagan, vp-education and research for the IIABA in Alexandria, Va. "They don't feel like the marketing reps have enough information available when they come visit to help them develop that marketing material."

"Prepackaged, ready-to-go, already approved, use-it kind of information is what agents are looking for, and they're seeing very little of it," Ms. Flannagan said.

"What a lot of agencies want is for the company to support their marketing efforts. They want to do it their way with their name up front and they want to choose the vehicle, and that's not always what the company's agenda is," said Kimberly Paterson, president of Creative Insurance Marketing Co., a Red Bank, N.J.-based marketing communications firm. "The company's agenda, over history, has been to get their product message out there and show the agent as the local provider. While both (agents and insurers) want to sell the product, their agendas don't always match, and that's a lot of where the frustration lies."

That has evolved over time to where many of the cooperative advertising dollars with insurers are now reserved for key agent groups, which is frustrating to agents not in those groups, Ms. Paterson said.

At the same time, Ms. Paterson said, some agents also are frustrated with the amount of money insurers contribute. While many insurers will reimburse up to half of the cost of an advertising campaign, there typically is a dollar limit, and in most cases, it isn't enough "to cover the costs of doing anything meaningful," she said.

George Nordhaus, chairman of Insurance Marketing & Management Services in Los Angeles, added, "I think a lot of it is communications, too."

Cooperative advertising is not a high item on insurers' priorities, he said. They don't get the training in how to help agents with

Continued on next page

INSURER TOPICS

Continued from previous page
advertising because "they're too panicked trying to get business," he said.

Not every agent is unsatisfied, however. And those that successfully co-brand an advertising program with insurers are seeing a return on their investment.

About two years ago, The Distinguished Programs Group L.L.C., a New York-based managing general agency, came together with the Kemper Insurance Cos. to put together a new directors and officers liability program for community associations.

"We decided to take a lead position in the marketing, therefore we knew we needed an intensive marketing strategy," said Carla Vel, president and chief executive officer of the real estate unit of Distinguished Programs.

'You have to have the right relationship and the right product. And both parties have to be of the same mind to embrace that approach.'

Carla Vel
Distinguished Programs Group L.L.C.

Working with Kemper's internal marketing staff, one brochure was produced dedicated to the end buyer-the community association's board-and one brochure was produced for the retail agents. The brochures, which were mailed out and distributed at trade shows and sales calls, highlighted the elements of the product and included both companies' logos. The cost of creating and printing the brochures was $50,000 and the mailing costs were about $10,000, Ms. Vel said. In addition, the cost of creating two ads and the cost of running the ads in various publications came to roughly $100,000, she noted.

Instead of simply splitting the costs with Kemper, the marketing costs were factored into the commission level Kemper pays to Distinguished Programs, Ms. Vel said.

She said other marketing costs, such as increased staffing and information technology expenses also were factored into commission levels.

The return on the investment is paying off. Over the past 18 months, Distinguished Programs has sold about 9,000 D&O policies to community associations, Ms. Vel said.

"I think it's very important to have a cooperative effort by insurers," Ms. Vel said. Kemper's name "was an important factor in our ability to sell the product. I doubt very much if it (would have) been as effective if it was the Last Chance Mutual," she said.

To be successful, "I think you have to have the right relationship and the right product," Ms. Vel said. "And both parties have to be of the same mind to embrace that approach."

One of the reasons that there are not more success stories like this, many observers say, is simply because most agents are not asking for the assistance from their insurers.

"A lot of companies will reimburse agencies on request, and too many agencies are not asking for the money," said Mr. Nordhaus of IMMS.

He knows of one insurer, for example, that has a $1 million cooperative ad fund that is never spent because agents don't use it.

"Part of the problem, I think, is that most agents don't ask for it," agreed Michelle Rupp, owner of Nowogroski Rupp Insurance Group. "A lot of my agent friends are shocked at how many agents don't ask for this."

Late last year, the Seattle-based independent agency went to Metropolitan Life Insurance Co. seeking help with a new personal lines marketing campaign that targeted certain demographic groups, she said. MetLife paid $1,000 of the program's total cost, which came to $3,700. The advertisement, which included the agency's and MetLife's logos, was placed in local ballet, symphony and opera programs, as well as in the newsletter of an upscale health club and the directory of a local yacht club, she said.

Since January, the campaign has generated eight telephone calls, resulting in six new policies written, Ms. Rupp said.

INSURER TOPICS

Kemper offering online services to aid its sales force

By RODD ZOLKOS

Kemper Insurance Cos. is looking to strengthen its relationships with its sales force by providing Internet-based tools aimed at making it easier for agents to sell Kemper products.

The company is using two new online programs to help support agents and help them deal with customers more efficiently and effectively.

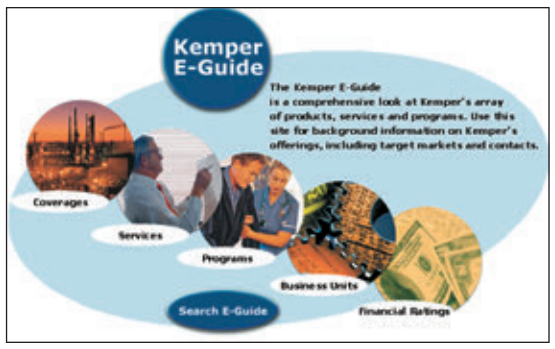
One online system, the Kemper E-Guide, provides agents with easy, around-the-clock access to comprehensive information about the insurer's products and services. The other tool, called Ecquire, ultimately will allow agents to quote and issue policies across several small-business lines.

"That's the key—to make working with Kemper easier for the agent," said David Smolensky, senior manager of integrated communications at Long Grove, Ill.-based Kemper.

The E-Guide system, Mr. Smolensky said, is basically "a Web-based catalog of information detailing all of Kemper's products and services."

Available online at the insurer's Web site, *www.kemperinsurance.com*, the Kemper E-Guide contains product descriptions, information on target markets for different products, marketing materials, contact information at Kemper for various products, sample forms and applications.

The guide also contains product-specific information, such as underwriting guidelines, coverage highlights and competitive comparisons that agents can paste into documents or include in attachments to e-mails.



"Basically, all the information that an agent needs either for himself or herself or to pass on to a client is available online now," Mr. Smolensky said.

And, because all of the information is available 24 hours a day, seven days a week, agents can get the information whenever they need it, he said.

The site also includes underwriting manuals, such as the entire Kemper Premier business owners policy manual. Because the online manual is updated whenever changes are made, agents always have access to the current version. "The agent has access to complete, updated information at his fingertips," Mr. Smolensky said.

The E-Guide system was designed to be easy for agents to navigate. "It's very intuitive," Mr. Smolensky said. "If you go on and play with it for five minutes, you know how to navigate it."

"One of the really neat things is, you can load all the information about Kemper products" on one of the new pocket-size personal computers "and carry it in your pocket," Mr. Smolensky said.

"From the agents' perspective, the acceptance of E-Guide has been phenomenal," Mr. Smolensky said, adding that a "very large" number of agents have registered for the system since Kemper rolled it out in February.

"We're in an electronic world, and the customer wants to get information electronically," he said. "And if they need it on the weekend, they can get it on the weekend."

Kemper's Ecquire system, meanwhile, is designed to enable agents to write four separate small-business lines—business owners policy, umbrella liability, commercial auto and workers compensation—using a single integrated online system.

Currently, agents can quote BOP, umbrella and commercial auto through the system, with workers comp quoting scheduled to be rolled out later this month. Eventually, Ecquire will allow actual online issuance of small-business policies.

Among other things, Ecquire currently enables producers to print out proposal report documents recapping premiums, policy terms and location coverage, which allows small-business owners to make quick buying decisions.

Based on the business address entered in the system, Ecquire also will automatically generate rating territory and protection class details, and plans call for expanding that capability in the future to support ratings on additional lines.

The system is designed to be user-friendly and to help agents perform their jobs more efficiently and increase their productivity. Most quote requests require information in 15 data fields or fewer, and a single-location BOP or umbrella policy be rated in a "quick quote" process in less than two minutes.

The Ecquire system resides completely on Kemper's server, with no software loaded onto agents' computers. Agents can use the system from any location with Internet access.

Training and help functions are integrated into the Ecquire system, with the most current training manuals always available online. Producers having problems with the system have access to help either online or from support representatives at Kemper's Syracuse, N.Y., and Overland Park, Kan., service centers.

INSURER TOPICS

Insurers get more time to ready for money laundering law

By RODD ZOLKOS

The U.S. Treasury Department's decision last month to defer the application of new anti-money laundering requirements to insurance companies may be good news for insurers, but it doesn't mean companies should put off efforts to comply with those regulations, insurance industry experts say.

On April 23, Treasury officials announced the department was deferring the application of the USA PATRIOT Act requirements to a group of financial institutions—including insurance companies—for up to six months to provide time for closer study of those industry sectors and the development of appropriate regulations.

Enacted as part of U.S. efforts to stem international terrorism following the Sept. 11 attacks, the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 included the anti-money laundering requirements.

One of the law's provisions requires financial services companies have some sort of procedure in place for verifying customers' identities. The requirements apply to any company defined as a "financial institution," including U.S. banks, agencies and branches of foreign banks in the United States, securities broker/dealers and insurance companies.

According to Scott Harrison, leader of the national insurance regulatory practice at KPMG L.L.P. in Washington, the Treasury's decision to delay the application of the requirements to insurance companies is significant.

"I think it tells us some important things," Mr. Harrison said. "It tells us the Treasury is making a very good faith effort here to design a regulatory scheme with respect to the business of insurance that is appropriate to the risks of money laundering," he said.

"I think it also tells us that Treasury is struggling a bit in understanding businesses that are outside their normal focus—that is, banks," he continued. "What I hear them saying with respect to insurance is not only are we struggling a bit with applying a regulatory scheme that was designed for the banking industry to insurance, we're also struggling a little bit with the sheer diversity of the insurance industry."

Although various insurance trade organizations—including the National Assn. of Mutual Insurance Cos., the National Assn. of Independent Insurers and the Alliance of American Insurers—have asked the Treasury to exempt property/casualty insurance companies from the anti-money laundering requirements, such an exemption isn't likely, Mr. Harrison and others say.

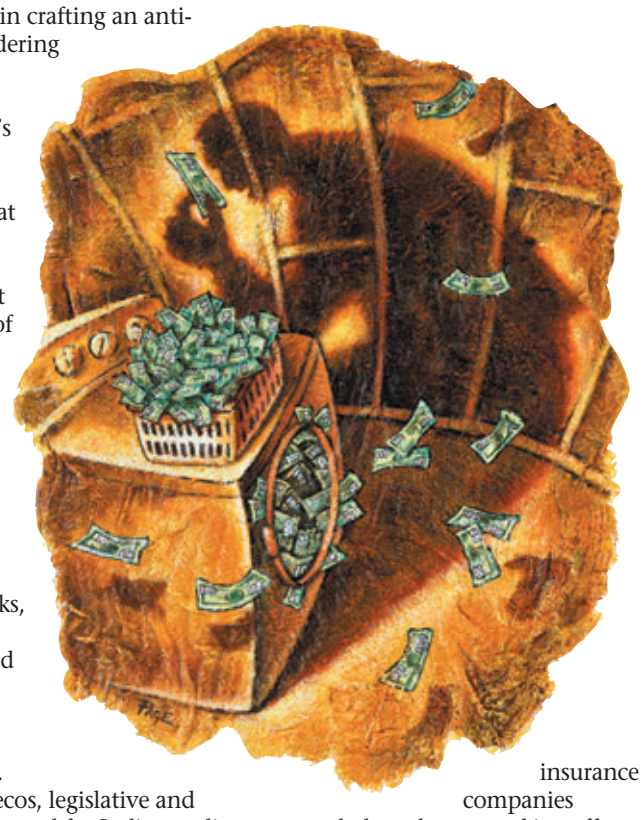
"It is clear that this is a reprieve for the industry that is temporary," Mr. Harrison said. "So, in terms of what the industry ought to be doing now, they ought to continue to prepare."

Speaking as part of a May 13 NAMIC teleconference on the issue, Frank S. Swain, a partner in the Washington office of the Baker & Daniels law firm, noted that the USA PATRIOT Act allows the Treasury to exempt entire classes of business from the requirements. However, he said, "thus far, Treasury has not indicated to anyone that they are considering any wholesale exemption of industries."

"We think it's unlikely that P/C companies are going to be let off the hook on this," Mr. Swain said.

Mr. Harrison said insurance companies "should be proceeding down a path that assumes that many of the rules that apply to banks will apply to their business." Insurers, he said, should be working to identify money laundering risks, setting appropriate policies and procedures and identifying compliance officers within their companies.

Although he said he doesn't think it wise "to lay down a long list of must-dos before Treasury comes out with its proposals," Mr. Swain said, "It seems to us common sense that you designate one or more compliance officers," who can begin crafting an anti-money laundering program.



And once the Treasury's rules are released, he suggested that companies' senior management be apprised of their company policies and procedures. And if certain lines of business are considered particular risks, company boards should be asked to approve the policies, Mr. Swain noted.

Peter Bisbecos, legislative and regulatory counsel for Indianapolis-based NAMIC, said that the best guideline for companies in developing anti-money laundering policies might be to imagine that they are defending their policy to a federal examining officer.

"If you are comfortable in defending the decisions that you have made, then you have probably done the right things," he said.

KPMG's Mr. Harrison said that insurance companies recently have begun making efforts to meet the new anti-money laundering requirements.

"Within the past four to six weeks, the companies have begun focusing on what their requirements are," he said.

"I've seen a lot of movement. I'm hopeful companies are not now going to stop what they're doing and lose the momentum on this issue that they have achieved ," Mr. Harrison said.

Communication key to litigation savings

IT Perspective

By Faiz Ahmed

Cost containment has always been a key issue for property/casualty insurers, but in today's business climate, costs have taken on a renewed priority.

The industry faces increasing loss and loss-adjustment expenses, flat premium growth, increased underwriting losses and reduced investment income. With the impact of Sept. 11 on insurance companies, the Insurance Services Office Inc. projects a "record-poor" year for 2001, with an industrywide combined ratio of 120%. In these times more than in any other, business success for insurers is ultimately defined by their ability to improve cost efficiencies.

Because claims litigation is a major source of costs, there has never been a better time for insurers to evaluate critically their claims litigation strategies. Given the current economic circumstances, though, it is tempting to skip thoughtful evaluation of litigation management in favor of quick fixes, such as implementing the latest technologies.

Certainly, technology improves the speed of communication and monitoring tasks; that has value as insurers face increasing claims volume and litigation rates. A careful evaluation of litigation management practices reveals, though, that bottom-line results cannot improve without a commitment to collaborating with legal counsel in managing litigated claims.

A close examination of common litigation management strategies shows an approach that misses the importance of collaboration and clear communication with counsel. Moreover, a typical approach overlooks the process inefficiencies that poor communication will ultimately produce.

At the outset of a claim, substantive concerns such as budget approval and overall case strategies are often ignored, leaving a fertile source of costly, time-consuming conflicts between counsel and the insurer as the case progresses. As litigation proceeds,

See LITIGATION/next page

INSURER TOPICS

Litigation: Insurer, counsel communication key

Continued from previous page

most communication between claims personnel and attorneys over these concerns remains quite poor, resulting in delays and wasted resources when changes occur in strategy or settlement.

Because these concerns and conflicts could be avoided, the results are all the more unfortunate: increased overall indemnity and legal costs and friction in the professional relationship between counsel and insurer over billing and fees. Instead of taking preventive measures, the cost-containment method of choice seems to be cutting legal expenses, either through the use of less expensive lawyers or by using third-party fee auditors to dispute legal bills.

Neither of these approaches effectively improves communication or the quality of outcomes. For example, the use of fee auditing leaves lawyers feeling second-guessed in their professional judgment and compromised in their ethical obligations to the policyholder client.

The industry is coming to recognize that establishing collaborative relationships and improving communication is a critical first step in resolving the inefficiencies that increase litigation costs. Unless communication between insurers and counsel improves, the value of other cost-saving strategies diminishes—including the implementation of new technology applications. In re-evaluating the claims litigation process, we need to understand the value of collaborative working relationships before considering the potential benefits of well-chosen technological tools.

The need for collaboration

Collaborating on budgeting and strategy produces better litigation outcomes and improved costs. By eliminating the sources of friction in the insurer-attorney relationship, collaboration allows both sides to focus on improving the quality of each step in the litigation process. When clear expectations are established up front, insurers and counsel can focus on managing outcomes.

How significant is the effect of collaboration between insurers and counsel? A recent study showed that, without effective collaboration, loss overpayments equaled a whopping 17% of the total loss indemnity payment on litigated cases. Without effective collaboration, litigation efforts are caught up in relationship conflicts, contradictory communications and myriad process inefficiencies. All this adds up to an unnecessarily lengthy litigation process.

These problems are compounded by reliance on nonautomated communication methods, which causes delays in invoice processing, forces billing reviews after services have already been performed and undermines collaborative potential in general. Studies have shown that the administrative tasks associated with legal invoice processing take up to 20% of an adjuster's workday. Collaboration allows this time to be redirected toward managing outcomes.

Without effective collaboration, litigation efforts are caught up in relationship conflicts, contradictory communications and myriad process inefficiencies.

A collaborative litigation process offers a dramatically different picture. If collaboration on case assessment and budgeting is established early on in the claim cycle, conflicts can be minimized or even avoided. For example, establishing, sharing and tracking litigation expenses from the outset ensures that both sides have clear expectations, resulting in a better chance that cases are handled on schedule and within budget.

In a truly collaborative relationship, claims personnel can determine how well counsel is communicating, delivering value and moving cases toward resolution. Insurers have a clear view of which firms are the most efficient and which are ultimately achieving the best indemnity results.

The quality of communication required for effective collaboration requires consistent interaction between insurers and counsel during the litigation process. Fortunately, technology now enables claims personnel to perform frequent communication tasks with considerable speed and productivity.

Yet technology does not offer "plug and play" capability for improving cost efficiency; there is no miracle application that delivers instant results. Insurers should recognize that technology is not a cure-all but, rather, a tool to promote communication and collaboration for better outcomes.

Leveraging technology

Internet-based technology is a key support for collaborative relationships. Even with insurers and counsel committed to collaboration, the tasks involved in setting up and monitoring claims while relying on phone, fax and paper-based processes present a herculean task.

With Internet-based technologies, automation and support of collaborative strategies, insurers and lawyers can quickly and efficiently devise a "game plan" for each case. Together, they can determine what legal tasks need to be completed on an individual claim and anticipate a time frame for completing those tasks. They can also come to a general agreement about the cost of legal services and continually compare case developments to that previously established plan.

Finally, Internet-based technologies offer analytical tools for a critical, top-level view of claims outcomes. Well-chosen applications not only provide accountability but also enable claims personnel to remain informed on litigation matters without incurring fees each time they need to ask a question of panel counsel.

Real-time tools

Real-time, instant communication capabilities and "anytime, anywhere" access have only recently caused a dramatic improvement in communication on litigation issues. Real-time technologies allow lawyers and claims personnel to review the same claims information at the same time on their desktop computers, resulting in effective and efficient efforts toward optimal case resolution.

Tools such as intranets, extranets and discussion boards allow users to share information, prepare documents, manage calendars and communicate about budgets. For example, attorneys can post comments, request additional information and offer suggestions for strategy. When investigating claims, a manager's report can be posted to a discussion board for review by counsel. Work product updates, deposition transcripts and claim-related materials can be electronically attached and made immediately accessible.

Many of these applications can be outsourced, meaning that they can be implemented without significant investments in software, deployment time or information technology personnel—leaving more time for managers to concentrate on containing costs and managing outcomes.

By sharing information, all parties ensure that quality standards are established up front and maintained. In this way, technology tools promote accountability-based relationships. Estimates on exposure, chances of success and settlement objectives are all open for ongoing review and comment. Critical tasks and dates can be tracked, and all team members can be updated on status and developments. The continuous monitoring of objectives is easy and efficient.

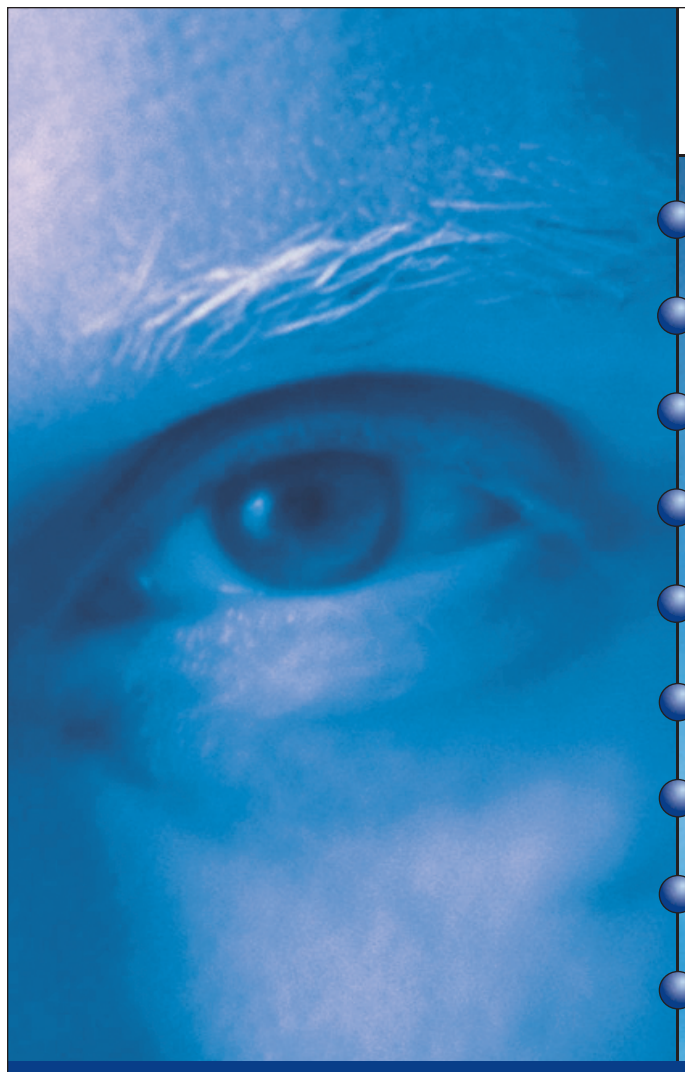
For example, threaded real-time discussions between adjusters and counsel can be used to track concerns and share constructive thoughts about how to resolve them, quickly producing good case results.

Finally, the analytical tools provided by some technology applications allow insurers to review outcomes and identify trends, patterns, inefficiencies and quantitative information across a variety of categories. Self-documenting processes simplify reporting on outcomes across lines of business and can compare performance among law firms. This analytical capability ultimately adds value to collaboration-based claims management.

In the end, the use of well-chosen technology provides the maximum value for the dollars spent on outside counsel.

In the current business climate, establishing collaborative relationships between insurers and panel counsel creates the top-level approach to litigation management needed to improve cost-containment efforts. As insurance companies re-evaluate the claims litigation process, managers should consider how collaboration empowers claims personnel to manage litigation cost control as effectively as they do other major projects.

Faiz Ahmed is chief executive officer of Chicago-based Visibillity Inc. Before co-founding Visibillity, Mr. Ahmed served as a claims officer for Employers Reinsurance Corp. and, before that, as a practicing attorney at Hinshaw & Culbertson in Chicago, where he represented insurers and their policyholders.



KEEP AN EYE OUT FOR THIS

BENEFITS MANAGEMENT

BI SPECIAL TAKE-OUT SECTIONS

BI's regular weekly reporting and daily e-mail alerts deliver all the news important to executives responsible for employee benefits.

Now, when top-level corporate executives look for more information on significant trends and developments in employee benefits, *BI* delivers special **Benefits Management Take-Out Sections**. Each will contain exclusive rankings and statistics on vendors of benefit services, while full directories of vendors will be available online. Each special take-out section will provide powerful reporting on topics vital to the success and profitability of businesses today.

These highly anticipated special take-out sections will be referred to by our readers all year long. Reach more than 134,000* corporate decision-makers and purchasing influentials. Advertise in the industry news leader.

* Includes pass-along readership.

MANAGED CARE TRENDS & ISSUES
Chart & Online Directory: Prescription Benefit Managers/Case Managers
Published: February 11

WORK & LIFE BENEFITS
Chart & Online Directory: EAPs & Dependent Care Resource & Referral Services
Published: April 8

NEW TECHNOLOGY & ONLINE SOLUTIONS
Chart & Online Directory: Benefit Information Systems
Issue: June 24 • Ad Close: June 12

GLOBAL BENEFIT TRENDS
Chart & Online Directory: Benefit Consultants
Issue: August 12 • Ad Close: July 31

PENSIONS/RETIREMENT PLANS
Chart & Online Directory: 401(k) Plan Administrators
Issue: September 30 • Ad Close: September 18

COMMUNICATION & EBC AWARDS
Chart & Online Directory: Benefit Communication Systems
Issue: December 9 • Ad Close: November 26

NEW YORK: 212.210.0133
CHICAGO: 312.649.5276
LOS ANGELES: 323.370.2456
BOSTON: 617.292.4856

www.businessinsurance.com
Business Insurance®

X Allison Taylor

Last year we signed up 250,000 new members.

{More than any other health plan in New York}

In 2001, more people changed to Empire than any other health plan in New York. We're now 4.6 million members strong. What do they know that you don't?

They know Empire has brought customer service to a whole new level:

- *On average, claims settled in 4 days*
- *Most calls answered in under 29 seconds*
- *An award-winning website with over 80 features and functions where members can manage their own health plan**
- *A new dental plan with a larger network and new preventive plan designs*
- *Access to personalized online health information*

We'll soon have an online Employer Portal to make it even easier to manage your employees' health benefits.

At Empire, we're changing to give you the choices you want and the service you deserve. We're determined to make healthcare hassle-free, both for you and your employees.

Call Your Broker

Empire BLUECROSS BLUESHIELD

More changes. More members.

www.empireblue.com

* Best of Show Award from Business Insurance's Best of the Web Awards 2001 (October 9, 2001).

VISION...

Our vision has ensured our success. Now it's time to "insure" yours.

State Compensation Insurance Fund

We can show you the way to a fulfilling career.

When you work for State Compensation Insurance Fund, you're working for the leading workers' compensation insurance carrier in California. In our 88-year history, we've created a rock-solid reputation for excellence in our industry, with the injured workers we serve, and with our employees.

With offices located throughout the state, State Fund provides exceptional benefits, outstanding training and advancement opportunities, and a sense of job security uncommon in today's uncertain job market. To find the stability, satisfaction, and mobility you're looking for in a career, look no further than State Fund.

Learn how you can join us. Visit our website at www.scif.com or contact Human Resources at 415-565-1722.

Career opportunities may be available in:

- Marketing
- Loss Control
- Claims
- Communications
- Administration
- Human Resources
- Finance and Accounting
- Business Services
- Customer Services
- Underwriting
- Information Technology
- Legal

benefits opportunities growth security training development job security stability mobility advancement education

STATE COMPENSATION INSURANCE FUND
Get More. Worry Less.®

American Assn. of Managing General Agents annual meeting

MGAs report reduced capacity, tougher terms

By JOANNE WOJCIK

LAS VEGAS—Insurance buyers and their agents turning to the surplus lines market for coverage are in for a rough time, according to members of the American Assn. of Managing General Agents' board of directors.

Capacity is limited, terms and conditions are being restricted, and many MGAs that did not produce profitable business for insurers during the soft market are finding their binding authority being cut, they say.

And the MGAs that do have sufficient capacity are being more selective about the agents and brokers with which they do business, the board members said during a meeting with reporters during the organization's 76th annual meeting, held May 5-9 in Las Vegas.

During the soft market, "there was ample (admitted) market capacity out there. Now, it's starting to shrink, and they're coming back to us. They've been left with nowhere to go. Many of their carriers and standard markets have just exited certain classes of business that we have typically written," said Baron Garcia, outgoing president of the AAMGA and president of Oklahoma General Agency in Oklahoma City. "It's nice to be wanted again."

A lot more buyers are shopping the surplus lines market, but not everyone is finding what they need, said Robert Giles, the AAMGA's incoming president and the president and chief operating officer of R.W. Scobie Inc. and Midwest General Agency, both in Eau Claire, Wis.

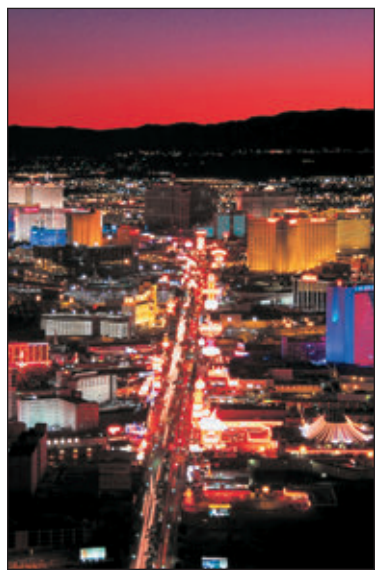
"If you were a general agent who came to this convention with the goal of finding two or three new companies to do business with, you're going to go home disappointed," he said. "Most insurance companies do not need any new best friends. They want to be talking to their old best friends who were there five years ago, three years ago, a year ago, when the market was soft."

Transportation is the risk most frequently making its way into Mr. Garcia's Oklahoma City agency. Other risks pouring into the surplus lines market include most professional liability lines, errors and omissions coverage and large umbrella business, according to Messrs. Garcia and Giles.

In certain lines of business, such as D&O, E&O and umbrella, "the pricing is going up so rapidly, and the terms and conditions are being restricted so significantly—that's the business that's being shopped," Mr. Giles said.

Insurers are being especially selective about umbrella business that involves certain exposures, such as terrorism, construction defects, professional liability and mold, Mr. Garcia said.

Most insurers' legal departments are not permitting MGAs to use manuscript policies or endorsements, Mr. Giles said.



Las Vegas hosted the 2002 AAMGA annual meeting.

"They're still out there. But I don't think you see nearly as many as you did 15 or 20 years ago," he said.

Surplus lines insurers also are requiring more applications—particularly those for professional liability coverages—to be submitted directly to them, rather than to MGAs, Mr. Giles said.

"We have not had anyone withdraw any underwriting authority from our office. Our application count coming into our office has probably doubled in the last six months," he said. Mr. Giles added that the number of submissions "has probably tripled."

Some companies have put caps on MGAs' binding authority, Mr. Garcia said. "Companies look at the food chain. If we're not doing a bang-up job, our numbers aren't good, we could very well be eliminated," he said.

MGAs are taking that same approach with retailers, Mr. Garcia said.

"We may have started last year with, say, 1,000 retailers in our state, taking business from all of them. Then your underwriters start saying, 'Every time I get something from this guy, it's a pain in the butt. He never completes (the applications). We don't have time for that,'" he said.

"We've got to transact business with those professional retail agents that understand how we operate, and we don't have to hold their hand," he said.

Mr. Garcia estimates he has cut the number of retailers with which he does business by 10% since the beginning of the year.

MGAs also are cutting back the use of agents who do not bring them a significant amount of business, Mr. Giles said.

"I heard several people say when they get a phone call from someone they never met or heard of before, they say, 'OK, maybe we'll send someone out to talk to you, but what type of premium commitment are you going to make?'" he said.

By contrast, "two years ago, if somebody called up and said, 'Hey, I want to do business with you,' I'd have three people in their office that afternoon," Mr. Giles said.

Likewise, incomplete applications were accepted because business was so scarce at that time, he said.

"If someone sent me an application that had just a name and an address on it, I'd call them back and say, 'We need a little more information,'" Mr. Giles said. "Now, we send it back and say, 'We're sorry. Unless you send it back completed we're not going to look at it.'"

American Assn. of Managing General Agents annual meeting

Growing mold problem prompts coverage restrictions

By JOANNE WOJCIK

LAS VEGAS—Wholesalers and managing general agencies are restricting coverage in certain line of business because of the growth of claims and litigation over damage from toxic mold, according to members of the board of directors of the American Assn. of Managing General Agents.

Many residential and commercial property damage claims are being reopened because of mold that was created when water damage wasn't properly repaired.

In some cases, insurers forced to pick up the tab for such mold problems are subrogating against contractors for shoddy work, even though in many cases their adjusters may have authorized only limited cleanup.

The situation has gotten so bad that nobody wants to write contractor business, particularly for roofers in rain-soaked or humid states, said the AAMGA board members, who met with reporters during the 76th annual meeting of the American Assn. of Managing General Agents, held May 5-9 in Las Vegas.

The mold-related claims are not exclusive to residential structures, the board members said, noting that a significant number of commercial projects have mold problems.

Roofers are one class of business particularly affected by the growth of mold litigation, said Robert Giles, AAMGA's 2002-2003 president and the president and chief operating officer of R.W. Scobie Inc. and Midwest General Agency, both in Eau Claire, Wis.

"When you think about all the things a leak in your roof causes, that's a really tough class of business," he said.

But construction contractors are not the only kinds of businesses affected by mold concerns. "It's got more to do with cleanup and remediation," Mr. Giles said.

Baron Garcia, AAMGA's outgoing president, agreed. "Those mold claims that you're seeing in Texas are from maybe a wind and hail claim. You've got water coming in the roof and not being properly taken care of," said Mr. Garcia, president of Oklahoma General Agency in Oklahoma City.

'In a humid state...mold, if it's not removed properly, will continue to grow and grow and grow and spread through other parts in the wall.'

Baron Garcia
Oklahoma General Agency

In the past, cleanup contractors usually put some sort of sealer on an area that had been exposed to water damage, but today, "in a humid state, that mold, if it's not removed properly, will continue to grow and grow and grow and spread through other parts in the wall," Mr. Garcia said.

"Kind of like the old movie 'The Blob,'" Mr. Giles quipped, referring to the 1958 science-fiction film.

Mold became an especially difficult issue for insurers in June 2001, when a jury in Texas awarded $32 million to a homeowner who sued Farmers Insurance Group over mold damage. While Farmers paid for damage resulting from a water leak, the policyholder sued the company for not picking up the tab for a subsequent mold claim.

"If this was a result of a covered cause of loss, which was wind or hail or water, the homeowner felt that whatever the end result of that covered cause of loss was should be paid by the insurer," Mr. Garcia said. "That's where this whole thing fell apart."

In some cases of mold-related damage, the mold may actually have occurred as a result of an inadequate cleanup, Mr. Giles acknowledged.

For example, "the adjuster comes in and says, 'OK, get Steamatic out here and clean up the carpet, and you can get some of this stuff you get in the hardware store to paint over the top of the Sheetrock, and then rehang the Sheetrock. That's what we'll authorize.' And five years later, they have a mold problem and they're saying, 'Mr. Adjuster, you should have authorized us to replace this carpet, take out the Sheetrock, properly get rid of the mold. If the mold is behind the Sheetrock, it's hidden damage.' Then, they're going after the homeowner carrier because they didn't do it right the first time," Mr. Giles said.

In addition to the homeowner's claim being reopened, the insurer might file a third-party action subrogating against the contractor that did the initial cleanup work, if the time limit for filing such claims has not passed, said Bernie Heinze, executive director of the AAMGA, which is based in King of Prussia, Pa.

Although mold itself is nothing new, "I'm not so sure if there aren't new strains of mold that maybe we didn't know about, and now there are claims there are strains of mold that are very life-threatening," said Mr. Garcia. "That's where this all started."

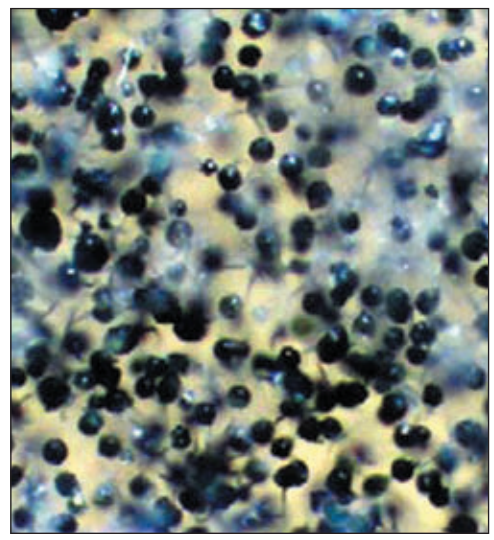


PHOTO: COURTESY OF UNIVERSITY OF MINNESOTA

Stachybotrys, a so-called "toxic mold," is drawing attention from insurers as policyholders file claims for mold damage.

Both he and Mr. Giles also attributed some of the growth in mold claims and litigation to the publicity generated by such litigants as Ed McMahon, who is seeking $20 million from his insurer for mold damage to his 8,000-square-foot Beverly Hills mansion.

The suit, which names American Equity Insurance Co., claims adjusters and environmental cleanup contractors, charges that the defendants failed to properly clean up after a water pipe burst, which allowed black mold to grow and proliferate. That mold, the suit asserts, damaged Mr. McMahon's home and most of its contents; ruined the health of Mr. McMahon, his wife and household servants; and killed his dog.

Hines: Hard market likely to last awhile

Continued from page 4

ket are the result of insurer cash flow issues and "P&L pain," Mr. Gallagher said, rather than the capacity problems that drove the hard market of the mid-1980s.

Mr. Gallagher said that, based on insurers' cash flows, balance sheets and profit and loss figures, "the hard market is clearly justified."

"Some markets are killer hard," he said, noting that although the pricing might be justified, that doesn't make it any easier for the buyer.

Mr. Mair said he thinks part of the problem lies in the fact that the insurance industry is trying to correct its problems overnight.

Risk managers who sought credit in their organizations for cutting insurance costs during the soft market are in trouble now, he said. And many risk managers in large and middle-market companies are considering alternative risk transfer techniques "like they never have before."

"If the market stays hard for any length of time…I think you'll see a lot of risk managers who learned about captives in the mid-'80s who now are applying that knowledge," Mr. Mair said.

Mr. Gallagher added that interest in the alternative market is not limited to large companies.

Mr. Marko said he thinks captives, self-insurance and other ART approaches are valid, important risk management techniques.

"I think it's inappropriate to transfer risks you should retain," he said. "I think it's inappropriate for us to encourage you to transfer risks you should retain."

The consensus among the panelists was that the current hard market will last for a few years.

"Same as we're going through a hard market now, we'll be going through a softening cycle two or three years from now," said Dirk Lohmann, group chief executive officer of Converium Ltd. in Zurich, Switzerland. The insurance industry, Mr. Lohmann said, "can't stand" underwriting discipline.

Mr. Marko said he expects the market conditions to drive some additional consolidation in the insurance industry. "We certainly have still some weak players in the industry today," he said. "If they can't manage their way out of the situation, they likely will either go out of business or be acquired."

But Mr. Lohmann suggested that such activity is not unique to the current climate. The insurance and reinsurance business, he said, has gone "through a continuous process of new formations and consolidations and capital entering and leaving the market."

The annual Hines Symposium honors the late Harold H. Hines Jr., who at the time of his death in 1984 was president and CEO of Rollins Burdick Hunter Co., now part of Aon Corp. The event is cosponsored by *Business Insurance*, the Chicago Chapter of the Risk & Insurance Management Society Inc. and the Insurance School of Chicago.

Kathryn J. McIntyre, former publishing director of *Business Insurance*, moderated the symposium.

American Assn. of Managing General Agents annual meeting

2001 a costly year for Lloyd's

By JOANNE WOJCIK

LAS VEGAS—If it's always darkest before the dawn, the insurance market has yet to see the light, said a leading Lloyd's of London underwriter.

The unprecedented losses from the Sept. 11 terrorist attacks hit an industry that was already facing significant losses from other events and diminished profitability, he said. As a consequence, it will be some time before Lloyd's and other insurance markets are able to restore their profitability, though steps are being taken to achieve that goal.

Even before the claims from the collapse of the World Trade Center started coming in, Lloyd's was hurting financially, said Stephen Catlin, chairman of Catlin Underwriting Agency Ltd. and active underwriter on Lloyd's syndicates 1003 and 2003.

Last year, Lloyd's books were just closing on the 1999 underwriting account, which was "the worst year I have ever experienced as an underwriter," Mr. Catlin told those attending the 76th annual meeting of the American Assn. of Managing General Agents, held May 5-9 in Las Vegas.

Even excluding WTC claims, 2001 "from a global specialty risk character, was bad," he added, pointing to such events as the destruction of planes in Sri Lanka, the loss of the Petrobras oil platform and a refinery fire in Toulouse, France.

Lloyd's exposure to these claims were a factor in its rating downgrade by Moody's Investors Service, he said (*BI*, Nov. 5, 2001).

"Any association needs a burning. We seem to have taken a particularly good burning," Mr. Catlin said.

Mr. Catlin estimated that Lloyd's gross losses from the World Trade Center disaster total £6.13 billion ($8.95 billion). That sum will be reduced to £1.98 billion ($2.89 billion) after reinsurance, he said, adding that he is confident all of the reinsurance will be collected because all reinsurers that were used are rated A or higher, with the remainder written by other Lloyd's syndicates.

"Sax Riley, the chairman of Lloyd's, said, almost immediately after WTC, Lloyd's has dealt with many disasters before and we will certainly deal with this one," Mr. Catlin recounted. "And he was right."

Despite 2001 losses of such a magnitude, Lloyd's is no worse off financially than the insurance marketplace as a whole, Mr. Catlin insisted.

While Lloyd's collective combined ratio is 140%, this compares with an average ratio of 130% for European reinsurers, 143% for U.S. reinsurers and 118% for the U.S. property/casualty insurers, Mr. Catlin said.

But Mr. Catlin acknowledged that Lloyd's losses will grow as the extent of claims from the WTC is realized.

"To know the truth about WTC, on an individual policy basis, you have to know the exposures. And I think you all know from experience that in this very soft market, standards have slipped," he said. "For that reason, I think there's a pretty good chance that WTC will" cause the loss ratios to deteriorate further. "In addition to that, there's asbestosis out there. That's probably $40 billion underreserved."

The new capital coming into the market, even when added to the additional capital being paid in the form of increased premiums, is not sufficient to curb the growing reserve deficiency, Mr. Catlin said.

"I can tell you from personal experience that raising capital is difficult. Replenishing capital is even more difficult. I think it's highly unlikely that the industry as a whole will be able to replenish the capital that's lost," he said.

As a result, he said, expect more bad numbers from insurers, fewer syndicates writing at Lloyd's in 2003, stricter underwriting criteria and growth in alternative risk financing.

"There's always going to be a need for risk transfer," he said, but higher pricing will likely cause buyers to reassess how much insurance they really need, just as insurers' appetite for risk diminishes in an effort to improve loss ratios.

MGAs, others flock to meeting in Las Vegas

LAS VEGAS—Approximately 1,400 MGAs, insurance company executives and other surplus lines industry service providers attended the 76th annual meeting of the American Assn. of Managing General Agents, held May 5-9 at the Bellagio Hotel in Las Vegas.

Nevada Gov. Kenny C. Guinn named the five-day meeting period "AAMGA Week" in a proclamation read by Nevada Insurance Commissioner Alice Molasky-Arman, who later met privately with AAMGA members to discuss possible solutions to the medical malpractice liability and construction defect insurance crises in her state.

Next year's AAMGA meeting will be held May 18-22 in Boca Raton, Fla.

For more information about AAMGA or the meeting, visit the organization's Web site at *www.aamga.org* or call 610-225-1999. AAMGA has relocated its headquarters from Kansas City, Mo., to 150 S. Warner Road, Suite 156, King of Prussia, Pa. 19406.

Potters Bar derailment latest in string of accidents

U.K. rails come under renewed scrutiny

By SARAH VEYSEY

LONDON—A fatal train crash in England earlier this month–the country's fourth large fatal railway accident in as many years—is drawing renewed scrutiny of the safety record of the United Kingdom's railway network and prompting calls for change in how that network is maintained.

Seven people died and more than 70 persons were injured in the accident, which occurred May 10 at the Potters Bar station, just north of London. A passenger train derailed from the tracks, sending one carriage crashing onto a platform and trapping other passengers in a rear carriage. A footbridge hit by a section of the train collapsed, killing a bystander.

The crash occurred just five miles from the scene of a 2000 fatal train crash near Hatfield, Bedfordshire, that killed four people and injured 34 (*BI*, Oct. 23, 2000). Last year, the U.K. rail system was rocked by another fatal accident at Great Heck, when two trains collided, killing 10 people and injuring 70 (*BI*, March 5, 2001). And in 1999, two trains collided at Paddington station in London, killing 31 people and injuring more than 100 (*BI*, Sept. 22, 1999).

The cause of the Potters Bar crash is still under investigation by the government's Health and Safety Executive, but a preliminary HSE report stated that initial indications are that "a fault in a set of points south of the station caused the derailment." The report added that there was no evidence to suggest any error by the train driver or any signaling failure.

Jarvis P.L.C., an engineering company that is responsible for the maintenance of the stretch of track involved, suggested that problems with the points, or rail switches, may have been the result of sabotage or vandalism. The HSE report did not rule out such speculation, but said there was no evidence yet to support the claim.

If the cause of the crash is found to be vandalism, the U.K. Criminal Injuries Compensation Board would compensate victims and their families.

The passenger train involved in the crash was operated by West Anglia Great Northern Ltd., a unit of London-based transportation company National Express Group P.L.C.

WAGN is insured by St. Paul International Insurance Ltd., a unit of The St. Paul Cos. Inc. A spokesman for St. Paul said it insured the company's rolling stock, or trains, as well as its public liability exposure, but declined to provide additional details of the coverage.

In addition, Lloyd's of London has confirmed that it has a potential exposure to the crash, but a spokesman said that no further information will be available until the cause of the accident has been determined.

St. Paul has set up a fund on WAGN's behalf to help relatives of the dead or injured travel to the scene of the accident or nearby hospitals, the spokesman said.

A spokesman for Hertford, England-based Jarvis said that the company had "all the relevant

See UK RAIL/next page

PHOTO: AFP

A May 10 derailment sent one car of the passenger train onto the Potters Bar platform.

Italian regulator clears way for vote

Fondiaria takeover by SAI grows likely

By ROBERTA KEDZIERSKI

FLORENCE, Italy—An Italian court's decision earlier this month not to hear an emergency appeal by La Fondiaria Assicurazioni S.p.A. opens the door for a rival insurer seeking to take control of the company to vote out Fondiaria's board.

In addition, late Friday, the Italian securities regulator, CONSOB, reportedly said it would not require other Fondiaria investors to launch a competing takeover bid for the insurer.

A Florence civil court declined to hear Fondiaria's argument that the other investors were acting "in concert" with Turin, Italy-based Società Assicuratrice Industriale S.p.A. as part of SAI's 10-month battle to take over Fondiaria. The court said it was not an appropriate forum for such claims and that Florence, Italy-based Fondiaria could take other action, including revoking a shareholder vote to oust its board at the insurer's annual meeting May 30.

Because CONSOB did not find that the five investors were acting in concert with SAI, which would trigger an obligation to launch their own takeover bid, observers expect that La Fondiaria is likely to be taken over by rival SAI.

SAI's attempts to take control of La Fondiaria began last year, after Milan-based industrial company Montedison S.p.A. announced its intention to sell its 24.4% stake in La Fondiaria. Montedison had been in talks to sell its stake to Toro Assicurazioni S.p.A., but La Fondiaria scuttled that deal by taking a stake in Toro's parent company, Fiat S.p.A. (*BI*, Jan. 14). Italian laws governing such cross-shareholdings hampered Toro's plans.

SAI initially acquired a portion of Montedison's stake but needed approval from ISVAP, the insurance regulatory agency, to further increase its holding in La Fondiaria. After ISVAP ruled that SAI could not increase its 29.9% holding, SAI responded by striking a call-and-put deal with five investors. The deal lets SAI buy back the shares at the same price it sold them.

The five Fondiaria investors are: JP Morgan Chase & Co.; Interbanca S.p.A; the Italian financier Francesco Micheli; Commerzbank A.G.; and Mittel S.p.A., a holding company.

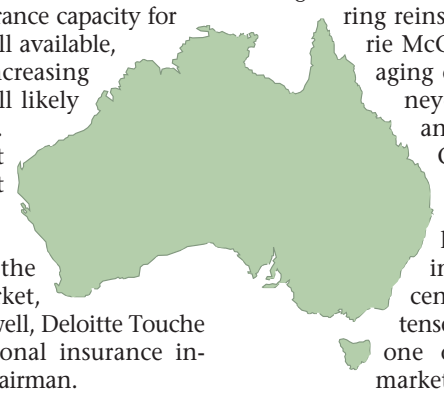
See SAI/next page

Losses, new rules spur reinsurer exit from Aussie market

By DAMIEN TOMLINSON

SYDNEY, Australia—Australian insurers are facing fewer reinsurance options as a growing list of reinsurers pull out of the market.

Large losses worldwide and increased regulatory requirements in Australia are discouraging some reinsurers from writing business in the market.



While reinsurance capacity for most lines is still available, prices are increasing sharply and will likely continue to rise.

Over the past few months at least four reinsurers have pulled out of the Australian market, said Peter Caldwell, Deloitte Touche Tohmatsu national insurance industry group chairman.

New York-based St. Paul Reinsurance Inc. exited the Australian market last December. Princeton, N.J.-based American Re-Insurance Co. earlier this year announced that it was transferring all of its international business to its parent, Munich Reinsurance Co.; Copenhagen, Denmark-based Copenhagen Reinsurance Co. Ltd., Australia's oldest registered reinsurer, has exited the market; and Sydney-based QBE Reinsurance Asia-Pacific Ltd. has ceased writing treaties in Australia and Singapore, reducing its lines to facultative property only.

Large losses from the Sept. 11 terrorist and the failure of Enron Corp. have contributed to several reinsurers' decisions to cut back their business generally, and regulatory changes in Australia also are deterring reinsurers, said Norrie McConochie, managing director of Sydney-based reinsurance broker Guy Carpenter & Co. Ltd.

"Reinsurers had been suffering losses in recent years with intense competition in one of the hardest markets ever. Sept. 11 was a big shock for a lot of them, and then Enron happened," he said.

And new regulatory requirements being introduced on July 1 by the Sydney-based Australian Prudential Regulation Authority (*BI*, Oct. 1, 2001), including the requirement for increased capital, were a deciding factor for some reinsurers leaving the Australian market, Mr. Mc-

See PULLOUT/page 19

World Updates

Groupama U.K. unit to exit large-risk market

Groupama Insurances, the U.K. subsidiary of France's Groupama-GAN S.A., plans to exit large commercial lines business to focus on small and midsize commercial property risks. The move comes a few months after Groupama-GAN canceled a planned sale of the London-based unit. Groupama Insurances' large property and liability books and its contingency business will be run off over the next 12 months, said Tim Ablett, managing director. Those lines produce £60 million to £75 million ($87.6 million to $109.5 million) in annual gross written premiums for the insurer. He said the U.K. small-to-medium enterprises sector—companies generating less than £7,500 ($10,950) in annual premiums—accounts for about £4 billion ($5.8 billion) in premiums. Groupama Insurances writes premiums of about £14 million ($20.4 million) in that sector.

London market launches benchmarking project

Lloyd's of London and the London Market Brokers' Committee are jointly launching a new system to benchmark the London market on coverage submissions and claims handling. The new benchmarking program is designed in part to allow risk managers to assess the performance and efficiency of the London market in handling claims. In addition, participating insurers and brokers will be able to examine their own performance relative to industry averages.

Independent's liquidator reaches deal with brokers

PricewaterhouseCoopers L.L.P. in London, liquidator of the failed Independent Insurance Co. Ltd., has reached a compromise deal with the British Insurance Brokers Assn. over premiums and commissions that PwC argues are owed to Independent (*BI*, Sept. 3, 2001). If the compromise deal is approved by a majority of the 300 brokers involved by the end of May, the brokers will turn over to PwC any unpaid premiums for business placed with Independent for the first six months of 2001, up to the insurer's collapse. They also will return any commissions, prorated for six months, earned on premiums that PwC has refunded to policyholders. PwC had argued that brokers should turn over premiums for the entire year, but many brokers had refused to pay premiums they were still holding for policyholders, a PwC spokeswoman explained. If a majority of the brokers accepts the deal, litigation will be avoided, she said.

Briefly noted

Trieste, Italy-based **Assicurazioni Generali S.p.A** reported profits of 202.4 million euros ($176.1 million)

See WORLD NEWS/page 19

U.K. rail: Safety under scrutiny

Continued from previous page
insurance policies in place," though he declined to provide details.

The HSE said it would investigate emergency response procedures carried out in the aftermath of the Potters Bar accident.

"As part of the follow-up to the incident, the experiences of the passengers involved will be taken into account in the investigation of the effectiveness of emergency arrangements on the train itself," the report said.

Safety checks have been carried out on other stretches of the country's track system.

Railtrack P.L.C., the operator of the United Kingdom's rail network, made checks on 800 rail switches around the country after the crash and found no problems with them, according to the HSE.

"We have immediately instructed that other points across the network be checked and so far no similar problem has been found. We will not, at this juncture be imposing speed restrictions across the network because of this accident," said John Armitt, chief executive of Railtrack, which was placed under government administration last year because of financial troubles. "However, as we find out more, we will be prudent and keep our safety responsibilities to the fore in any decision," he added.

The accident prompted calls for a full, public inquiry into the crash.

Louise Christian, a solicitor representing victims of the 1997 Southall and 1999 Paddington rail disasters, was among those demanding an immediate public inquiry into the accident.

'The safety culture on Britain's railways has been fundamentally undermined by fragmentation.'

Bob Crow
Rail, Maritime and Transport Union

But Richard Bowker, chairman of the government's Strategic Rail Authority, which regulates the U.K. rail industry, said a public inquiry is not necessary at this time. "Until the independent safety regulators deliver their full report, I don't believe there is any merit in repeatedly saying 'let's have a public inquiry,'" he said in a statement.

But calls for a public inquiry were echoed by Bob Crow, chairman of the Rail, Maritime and Transport Union, the rail workers' labor union. "We need a public inquiry, not solely into the causes of the Potters Bar tragedy, but also into the shambolic (sic) way in which infrastructure maintenance is organized," he said. He argued that the current system, under which Railtrack contracts out with various companies like Jarvis for railway maintenance around the country, contributes to accidents such as the one at Potters Bar.

"The safety culture on Britain's railways has been fundamentally undermined by fragmentation," he said. "We have contractors who use sub-contractors who use agencies who use casual labor. And they're all in it for profit, not safety," he said. "Maintenance needs to be brought back in-house now," he added.

U.K. Transport Secretary Stephen Byers told the House of Commons that Railtrack had made "insufficient progress" in implementing recommendations about the screening and oversight of contractors.

The Cullen inquiry into the 1999 Paddington crash said that by March 2002, action should have been taken to improve the selection, training and performance of the maintenance contractors and subcontractors used by Railtrack. Earlier this month the Health and Safety Commission warned that those measures would likely not be in place until September 2002 at the earliest. Mr. Byers said he had asked the HSC for a report on the use of contractors.

The accident also renewed calls for improving rail safety systems. For example, implementation of a train protection system designed to stop trains passing red lights was one of the recommendations of the Cullen inquiry. But while the report called for such a system to be adopted by 2010, the Strategic Rail Authority said it would not be introduced in the United Kingdom until 2015, and then only on high-speed rail lines. Bulgaria and Switzerland already have such systems in place, while Germany, Italy and Spain expect to have them by 2004.

SAI: Court rejects appeal

Continued from previous page
Meanwhile, Mediobanca, the Milan-based merchant bank, holds 13.5% of Fondiaria.

Neither SAI nor Mediobanca would comment on developments.

CONSOB's decision late last week, reported by Reuters Ltd., means that the group of investors at Fondiaria's annual general meeting at the end of this month could elect board members who would agree to a merger with SAI.

A merger between SAI and Fondiaria would create one of Italy's largest nonlife insurers after leader Assicurazione Generali S.p.A.

At year-end 2000, the latest year for which figures are available, Fondiaria's gross premiums written totaled 6.221 trillion lire ($3.03 billion), while SAI's gross premiums were 7.461 trillion lire ($3.63 billion).

"Back-office operations could be merged and best practices adopted," said Federico Salerno, an insurance analyst at Milan-based UBM-Unicredito Italiano S.p.A. But, "Italian employment law is very strict on job cuts. You cannot just shed positions. So the savings would be relative," he said. "There is little to indicate, though, that the extra size of the company would make SAI/Fondiaria abandon their current core business and move into a different field."

Both companies cover commercial risks, but their largest area of business is auto insurance.

Pullout: Reinsurers scale back in Australia

Continued from page 17

Conochie said.

But Ross Littlewood, Sydney-based agent for five international reinsurers, including Hannover Ruckversicherungs A.G., said reinsurers' decisions to exit Australia were not based solely on their performances in Australia.

"None of the companies involved has identified Australia as being a bad market or had any particular reason for getting out of here," he said. "All these moves have been part of a larger, global initiative either to stop writing a certain class of business, or as part of the closure of whole companies."

The reduction in the number of reinsurers has not caused a capacity problem in Australia, said Mr. Littlewood.

"The capacity is still there, but the existing reinsurers are now charging the correct rates to make the business profitable. They've been losing for too long," he said.

Reinsurers remaining in the market will likely continue to charge higher rates, agreed Mr. McConochie.

"Reinsurers in the market now are in a prime and unique position. They are free to price risks as they see them to raise the capital required to absorb any big claims," he said.

Insurers are trying to offset the increased reinsurance costs by retaining more of their business, but they are still eager to buy reinsurance protection for volatile risks, Mr. McConochie said.

"In volatile risks like liability, they will be desperate to offset their risk, and will be willing to pay for it," he said

Deloitte's Mr. Caldwell said the Australian reinsurance market was undergoing a restructuring, and that no clear trend had emerged as to the future of the market there. New Australian state and federal government legislative proposals, which aim to reduce the cost of insurance through tort reform, will have to be in place for stability to return, he said.

Andrew Plympton, chairman of broker HLG Australasia Pty. Ltd., said the reinsurance market "shakeout" would affect specialty markets, such as directors and officers and professional indemnity.

While new capital was flowing into Bermuda, reinsurers wanted to place their cash in places where they would get the highest return. Australia "does not rate highly" in the international market for capital returns, so it is a matter of "joining a queue" in Bermuda and similar locations, Mr. Plympton said.

World Updates

Continued from page 17

Briefly noted

Trieste, Italy-based **Assicurazioni Generali S.p.A** reported profits of 202.4 million euros ($176.1 million) for first-quarter 2002, down 41.8% from the same period last year. Much of the drop was due to reduced investment income, it said. Generali reported gross premiums of 12.75 billion euros ($11.10 billion) for the first quarter, up 3.3%. Nonlife premiums fell 2.9% to 5.6 billion euros ($4.9 billion)....Paris-based **AXA S.A.** will cut about 700 jobs from AXA Insurance, its U.K. property/casualty arm. The cuts, which represent 13% of AXA Insurance's workforce, are expected to bring savings of 20% by the end of 2004, AXA said....London-based reinsurance broker **Benfield Group P.L.C.** has opened two offices in Eastern Europe. The new offices in the Czech Republic and Slovakia stem from Benfield's acquisition of reinsurance broker BMS Harris & Dixon....Dutch insurer **ING Groep N.V.** has agreed to sell its Indonesian property/casualty unit to Australian insurer QBE Insurance Ltd. for an undisclosed amount. ING said it will now focus on life and health insurance business in Indonesia....U.K. broker Marcus Hearn & Co. Ltd. has relaunched its **airline failure insurance** policy. The policy insures travel agents against the cost of refunding tickets in the event of a scheduled airline liquidation or bankruptcy. The policy offers coverage for up to £2,500 per passenger. Marcus Hearn said it had seen great interest in the policy since last Sept. 11....After receiving approval from New York insurance regulators, **The People's Insurance Co. of China** is planning to open an office in New York City next month, its first U.S. office. PICC is China's largest property insurance company. Yanqing Xu, a company representative, will run the new office....**Sulzer Medica Management A.G.** said that almost all of the nearly 4,000 claimants in a product liability suit have accepted the company's $1.0 billion settlement offer. The plaintiffs alleged they received defective hip and knee implants from Sulzer Orthopedics Inc., an Austin, Texas-based unit of Zurich, Switzerland-based Sulzer Medica. A court gave final approval to the settlement earlier this month.

Texas: Appeals courts rule on two pollution exclusions

Continued from page 3

"The ruling goes a little further to enforce the idea that Texas courts will stand behind the exclusion in a variety of settings and not limit its application," said insurer attorney Laura A. Foggan, counsel for the Complex Insurance Claims Litigation Assn. and a partner with Wiley Rein & Fielding L.L.P. in Washington.

Policyholder attorney Robert M. Horkovich, who was not involved in the case, predicted that the ruling would have little influence on other courts because the Texas appellate court did not take the "common sense approach" that other courts have adopted in evaluating the exclusion's applicability.

Even in insurer victories in cases challenging the exclusion's breadth, other courts examined whether the substance central to the policyholder's claim could be considered a pollutant, noted Mr. Horkovich, a partner with Anderson Kill & Olick P.C. of New York.

Even insurer attorney Jule Rousseau questioned the court's decision, given the facts in the case.

"It's hard to say that's really the result that anyone intended in the beginning," when insurers drafted the exclusion, said Mr. Rousseau, a partner with London Fischer L.L.P. of New York.

Mr. Rousseau predicted that other Texas courts, which he said have not been strong insurer advocates in general, would not likely follow the ruling in future cases. He also speculated that such a sweeping ruling could prompt the Texas insurance commissioner to restrict the exclusion's application, just as Louisiana insurance regulators have done under similar circumstances (*BI*, Jan. 8, 2001).

Insurers 'are not supposed to be bound by some presumed underwriting intent of 30 years ago.'

George B. Hall Jr.
Phelps Dunbar L.L.P.

Attorney George B. Hall Jr., who represented Bio Zapp's insurers, said insurers "are not supposed to be bound by some presumed underwriting intent of 30 years ago." He is a partner with Phelps Dunbar L.L.P. of New Orleans.

On appeal, the Zaiontzs are arguing that the appellate court did not consider, as required under Texas case law, the reasonableness of Bio Zapp's coverage expectations based on a Trinity agent's and underwriter's representations, said plaintiffs' attorney Michael A. Chovanec, a partner with Wolff Ardis P.C. of Memphis.

In its unpublished May 2 decision on the sudden and accidental pollution exclusion, a Texas appellate court in Dallas ruled that exclusion does not bar indemnification of pollution-related claims covered by the personal injury provision of a cotton mill's general liability policy.

Chickasha Cotton Oil Co. of Commerce, Texas, agreed to pay hundreds of nearby residents around $7 million after they claimed that the mill's operations caused them mental anguish and other problems.

The plaintiffs fear they may develop cancer because the mill for years polluted their environment with arsenic when it incinerated the burr of cotton treated with an arsenic defoliant.

Chickasha's general liability umbrella coverage from 1972 until 1986 contained personal injury provisions that provided coverage for various bodily injuries and mental anguish claims as well as for invasion of privacy rights, wrongful eviction, libel and slander.

Insurer attorneys say the mill's personal injury provision was oddly worded because it covered bodily injury and mental anguish. But, the personal injury provision in the Insurance Services Office Inc.'s standard general liability policies does provide some coverage for bodily injuries arising from products and completed operations.

Milton Zaiontz et al. vs. Trinity Universal Insurance Co. et al., Texas 4th District Court of Appeals, No. 04-01-00329-CV; April 30.

Chickasha Cotton Oil Co. vs. Houston General Insurance Co. et al., Texas 5th District Court of Appeals, No. 05-00-01789-CV; May 2.

PPG, insurers agree to big asbestos pact

By DOUGLAS McLEOD

PITTSBURGH—PPG Industries Inc. and about three dozen insurers have agreed to pay $2.7 billion to settle current and future asbestos claims arising mainly from PPG's 50%-owned affiliate Pittsburgh Corning, which is in reorganization.

The proposed settlement calls for the creation of a claims settlement trust as part of a reorganization plan for Pittsburgh Corning, which filed for Chapter 11 protection in 2000 amid rising asbestos liabilities. Insurers would contribute about $1.8 billion of the $2.7 billion in cash paid into the trust, while PPG would contribute about $900 million. PPG would also contribute 1.4 million shares of PPG stock and PPG's stake in Pittsburgh Corning, a PPG spokesman said. Insurers would have the option of making a single trust payment in 2004 or making annual payments until 2023.

Several insurers disclosed their expected payouts under the deal.

Travelers Property Casualty Corp. said that the discounted current value of its share would total $240 million aftertax and that that amount would be covered by reserves and charges that it could recover from its majority shareholder, Citigroup Inc. The Hartford Financial Services Group Inc. said its discounted share would amount to $120 million to $150 million net of reinsurance recoveries. Chubb Corp. said it would pay out $34 million from already-established reserves.

PPG itself would record an aftertax charge of $500 million when a final deal is imminent, reflecting its discounted cash and stock contributions to the trust, the company said.

Corning Inc., Pittsburgh Corning's other 50% shareholder, is not involved in the deal, a Corning spokesman confirmed.

Although representatives of current and future claimants of Pittsburgh Corning have agreed to the settlement, the deal is still far from final. It still must be incorporated into a reorganization plan for Pittsburgh Corning and will not become effective until 30 days after the plan is approved by the bankruptcy court and is no longer subject to appeal, a process that will take a year or more.

Support for the plan is also not universal. Equitas Ltd., the runoff reinsurer of Lloyd's pre-1993 long-tail liabilities, will oppose the settlement, an Equitas spokesman said. Equitas contends, among other things, that asbestos product liability claims have virtually exhausted Pittsburgh Corning's London market excess limits and that non-products losses must be borne largely by the company's primary insurers, he said.

Nevertheless, PPG is "confident the settlement will be approved," a PPG spokesman said. "We don't see any significant roadblocks."

Cost control: Companies succeed by taming care costs

Continued from page 3

ployers also were a success, as defined by the survey.

That compared with only 16% of cautious employers that were successful and 12% of those labeled incrementalists.

While the survey does not state that an aggressive strategy toward health care directly leads to financial success, it notes that the link exists, "perhaps growing more out of the leadership orientation of the organization."

The survey asked employers to list the strategies they are using to control health care costs, finding wide disparity in adoption of some strategies.

For example, calculating return on investment as part of health care decision making was employed by 25% of aggressive employers, 10% of incrementalist employers and 1% of cautious employers, the survey shows.

Giving employees greater choice when designing health care benefits was used by 39% of aggressive employers, compared with 14% of incrementalists and 1% of cautious employers.

Using clinical risk adjustment—in which the quality and value of a plan are used to calculate employee premiums—was adopted by 14% of aggressive employers, compared with only 1% of incremental employers and none of the cautious employers.

The study also found that companies that met its definition of "successful" differed from other companies in terms of their health care management strategies.

The winning organizations give their employees financial incentives, the necessary information to make decisions "and a clear understanding of what their responsibility is," explained Maureen Cotter, global practice director for group benefits and health care consulting for Watson Wyatt Worldwide in Southfield, Mich., and author of the survey.

For example, the survey found, successful companies were more likely to manage their health care program like any other aspect of their business, push their employees to become health care decision-makers and use technology and information to make better health care choices.

Winning organizations give their employees financial incentives 'and a clear understanding of what their responsibility is.'

Maureen Cotter
Watson Wyatt Worldwide

Almost three-quarters—72%—of successful employers directly manage their health care providers, such as doctors and hospitals, as they would any other business vendor. That compares with 41% of other employers that directly manage health care suppliers.

The survey also shows that 30% of successful employers empower their employees to take responsibility for health care benefits, compared with 18% of other companies.

As part of this effort, successful employers are using technology to provide their employees with tools to help them make better decisions. The survey shows that 44% of the successful companies provide information to employees on health care costs, compared with 24% of other companies.

"Whether providing employees with information on health care costs, quality or specific health care issues, winners push information to employees and educate them on its role in their health care decision making," the survey states.

In addition to exploring differences in the strategies employed by successful companies vs. others, the survey also examined how employers in general are changing their health care management approaches.

According to the survey, 43% of employers plan to increase employee "consumerism," which the survey defined as use of "systems that inform and empower employees to participate more actively in health care buying decisions." Only 18% of companies currently embrace such an approach.

"Increasingly, companies are indicating that promoting individual responsibility is a key goal of their health care program," the survey states.

Fifty-seven percent of employers indicated that they would provide more information to assist employees in making health care choices, compared with 51% of employers that did so the previous year, the survey found.

While employers support the idea of empowering employees, they also have some reservations. Seventy-seven percent of employers said a drawback of this approach is that employees might forgo necessary care to save money.

Copies of the survey, "New Rules for Managing Health Costs: Seventh Annual WBGH/Watson Wyatt Survey Report 2002," can be obtained at www.watsonwyatt.com.

Results: Managed care cost shifting to continue

Continued from page 2

cies," said John L. Ward, chairman of the Cincinnati-based Ward Financial Group.

"Double-digit premium rate increases wash away all sins," said Rob Mains, an analyst with Albany, N.Y.-based Advest Inc. The same trends have been evident for a while, he said. "Medical costs are rising quickly, but kind of in an orderly fashion. It doesn't seem to be like the drug price conflagration that was out there a few years ago, and with premium rate increases as high as they are, companies by and large are meeting or exceeding expectations."

The outlook is "pretty positive," said David Olson, vp-investor relations for Woodland Hills, Calif.-based Health Net Inc. Rates are holding while medical cost trends "although high, appear stable."

It "doesn't seem that there's any component of medical costs that is spiraling out of control," said Mr. Mains.

"You've got pretty hefty medical inflation," but it is not extreme, "so insurers should do well if their rates exceed the rate of growth of their costs, and it appears we've got that for 2002" and likely into 2003, he said.

Patrick Finnegan, senior vp at Moody's Investors Service Inc. in New York, said results are "going to be improving, but not tremendously so. I think we're going to see a healthy trend," but not as strong as it has been in the past year.

Richard Shaw, an analyst with Oldwick, N.J.-based A.M. Best Co., said he expects more product diversification.

"You're going to see enrollment contract as (managed care firms) continue to refine their books and eliminate the non-profitable business, but I also think you're going to see HMOs diversify their product lines to be able to try and maintain that enrollment in another product," he said.

Managed care companies that do not already have a preferred provider organization product, for example, will find ways to offer one to their clients, whether it be through an affiliation, acquisition or some other arrangement, he predicted.

'Employers can't continue to absorb these large rate increases. Now they are going to have to get the employee involved.'

Richard Shaw
A.M. Best Co.

Meanwhile, in response to the rate hikes, "employers are going to try and get the employee more and more involved in the cost sharing," Mr. Shaw said. "The employers can't continue to absorb these larger rate increases. Now they are going to have to get the employee involved," he said.

Cost-sharing efforts by employers "could be something that accelerates in 2003 with greater cost sharing of the benefit packages," agreed Greg Crawford, an analyst with Fox-Pitt Kelton in San Francisco. "That may be really the employers' best strategy given the current outlook for costs right now," he said.

Approaches such as higher copayments "have been on the table for awhile, but the employers haven't cried 'Uncle' yet, and perhaps in 2003 we'll see the beginnings of real, substantive changes in benefit packages," he said.

However, Mr. Ward said he does not foresee a strong trend toward employers asking employees to share more of their health care costs. "I think most employers recognize the asset value of their work force and so they're trying to wring all the inefficiencies out of the system before they go back and ask the employee to share in the pain."

Just as employers are being hit with cost increases, managed care companies also are being asked to pay more.

Firms are being pressured to raise the rates they pay hospitals, many of which hold near monopolies in some markets following a wave of consolidation activity, and this is expected to continue. "I think you're going to see a lot more pressure from the provider community on the health care companies," said Mr. Shaw.

"Hospital groups are becoming much more aggressive" in seeking higher rates, he said. As a result, HMOs are passing these on to employers because the HMOs cannot afford to absorb them themselves

'Employers haven't cried "Uncle" yet, and perhaps in 2003 we'll see the beginnings of real, substantive changes in benefit packages.'

Greg Crawford
Fox-Pitt Kelton

"It almost becomes a pass-through expense," said Mr. Shaw.

The pressure on HMOs to pay providers more is likely to get worse as hospitals contend with staffing and other issues, said Jack Reichman, director at Standard & Poor's Corp. in New York. "They're going to use their clout to get better deals."

"I think that generally speaking the concentration of market power in the hospitals is an issue that's going to have to be addressed going forward," said Health Net's Mr. Olson.

In light of market conditions, analysts generally expect HMO stocks to continue to do well.

Fox-Pitt Kelton's index of major HMO stocks, for example, increased 52% for the year through May 10, said Mr. Crawford.

"The HMO stocks are going to continue to be home runs," said Mr. Le Coney. This is a managed care organization "paradise," he added. The managed care industry "is one of the very, very few sectors of the U.S. economy where it is dong better than expected."

Mr. Olson said also in an uncertain market, health care stocks such as managed care companies "do become more attractive as defensive plays, so in that sense, in that context, I think we like our prospects."

P/C directory deadline June 5

Business Insurance will publish its online Directory of International Property/Casualty Insurers in conjunction with the June 17 issue.

That issue of *BI* will feature a Spotlight report on the European Union market and a ranking of the top international property/casualty insurance companies.

The directory is published as an editorial service, and there is no charge to be included. To be listed, a company must provide property/casualty insurance in countries other than that in which it has headquarters.

If your company meets that requirement and has not received a questionnaire, please request one immediately by calling Assistant Directory Editor Carrie Brittain at 312-649-5313.

Copies of the questionnaire also can be printed from the *BI* Web site at *www.businessinsurance.com.*

Completed questionnaires must be submitted by the extended deadline of June 5.

ADVERTISER INDEX

Issue of May 20

California: Need for minimum comp rates debated

Continued from page 3

shape—it's in terrible shape," Mr. White said. If A.B. 1985 "doesn't pass and the trends continue, we're going to have a very sick workers compensation system."

Since the implementation of open rating seven years ago, 18 workers comp insurers, with annual written premiums totaling $2.5 billion, have been placed in conservation or under regulatory supervision, according to the Department of Insurance. Those insurers represent 28% of California's workers comp market.

Meanwhile, the market share of the California state-run workers comp fund, the State Compensation Insurance Fund, has grown to 44% from 21% during the same period.

"In short, the business of writing workers compensation policies in California is not profitable," according to an Assembly analysis of A.B. 1985. "The few remaining (insurers) are suffering rating downgrades, and new companies are not entering this business. The concentration of market share in SCIF makes businesses overly dependent on this source of workers compensation insurance and vulnerable to any adverse developments that might affect this insurer."

A.M. Best Co. also has cited concerns about the amount of business being written by SCIF. Oldwick, N.J.-based Best downgraded the fund's financial strength last month to B- from B+, noting that it was concerned about SCIF's "substantial growth in the California workers compensation market." Shortly after the downgrade, SCIF withdrew from Best's rating process.

Overall, workers comp insurers in California faced a $7.1 billion reserve deficiency at the end of 2000, according to the state Workers' Compensation Insurance Rating Bureau. A new WCIRB report on reserves is due out soon, and there is little reason to think the situation will have improved significantly, said Dave Bellusci, senior vp and chief actuary for the San Francisco-based WCIRB.

If A.B. 1985 'doesn't pass and the trends continue, we're going to have a very sick workers compensation system.'

Larry White
California Department of Insurance

There has been some recent improvement in loss costs, though observers say it is not enough. In 2001, insurers paid out an estimated $1.32 in benefits and expenses for every dollar in premium. That compares with the $1.74 paid out for every dollar in premium earned for 1999, according to the WCIRB.

While some observers blame the state's workers comp woes on rising medical and indemnity costs, others say open rating has also had an impact.

Open rating is a so-called "file and use" system that allows insurers to set their own rates without obtaining prior regulatory approval. Before workers comp reforms introduced open rating, workers comp insurers in California could not reduce their prices below a certain floor set by regulators.

The goal of open rating was to provide employers with the benefit of competitive pricing. Following its implementation in 1995, rates dropped significantly over several years as insurers fought for market share.

The open rating law went further than anyone expected in reducing rates, said Willie Washington, legislative director for the Sacramento-based California Manufacturers & Technology Assn. But the market is now experiencing a correction, with employers seeing rate increases averaging 22%.

Mr. Washington's group opposes A.B. 1985 because it does not go far enough in regulating insurer operations, he said. Mr. Washington said he would like to see regulators exercise greater control over insurance and reinsurance industry funds to ensure they are available to pay claims in insolvencies.

The Insurance Department, for its part, says A.B. 1985 would give it authority it now lacks, without removing the file-and-use system. Existing law precludes the department from taking steps to ensure an insurer's rates are adequate until it is too late to prevent an insolvency, Mr. White said.

Peter Gorman, vp of the Alliance of American Insurers' western region in San Francisco, said the bill would strip insurers of their ability to lower rates for employers that implement good loss control programs. The American Insurance Assn. agrees with that point.

Under the bill, insurers would be forced to provide loss data to the Insurance Department before they could give rate discounts to accounts that had implemented new programs to reduce losses. But improved employer safety records and loss data may not be available until long after rates are assessed, Mr. Gorman said.

Mr. White, however, said the legislation is not that strict. Insurers could submit other data, he said, such as information about an employer's newly implemented safety plan.

In the end, however, the legislation may not have the impact the Insurance Department expects, Mr. Gorman said. A.B. 1985 "might keep other carriers from entering the marketplace because they are facing new regulation of their rates," he said.

HRH: Hobbs deal expands scale, reach

Continued from page 1

tion," Mr. Rogal said. According to the CEO, Marsh and Aon "no longer give their A teams to those prospects; those A teams go the Exxon Mobils of the world and they should. But what that has left is a tremendous opportunity to move into an end of the market that is not beyond our strategic perimeters as a middle-market intermediary, and one where there is lack of service."

The idea behind the Hobbs deal "is to make a move into that market and give risk managers more choice, more attention and, quite frankly, more clout," Mr. Rogal said.

Hobbs provides that larger account platform for HRH to launch from and build on, said Thomas A. Golub, president and CEO of Hobbs, who will join HRH as executive vp and a member of the board of directors.

"We see this as a big step in our journey to build the world's premier insurance broker and risk management services company," Mr. Golub said of the deal. "In our view, HRH is a great partner for us as far as our cultures fit well. Also, we are really largely in two different markets today, but we conduct business in a very similar fashion," he said.

Hobbs Group was formed following a 1997 management buyout of the firm from former owner Arkwright Insurance Co.

At the time of the HRH deal, 74% of Hobbs' shares were owned by employees, Mr. Golub said. The only substantive outside investor in Hobbs was a private equity fund managed by Conning & Co., which bought 21% of the firm in April 1999. Mr.

The idea behind the Hobbs deal 'is to make a move into that market and give risk managers more choice, more attention and, quite frankly, more clout.'

Andrew Rogal

Golub said that Conning has been a "terrific partner" and there was no pressure from it to sell the company.

Under terms of the deal, HRH will pay a combination of cash and stock with a fixed amount of $142 million payable at closing. That payment includes the assumption of $55 million of Hobbs' debt. HRH also will pay Hobbs up to $102 million in cash and stock over the next two years if certain financial performance goals are met. HRH also will pay $30 million in cash and stock, assuming existing incentive plans from Hobbs' prior acquisitions.

For the time being, Hobbs Group will act as a division of HRH and maintain its name and office locations, Mr. Rogal said. Mr. Golub will continue in his role as president and CEO of Hobbs' operation and will guide HRH's expansion into the large risk management account market.

"We're not looking to consolidate and we're not looking to create cost savings," Mr. Rogal said. "It's all about building something up and the hope is, if we can digest this and do it well, that somewhere down the line we can attract other of this type to join us."

"We're looking to break out of the pact in that mid-market group and we feel (Hobbs) gives us a real chance at making a strong run at that," he said.

Observers are generally positive about the deal.

"I think it's a good fit," said Adam Klauber, managing director of Cochran, Caronia Securities L.L.C. in Chicago. Whereas Hilb focuses on more traditional middle-market accounts, Hobbs tends to be more upper-middle-market focused, he said.

At the same time, "putting two good-sized firms together really propels them in terms of critical mass," Mr. Klauber said. "It allows HRH to leapfrog and puts Hobbs in a whole new category of brokers."

David West, director of research at Davenport & Co. in Richmond, Va., agrees.

"For HRH, which has developed a reputation of servicing mainstream America, this is a chance for them to move upstream, but not bump up against really huge agencies that are focusing more on the Fortune 500," he said. "It's an interesting strategic move for them."

"Hobbs presented significant strategic value to Hilb, which is certainly reflective of the price they paid," said Timothy J. Cunningham, a partner with agency consulting firm OPTIS Partners L.L.C. in Chicago. "The challenge is going to be pushing the Hobbs' platform into Hilb's organization and to grow Hobbs' platform organically," he said.

COBRA: Employers wary of bite from new proposal

Continued from page 1

tion would, if passed, mark the first time the federal government has directly subsidized COBRA premiums since the Consolidated Omnibus Budget Reconciliation Act was enacted in 1986. With COBRA premiums easily costing $7,000 a year for family coverage, a 70% government subsidy would mean displaced workers could save thousands of dollars in COBRA premiums.

Although the savings would be dramatic for displaced employees, the mechanics of the subsidy and how it would affect employers providing COBRA coverage are far from clear.

Normally, COBRA beneficiaries pay premiums, typically on a monthly basis, to their former employers or to a third-party that handles COBRA administration for employers to continue health care coverage they previously had. The coverage continuation for former employees is generally limited to 18 months.

Under the proposed subsidy, eligible workers would pay their 32% share of the COBRA premium to the employer or plan administrator. But the 70% share subsidized by the government, which the legislation describes as a "trade adjustment assistance health insurance credit," would be handled in a different—and, as yet, not clearly defined—manner.

While other COBRA beneficiaries must pay COBRA premiums as they come due, the trade assistance measure calls for displaced workers to receive an "advance credit" for the 70% share of the premium assumed by the government.

Essentially, that would mean displaced employees would pay only their 32% share of the COBRA premium and employers would have to seek reimbursement from the government for the remaining 70% they front.

The COBRA provisions—which were proposed by Senate Finance Committee Chairman Max Baucus, D-Mont.; and Charles Grassley, R-Iowa, the committee's ranking minority member—would leave it to the secretary of the Treasury Department to develop rules for government reimbursement of COBRA premiums to employers.

But the legislation does not set any deadline for the development of those rules, even though the COBRA health insurance credit provisions would go into effect as soon as the measure is enacted. The result, say benefit experts, would be confusion and uncertainty for employers.

"To begin this on the date of enactment is certainty a recipe for confusion," said Frank McArdle, a consultant with Hewitt Associates L.L.C. in Washington.

"The mechanics are not clear. That is why an immediate effective date is not workable," said Paul Dennett, vp-health policy with the American Benefits Council, a Washington-based benefits lobbying group.

In short, "Congress has bucked the administrative doability to the Treasury Department," said Mark Ugoretz, president of the ERISA Industry Committee, another benefits lobbying group in Washington.

Some benefit consultants say one approach that could be proposed would involve employers offsetting the federal income and Social Security payroll taxes they withhold from employees and forward to the government by the amount of any COBRA subsidies the government would owe. Consultants say there was discussion among congressional staffers of such an approach when Congress considered legislation last year that would have provided government COBRA subsidies for employees who were laid off after the Sept. 11 attacks. That legislation, though, was never passed.

Although the reimbursement mechanism is not spelled out, the current trade legislation does set forth employers' administrative responsibilities, which would be significant.

Under the law, employers would have to file reports with the federal government providing the name, address and Social Security number of each eligible COBRA participant, as well as the aggregate amount of COBRA advance credit provided to the participant.

In addition, the employer would each year have to provide an individualized statement to each laid-off employee detailing the amount of the advance credit provided to that employee.

"There is a lot of informational reporting required," said Andy Anderson, a consultant with Hewitt Associates in Lincolnshire, Ill.

In addition to creating more administrative work, the COBRA mandate likely would increase affected employers' own COBRA costs, benefit experts say.

Today, COBRA beneficiaries incur about $1.50 in claims for every $1 in premiums collected by the employer. That is because most of the people who opt for the expensive COBRA coverage are individuals who expect to make heavy use of health care services, consultants note.

If government were to pay 70% of the premium, this adverse selection likely would be reduced, though not eliminated, because more people likely would regard COBRA premiums as affordable, said Joe Martingale, national leader for health care strategy at Watson Wyatt Worldwide in New York.

"The cost still would outstrip premiums. It would be a painful hit to companies' bottom lines," Mr. Anderson said.

And those COBRA-related costs would be absorbed by employers that already are suffering economically because of foreign competition—the very companies the measure is intended to help.

"Talk about a group that can't afford extra costs," said Paul Sullivan, an assistant vp with Aon Consulting in Newburyport, Mass.

To be sure, the fate of the COBRA provision has not been settled. Once the Senate passes the trade bill, which could happen this week, its version of the legislation will have to be reconciled with a measure the House passed last year. The House bill lacks a comparable health care assistance provision.

While no one knows for certain if the COBRA provision will remain intact, bipartisan support in the Senate for the health care assistance package increases the likelihood some version will survive, said Leslie Kramerich, an attorney at Mercer Human Resource Consulting in Washington.

If the provision does survive, its odyssey would roughly parallel the original COBRA statute. Congress in 1985 attached a free-standing health care continuation bill to a broad budget measure that gives the health care continuation mandate its name. The health care provisions never were debated and the effective date, for most employers, was just a few months after passage in 1986.

It took the Treasury Department 13 years after passage of COBRA to publish final regulations. That delay in working out the rules for the coverage program is a key reason for employers' concern about the current proposal.

Changes in COBRA

1986: Landmark COBRA statute enacted to allow former employees and dependents to continue group coverage. Former employees can buy COBRA coverage for up to 18 months after they lose group coverage. Surviving or divorced spouses can obtain coverage for 36 months. Premium is set at 102% of the group rate.

1989: Disabled former employees given the right to buy extra 11 months of COBRA coverage by paying a premium equal to 150% of the group rate.

1989: Employees with pre-existing conditions allowed to retain COBRA coverage even after they become covered under a new employer's health plan.

1990: States allowed to pay COBRA premiums on behalf of low-income workers and dependents eligible for Medicaid.

1994: Employees in reserves called up for active military duty permitted to buy COBRA-like coverage from their employers.

2002: Congress considering new federal COBRA premium subsidies for employees who lose jobs due to foreign competition.

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

Zurich taps Schiro as its next CEO

James Schiro has been named chief executive officer of Zurich Financial Services Group, replacing Rolf Hueppi, who is stepping down. Mr. Schiro, who is chief operating officer-finance of Zurich, Switzerland-based ZFS, will assume the CEO post on May 17. ZFS announced last month that Mr. Hueppi would leave his posts as CEO and chairman by mid-2002. Mr. Schiro joined ZFS in March 2002. Prior to that, he was CEO of PricewaterhouseCoopers L.L.P.

Mr. Schiro

St. Paul forms large-risk property unit

The St. Paul Cos. Inc. has created an underwriting operation to target large national and regional U.S. property risks. Property Solutions will focus on risks in the real estate, office, retail, hotel, hospital and light-manufacturing sectors, the St. Paul, Minn.-based insurer said. The operation will be led by Senior Vp Kevin Nish, who will report to Marita Zuraitis, St. Paul's executive vp-commercial lines. In a statement, Ms. Zuraitis said, "We see an opportunity for The St. Paul to provide needed capacity to the property marketplace, and we will leverage our existing underwriting expertise to meet the need."

Oklahoma court takes broad reading of exclusion

Rejecting the policyholder argument that the absolute pollution exclusion bars general liability coverage only in environmental contamination cases, the Oklahoma Supreme Court has ruled the exclusion unambiguously applies any time a pollutant causes a loss. The April 30 decision was the state high court's first on the breadth of the absolute pollution exclusion. "An insured cannot insist upon a strained construction of relevant policy language in order to claim a patent ambiguity exists nor can it contradict the written instrument's plain terms under the guise of a latent ambiguity," the decision states.

Berkshire reinsurance units post losses

The reinsurance operations of Berkshire Hathaway Inc. reported underwriting losses for the first quarter of 2002, though both saw improvements compared with last year's first quarter. Berkshire unit General Re Corp. saw an underwriting loss of $88 million for the first quarter, compared with a $133 million loss a year earlier. Premiums for the quarter were $1.97 billion, down 1.5%. The company's other large reinsurance operation, Berkshire Hathaway Reinsurance Group, recorded an underwriting loss of $8 million for the quarter, compared with a $78 million loss for the first quarter of 2001. BHRG posted premiums of $755 million, up from $160 million a year earlier.

ISO acquires Applied Insurance Research

Insurance Services Office Inc. has acquired catastrophe modeling company Applied Insurance Research in a bid to help property/casualty insurers better assess the impact of large-scale disasters. In the wake of the Sept. 11 terrorist attacks, insurers have a greater need for tools to model catastrophes that affect multiple lines of business, ISO President and Chief Executive Officer Frank J. Coyne said in a statement. AIR will operate as an independent subsidiary of ISO, and AIR founder Karen Clark will continue as the company's president and CEO. Terms of the deal were not disclosed.

Ms. Clark

Colorado regulators face expiration of authority

Colorado's Division of Insurance plans to conduct business as usual this year, even though its statutory authority officially expires July 1. Like all Colorado state agencies, the insurance division undergoes periodic sunset review by state lawmakers, a division spokeswoman explained. This year, however, the Legislature failed to finalize legislation for the division's continuance, she said. Under Colorado law, however, the Division of Insurance can continue operating with no limitation of powers for one year, during a so-called "wind-up period," the spokeswoman explained.

Rising medical costs curb Magellan profits

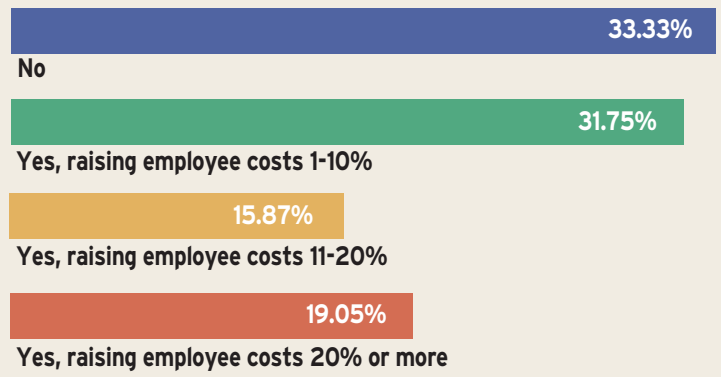
Rising health care costs helped dampen Magellan Health Services Inc.'s profits for the first half of its fiscal year. The Columbia, Md.-based managed care company reported net income of $16 million for the six months that ended March 31, down 13%. Magellan's second-quarter income for the fiscal year fell 43.8% to $6.3 million. Mark S. Demilio, chief financial officer, said the cost of health care at Magellan "is approximately 6% to 8% above last year's level, and we expect this trend to continue for the foreseeable future."

Briefly noted

Denver-based **Pinnacol Assurance**, the Colorado workers compensation insurance fund, would be converted into a modified mutual insurance company under legislation passed last week by the Colorado Legislature. The measure, H.B. 1135, requires that the state treasurer retain supervision over investments and prohibits Pinnacol from doing business outside Colorado or writing any type of insurance other than workers compensation....Boston-based insurance broker **William Gallagher Associates** has named Patrick Veale president. Mr. Veale, formerly a principal of the company, has been with WGA since 1994. He succeeds Philip J. Edmundson, who will remain with the broker as chief executive officer....New York-based **Odyssey Re Holdings Corp.** reported first-quarter net income of $56.3 million, an increase of nearly 200% from the same period a year earlier. Odyssey Re attributed the large increase in profits to a change in accounting practices. OdysseyRe's gross premiums written totaled $403.8 million during the quarter, a 60.4% increase over the year-earlier period.

Online Poll [5/13 - 5/17]

Will your organization be increasing the amount of health insurance premium that employees pay?



Take part in our weekly poll at *www.businessinsurance.com*

Endurance: Startup growing

Continued from page 1

earned premium reserves as of April 1, 2002.

LaSalle Re's business will be added to the $250 million in gross premiums that Endurance has written since it set up in December, said Kenneth J. LeStrange, president and chief executive officer of Endurance Specialty. In addition to the property catastrophe business, Endurance has taken on several property risk excess contracts written by LaSalle Re, Mr. LeStrange said.

Endurance was formed by Chicago-based Aon Corp. and Zurich, Switzerland-based Zurich Financial Services Group.

Many of the reinsurers that formed in Bermuda late last year to take advantage of rising reinsurance prices in the wake of Sept. 11 were disappointed in the amount of property catastrophe reinsurance business they wrote at Jan. 1 renewals, said Donald Watson, a director at Standard & Poor's Corp. in New York. The existing property cat reinsurers had sufficient capacity to meet the demand of most insurers, he noted.

But the LaSalle Re deal "gives Endurance first dibs on LaSalle's business, so they will become a major player immediately," Mr. Watson said.

Under terms of the deal, Endurance will purchase LaSalle Re's business through a 100% quota-share reinsurance arrangement effective April 1, 2002. Endurance will pay Trenwick a 25% ceding commission on the business and additional profit-sharing of 50% if losses do not exceed a 45% loss ratio. Endurance will have the right to offer renewals to LaSalle Re's cedents and will pay Trenwick a 12.5% commission on the business renewed for the first renewal only.

Twenty LaSalle Re employees, which is most of its workforce, will go to Endurance, taking Endurance's total staff to 63. But LaSalle Re's senior executives, including LaSalle Re CEO Guy D. Hengesbaugh, will not join Endurance. He will remain with Trenwick, though the company would not comment on his new role.

Trenwick structured the deal as a reinsurance contract to ensure that it could be completed quickly. Additional regulatory approvals would have been necessary had it sold the business outright, James F. Billett, chairman, president and CEO of Trenwick, said in a conference call with analysts.

Trenwick will use part of LaSalle Re's $364 million in capital to repay $195 million in debt. It will then be able to use the remaining capital to support its operations in the United States and London, he said. As a group, Trenwick has about $1 billion in capital.

The deal also removes a volatile book of business from Trenwick, Mr. Billett said.

"The events of Sept. 11 were unprecedented in terms of both losses and correlation. The magnitude of damaged caused us and many others in our industry to reassess our evaluation of risk and capacity for volatility," he said.

BI Stock Index [5/13 - 5/17]

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

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

BI Stock Index	Dow Jones	S&P 500
2181.50	10,353.08	1106.59

Largest gains

PacifiCare Health Systems	16.20%
Argonaut Group	14.62%
Clark Bardes Holdings	12.88%
Willis Group Holdings	8.98%
Unico American Corp.	8.86%

Largest losses

Baldwin & Lyons Inc.	-11.87%
Seibels Bruce Group	-11.32%
Selective Insurance Group	-4.90%
EMC Insurance Group	-4.74%
Sierra Health Services	-3.78%

Weekly change by market segment

Brokers	5.18%
Insurers/Reinsurers	1.60%
Managed Care Organizations	1.29%

Source: CNET Investor (investor.cnet.com)

DO YOU MAKE HEADLINES OR DO YOU READ THEM?

Invent a cure. Create a new business model. Try something different. If you like to push the boundaries, there's AIG. The organization with more ways to manage risk and more financial solutions than anyone else. Everything from environmental insurance to risk management services to financial protection for high net worth individuals, to name a few. So if you want to see your bold idea in bold headlines, contact AIG.

THE GREATEST RISK IS NOT TAKING ONE.℠

AIG **INSURANCE, FINANCIAL SERVICES AND THE FREEDOM TO DARE.**

Insurance and services provided by members of American International Group, Inc., 70 Pine Street, Dept. A, New York, NY 10270. www.aig.com