Risk manager compensation rising, survey finds / 3

Groundbreaking retiree health plan uses VEBA to fund coverage / 3

May 30, 2005

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AIG UNDER PRESSURE

DOWNTOWN SHOWDOWN

Spitzer charges AIG, Greenberg with fraud

By JUDY GREENWALD

NEW YORK—In the culmination of a months-long investigation, American International Group Inc., the insurer's former chairman and another former official are charged with orchestrating numerous fraudulent transactions to manipulate the insurer's financial results, in a civil lawsuit filed last week by New York Attorney General Eliot Spitzer and New York State Insurance Superintendent Howard Mills.

"The irony of this case is that AIG was a well-run and profitable company that didn't need to cheat," Mr. Spitzer said in a statement. "And yet, the former top management routinely and persistently resorted to deception and fraud in an apparent effort to improve the company's financial results."

The suit, which seeks unspecified punitive damages, was filed in State Supreme Court in Manhattan and names AIG, its former Chairman and Chief Executive Officer Maurice R. Greenberg and its former Chief Financial Officer Howard I. Smith as defendants.

Many observers expect AIG to eventually reach a settlement of the suit and put the matter behind it.

See AIG / page 28

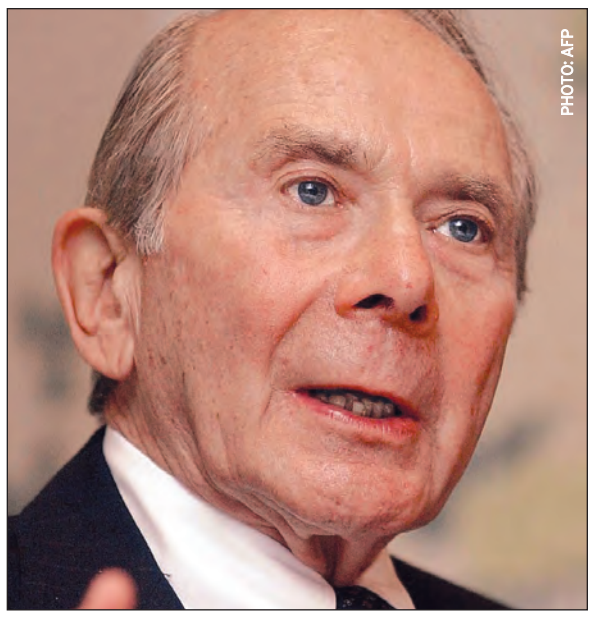
PHOTO: AFP

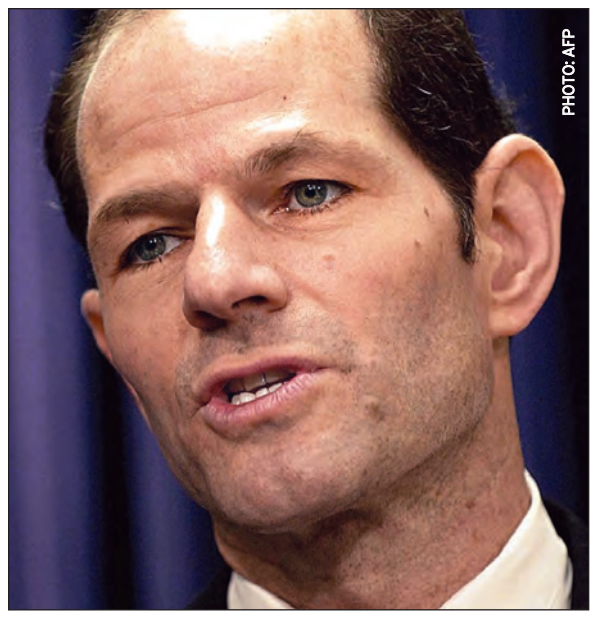
PHOTO: AFP

AIG's former Chairman and CEO Maurice R. Greenberg, left, is a defendant in a fraud suit filed by Eliot Spitzer.

INSIDE

Buyers see broad industry impact resulting from charges against AIG

By JOANNE WOJCIK

The fallout from New York Attorney General Eliot Spitzer's lawsuit against American International Group Inc. might not be contained to the insurer and its management, industry observers say.

Risk managers and other insurers could also see significant changes, as the insurance community struggles to come to terms with yet another scandal.

Increased due diligence by buyers, restrictions on the types of coverage offered by insurers and increased regulatory scrutiny could all result from the lawsuit filed last week by Mr. Spitzer and New York Superintendent of Insurance Howard Mills, they say.

The suit, which alleges fraud in connection with several transactions involving offshore facilities and finite reinsurance (see related story), might discourage the use of such alternative risk financing vehicles even when they are used appropriately.

The litigation also is likely to spur risk managers to exercise greater due diligence to ensure that all future insurance transactions are made more transparent and easier to understand by those outside of the industry, they say.

There might be "ripple effects" throughout the industry that could affect how risk managers structure some risk financing deals, said Richard S. Betterley, president of Betterley Risk Consultants Inc. in Sterling, Mass.

Insurers, brokers and risk managers are "all in this big community. We know what's generally acceptable and what's generally questionable. But the thing that's always difficult is, what's the CFO going to think?" Mr.

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Late News

Senate panel passes asbestos fund bill

The U.S. Senate's Judiciary Committee last week passed the Fairness in Asbestos Injury Resolution Act. The act would create a $140 billion no-fault trust fund to replace the current litigation-based system for compensating victims of asbestos-related diseases. Defendant companies, their insurers and existing asbestos bankruptcy trust funds would pay for the new fund. The FAIR Act now goes to the full Senate, where it faces continued opposition, as demonstrated by the fact that three of the 13 senators who voted for the bill in committee said during the markup that they would vote against it on the Senate floor unless it were changed significantly.

Marsh mulling options for wholesaler Crump

Marsh Inc. has retained Banc of America Securities L.L.C. to explore "strategic alternatives" for its wholesale brokerage units, Dallas-based Crump Group Inc. and London-based Price Forbes Ltd. A Marsh spokesman declined to elaborate on the move other than to say the broker has stated recently that it is looking for ways to improve shareholder value. Willis Group Holdings Ltd. in February sold its New York-based wholesaler, Stewart Smith Group, to Charlotte, N.C.-based American Wholesale Insurance Group. Soon after, Aon said it was exploring alternatives to its ownership of New York-based Swett & Crawford Group, the world's largest wholesaler.

Representatives seek drug reimportation vote

A large group of lawmakers in the U.S. House of Representatives last week asked for a vote on a bill that would allow prescription drugs to

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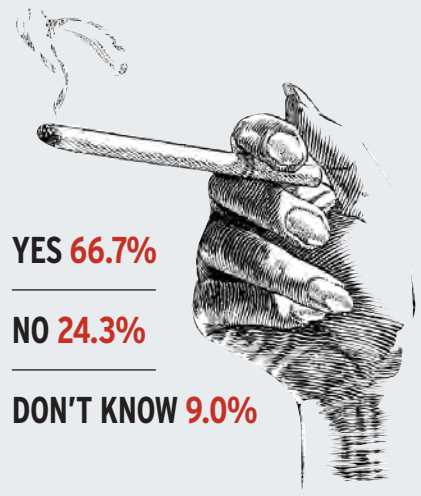
NEWSPAPER

Inside

Online poll - [5/23 - 5/27]

Should states levy higher charges for health insurance on employees who smoke?



YES 66.7%

NO 24.3%

DON'T KNOW 9.0%

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Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Colleges try VEBAs for health

Design for prefunding retiree benefits called groundbreaking

By JERRY GEISEL

A pioneering program is enabling some colleges and universities to offer retiree health care plans for the first time, while making coverage more affordable for those that already do so.

The program, which bucks the national trend of employers terminating coverage (see graphic, page 30), offers what participants and outside experts say is a first-of-its kind approach in the design and prefunding of retiree health care plans for the academic community.

"This is a groundbreaking and creative program," said James Foreman, senior vp of national accounts at Hartford, Conn.-based Aetna Inc., which is providing several health care plans that will be available to retirees.

How it works

Under the program, participating schools—currently 29 in number—will make contributions to tax-exempt trusts, known as voluntary employees' beneficiary associations, or VEBAs. Each school will decide its contribution based on the level of financial support it wants to provide.

> In an unusual, if not unprecedented, design, employees will direct the investment of both their own and their employers' VEBA contributions into a set of mutual funds.

Employees also will contribute on an after-tax basis to separate VEBAs. In an unusual, if not unprecedented, design, employees will direct the investment of both their own and their employers' VEBA contributions into a set of mutual funds offered by Fidelity Investments. Typically, employees in VEBA arrangements do not direct employer contributions. Mutual funds available include a money market fund and so-called "lifecycle" funds, in which the investment mix becomes more conservative as employees approach retirement.

Those contributions and the investment income will earn tax-free interest. When employees retire and are eligible for Medicare, they can withdraw funds tax-free to pay premiums for one of three health care plans—including one that will offer only prescription drug coverage—provided by Aetna. Retirees also can take out funds to pay for other uncovered health care expenses, such as claims that fall under a deductible, as well as Medicare Part B and Part D premiums.

Employees who have met their academic institution's retirement eligibility require-

See VEBA / page 30

West Virginia levels antitrust charges against Acordia

By SALLY ROBERTS

Fallout from the investigations into brokerage practices continues, with one of the world's largest brokers facing a new state lawsuit and another announcing management changes stemming from the probes.

West Virginia Attorney General Darrell V. McGraw Jr. recently filed a lawsuit against Acordia Inc., alleging that the Chicago-based middle-market brokerage and its Acordia of West Virginia Inc. subsidiary earlier this month violated state antitrust and consumer protection laws by accepting contingent commissions from insurers for steering business their way.

Meanwhile, brokerage Hilb Rogal & Hobbs Co. last week said that its president and chief operating officer had resigned after questionable payments involving its Hartford, Conn., office came to light during authorities' examination of the company (see story, page 30).

The West Virginia action against Acordia, filed May 19 in the state Circuit Court of Hancock County, comes in the wake of settlements by the world's four largest brokerages with authorities in various states over similar compensation practices. Only Marsh & McLennan Cos. Inc. and Aon Corp. were sued, though. Willis Group Holdings Ltd. and Arthur J. Gallagher & Co. reached agreements with state authorities to settle concerns, with no civil actions taken.

Acordia keeping contingent pay

While all of the settlements call for the elimination of contingent commissions, MMC, Aon, Willis and Gallagher voluntarily announced they would cease collecting the commissions last year, following New York Attorney General Eliot Spitzer's blockbuster suit against MMC.

Acordia, whose parent company, Wells Fargo & Co., is the world's fifth-largest brokerage, continues to collect the commissions, but if Mr. McGraw has his way, the practice will end soon.

"The world's largest insurance brokers have already sworn off secret payments. I expect Acordia to be next," Mr. McGraw said in a statement announcing

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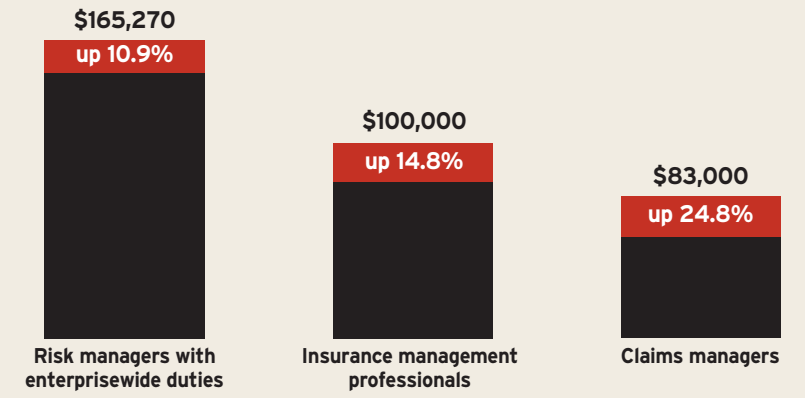
Average pay rises for risk management jobs



Source: RIMS/Mercer

Risk managers see pay increases in 2005, RIMS survey reveals

By MICHAEL BRADFORD

Risk management professionals are taking home bigger paychecks this year, a survey reveals.

The "2005 RIMS/Mercer Risk Management Compensation Survey," which polled around 600 U.S. and Canadian organizations, shows that salaries for most risk management positions rose by between 10% and 25% on average.

The survey, conducted by the Risk & Insurance Management Society Inc. and Mercer Human Resource Consulting, provides figures on base pay, cash compensation and bonuses for 12 positions, including risk managers, risk analysts, employee benefits managers, claims managers and safety managers.

Claims managers saw some of the biggest salary increases, with average compensation jumping 24.8% to $83,000 in 2005. Insurance management professionals also are doing well, with compensation rising 14.8% to $100,000, according to the survey.

Risk managers with enterprisewide responsibilities, meanwhile, saw an average compensation gain of 10.9% to $165,270.

Only administrative assistants bucked the trend, with pay for those positions remaining flat.

The survey results were not surprising, said Joyce Cain, with Mercer's data information group in Louisville, Ky.

"We would have expected to see salaries going up" after years in which increases were harder to come by, she said. "Companies were predicting that this would be the year that salaries would go up in advance of the cost of living."

The survey results may be skewed, though, by an increase in the number of respondents from large companies, Ms. Cain said.

"You expect to see large companies

See PAY / page 30

Market softening doesn't hit P/C insurer results

Rate hikes, low catastrophe losses contribute to 8.8% profit increase

By JUDY GREENWALD

Bolstered by the impact of past rate hikes and helped by low catastrophe losses, commercial property/casualty insurers are continuing to report strong results despite the softening market.

The good results are expected to continue at least through this year, with the softening trends not likely to become apparent in earnings until 2006, say observers.

This year "should continue to produce strong underwriting returns that are at least flat with last year," said Peter C. Streit, an analyst with Williams Capital Group in New York. "In 2006, we would expect to begin to see some deterioration in underwriting results as a result of the pricing pressures that we're seeing today."

The 13 major P/C insurers surveyed by *Business Insurance* posted an 8.8% increase in net income, to $2.98 billion.

Results do not include American International Group Inc., which has said it will restate its financial results for several periods by May 31 because of improper accounting for certain transactions. AIG also has not yet provided a schedule for the release of its first-quarter 2005 results.

Among the survey findings for the 13 remaining insurers:

- The insurers reported an aggregate weighted combined ratio of 92.8% for the first quarter, vs. 94.2% for the comparable period a year ago.
- Net premiums written increased 8.6%, to $23 billion.
- Policyholder surplus for the 12 insurers that report this data increased 7.1%, to $54 billion.

"I think a lot of the results came in better than expected," said Mr. Streit. "The results were driven by favorable frequency trends, by low levels of catastrophe losses and continued strong underwriting profitability."

"Very nice, favorable weather, plus reasonable discipline in a softening market led to some pretty good underwriting results for just about every company in the sector," said J. Paul Newsome, vp and senior equity analyst with A.G. Edwards & Sons Inc. in St. Louis.

"It was definitely a very strong quarter for the industry," said John Iten, a director at Standard & Poors Corp. in New York. Most of the combined ratios of the companies studied by S&P were in the range of 88% to 95%, with just a few over 100%, Mr. Iten said. He noted that this represented an improvement over 2004 results.

"Clearly, the industry continued to improve in the first quarter, which is interesting, because the pricing did start to soften last year," Mr. Iten said. "Maybe pricing isn't softening as quickly, or as much, as we and other people feared it might."

The softer pricing is becoming evident, though.

John L. Ward, Cincinnati-based independent insurance analyst, said first-quarter results "were especially strong on the bottom line, but the top line, the premium line, is definitely showing some signs of softening, and I would expect that the growth in premiums for 2005, based on the first quarter, is going to be definitely single-digit territory."

Observers say the downward slope of the P/C cycle so far has been gentle. Michael Lewis, senior insurance analyst with UBS War-

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Execs expect soft market to continue

By JUDY GREENWALD

Insurance buyers can expect a continued soft market at least through the end of next year, according to a group of insurer executives surveyed by American Re-Insurance Co.

But insurers still expect to keep their combined ratios relatively low.

Princeton, N.J.-based American Re surveyed 48 chief executive officers and senior managers of regional and middle-market national insurers who attended its 11th annual CEO Roundtable Forum earlier this month.

The survey also found that a significant portion of executives believe the industry will be substantially changed as a result of the current insurance industry investigation by New York Attorney General Eliot Spitzer and others.

A total of 83% of the respondents to the survey said the soft market will last at least through 2006. Of these, 35% said the soft market will last only through 2006, while 24% said it will last through 2007 and 24% said it will endure beyond 2007.

Despite expectations of a continued soft market, though, 78% of executives from stock companies said they are targeting a combined ratio of below 95% for 2005-2006, while another 22% said they are targeting combined ratios in the range of 95% to 100%.

Among mutual companies, which accounted for 61% of the respondents, 26% said they are targeting a combined ratio of below 95%, while 65% said they are targeting a ratio in the range of 95% to 100%.

"We were a little bit surprised, with the talk of the softening market, that they all see their combined ratios staying relatively low," said Bill Fellows, American Re marketing vp. He said it may reflect the expectation among these insurers that they will not write as much business "but what they do write is at a decent combined ratio."

Jack Snyder, American Re's chief marketing officer, said he was also surprised by the change in the areas in which executives said their companies need to improve. According to the latest survey, the three areas that tied for first place are policy processing, claims processing and management, and marketing. In last year's survey, the top three areas were underwriting capability, planning and—in a tie for third place—strong capital position and policy processing.

See ROUNDTABLE / page 27

Buyers, sellers must cooperate on standards: Hines panelists

By MEG FLETCHER

CHICAGO—In the wake of insurance industry investigations and settlements, buyers and sellers are evaluating traditional marketplace practices to determine how the industry can meet the higher standards of producer compensation disclosure that now are considered essential.

The investigations have "severely impacted the insurance buyers' confidence and trust," said Peggy Rychtarik, the outgoing president of the Chicago Chapter of the Risk & Insurance Management Society Inc. She opened this year's Harold H. Hines Jr. Memorial Symposium, held earlier this month in Chicago. Ms. Rychtarik is vp-risk management for Grubb & Ellis Co., a Northbrook, Ill.-based property management company.

"I think we are at one of the seminal moments where we will see major changes."

Ken A. Crerar
Council of Insurance Agents & Brokers

Panelist Ken A. Crerar, president of the Washington-based Council of Insurance Agents & Brokers, emphasized that all components of the insurance industry need to concentrate on rebuilding trust. "I think we are at one of the seminal moments where we will see major changes," he said. It is first time that buyers, agents and insurers are focusing their attention on the background components of insurance, he said.

Panel participants representing both buyers and sellers predicted that there would be "multiple models" of broker compensation in the marketplace, some of which could include contingent commissions

See HINES / page 10

Tort reform advocates pleased with victories in state legislatures

By MARK A. HOFMANN

WASHINGTON—As many state legislative sessions wind down, tort reform advocates have much with which to be pleased.

They scored victories in some previously unlikely venues such as Missouri, South Carolina and West Virginia. They built upon past victories in states such as Texas. And while efforts continued to focus on such long-term goals as medical malpractice reform and venue reform, a new issue—requiring that claimants in asbestos and silica dust injury cases prove actual impairment before their cases can move forward—proved to be particularly attractive to state lawmakers.

"Each state's business community helped put the legislative reforms over the top by remaining unified and galvanized."

Steven B. Hantler
American Justice Partnership

"This past year in the states has been one of the most successful for businesses and others seeking more balance in the civil litigation system," said David Snyder, vp and assistant general counsel for the American Insurance Assn. in Washington. "That of course, was most obvious with the enactment of the federal legislation, but that has not in any way lessened the need for and the efforts behind state tort reform and modernization," said Mr. Snyder, referring to the Class Action Fairness Act (see story, page 22).

"It's been a very good year when we look at the efforts in Georgia, South Carolina, Missouri and Texas, as well," said Sherman Joyce, president of the American Tort Reform Assn. in Washington. "In Missouri, you had very strong bills that were vetoed, but this year a bill was enacted," he said. Mr. Joyce also pointed to South Carolina, where reform proponents managed to enact significant legislation in "an area that's been a challenge."

"Both the legislative and political victories were achieved with the winning combination of gubernatorial leadership and a unified business community," said Steven B. Hantler, executive director of the recently formed American Justice Partnership.

"Each state's business community helped put the legislative reforms over the top by remaining unified and galvanized," said Mr. Hantler, who is also assistant general counsel of Daimler-Chrysler Corp. in Auburn Hills, Mich. "Instead of fracturing over which reforms would benefit some industries more than others, the business communities joined together for the greater good of the legal reform effort—setting a successful model for other states to follow."

A case in point was South Carolina, where reformers managed to change the state's joint and several liability law to require that a "deep-pocket" defendant would have to be found at least 50% responsible before it could held responsible for the whole award. The state also enacted venue reform and reduced the statute of repose, which was previously 13 years, to eight years.

"What we did was unify the business community. That (was) easier said than done," said Cam Craw-

See TORT REFORM / page 22

Address all sides of D&O protection

By Joe Underwood

Directors and officers liability insurance is exhibiting soft-market trends for many corporate insurance buyers. Some are choosing to apply their premium savings to expanded protection for their directors and officers. At renewal, many public companies are presented with an option for Side A excess D&O insurance. We are often asked: Should I be buying this additional coverage? The answer is never simple, but the following hopefully will provide insight on the question.

Under the standard D&O policy, three coverage grants are provided. Side A provides a direct financial benefit to directors and officers in situations in which the company cannot indemnify (e.g., when hit with shareholder derivative suits in some states or when facing financial distress) or will not indemnify (e.g., when wishing to avoid a negative public reaction or in cases of allegations of conflicts of interest). Side B provides reimbursement to the entity for its indemnification of directors and officers as allowed by corporate bylaws and state statute. Side C provides coverage to the entity for securities claims for public companies.

When D&O coverage initially made a foothold in the 1960s, coverage was available only for Side A and B, which were written as separate contracts.

In the years that followed, competition increased, pricing decreased and coverage terms were broadened. Insurers wrote Side A and B on a single policy with a higher limit of protection.

Claims activity increased significantly in the 1970s and 1980s, and plaintiffs named everyone in their lawsuits. In the era of Side A and B only, insurers allocated defense and settlement costs between an entity's directors and officers, who were covered, and the entity, which was not covered, thereby reducing their claim payment obligations.

Desiring to gain market share in the soft market of the 1990s, insurers began offering preset allocations to reduce policyholder uncertainty. Continued competition led insurers to offer to for-profit companies Side C coverage, which had historically been available only to nonprofits.

Now, bankruptcy courts can freeze the D&O policy to prevent the erosion of protection otherwise available to the bankrupt estate. Therefore, innocent directors and officers could be left high and dry, undermining the very reason D&O insurance was initially purchased. Additionally, insureds must contend with insured vs. insured exclusions, broad application warranties, severability and policy rescission.

Insurers are selling more Side A excess policies to address many concerns about protection for innocent directors and officers. Side A excess coverage is not merely excess protection over standard Side A coverage. It also provides difference-in-conditions coverage with fewer exclusions and more favorable severability language. It often is nonrescindable and is difficult for a bankruptcy court to seize, as it is a separate contract.

> If your corporate risk philosophy heavily favors retention, you might consider buying a Side A policy only, but be careful.

As an example of how Side A excess could be instrumental, consider the following scenario: a securities class action could spawn a derivative action against directors. The class action might exhaust the standard D&O limits, leaving no coverage for the ensuing derivative suit. With a separate Side A excess policy, dedicated protection for the derivative claim would be available.

While a Side A excess D&O policy is a powerful tool, it is not the only answer.

Before considering Side A excess, make sure that your indemnification language is as broad as legally allowed and that you are comfortable with your standard D&O limits. This approach will protect you from the most likely claim scenario, a Side B indemnifiable claim. There are numerous sources available to benchmark your limits against industry peers.

If your corporate risk philosophy heavily favors retention, you might consider buying a Side A policy only, but be careful. While buying insurance only to protect the personal assets of directors and officers may seem like a good idea, the suit may also allege securities violations by the entity, possibly resulting in the unfavorable allocation of settlement and defense costs by your Side A insurer.

Or consider purchasing independent directors liability coverage. Like Side A excess and difference-in-conditions insurance, IDL insurance provides coverage only in excess of the corporate D&O policy and any amounts reimbursed by the company. The essential difference is that IDL is limited to "outside directors"—those board members who are not officers or employees. As outside directorships become more critical under the Sarbanes-Oxley Act, this may be a less costly alternative.

Or have outside board members purchase personal D&O policies. This may be an especially effective option for those outside board members who have directorships on more than one board.

One additional alternative that has not been embraced by the D&O insurance market is the acquisition of two policies—one Side A policy with a dedicated limit for the benefit of directors and officers and another Side B and C policy with a dedicated limit for the entity. The Side A policy would be protected from limit erosion and bankruptcy seizure; the Side B and C policy would typically be free from allocation among individuals and the entity. While it may seem unconventional, this approach is closer to the way D&O coverage was originally structured. Perhaps with time, the D&O market will reconsider the dual policy structure and price it more appropriately.

To the question "Should I buy Side A excess D&O insurance?" the most definitive answer may come from your board. Many board members are being marketed to directly, and you may be asked or required to purchase Side A excess. We recommend that you consider it, but first make sure you address the other facets of D&O protection. As always, seek professional advice in designing your program, reviewing policy language and monitoring marketplace developments.

Joe Underwood is a senior risk management consultant with Albert Risk Management Consultants in Needham, Mass.

Illegal alien eligible for workers comp benefits

Fraud perpetrated by an illegal immigrant in using false papers to obtain employment did not vitiate the immigrant's right to receive workers compensation benefits, according to the Court of Appeals of Georgia.

Juana Sandoval Palacias was injured on the job while working for Continental PET Technologies Inc. Ms. Palacias had been illegally in the United States since 1994 and had worked for and been paid by the employer in a full-time capacity for the five years prior to her accident. Ms. Palacias had originally used fraudulent documents to secure her position as a janitor for the employer. The employer denied her claim for workers compensation coverage for medical expenses and lost wages, but an administrative law judge awarded her benefits. The compensation board and a trial court affirmed this decision. The employer appealed.

On appeal, the employer argued that Ms. Palacias was barred from seeking workers compensation benefits under Georgia law because federal law makes it unlawful to employ an illegal alien and, therefore, any employment contract between the employer and Ms. Palacias was void. The appellate court noted that Georgia law defines employees as "every person in the service of another under any contract of hire." This broad definition, the court said, would include illegal aliens. Finally, the court concluded that the federal immigration law did not pre-empt state law for employment purposes relating to workers compensation. The court affirmed the award of benefits to Ms. Palacias.

Continental PET Technologies Inc. vs. Palacias, Court of Appeals of Georgia, Sept. 13, 2004 (BI/01/Ju.-$10)

Legal Briefs

'Going and coming' rule not applicable to accident

The Supreme Court of Kentucky ruled that an employee's injury sustained after he fell asleep at the wheel on the way to work was work-related and thus compensable under the Workers Compensation Act.

Billie Stroud worked primarily as a mechanic or electrician in the mining industry. Warrior Coal Co. L.L.C. hired him in 1998 to work as an electrician at its Cardinal Mine. Mr. Stroud was injured in March 2001 while driving his personal vehicle to work. The accident occurred on a one and one half-mile gravel access road that connected a county road with the parking lot used by mine employees. Both the access road and parking lot were located on property that the employer leased and maintained. Both were used solely by employees. Shortly after passing the gate on his way to report for the third shift, Mr. Stroud fell asleep at the wheel and failed to negotiate a curve. His vehicle went off the road and struck several trees before ending in a ditch. Mr. Stroud alleged a disabling neck injury. He filed for and was awarded compensation benefits. The employer appealed. The Court of Appeals affirmed the award. The employer appealed to the state Supreme Court.

On appeal, the employer argued that Mr. Stroud should be denied benefits under the rule that injuries occurring while going to or coming from work are not compensable. But the appellate court said that an exception to the "going and coming" rule permits compensation if an injury occurs on the employer's "operating premises." The court said that it was apparent that Mr. Stroud was on the employer's private property when he was injured. According to the court, the access road led only to the parking lot and there was no evidence that Mr. Stroud was on a personal mission when the accident occurred. The court said that it was not persuaded that falling asleep at the wheel was a substantial deviation from Mr. Stroud's making his way to the parking lot for the purpose of reporting to work. The court affirmed the award of benefits.

Warrior Coal Co. L.L.C. vs. Stroud, Supreme Court of Kentucky, Dec. 16, 2004 (BI/04/Ju.-$10)

ERISA doesn't bar expansion of group

An employer's expansion of a qualifying group of employees did not violate the Employee Retirement Income Security Act prohibition against conduct that interferes with the attainment of ERISA rights as to the remaining employees, according to the 6th U.S. Circuit Court of Appeals.

This action arose out of the June 30, 2000, closure of Phillip Morris Inc.'s Louisville, Ky., plant. The closure forced some employees, members of the union, to be laid off. Following their layoffs, the employees sued Phillip Morris and others, alleging, among other charges, violation of ERISA. The basis of their complaint was that the employer failed to offer them retirement benefits that were offered to other company employees. The trial court ruled against the employees. They appealed.

On appeal, the court said that for the employees to succeed on their ERISA claim, they must show that the employer engaged in prohibited conduct for the purpose of interfering with the attainment of a right to which the employee may become entitled. The employees argued that the employer's decision to expand the sphere of employees entitled to enhanced benefits to certain employees but not to them was motivated by a desire to avoid pension liability. The court disagreed, stating that the employer was not obligated to expand its benefits to any group of employees. "The fact that it chose to do so with respect to a group of employees with a certain level of seniority certainly does not indicate a desire to avoid pension liability as to employees who had not attained such seniority," the court said. The trial court decision was affirmed.

Baize vs. Phillip Morris Inc., 6th U.S. Circuit Court of Appeals, Dec. 17, 2004 (BI/02/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. Please provide the listed number for each opinion ordered.

Editorial

Retiree plan should be available to all

FOR AT LEAST the last decade, just about every story about retiree health care plans has cited the continuing erosion of the plans, as more employers eliminated their programs.

Therefore, it really is news when employers say they are for the first time offering retiree plans. As we report on page 3, colleges and universities across the country are joining a new program, Emeriti Retirement Health Solutions, that will let many offer plans for the first time and enable others already doing so to provide more affordable coverage.

What stands out about this program is its creativity. Participating employers and employees will contribute to special tax-exempt trusts known as voluntary employees' beneficiary associations. Employees will direct those contributions in a range of mutual funds.

The investments earn tax-free interest and then are withdrawn—also tax-free—when employees retire. Distributions can be used to pay premiums for Aetna Inc.-provided Medicare supplemental policies, as well as for out-of-pocket health expenses.

Contrast this with old-style retiree plans. Those plans are not prefunded, meaning there is no specific financial security behind the promise. And unless the employer has limited its contribution, it has few ways to control its liability. No wonder that employer-provided plans have fallen by the wayside.

When employers walk away from those plans, they may think they've shed an enormous obligation. In a sense they have, but that approach can create new problems. If employees lack retiree coverage, some are certain to work longer. That is fine to a point, but it means these older employees still will be covered—at an ever-higher cost—in the employer's health plan for active employees.

What the Emeriti program does is take the needed middle ground between the extremes of no coverage and traditional coverage that is becoming less and less affordable.

Regrettably, because of shortsighted federal legislation, many private employers cannot, in a tax-effective way, adopt programs similar to Emeriti. As employer-provided retiree coverage dwindles, we hope Congress reverses those laws blocking prefunding, to ensure greater health care security for retirees.

House again takes lead in meaningful tort reform

THE HOUSE JUDICIARY Committee has taken a significant step toward meaningful tort reform with its approval last week of the Lawsuit Abuse Reduction Act.

By voting in favor of the bill, which would require mandatory sanctions on attorneys who bring frivolous lawsuits and which would curb the abusive practice of so-called "forum shopping," the committee set out on a path that is already well trodden.

After all, the full House gave its blessing to an earlier version of LARA less than a year ago. But that bill, like all too many other previous tort reform bills, failed to make it through the Senate.

That's too bad, too, for LARA has much to recommend it. Businesses have long complained that they have been the targets of frivolous litigation that often seems crafted more to win a pretrial settlement than to right a true wrong. Mandatory sanctions for lawyers who bring such actions would certainly help remedy that.

Businesses have also complained, with some justification, of having to defend themselves in jurisdictions that are known as being so friendly to individual plaintiffs that a corporate defendant can't get a fair hearing. LARA would go a long way toward correcting the problem of forum shopping by making sure suits are filed in appropriate venues.

LARA has much to recommend it, just as it had much to recommend it in its previous incarnation. The House Judiciary Committee's action has started a journey down a familiar path. We hope that that journey will be completed this time around without encountering any obstacles in the Senate.

Schillerstrom

Letters

Pension Benefit Guaranty Corp. not run like a real insurer

To the editor: I am amazed that in all of the articles regarding the United Airlines pension default, little script is given to the fact that its management and employees helped dig the pension hole in which they find themselves, due to the magnitude of the pensions negotiated and granted over the years.

Certainly, a company can provide any of a number of benefits to its employees and incur the requisite cost.

What is troubling about the current Pension Benefit Guaranty Corp. framework of pension "insurance" is that it is not run like insurance at all.

Where are the underwriting criteria that every company that buys any type of insurance must face? If a company has granted over-the-top benefits, then why is it not charged a higher PBGC premium, thereby paying the requisite cost?

The last time I checked, many companies are granted lower fire insurance premiums if they meet highly protected risk criteria, thereby reaping the benefit of their prudent actions.

As long as the government continues to run the Pension Benefit Guaranty Corp. as a one size fits all, all employers will end up paying the bill for companies that have given away the pension store.

Wayne P. Neeley
Ogden, Utah

Write Us

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AUDIT BUREAU OF CIRCULATIONS ABM

Hines: Industry must regain buyers' trust in wake of scandals

Continued from page 4

from insurers. But there was a lack of consensus about other potential marketplace developments.

The process of rebuilding trust will require that risk managers be more active in seeking efficient solutions to their insurance needs, said R. David Turner, senior vp of Chicago-based Equity Office Properties Trust, which owns commercial office buildings throughout the United States.

Among "the positive changes" he described were some brokers eliminating the "tying" of transactions and brokers establishing compliance committees.

Mr. Turner, however, had mixed views about contingent commissions. While he spoke favorably about some large brokers' refusing contingent commissions from insurers, he added that there may be a role for such commissions in transactions with "middle-market brokers." Buyers, though, may pay higher commissions depending upon how such deals are crafted, Mr. Turner added.

Panelists differed, however, in their perception of the dimensions of the problem—which began with investigations into brokerage compensation issues and then expanded into an inquiry about reinsurance accounting issues—and the resulting need for change.

"At some point, I hope the law will catch up with the headlines," and prosecutors will limit their focus to persons who have broken laws.

Ernie Csiszar
Property Casualty Insurers Assn. of America

Ernie Csiszar, president of the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America, complained about a prosecutor—New York Attorney General Eliot Spitzer—who "acts like judge and jury" and seeks career-enhancing publicity. "At some point, I hope the law will catch up with the headlines," and prosecutors will limit their focus to persons who have broken laws, Mr. Csiszar said. He also complained about the industry's lack of "a public voice" to refute allegations.

Mr. Crerar summarized the problem as "a few bad apples" who should be punished.

Bolstering his view, he said, were CIAB polls of chief financial and chief executive officers conducted in December 2004. Those polled generally trusted their brokers, but wanted greater disclosure about compensation issues, which he said were "pretty surprising results."

In terms of deciding how much disclosure is necessary, "the buyer will be in the driver's seat," Mr. Crerar said.

Mr. Csiszar questioned what brokers will be disclosing: "Disclosure of what…free trips?" Insurers and brokers, in the past, have sometimes offered incentive trips to employees.

Mr. Crerar and Mr. Csiszar also squared off on the role of state insurance regulators.

Mr. Crerar recommended that the industry support the model producer disclosure draft developed by the National Assn. of Insurance Commissioners.

Mr. Csiszar—a former NAIC president and director of the South Carolina Insurance Department—called the NAIC "a paper tiger" and emphasized that the push for new broker disclosure laws creates the potential for lawsuits. He said he is more optimistic about ongoing Congressional efforts to achieve uniformity by pre-empting some state laws.

The annual Hines Symposium honors the late Harold H. Hines Jr., who at the time of his death in 1984 served as president and chief executive officer of Rollins Burdick Hunter Co., now part of Aon Corp. The symposium is sponsored by the Chicago RIMS chapter along with the Insurance School of Chicago and *Business Insurance*.

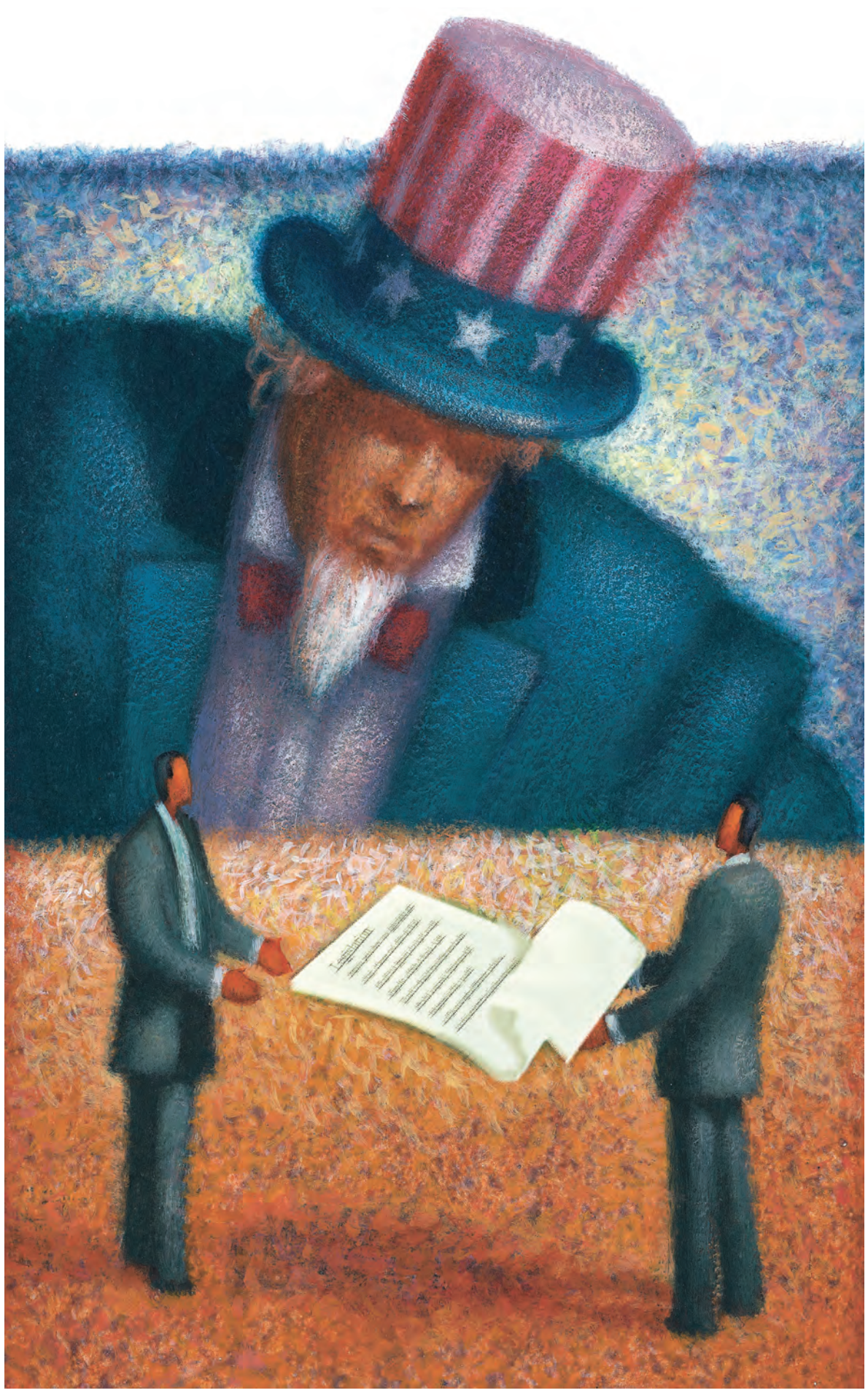
Paul Winston, editorial director of *Business Insurance*, moderated this year's event.

BENEFITS MANAGEMENT

Regulatory & Legislative Developments

Canada's pension regulators aim to harmonize legislation / page 14

Some states using 'name and shame' tactic against employers / page 18



Employers fight states' efforts to shift cost of care

By JOANNE WOJCIK

Strapped by tight budgets and the growing cost of caring for the uninsured, U.S. states are turning to legislation to force employers to help them out.

State governments say taxpayers are unfairly picking up the tab for too many uninsured workers who turn to government programs, such as Medicaid, for health care coverage or simply show up in the emergency rooms of hospitals subsidized by the state.

But employers are fighting back through aggressive lobbying efforts, asserting that the economy will suffer if they are forced to pay for more of their employees' health care at a time when medical inflation remains high.

In Maryland, Gov. Robert L. Ehrlich Jr. vetoed legislation recently that would have required employers to spend at least 8% of their payroll on health care for their workers. The veto took place in a public ceremony attended by executives from Wal-Mart Stores Inc., the employer that would have been the most affected by the legislation.

While observers say it's too early to predict the outcome of pending legislation because many state legislatures are still in session, there is definitely more legislative activity currently seeking to address the issue of the uninsured than there has been in recent years. Various types of measures addressing the issue are on the table in at least 30 states, according to the HR Policy Assn., a Washington-based organization of human resource executives from the nation's largest companies.

"There are literally thousands of bills introduced each year. It is a very intimidating task to try to track all of these. It's difficult to say which will get traction and which will die on the vine," said Jeff Munn, a senior health care consultant with Hewitt Associates Inc. in Falls Church, Va. "But this year is a year where these bills have a level of urgency," Mr. Munn acknowledged.

Although some employers may have felt relief last November when

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State laws may stymie HSA development

By JERRY GEISEL

One of the hottest health insurance plans may no longer be available to small and midsize employers starting next year in close to a dozen states if state legislators do not move quickly to remove a crippling obstacle.

In addition, another state issue—the tax status of employee contributions to health savings accounts linked to high-deductible insurance plans—already is complicating HSA administration for employers and diluting tax breaks for HSA plan participants in just over half a dozen states.

The first obstacle—first identified last year and only slowly being addressed by state legislators—involves the interplay of federal and state law. Under the 2003 federal law that created HSAs, the accounts must be linked to plans with deductibles of at least $1,000 for sin-

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LOOK FOR THE JUNE 20 BENEFITS MANAGEMENT SECTION: Work & Life Benefits

HSAs: States act to remove HSA obstacles, but conflicting rules remain

Continued from previous page

gle coverage and $2,000 for family coverage.

Some benefit expenses, though, such as annual physicals and other preventive services, can be covered on a first-dollar or low-deductible basis.

Soon after the HSA law took effect on Jan. 1, 2004, supporters of the innovative arrangements informed the Treasury Department—the federal agency that has the primary responsibility for developing guidance for HSAs—that some state-mandated benefit laws could prevent insurers from offering the high-deductible plans that must be linked to HSAs. Under those state laws, which vary widely, insurers are required to provide specific benefit coverages in the plans they sell to fully insured customers. In many cases, the benefit mandates specify a level of coverage that is far richer than the $1,000 or $2,000 deductibles.

Perhaps the state benefit mandate that best illustrates the problem is one in New Jersey. That state requires that insurers that offer policies to employers with at least 50 employees provide first-dollar coverage for testing blood lead levels in children, as well as any follow-up treatment. That puts the New Jersey law at odds with the cost-sharing requirements for high-deductible plans linked to HSAs as mandated under federal law.

The problem doesn't apply to employers that self-insure their health care plans, which typically are large organizations. That is because, under the Employee Retirement Security Act, states can impose benefit mandates only on plans offered by commercial insurers and health maintenance organizations and not on self-insured plans.

Aware of this conflict between federal and state law—and the potential to dry up HSA availability to small and midsize employers—insurers and others sought relief from the Treasury Department.

The Treasury Department last year responded to this call for help by waiving—for 2004 and 2005 only—the high-deductible requirements for HSA-linked plans in cases where state benefit mandates clash with the requirements.

At the time that it announced the two-year reprieve, the Treasury Department said it recognized that states lacked sufficient time to modify their mandated benefit laws to accommodate high-deductible plans due to the short time—just a few weeks—between the enactment of the HSA legislation and the measure's effective date. The intent of Treasury's transition relief was to give states time to rewrite their insurance laws to remove the obstacles that could block insurers from offering HSAs.

Some states moved quickly to remove those obstacles. One of the first to act was Kansas. Its legislature last year passed a measure repealing a portion of a law setting coverage requirements for the treatment of mental disorders and alcohol and drug abuse. Under the Kansas law, first-dollar-coverage is required for the first $100 of expenses for the treatment of mental disorders and substance abuse, 80% of the next $100 of expenses and 50% of the next $1,640 of expenses.

"These plans are a huge benefit to employees, and I'm optimistic states will make the needed changes."

Charles Klippel
Aetna Inc.

While that mandate remains in effect for traditionally insured plans, the requirement under the 2004 Kansas law was waived for high-deductible plans linked to HSAs.

Other states also have acted to revamp laws that would effectively block—starting next year—HSA linked plans. Those states include:

- Maryland, which passed legislation, S.B. 521, this year to exempt HSA-linked plans from a state law that bars the application of a deductible for certain home visits by medical professionals to mothers and newborns.
- Texas, which passed legislation, H.B. 1602, exempting HSA-linked plans from a state law requiring first-dollar coverage for the screening of newborns for hearing loss and any needed diagnostic follow-up care.
- North Dakota, which approved a measure, H.B. 1208, exempting HSA-linked plans from a state law requiring, among other things, first-dollar coverage for the first five outpatient visits to a physician or therapist for treatment of substance abuse.

But plenty of state obstacles remain. At least half a dozen states—no one has an exact count—still have laws on their books that in some way could block insurers from offering HSA-linked high-deductible plans next year.

"It is a real problem," said Janice Kupiec, legislative director of state affairs for the National Assn. of Health Underwriters in Arlington, Va.

Insurers say they are devoting much time and effort to educating state legislators of the problem, and they say they hope several more states will revise their state-mandat-

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HSAs: Availability could be limited if states don't act to remove obstacles

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ed benefits by the end of the year to eliminate the HSA conflict.

"We have identified this issue as one of our top priorities, and we are working, along with others, to get this problem fixed," said a spokesman for America's Health Insurance Plans, a Washington-based trade group representing the managed health care plan industry.

"There is a cautious optimism that the problem will be resolved," said Charles Klippel, senior vp and deputy general counsel in Hartford, Conn., for Aetna Inc., a major insurer in the HSA/high-deductible health insurance plan market.

To date, though, the potential that HSAs might not be available in a number of states has not yet chilled the interest of small and midsize employers in the plans, insurers say.

That is largely because employers in that market often do not make their purchasing decisions for the following plan year until late summer or early fall.

But if states do not act soon, small and midsize employers in the affected states likely will put off until 2007 their decisions on whether to add HSA-linked plans, insurers say.

Some experts predict that, while legislative action may not be imminent in some states, they ultimately are going to change their statutes to accommodate HSAs.

"These plans are a huge benefit to employees, and I am optimistic states will make the needed changes," Mr. Klippel said.

Meanwhile, states are grappling with a second HSA-related issue: the taxation of contributions. Under federal law, employees can make tax-free contributions to the accounts. If the HSA is part of a Section 125 flexible plan, employee contributions are made through salary reduction; otherwise, employees would take tax deductions on their federal tax returns for the contributions.

Most states automatically conform their tax laws to mesh with federal law and, as a result, don't have to amend their statutes when federal law is changed.

But close to a dozen states don't automatically conform their laws and, in the absence of conformity, HSA contributions would not receive the same favorable tax treatment in those states as they do under federal law. For example, in the case of an employee HSA contribution made through salary reduction in a nonconforming state, the employee's taxable income would not be reduced to reflect the HSA contribution.

Several states—including Arkansas, Indiana and Iowa—have this year conformed their laws to mesh with federal tax law in the case of HSA contributions. But at least six other states still don't conform.

For multistate employers offering HSAs, this lack of conformity is going to cause "little headaches" because companies have to keep track of the tax status of HSA contributions in the states in which they offer the plans, said Gregg Larson, a principal with Mellon's Human Resources & Investor Solutions in Minneapolis.

Regulators seek to reconcile Canadian pension laws

By GLORIA GONZALEZ

In a perfect world, Canadian pension laws would be uniform across all provinces, making it easy for national employers to manage plans regardless of where their employees live.

In reality, pension laws vary greatly from province to province, creating an administrative nightmare for Canadian employers and unequal benefits for employees.

In an attempt to harmonize Canadian pension legislation, an association of pension regulators has developed a proposal for a model pension law that would simplify regulation of plans, making it easier for employers with employees in multiple provinces to administer their plans.

Most observers, though, are skeptical that the model pension law will ever become a reality because of strong disagreements over its most controversial provisions and because of political difficulties.

In Canada, each province has the right to regulate pensions within its borders, resulting in vast differences in pension legislation. Employers with operations in multiple provinces must comply with the legislative requirements of each province, which is difficult and costly, observers say.

The model pension law proposal, developed by the Toronto-based Canadian Association of Pension Supervisory Authorities, would address these issues by streamlining the regulatory framework for multiprovincial pension plans. "If we eliminate, over time, differences in pension legislation, it makes the administration of the plans simpler and hopefully less costly," said Nurez Jiwani, director, regulatory coordination, for Toronto-based Financial Services Commission of Ontario, which regulates pensions in that province. Mr. Jiwani is chair of the CAPSA Task Force on Common Pension Standards.

A model pension law "will save plan sponsors a lot of headaches, a lot of time, effort and money in managing plans when they have employees in a lot of different provinces," said Scott Perkin, president of the Toronto-based Association of Canadian Pension Management, which represents plan sponsors in Canada.

The principles have been divided into three categories based on the level of consensus each has in the industry (see box). There are several principles that Canadian employers are very much in favor of, the main one being the elimination of partial wind-ups of pension plans. A partial wind-up refers to the termination of part of a pension plan and the distribution of the assets of the pension fund related to that part of the plan. A Supreme Court of Canada decision in the Monsanto pension case last year required distribution of surpluses for partially wound-up pension plans *(BI,* Aug. 9, 2004).

The ACPM supports the elimination of partial wind-ups partly due to an expected increase in litigation arising from the Supreme Court's Monsanto decision. "We're getting court decisions which the industry is sometimes finding hard to live with, like Monsanto," Mr. Perkin said.

The elimination of partial wind-ups "would alleviate a lot of confusion because that would eliminate all the issues of the Monsanto decision," said Mariette Matos, director, tax and legal, for Mellon Human Resources and Investor Solutions in Canada, based in Toronto.

Meanwhile, a principle that specifies that pension benefits be calculated based on the laws of the jurisdiction where a member last accrued benefits has been roundly applauded by employers, because it resolves problems that arise when a plan member has worked in multiple provinces.

However, several aspects of the proposal trouble observers, namely the lack of clarity on surplus issues.

"A clarification on the treatment of surplus, and access to surplus, was badly needed, and the principles didn't provide enough of a clarification," said Paul Purcell, retirement leader for Mercer Human Resource Consulting in Toronto.

The key issue for employers is that the principles did not definitively give plan sponsors control over pension surpluses. In fact, the principles state that in certain situations, plan members are deemed to own surpluses. Calgary, Alberta-based ATCO Group, which sponsors defined benefit and defined contribution pension plans, "does not believe that members should be deemed to own the surplus as a default in any event," the company said in a letter to CAPSA regarding the proposal.

Citing the experience of its employer members in Quebec, the ACPM has also objected to a principle that would require most plans to be administered by a pension committee with at least two representatives designated by plan members. The ACPM said this type of structure creates a disconnect between the responsibility to fund the plan, which is the employer's, and the responsibility and power to invest its assets, which is the administrator's.

Some employers are also concerned about a principle that would require immediate vesting of pension benefits for all plan members upon entering a plan. This would address an issue that results in uneven benefits provided to employees when provinces have different vesting rules. For example, Quebec mandates immediate vesting upon entering a plan, but Ontario does not, meaning Quebec employees have their benefits vest immediately, while employees of the same company in Ontario must endure a waiting period unless the company chooses to have a uniform vesting policy in all provinces. While an employer could always institute uniform immediate vesting, "many will go with the minimum standards," Ms. Matos said.

In its letter, ATCO Group suggested that immediate vesting not be adopted as a minimum standard. "Immediate vesting of pension benefits could significantly increase employer costs, especially for small employers," the company said. "This could contribute to underfunding in defined benefit pension plans as their liability would increase as a result of this provision. Immediate vesting could deter employers from implementing new pension plans."

Ms. Matos noted, though, that employers can simply adjust the eligibility period for pension benefits—usually about two years before the member is eligible to enter the plan—to minimize any costs issues.

In addition, CAPSA says immediate vesting would make partial wind-ups unnecessary. Post-Monsanto, most employers would gladly trade any increased costs related to immediate vesting for the risk mitigation of eliminating partial wind-ups, said David Burke, retirement practice director for Watson Wyatt Canada in Montreal. "More plan sponsors would take that quid pro quo," he said.

CAPSA has decided to take a phased approach toward implementing these principles, Mr. Jiwani said. The organization is creating a task force to examine comments on Category 1 principles and develop a final set of principles for CAPSA approval, which will take about a year, he said. CAPSA will then tackle the Category 2 principles, which will be considered over the next two or three years. Because of the contentious nature of the Category 3 principles, there is no timeframe for approving them.

Once CAPSA completes its work, it will submit the proposals to the provincial legislatures and ask them to adopt the principles. Mr. Jiwani said CAPSA is quite optimistic that the principles will be adopted, citing the fact that recent pension legislation in Manitoba adopted a number of the CAPSA principles, including immediate vesting.

Independent observers, though, are extremely skeptical that the model pension law will ever be adopted. "The game plan here is very unlikely to work," Mr. Purcell said. "It's frankly a pipe dream."

The main obstacle is that the principles would need to be adopted by 10 provincial legislatures, which legal and industry observers say is unlikely because the provinces can be quite territorial about their authority and may be unwilling to adopt any principles at odds with their own legislation. "We still have to find the political will across the country to adopt these model law principles," Mr. Perkin said.

The less contentious Category 1 principles are the most likely to be adopted, and observers are in favor of adopting them even if this neglects some of the most important pension issues, such as the elimination of partial wind-ups, which falls into Category 3.

"Anything that the government can do to simplify the pension environment in Canada is a good thing," Mr. Burke said.

It is unlikely that the more contentious principles will be adopted, observers say. "The expression 'snowball's chance in hell' comes to mind," said Karen DeBortoli, acting director of Watson Wyatt's Canadian Research and Information Center in Toronto.

Principled differences on pension rules

Canada's model pension law proposal covers a broad range of pension issues, from vesting to contribution holidays to surplus withdrawal. The model law contains 46 principles that fall into three main categories.

- The first category, which includes about 70% of the principles, are those on which there was a consensus after a series of written and public consultations regarding the model pension law proposal. For example, one would establish minimum standards for members' pension entitlements upon termination, death or retirement.
- The second category, including about 10% of the principles, consists of proposals that elicited general comments and requests for more details. For example, a principle says an employer could take a contribution holiday in accordance with the terms of the plan and pension legislation.
- The third category, the remaining 20% of the principles, involves proposals that were contentious. For example, a principle based on Quebec law would require most plans to be administered by a pension committee that has at least two representatives designated by plan members.

Source: Nurez Jiwani, Financial Services Commission of Ontario

Uninsured: States turn to legislatures to force businesses to provide health coverage

Continued from page 11

California voters repealed a "play-or-pay" measure that had been enacted by the state Legislature, "the movement to require employers to provide health insurance coverage is by no means dead," according to the HR Policy Assn.

California's landmark legislation—which would have required employers either to directly provide coverage or to pay into a state fund that would have helped insure their workers—still served as a harbinger despite its repeal, according to Laura Tobler, a health policy analyst at the National Council of State Legislatures in Denver. When lawmakers in other states saw California succeed with a bill that could possibly withstand a challenge under the Employee Retirement Income Security Act, they decided to follow suit with similar measures, Ms. Tobler said.

For example, Washington state Sen. Karen Keiser, the Democrat whose Health Care Responsibility Act is still under consideration, said she crafted the measure carefully so that it could survive a possible ERISA challenge (*BI,* Feb. 28). ERISA pre-empts state laws and rules that relate to employee benefit plans.

In an effort to forestall such mandates and other potentially burdensome legislation for employers, the HR Policy Assn. launched its own voluntary initiative, attempting to increase access to health insurance by encouraging employers to offer coverage to part-time, temporary and contract workers on an employee-pay-all basis (*BI,* Jan. 31).

And, in a policy brief published in March, the organization urged its members to take "the offensive" in coming up with private-sector solutions to the problems of the uninsured.

"The plethora of pending legislation—which does not offer workable, long-term solutions to the problem of the uninsured—underscores the importance of employers affirmatively contributing to policy discussions and taking the offensive in developing solutions. Only through the combined effort of employers, government, health insurers and individuals can we begin to resolve this crisis," the policy brief asserts.

> "There are many other ways states are trying to build a positive public-private partnership to increase access" to health care.
>
> **Susan Laudicina**
> **Blue Cross & Blue Shield Assn.**

By the association's count, at least 10 states have looked into some sort of play-or-pay requirement such as the bill that passed in Maryland.

As an alternative to forcing employers to provide health insurance, numerous states have either passed or are considering legislation that would shame employers that don't provide coverage by requiring that any beneficiary or applicant for public aid provide the name of his or her employer and that that information be made public (see related story).

Several other states, such as Vermont, are considering even more sweeping universal health care bills that would replace the current employment-based health insurance system with a single-payer system, financed through taxes and administered by the state.

"The problem of the uninsured continues to grow and continues to get a lot of attention. The other issue is that many states are facing a fiscal crisis. Not only do they have very high health care costs, but their revenues are down because of the lackluster economy. For most states, Medicaid expenditures are the No. 1 expenditure on the state budget, even higher than public education," said Hewitt's Mr. Munn.

"It's one of several initiatives to stretch scarce health care dollars," concurred Susan Laudicina, director of research for the Blue Cross & Blue Shield Assn. in Washington. "States do not want to see private coverage eroded, because that means more people will end up on Medicaid" and the State Children's Health Insurance Program.

While the more controversial bills, such as the employer mandates or single-payer approaches, are capturing the most attention, "there are many other ways states are trying to build a positive public-private partnership to increase access," Ms. Laudicina said. She noted, for example, that legislation is pending in Iowa, Michigan, Oklahoma, South Carolina and Wisconsin that would create health tax incentives for employers and employees to make it easier for them to purchase coverage.

Linda Bergthold, a senior consultant at Watson Wyatt Worldwide in Los Angeles, said the groundswell of legislation seeking to address the uninsured problem is part of a recurring cycle.

> "The only real solution to the uninsured is a comprehensive solution that brings everybody into the game."
>
> **Linda Bergthold**
> **Watson Wyatt Worldwide**

"It's been 12 years since the Clinton plan," Ms. Bergthold said. "And, in the last 12 to 13 years, the number of uninsured has grown. It makes sense to me that every 10 years there's some sort of attempt to solve this problem."

The current interest in reform efforts is also, in part, welcomed by some employers who say that they provide more generous health benefits than their competitors, she said. In particular, some retailers that have collective bargaining agreements that require them to provide coverage for their employees feel that they can not compete effectively with other retailers, such as Bentonville, Ark.-based Wal-Mart.

The discount store's competitors say that Wal-Mart's overheads are lower because it employs a lot of part-time workers who do not participate in the company's health plan.

"Some of these companies that compete with Wal-Mart are beside themselves with frustration," Ms. Bergthold said. "For them, the idea of having a mandate is not so unattractive."

Wal-Mart has stated previously that 86% of its store associates have medical insurance. Wal-Mart says that 55% of its covered employees are in the company's health plan and the remainder are covered through another employer, a family member, the military or Medicare.

The retail giant is getting support from an unlikely source: small business, which historically has opposed mandated health care.

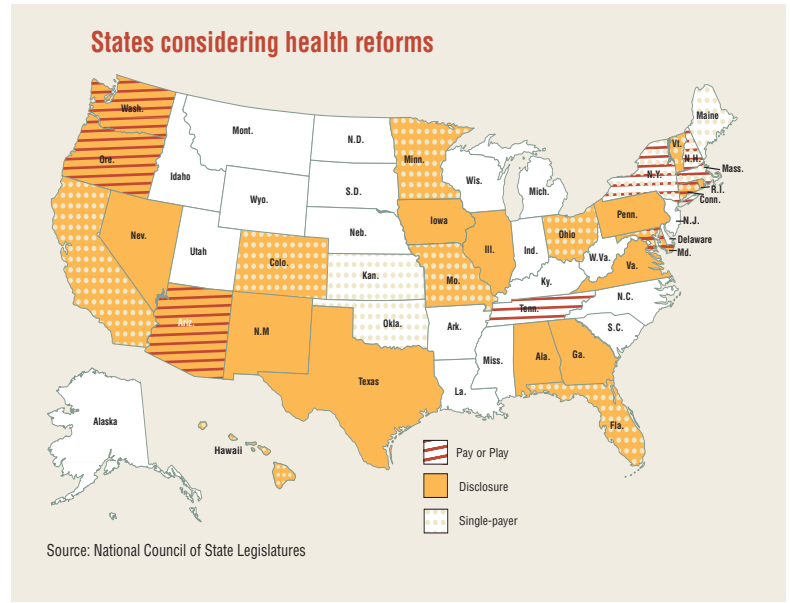
"There are so many of them. They all can write their congressmen. The NFIB has more power than GM in effecting change," Ms. Bergthold said, referring to the Washington-based National Federation of Independent Business, an organization comprised of small-business owners that has come out publicly against legislation requiring employers to provide health benefits.

But "that ideology has to change," Ms. Bergthold said, because "the only real solution to the uninsured is a comprehensive solution that brings everybody into the game. There are only two ways to do that: make it mandatory or be willing to wait 20 or 30 years, because that's how long it's going to take for every marginal, incremental change to take effect."

While Ms. Bergthold predicted that some of the state legislative proposals might become law, she does not expect that any of the measures to become a model for a national solution.

"What works in Massachusetts might work for Massachusetts, and it might spread to neighboring states with similar cultures. But I don't see it happening in Florida, Texas, California, Colorado. In the East, there's a much larger tolerance for universal or regulatory solutions than anywhere in the West or the rest of the country," she said.

Unfortunately, without a national solution, "we're going to end up having regionally based solutions. That's not going to help large national employers," Ms. Bergthold said.



States employ shame as tactic

By JOANNE WOJCIK

Although several states are attempting to force employers through legislation to provide health care coverage for employees, others are trying achieve the same goal by shaming employers.

Laboring under the costs of Medicaid programs, at least one state already has, and many others are considering, laws on the books that require making public the names of companies that have Medicaid-eligible employees.

Massachusetts passed legislation in 2004 that requires employed Medicaid applicants to provide their employer's name, which is then made public by the state.

Twenty-four states are following Massachusetts' lead and have similar legislation pending.

"Medicaid has made a lot of headlines because it's costing the states so much money, and the prediction is that's not going to go away," said Laura Tobler, a health policy analyst at the National Council of State Legislatures in Denver.

Such laws usually don't cost the state or the business community any additional money, she said.

"What you're asking for is data, and data doesn't affect employers' bottom lines," Ms. Tobler said.

However, "the suspected industries," such as restaurant and retail companies, have fought the legislation in several states, Ms. Tobler said.

Massachusetts released its initial report on its program on Feb. 1. The report, which provides a breakdown by name of each employer and the number of employees receiving public health assistance, finds the state's total cost of care for employees and their dependents was $52 million.

The report says 77% of the recipients of public health assistance did not list a valid employer. Of the employers with more the 50 employees, which can include part-time workers, that used public health assistance, the top three were: Dunkin' Donuts Inc.; Stop & Shop Supermarket Cos. Inc.; and Wal-Mart Stores Inc.

Dunkin' Brands Inc. said the public health assistance beneficiaries identified in the Massachusetts report are employees of independent franchisees and not the company itself, which provides comprehensive health care coverage to virtually all of its employees.

Dunkin' Brands has more than 600 Dunkin' Donuts franchise holders in Massachusetts, which operate more than 950 shops. Because each shop has an average of 25 to 30 employees, they should have been exempt from the reporting requirement, which applies to employers with 50 or more employees, the company said in a statement.

Neither Wal-Mart nor Stop & Shop returned phone calls seeking comment.

According to a February study published by the Henry J. Kaiser Family Foundation, Medicaid programs had a 5.2% enrollment growth in fiscal year 2004 and expect 4.7% growth in 2005. Since 2001, Medicaid enrollment has grown by almost one-third, and spending growth outpaced state tax revenue growth, 9.5% vs. 3.4% in fiscal year 2004.

Workers receiving Medicaid benefits

Massachusetts created a public list of employers that have workers using Medicaid. These three have the most Medicaid-eligible employees:

Company	Total individuals covered	Cost to state
DUNKIN' DONUTS	3,454	$3,146,221
STOP & SHOP	2,640	$3,074,284
WAL-MART	2,914	$2,904,543

Source: Mass. Executive Office of Health and Human Services, Division of Health Care, Finance and Policy

COMINGS & GOINGS - INDUSTRY


Mr. Whiter


Mr. Daoussis


Mr. Wood


Ms. Baker


Mr. Daume


Ms. Rinaldi

Reinsurance:

Dallas-based EWI Risk Services Inc. has appointed **Steve McElhiney** president. Mr. McElhiney also serves as president of Tall Pines Insurance Co. Previously, he was corporate vp of finance and treasury at Argonaut Group.

London-based Aspen Insurance UK Ltd. has named **David Whiter** as senior underwriter for aviation insurance. Previously, he was senior vp of aviation at XL London Markets.

Andrew Bustillo has been named executive vp of client development at Benfield Group Ltd. in New York. Also at Benfield, **Gregory Sandvik** and **Robert Reinarz** have been named senior vps, client development in the reinsurance brokerage's Westport, Conn., office. Before joining Benfield, all were managing directors at Guy Carpenter & Co. Inc.

Willis Re has named **Yakov Lantsman** as senior vp to lead Willis Re Analytics Research & Development. Previously, he was senior vp and head of quantitative services at Fitch Risk Management Services.

Insurers:

Michael S. Daoussis has joined Countrywide Insurance Group in Irvine, Calif., as senior vp of its commercial lines national construction practice. Previously, he was a senior vp at Lockton Insurance Brokers Inc.

Illinois R.B. Jones, a Kaufman Group Co., has made two senior-level appointments.

● **Morris Nelson** is the director of Illinois R.B. Jones of Denver. Previously, he was president of Colorado Western Insurance Co.

● **Barry Starbuck**, previously vp of underwriting at Colorado Western, will serve as head of underwriter in Denver.

New York-based Mutual of America Life Insurance Co. has made several senior-level appointments.

● **Jared Gutman** has been named executive vp, administrative technical services. Previously, he was senior vp, technical services.

● **Vincent Draddy** has been named senior field vp. Previously, he was head of the San Francisco regional office.

● **Louis A. Montanti** has been named senior field vp. He had been head of the Pittsburgh office.

Agents/Brokers:

David Pagoumian has been named president and chief operating officer of Napco L.L.C., an Edison, N.J.-based wholesale broker. Previously, he was senior vp.

Patrick Walsh is the new area president of Arthur J. Gallagher & Co.'s operations in Cleveland. Previously, he was chief operating officer of Gallagher Strategic Risk Solutions and managing director of Gallagher Financial Products.

Heath Lambert Group in London has named **Steve Maggs** as managing director of a new commercial operation in Reading, England, and **Stephen Wood** as managing director of the Swindon, England, office. Mr. Maggs most recently was corporate business unit director for Aon Corp. in Reading, and Mr. Wood was deputy managing director of U.K. operations for Aon.

Aon Risk Services Inc. of Massachusetts has appointed **Samuel D. Daume Jr.** managing director and New England market area sales leader. Previously, he was client executive, New England higher education and financial institutions practice leader for Marsh Inc.

Other providers:

Dublin, Ohio-based Frank Gates Cos. has named **Deborah Baker** to senior vp, west region manager. Ms. Baker, who will be based in Scottsdale, Ariz., previously was vp and regional manager, special operations west.

Philadelphia-based law firm Cozen O'Connor has named **Elaine Rinaldi**, formerly hiring partner, to the post of director of strategic expansion. Also at Cozen O'Connor, **Frances R. Roggenbaum** has been named a senior member of the firm in its insurance corporate and regulatory practice group. Formerly, she was a partner at Saul Ewing L.L.P.

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers.
Please send news of recently promoted, hired or appointed senior-level executives to: Joe Walker, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; jwalker@businessinsurance.com.
Photos should be sent to: Kathy Barnes, Business Insurance, 360 N. Michigan Ave., Chicago, Ill. 60601-3806; kbarnes@businessinsurance.com.

Tort reform: Advocates build on advances in several states

Continued from page 4

ford, executive director of South Carolinians for Tort Reform in Columbia. Mr. Crawford said that meant getting businesses of all sizes to come together and agree that tort reform was "the No. 1 business issue."

"We called it our 'black eye bill'—we identified the issues that gave South Carolina a black eye nationwide," he said.

"That takes time and effort. It takes humility on everybody's part—everybody has to put other agendas aside. It truly was a team effort," said Mr. Crawford.

"You're going to have to build your case for several years," said John Lobert, senior vp-state legislative affairs for the Property Casualty Insurers Assn. of America in Des Plaines, Ill. He cited the successful effort to repeal West Virginia's third-party bad-faith law as an example of how this strategy paid off. Efforts to repeal the law began in 1999.

Taking a long-term view was also key in Texas, said Ralph Wayne, president of the Texas Civil Justice League in Austin.

Texas tort reform efforts began in the late 1980s, he said. Although the legislature approved what Mr. Wayne called "some tough reform," the Texas Supreme Court struck down the changes on constitutional grounds.

Over a period of several years, pro-reform forces focused their attention on placing pro-reform justices on the Texas high court, said Mr. Wayne, and the strategy paid off. "I think by changing the court, that generated a realistic view that we could get tort reform accomplished in Texas," he said.

> "I think by changing the court, that generated a realistic view that we could get tort reform accomplished in Texas."
>
> **Ralph Wayne**
> **Texas Civil Justice League**

Political changes in the legislature and governor's office also helped. Mr. Wayne noted that during his successful campaign to become governor of Texas, now-President George W. Bush made tort reform one of his four key points. Both then-Gov. Bush and his successor, Rick Perry, backed reform efforts, noted Mr. Wayne. These included medical malpractice liability reform and, most recently, legislation that requires that people claiming asbestos injury meet specific medical criteria before their claims can proceed in court. Mr. Wayne noted that a broad-based coalition pressed for passage of the asbestos bill.

They proved successful and Gov. Perry signed the bill into law on May 19. Texas became the fourth state—after Ohio, Georgia and Florida—to adopt medical criteria for asbestos injury claims in the past year.

Texas also provided "the prime example" of medical malpractice reform's impact, said Larry Smarr, president of the Physician Insurers Assn. of America in Rockville, Md.

Texas passed legislation that, among other things, capped noneconomic damages for medical malpractice claims in 2003, he said. Voters also decided in a referendum that caps on such damages were indeed constitutional, he said.

As a result, "the first thing that happened was the largest insurer in the state reduced its rates by 12%," he said. Since then, the insurer—Texas Medical Liability Trust—has reduced rates another 5%," according to Mr. Smarr.

"While the other carriers were little slower to react, every one of them has either reduced rates or stopped increasing them. It changed the whole picture in Texas," he said. He added that medical malpractice insurers in Georgia have indicated that they, too, will reduce rates if that state's recent medical malpractice reforms past constitutional muster.

But medical malpractice reform suffered a significant setback in Maryland, said Mr. Smarr. Gov. Robert Ehrlich "propounded what would be effective legislation, unfortunately the legislature came out with something that is far from it," he said. In fact, part of the legislation that emerged actually levied a new tax on HMOs.

"We ran into the same problem in Maryland that others have run into in other states," said Jane McConnell, executive director of the Maryland Medicine Comprehensive Insurance Program, which is a joint venture of the University of Maryland Medical System and University Physician Inc., in Baltimore.

"Many members of the legislature are lawyers, who favor the plaintiffs bar. I think the individuals that have the most impact on effecting change in the state legislature are the physicians, because they are the ones that really have the day-to-day relationships with the patients," said Ms. McConnell. The fact that the state's largest medical malpractice insurer raised rates 33% one year and 28% the next "was the key that enabled the legislature to make some changes; they were only modest, but there were some," said Ms. McConnell, who is a member of the Risk & Insurance Management Society Inc.

"You can assume defeat anywhere where the trial bar has the legislature locked up," said PCI's Mr. Lobert. He pointed to Oklahoma as a state where the trial bar was able to fend off tort reform.

A prominent consumer advocate disagreed that the tort reformers had suffered many significant setbacks in the current and recently recessed state legislative sessions.

"You're just talking about degrees of cruelty, because in every case where there has been an ability to hold off a bill," it's been where there has been an effort to make the law worse than it already is," said Joanne Doroshow, president and executive director of the Center for Justice & Democracy in New York.

"They're extremely greedy and what they're trying to do is undermining the tort system and when they don't get a complete undermining of the tort system, they consider that a defeat," she said.

CAFA supporters watching impact on states

The jury is still out on what impact the federal Class Action Fairness Act will have on state tort reform efforts and a verdict will probably be some time in coming, say tort reform advocates.

CAFA, which President Bush signed into law earlier this year, allows the removal to federal courts from state courts of certain—but by no means all—class actions that involve plaintiffs and defendants from different states.

Prior to its enactment, proponents of CAFA said the law would cut down on what they considered abusive "forum shopping" by plaintiffs attorneys. According to tort reform advocates, forum shopping occurs when a plaintiff's lawyer seeks the most pro-plaintiff jurisdiction possible in which to file a class action, even if the connection between the jurisdiction and the parties in the suit is tenuous.

CAFA supporters are watching what happens in the states closely.

"It may be a little early to tell," said Lisa Rickard, president of the U.S. Chamber Institute for Legal Reform in Washington. State class actions still remain a significant problem and concern for "companies, and, I think, the creative plaintiffs lawyers will attempt to structure their class and claims in a way to try to keep them in state courts," said Ms. Rickard.

"I do not detect any impact at this point," said Victor Schwartz, general counsel of the American Tort Reform Assn. in Washington. Mr. Schwartz said that CAFA might have a future impact by causing some states to re-examine their own class action laws simply because CAFA is likely to result in more state class actions.

While he acknowledged that, under CAFA, "if you're an out-of-state defendant, you can move the case into federal court, provided it's over $5 million," he noted that an amendment to the law also provides a "complicated formula for suing in state court." So, "as a practical matter over the next few years, states that have a lot of corporate registrations are going to be a site of a lot of class actions," Mr. Schwartz said.

He also said that CAFA gives an additional reason for a company not to move to a state with "bad" tort law. "If you have bad tort law, that's not a place you want to locate, because class actions will be brought under that state law," Mr. Schwartz said.

"We know that already the plaintiffs bar is looking to find ways around the federal Class Action Fairness Act and, consequently, that makes state tort reform as important today as it has been in the past," said Dave Snyder, vp and assistant general counsel with the American Insurance Assn. in Washington. "While the federal reform was a positive development for some types of cases, the reality is a huge percentage of litigation will continue in the states and the need for reform" will remain, he said.

–By Mark A. Hofmann

Family health care costs increase 9.1%, study says

By RUPAL PAREKH

Health care costs for the typical family of four in the United States will average $12,214 in 2005, says a report released Wednesday by Milliman Inc.

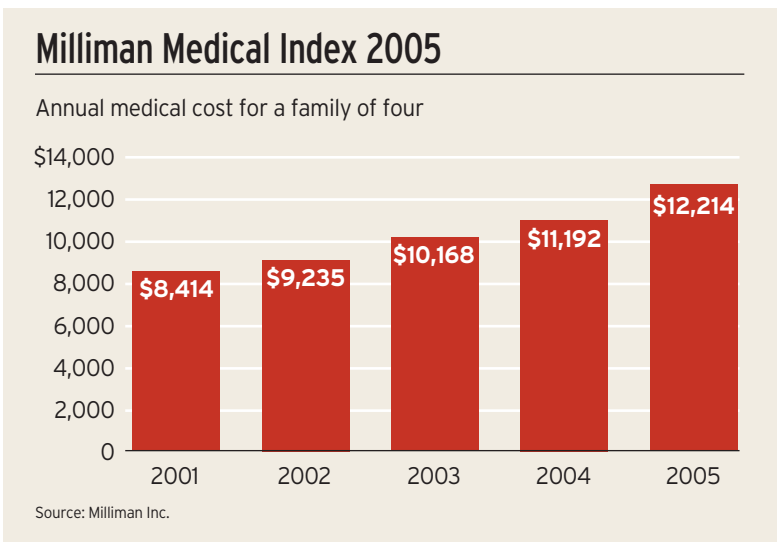
The Milliman Medical Index 2005 measures changes in medical costs over a five-year period for a family of four covered by an employer-sponsored preferred provider organization—the plan design most commonly offered by U.S. companies.

The report, which is based on hospital inpatient data and claims information for approximately 15 million covered individuals, calculates total health care costs as the combination of benefit plan payments and employee-paid contributions, not including premiums.

According to Seattle-based Milliman, in the past year, annual medical costs for a family of four jumped 9.1%, from $11,192 on average in 2004 to $12,214 in 2005. The average rate of growth between 2001 and 2005 was 9.8% a year.

In 2005, roughly 45% of total medical costs will be spent on inpatient and outpatient hospital care, 37% will go to physician services, 15% will be spent on prescription drugs, and about 3% will be spent on miscellaneous services, according to the study.

While workers have had to pay larger dollar amounts for care as overall health-related costs have increased, member cost-sharing has decreased in the past few years, Milliman reported, from a 17.6% share of the total costs in 2001 down to 16.7% in 2005.



Based upon a typical PPO plan design, Milliman estimates out-of-pocket spending—in the form of deductibles, coinsurance and copayments—for families at $2,035 on average in 2005.

Employees are, however, paying relatively more for prescription drugs in 2005, the study noted, as employers are shifting more than 25% of pharmacy costs to employees, compared to the average 16.7% for total health costs.

Going forward, increases in medical costs will continue for several years to come at levels "fairly consistent" to those in the study, predicted William J. Thompson, a principal and consulting actuary for Milliman in Windsor, Conn. who co-authored the study.

A copy of the report is available at *www.milliman.com*, or by calling Jim Loughman at 203-698-0008.

Between the Lines

Compiled by Joanne Wojcik

Burying the hatchet to promote health care

Perhaps to prevent history from repeating itself, Sen. Hillary Rodham Clinton, D-N.Y., has picked up an unlikely ally in her fight to change the nation's health care system.

Longtime political foes Newt Gingrich and Sen. Clinton announced earlier this month they will be working together to promote legislation that would modernize medical record keeping.

"At our first meeting, when we were agreeing so much with each other, I think people thought, 'The end is near,'" said the former first lady, who received considerable flak for her last foray into health care policy some 12 years ago.

Despite their past philosophical differences, the former Republican representative from Georgia and speaker of the House of Representatives, once known for bashing liberals, apparently has decided to extend an olive branch.

"We're at the stage in our lives where getting some good things done for the country strikes us as a pretty important way to spend your time," he said, appearing with Sen. Clinton May 11 outside the Capitol.

Demonstrating that even conservatives sometimes mellow with age, he told a meeting of newspaper editors in Washington last month that not only does he expect Sen. Clinton to win re-election next year but to capture the Democratic presidential nomination in 2008, and perhaps even win.

"Any Republican who thinks she will be easy to beat has total amnesia about the Clintons," Mr. Gingrich said. He also pointed out that she would have the added benefit of her husband, "the smartest American politician, as her adviser."

Brothers to bike across U.S. for MS

Given his additional post as chief actuary, it figures that Cairnstone Re Vp Paul Fallisi would have tabulated the course that he and his brother, William, are taking as they spin their way from coast to coast on bicycles.

Based on Mr. Fallisi's precise calculations, the 3,333-mile trek, which began in San Diego on May 13, will terminate 30 days later, on June 12, at the New Hampshire coast—as long as they cover exactly 111.1 miles each day.

William Fallisi, left, and his brother, Paul, of Cairnstone Re, will bike across the United States to raise money for the National Multiple Sclerosis Society.

The Fallisi brothers' transcontinental journey will generate $30,000 in donations for the Massachusetts-based Jimmy Fund, which supports the fight against cancer in children and adults, and the National Multiple Sclerosis Society.

The 44-year-old executive said he got hooked on cycling 10 years ago, when a friend challenged him to ride the length of Vermont.

To donate to Mr. Fallisi's cause or to track his progress, visit *www.cairnstone.com* and click on the Cycle Across America link.

Hanover will sponsor Worcester Tornadoes

While property/casualty insurers generally keep their distance from tornadoes, Hanover Insurance Co. has decided to make an exception and become the primary sponsor of the Worcester Tornadoes, the first professional baseball team in Worcester, Mass., in 71 years.

The sponsorship gives the insurer the naming rights to the extensively renovated ballpark at Fitton Field, on the campus of The College of the Holy Cross, in Worcester, Mass., where the Tornadoes will play their 52 home games. The stadium, which is being expanded to accommodate 3,000 seats, will be renamed Hanover Insurance Park at Fitton Field in time for the team's home opener, scheduled for June 6 against the Brockton Rox.

The Tornadoes are the newest member of the Canadian-American Assn. of Professional Baseball, an independent professional minor league.

Hanover is a member of the Allmerica Financial Corp. group of insurance companies. Both companies are based in Worcester.

Tips and feedback from readers are welcome. Please send information to jwojcik@businessinsurance.com.

Beecher Carlson recruits industry executives to lead expansion, new health care practice

ATLANTA—Atlanta-based brokerage Beecher Carlson Holdings Inc. is launching a national health care industry practice, expanding its national energy practice and increasing its footprint in the western United States with the help of rivals Aon Corp. and Willis Group Holdings Ltd.

Frank McKenna and Steve Harri, former co-chairs for Aon's national health care practice, have joined Beecher Carlson to anchor its new health care practice. Mr. McKenna, senior managing director, will be based in the brokerage's new Los Angeles office, and Mr. Harri, managing director, will be based in New York.

The new health care practice will focus exclusively on providing comprehensive risk management, human resources and benefits services to the health care provider and payer industry including physician groups, clinics, hospitals, long-term care facilities and managed care organizations.

"Health care, from our perspective…is not a class of business you can enter into and succeed at if you're taking a generalist approach," said Tom Golub, president and chief executive officer of Beecher Carlson. "All the coverages are pretty unique, and the risk exposures are very unique." Therefore, "you need depth and long term expertise and that's what we've acquired."

The brokerage also is expanding its national energy practice with the addition of Paul Pachomski, a former executive vp of Aon Specialty Re's property practice. Mr. Pachomski, senior vp with Beecher Carlson, will be responsible for the production, marketing and servicing of clients in the energy industry and will be based in New York.

Beecher Carlson also has lured away Mike LaRocca, former regional executive officer with Willis North America, to expand its operations in the West Coast. Mr. LaRocca, executive managing director, will be responsible for increasing Beecher Carlson's existing business in Southern California and expanding operations to additional western U.S. locations.

Beecher Carlson has an existing office in Woodland Hills, Calif., and locations are being opened in Los Angeles and in Orange County, Calif. Mr. LaRocca will operate from the Los Angeles office.

—By Sally Roberts

Errors & omissions

This chart of the largest bundled risk management information systems was inadvertently omitted from the May 23 Spotlight report on Risk Management: New Technology & Online Solutions, which included rankings of RMIS vendors.

Largest bundled risk management information systems*

Ranked by installations in corporate risk management departments**

Rank	Company	System name	2004 number of installations	First installation
1	Gallagher Bassett Services Inc.	RISX-FACS	9,818	1983
2	St. Paul Travelers Cos. Inc.	e-CARMA	9,460	1983
3	ESIS Inc.	Global RiskAdvantage	4,600	1998
4	Specialty Risk Services	@venture	4,400	1999
5	Chubb Corp.	Chubb RMIS Suite of Products	3,000	1994

* Systems offered to clients bundled with other services provided by the company. **Licensed users.
Source: *BI* survey

Aussies see policy tax jump 80%

Insurers expected to shift cost to New South Wales policyholders

By ELIZABETH FRY

SYDNEY, Australia—Policyholders in New South Wales could face increased insurance costs after an 80% increase in stamp duty on many insurance policies is applied later this year.

Despite calls by the state's government for insurers to retain the increase in costs, the tax hike likely will be passed on to insurance buyers, insurers and risk managers say.

New South Wales Treasurer Dr. Andrew Refshauge announced last week that the stamp duty on most insurance policies would increase from 5% to 9%.

The increases almost reverse a cut in stamp duty granted in 2002 that was intended to soften the impact of premium increases following the collapse of HIH Insurance Ltd.

Dr. Refshauge said that in addition to the 2002 tax cut, insurers had benefited from reduced claims costs as a result of a raft of tort reform efforts that had been implemented in Australia.

> "The New South Wales government's justification for increasing stamp duty on insurance policies by 80% in the budget was littered with flawed logic and red herrings."
>
> **Alan Mason**
> **Insurance Council of Australia**

The increased stamp duty will be applied starting Sept. 1 to most commercial and personal insurance policies in the state.

According to Dr. Refshauge, only workers compensation policies, policies issued to charities and motor vehicle insurance will remain free of duty. Stamp duty on motor vehicles, aviation, professional indemnity, disability income and consumer credit insurance will remain at 5%, he said.

"But while we still require a definitive response as to the breadth of application of the new rates, clearly, the state government is targeting (profitable companies), and the increase will likely cover everything that is not currently exempt, i.e., industrial special risk, product liability, and D&O," said Eamonn Cunningham, vp-global risk management at Sydney-based Westfield Group.

In his budget speech to the NSW Legislative Assembly, Dr. Refshauge called upon the insurance industry to absorb the rate increase, rather then pass it on to policyholders.

But Alan Mason, executive director of the Insurance Council of Australia, said that is unlikely.

"No business is going to bear the cost of a consumption tax charged on its products and then not build it into its cost price," he said.

"This impost is another unfair burden on insurance buyers and has the potential to decrease risks being insured, leading to increased exposures," said Brad Greer, president of the Risk Management Institution of Australasia Ltd.

Chris Spraggon, group risk manager of Sydney-based energy provider AGL Ltd., said he could not understand why the tax on insurance was the only significant revenue increase proposed by the treasurer. "The stamp duty rate increase came out of the blue and will clearly have a significant impact on the price of insurance," he said.

The treasurer's comment—that because tort reforms in NSW had reduced the cost of claims, insurers should now absorb a new tax—came in for special criticism.

"The New South Wales govern-

See STAMP DUTY / page 26

ZFS units acknowledge missteps in finite deals

By SARAH VEYSEY

SYDNEY, Australia—In a settlement with Australian regulators, two units of Zurich Financial Services Group have admitted to misrepresenting financial reinsurance transactions over a five-year period, which regulators contend falsely propped up the companies' balance sheet.

Zurich Financial Services Australia Ltd. and its nonlife unit, Zurich Australian Insurance Ltd., Thursday announced they will submit to "enforceable undertakings," or corrective actions, imposed by the Australian Prudential Regulation Authority and the Australian Securities & Investments Commission. In exchange, APRA won't pursue legal charges against the companies.

APRA said that its investigation found that deliberate misrepresentations about the nature and accounting treatment of loss-portfolio transfers and related contracts resulted in Zurich Australian Insurance Ltd.'s 2000 profits being overstated by $61 million Australian ($34.1 million). This made it appear that the company met regulatory solvency requirements, when in fact it did not, APRA said. The regulator said the insurer now meets those solvency requirements.

In announcing the settlement with regulators, Zurich stated that information about two finite reinsurance contracts the Australian insurer purchased in 2000 from General & Cologne Re Group Australia was "withheld and misstatements were made" to APRA, and to the companies' auditors and actuaries. In addition, the insurer acknowledged that some people knowingly misled APRA about the true nature of the contracts "over an extended period of time."

As part of the settlement, the two ZFS units have agreed to improve corporate governance procedures and the way in which they account for reinsurance transactions, among other things, according an APRA statement. APRA noted, though, that it is still considering what action, if any, to take against individuals involved in the transactions.

In addition to the settlement with APRA, the insurers also reached an agreement with ASIC to prepare a note to their 2004 financial statements detailing the accounting errors, and to add supplementary notes to their 2000, 2001, 2002 and 2003 accounts regarding the reinsurance contracts.

APRA launched an investigation into the Zurich units' financial reinsurance transactions in May 2004 and alerted ASIC to its investigation. ASIC said in a statement that its own investigation into the matter is ongoing.

In a statement, Zurich Financial Services Australia said that there would be no effect on the company's day-to-day business and that the enforceable undertakings will not materially affect the units' balance sheets for 2004. The Australian insurers have delayed reporting 2004 results while the regulator investigation was ongoing.

Marsh U.K. unit appears 'signed up' to accept compensation model

By BARBARA COCKBURN

LONDON—Marsh Ltd., the U.K. arm of Marsh Inc., is close to agreeing to a remuneration model with London market underwriters that would replace abandoned contingent commission arrangements, according to the chief executive of the Lloyd's Market Assn.

Simon Sperryn, chief executive of the Lloyd's Market Assn., said at a seminar last week that Marsh is close to signing a model agreement proposed by a joint LMA and International Underwriting Assn. committee.

A spokeswoman for Marsh declined to comment.

The committee, which is headed by Andrew Beazley, chief executive officer of Beazley P.L.C., was set up in January to discuss proposals made by brokers for new business models to replace income from contingent commission arrangements.

Many brokers, including Marsh, abandoned contingent commission and volume-driven commission arrangements last year in the wake of investigations into broker compensation practices.

Brokers in the London market argue, though, that they provide services to underwriters, such as claims administration, that are not customarily provided by brokers in other markets. Underwriters in London, therefore, should provide some form of remuneration in addition to traditional placement commissions, the brokers say.

Earlier this month, Aon Ltd., the U.K. arm of Aon Corp., reached an agreement with the underwriter committee about a new compensation model and abandoned a previously announced model.

In a speech to the seminar in London, sponsored by law firm Reynolds Porter Chamberlain, Mr. Sperryn said that talks between the group and brokers "continue almost daily."

"Aon are signed up," he said. "We think Marsh are signed up. Others are close."

Aon agreed, among other things, to detail on London market slips all of the payments it receives from policyholders and insurers when placing business in London (*BI,* May 9).

Under Aon's model, no fixed percentages of premiums for classes of business will be set; instead, charges will be levied on a case-by-case basis.

In agreeing to the model, Aon shelved a previously announced approach under which it proposed to charge underwriters a fixed percentage of premium—based on the line of business—for services it provides on specialty business in London.

Underwriters objected to that model, arguing that imposing a charge on underwriters for services contravened the principle that the broker is the agent of the buyer.

Other brokers, including Marsh, have proposed similar models.

Updates

E.U. reinsurance measure delayed

Voting on a European Union reinsurance directive that would harmonize reinsurance regulation across the 25 E.U. member states has been delayed. The European Parliament had been scheduled to vote on the directive in Brussels, Belgium, last week, paving the way for it to be sent to the European Union's Council of Economics & Finance Ministers in June and then passed into law. But the directive has been withdrawn from the Parliament agenda for the current session because amendments have not been translated into all 20 official E.U. languages. The next session of the European Parliament is slated for June 6 in Strasbourg, France.

Net income down for Bermuda reinsurers

Bermuda-based reinsurers experienced a 9% drop in net income in the first quarter of 2005, according to a report by London-based reinsurance broker Benfield Group Ltd. Benfield studied 16 Bermuda-based reinsurers. The report showed that the companies' total net income dipped to $2.0 billion, 9% below the comparable period in 2004. The combined ratio of the group of 16 increased by 3.4 percentage points compared with the first quarter of 2004, to 90.9%. Gross written premiums for the group of 16 reinsurers totaled $16.4 billion in the first quarter of 2005, a 2% increase over the comparable period last year.

Zurich's Dublin unit to write E.U. coverage

Zurich Financial Services has restructured its operation in Dublin, Ireland, to become its main vehicle to write global commercial insurance cover within the European Union. Zurich Insurance Ireland Ltd., which was formerly known as Eagle Star Insurance Co. (Ireland) Ltd., will specialize in coverage for cross-border risks to European corporate customers, ZFS said in a statement. The Dublin-based unit has also opened a London branch office, Zurich Insurance Ireland Ltd. U.K. Branch, which will underwrite coverage for non-U.K. domiciled business for ZFS' U.K. customers.

Arch's European unit joins IUA

Arch Insurance Co. (Europe) Ltd. has joined the International Underwriting Assn., the body that represents insurers and reinsurers in the London company market. Arch Insurance Co. is a subsidiary of Bermuda-based Arch Capital Group Ltd. Separately, Gerry Albanese, president and chief operating officer for Markel International Ltd., the London-based subsidiary of Markel Corp., has joined the board of the IUA.

House committee approves tort reform bill

LARA heads for full House vote, Senate support uncertain

By MARK A. HOFMANN

WASHINGTON—The House of Representatives could soon give its approval to the Lawsuit Abuse Reduction Act.

It wouldn't be the first time the House has done so, either. In fact, lawmakers passed an earlier version of LARA, H.R. 420, last September, but the Senate never took up the matter.

The House's new chance comes after the House Judiciary Committee approved the latest version of LARA on a 19-to-11 party-line vote last week. LARA, which was introduced by Rep. Lamar Smith, R-Texas, would, among other things, amend Rule 11 of the Federal Rules of Civil Procedure to require that federal judges impose sanctions on attorneys who bring frivolous lawsuits in their courts.

Before approving LARA, the committee accepted several amendments to the measure. One would require a federal judge to suspend an attorney from appearing before the district court for a year if the judge determines that the attorney has brought at least three frivolous lawsuits in the court over the attorney's career. Another amendment imposes new sanctions for destroying documents in a case involving Rule 11.

The measure also would prevent so-called "forum shopping" by requiring that a personal injury lawsuit be brought only where the plaintiff resides, where the alleged injury occurred or where the defendant's principal place of business is located.

Democrats skeptical

Despite the committee's acceptance of some Democratic amendments, many of the committee's Democratic members made no effort to mask their skepticism of the bill. For example, Rep. Anthony Weiner, D-N.Y., said that he feared that rather than curb litigation, LARA could lead to a spate of new suits. "You're going to have all kinds of litigation within litigation" over Rule 11 procedures under the act, he said.

Pro-LARA groups wasted little time in praising the committee's actions. Sherman Joyce, chairman of the Washington-based Lawsuit Abuse Reduction Coalition, issued a statement calling the measure "common-sense legislation" that "would help millions of small businesses that have been or are potential victims of some of the worst abuses of our civil justice system—frivolous lawsuits and forum shopping." Mr. Joyce is also president of the American Tort Reform Assn.

The committee also approved two other pieces of tort legislation in last week's markup. The Personal Responsibility in Food Consumption Act—H.R. 554—would provide manufacturers and sellers of food products a defense against lawsuits brought by people who claimed the food involved caused their obesity. The Protection of Lawful Commerce in Arms Act, H.R. 800, would grant makers and sellers of firearms broad immunity against suits brought against them by victims of gun violence.

Lisa Rickard, president of the U.S. Chamber Institute for Legal Reform, issued a statement praising the committee for approving the three bills. "Lawsuit abuse is crippling employers, stifling job growth and driving up the cost of everything we buy," she said.

Stamp duty: 80% increase

Continued from page 25

ment's justification for increasing stamp duty on insurance policies by 80% in the budget was littered with flawed logic and red herrings," said Mr. Mason.

Mr. Mason said insurers had responded to the tort reforms by lowering premiums. "This will, obviously, push the price of coverage back up." For example, "an average public liability premium of $1,170 will now cost $1,402.83," he said.

He cited a recent pricing survey of public liability insurance undertaken by Australia's antitrust regulator—the Australian Competition & Consumer Commission—that showed the price for public liability insurance fell 15% in the first half of 2004.

Mr. Mason also noted that since the tort reforms, at least two insurers had dropped their prices by another 10%.

Property/casualty insurers' 2005 first-quarter results

Ranked by net income. All amounts are in thousands of dollars.

	Corporate			Property/casualty operations					
	Net income	Percent increase (decrease) 2004-2005	Consolidated revenues 2005	Combined ratio 2005[1]	Combined ratio 2004[1]	Net premiums written 2005	Percent increase (decrease) 2004-2005	Policyholder surplus 2005	Percent increase (decrease) 2004-2005
Hartford Financial Services Group Inc.	$666,000	17.3%	$5,991,000	88.6%	89.8%	$2,579,000[2]	7.5%	$6,700,000	0.5%
Chubb Corp.	469,600	30.2	3,448,700	89.4	92.6	3,056,200	1.3	8,250,000	22.2
ACE Ltd.	433,028	(3.1)	3,155,682	89.6	86.9	3,365,142	3.9	9.965,300	1.3
Liberty Mutual Insurance Co.	396,000	39.4	4,971,000	99.3[2]	103.8[2]	3,521,000[2]	(0.3)	9,535,000	33.8
The St. Paul Travelers Cos. Inc.	212,000	(63.9)	6,105,000	90.5	91.9	4,780,000	40.6	15,441,000	75.7
SAFECO Corp.	212,000	(10.2)	1,580,500	88.5	89.9	1,457,100	5.9	3,633,100	20.0
CNA Financial Corp.	178,000	N/M	2,360,000	109.0[2]	105.1[2]	1,800,000[2]	(3.8)	N/A	N/A
Cincinnati Financial Corp.	144,356	(1.2)	916,288	88.9	87.1	796,743[2]	0.9	4,064,636	45.6
Old Republic International	114,331	7.4	880,646	92.1	93.0	429,605[2]	12.7	1,998,341	5.2
American Financial Group	62,900	(14.1)	932,000	92.4	93.8	593,700	10.1	2,214,600	14.5
Ohio Casualty Corp.	37,700	96.3	410,700	95.6	103.8	358,500[2]	(1.5)	914,500	3.0
RLI Corp.	29,307	73.0	141,636	78.8	91.5	110,788	(10.0)	631,340	1.2
Argonaut Group Inc.	26,000	42.1	183,800	95.6	97.9	151,100	4.1	614,500	8.9
American International Group*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cumulative	$2,981,222	8.8 %	$31,076,952	92.8 %	94.2%	$22,998,878	8.6 %	$53,997,017	7.1 %

1 Includes dividends. 2 Statutory. N/M Comparison not meaningful due to 2004 loss. N/A Company did not provide data. * AIG has delayed reporting its 2004 and 2005 results.
Source: *BI* survey

Results: Strength despite softening market

Continued from page 4

burg in New York, said, "At this point in time, I think you're looking at pretty disciplined competition," although he noted that it is more intense in the property area.

Overall, "the glide path of the backside of the commercial lines cycle" has been relatively shallow, Mr. Lewis said. There are "still numerous coverages that provide insurance companies adequate hurdle rates of return to make it attractive," he said.

"It's not like you're going to see one quarter's good results, the next quarter's bad," Mr. Newsome said. "Instead, you're going to see continued modest deterioration over the next couple of years."

Observers agree that results will be good at least through this year, though. "Bottom-line results for the year will continue to remain fairly strong," said Mr. Ward. "Prices are softening, but the market is still rational, in the sense that there's no price wars" and prices "are adequate, for the most part, for the business being written."

James B. Auden, senior director at Chicago-based Fitch Ratings, said, "We'd expect underwriting results to deteriorate a bit as the year progresses, reflecting some of the declines in pricing that have been flowing through the market, but we don't see results falling off the cliff, either. So, barring unusual catastrophe losses, it should still be a pretty decent year," he said, stressing that performance will vary by insurer. Mr. Auden noted, though, that the better insurers "should be able to post pretty favorable results."

The soft market will become more apparent in 2006, say observers. Mr. Auden said that while he expects the industry to earn an underwriting profit this year, that is less likely to occur next year, "just given the pricing fundamentals."

Mr. Ward said also that results next year will not "be as bad as some years in the recent past, but I suspect the industry will post an underwriting loss, and there'll be a noticeable deterioration in industry results."

> "It's not like you're going to see one quarter's good results, the next quarter's bad. Instead, you're going to see continued modest deterioration over the next couple of years."
>
> **J. Paul Newsome**
> **A.G. Edwards & Son Inc.**

Jeffrey Berg, an analyst with Moody's Investors Service in New York, said Moody's outlook on the sector remains negative. The question as the industry enters the soft market, he said, is whether insurers' earnings will "be strong enough over the cycle to justify the ratings levels that they have." Mr. Berg noted that concerns about reserve adequacy persist, although the situation has improved.

Uncertainty on AIG

One uncertainty the industry faces is the outcome of the regulatory investigations into the insurance industry, including the resolution of AIG's problems. Besides AIG's financial restatements expected this week, New York Attorney General Eliot Spitzer and the New York Insurance Superintendent Howard Mills last week filed a civil suit against AIG, ex-Chairman Maurice R. Greenberg and former Chief Financial Officer Howard I. Smith (see stories, page 1).

The uncertainty facing AIG, given its prestige, "is a big negative for the industry overall, and, until that uncertainty is resolved, it will be a cloud" that hangs over the entire industry, said Mr. Ward.

He added, "I think the fear, the anticipation of what will happen, is having a more adverse impact than what we will see" once everything is resolved.

"One thing that's clear about it is there will be much better corporate governance going forward than there has been in the past," said James Inglis, managing director at Stamford, Conn.-based Philo Smith & Co., an investment banking firm.

There could also be more underwriting discipline because the regulatory scrutiny means there is "less ability to smooth earnings. There's less wriggle room in the numbers," Mr. Lewis said.

Insurers also are benefiting from the cutback in contingent commissions, Mr. Lewis said. Many brokers no longer accept contingent commissions from insurers as a result of the investigations by Mr. Spitzer and others, which has led to settlements with several brokers.

"There's lots of things going in (insurers') favor right now," he said, "and I guess we'll have to see how the complete game plays out when the whole regulatory investigation runs its course."

Roundtable: Execs surveyed

Continued from page 4

With respect to this year's survey, "when you look at those areas collectively that they felt needed the most improvement, it's all about trying to develop new customers" and maintain market share, noted Mr. Snyder. The industry is "in kind of a transition" from earlier years, when it was focused on improving its pricing and related issues, to the current situation, in which "they've gotten there, and now they're trying to maintain their market share going forward as they go into a softening market," he said.

In response to a question on the most critical issues faced by their individual companies, in the 2005 survey executives ranked maintaining underwriting discipline and price adequacy first, followed by managing their distribution or agency plant and managing their cost structure. In the 2004 survey, maintaining underwriting discipline was also ranked first, but it was followed by maintaining their rating and the cost and coverage of reinsurance.

In addition, when asked about the most critical issues faced by the primary insurance industry, respondents in 2005 ranked low interest rates and capital market returns as first, followed by restrictive state regulation and the ability to file and use adequate rates due to state regulation. In 2004, the ability to file and use adequate rates ranked as No. 1, with low interest rates and claim cost inflation tied for second place.

Now that pricing has improved, Mr. Snyder said, it's a question of whether they can "continue to maintain good returns and ace the competition" in "the face of the continuously low interest rate environment that the industry's now had for the last several years."

Survey participants were also asked about the current investigations of the insurance industry. A total of 57% said they expect the industry will be as profitable after the investigations are concluded as before, while 35% said they expect it will be less profitable. In addition, 41% said they expect the insurance industry will be more competitive at the conclusion of the investigations, while 37% said it will be as competitive. A total of 57% also said they believe the industry will be as cyclical as it has been, while 35% said it will be more so.

Mr. Snyder pointed out that at least one-third of the executives believe the industry will be less profitable, more competitive and more cyclical after the investigations' conclusion. "Reading between the lines," he said, "there is a solid minority" that believes "the industry's heading to a new era" in which—because of an increased transparency, a greater stringency of accounting requirements and a diminished use of tools such as finite reinsurance to manage earnings—the industry will report accounting results that more accurately reflect the economic results.

When asked the order of priority in which Congress needs to act on certain issues, respondents ranked general tort reform first, followed by the reauthorization of the Terrorism Risk Insurance Act and medical malpractice reform.

A total of 72% of the respondents said TRIA should be renewed as is. Half of the executives said they would exclude acts of terrorism in their policies if TRIA were not extended, while 26% said they would not exclude acts of terrorism but would seek reinsurance coverage.

The survey results are available at American Re's Web site, www.amre.com.

AIG UNDER PRESSURE

AIG: Fraud charges leveled

Continued from page 1

Criminal charges, though, may also still be filed against Messrs. Greenberg and Smith, though Mr. Spitzer has said he does not plan to file criminal charges against the company.

Mr. Spitzer reportedly is presenting evidence to a New York grand jury, which will decide whether to issue indictments against current or former AIG officials (*BI*, May 23). A spokesman for Mr. Spitzer had no comment on the issue.

AIG said in a statement, "We have been cooperating and will continue to cooperate with the attorney general, the superintendent and other regulatory agencies on all these matters.

"We are pleased that Attorney General Spitzer has recognized our cooperation and has previously indicated his expectations for reaching a civil settlement with AIG," AIG said.

In a statement, an attorney for Mr. Greenberg said, "We will respond in due course denying any fraudulent conduct by Mr. Greenberg, and we will vigorously defend the case." Mr. Smith's attorney could not be reached.

Wall Street reacted favorably to the lawsuit, boosting AIG's stock price 3% on Thursday, the day it was filed. Shares closed at $56.40 on Friday, up 1.24% on the day.

Analysts say the lawsuit revealed little new material information against AIG that hadn't already been made public, and they noted that its primary focus was Messrs. Greenberg and Smith, rather than the company itself or current management (see story, page 29).

The lawsuit notes that when asked about certain transactions, both Mr. Greenberg and Mr. Smith repeatedly refused to answer on the grounds their testimony would tend to incriminate them. Also frequently cited in the lawsuit is AIG Senior Vp Joseph Umansky, who has reportedly testified before the grand jury in exchange for immunity.

Broad charges

According to the lawsuit, from at least the 1980s until Mr. Greenberg's resignation earlier this year, the defendants "routinely engaged in misleading accounting and financial reporting."

Much of the broad outlines of the alleged misdeeds that are described in the lawsuit have already been revealed, including many made in a statement issued by the insurer earlier this month, in which it announced it would restate its financial statements for several periods by May 31. But the lawsuit provides precise details, including—in its attached exhibits—documentation of these transactions.

The lawsuit presents further information, for instance, on the four-year-old, $500 million loss-portfolio deal between AIG and General Reinsurance Corp., which AIG has admitted should not have been accounted for as insurance. The lawsuit alleges the suit was motivated by analysts' concerns about AIG's reserves and involved no risk transfer.

"To cover up this scheme, AIG and Gen Re created additional false documents, making it appear that Gen Re had approached AIG and asked to buy reinsurance," when, in fact, Mr. Greenberg had taken the initiative, the lawsuit charges.

> While much of the broad outlines of the alleged misdeeds that are described in the lawsuit have already been revealed, the suit provides precise details, including documentation of these transactions.

"The entire AIG-Gen Re transaction was a fraud," the suit states. "It was explicitly designed by Greenberg from the beginning to create no risk for either party—AIG never even created an underwriting file in connection with the deal," the complaint continues.

The lawsuit said the $10 million Gen Re actually paid was paid back by AIG along with a $5 million fee, by entering a "convoluted series of transactions" in which an AIG subsidiary accepted $15 million less than it was owed in an unrelated deal with Gen Re.

Mr. Greenberg is frequently cited in the lawsuit for his close involvement with AIG's questionable activities. The lawsuit charges, for instance, that to avoid paying higher premium taxes and additional monies into state funds on its workers compensation business, AIG would reach secret side agreements with customers that had the effect of recharacterizing a portion of the premiums as general or auto liability insurance, where there were no such assessments.

The lawsuit says a witness recounted a meeting he and others had with Mr. Greenberg on this issue. According to the notes made at the time, the suit states, Mr. Greenberg asked, "Are we legal?"' When an employee responded, "If we were legal we wouldn't be in business," Mr. Greenberg "began laughing and that was the end of it,'" the suit states.

"Although AIG has reported that it is confident today that the misbooking has stopped, it has been unable to say when the misbooking stopped," states the lawsuit. "In addition, AIG has admitted having no evidence that disclosure of the decades of deception was ever made to regulators of any state," the complaint says.

Reserves concerns

The lawsuit also charges that the defendants used fictitious adjustments to create additional reserves.

The suit alleges that Mr. Smith personally directed that alterations be made to AIG's reserve numbers in late 2000 and early 2001, instructing a subordinate, who wrote the changes down in a spiral-bound notebook. The subordinate, the suit claims, then photocopied the relevant pages and handed them to a clerk to enter into the official books and records; the clerk retained copies of the photocopied pages for his records.

"As a result of these terse handwritten directions, AIG reserves increased in the fourth quarter of 2000 by approximately $32 million and in the first quarter of 2001 by approximately $70 million," says the lawsuit. But no documentation was found to support the direction contained in the notebook, states the suit, which charges that similarly unsupported changes were made at least as far back as the early 1990s.

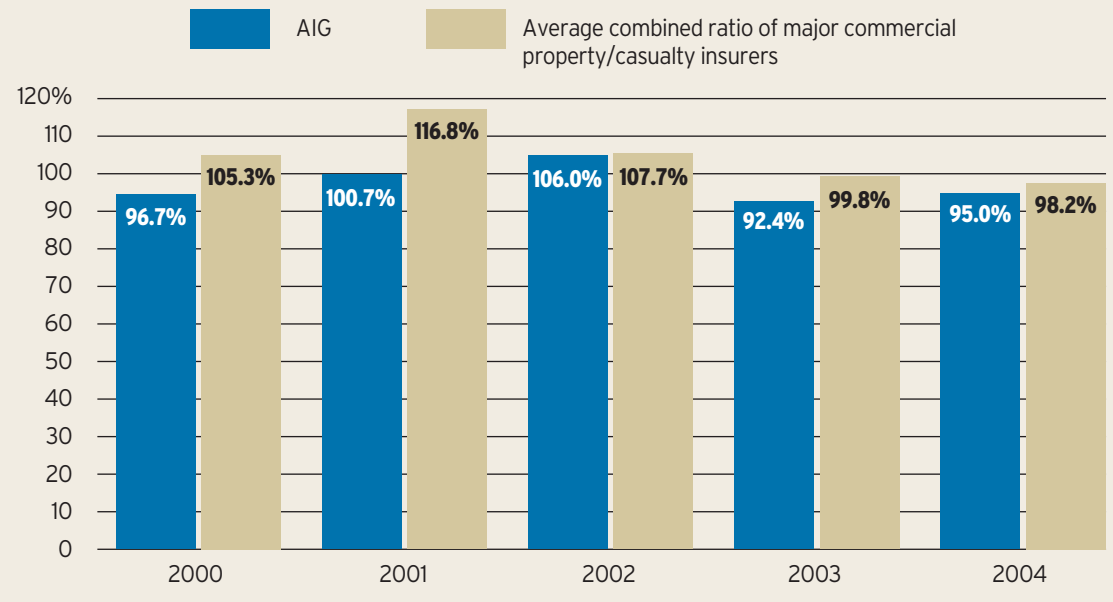
"For quarter after quarter, AIG's official books and records were altered on the basis of nothing more than Smith's say so and (the subordinate's) handwritten sheets, with hundreds of millions of dollars shifting from account to account."

The defendants are also charged with misleading regulators about offshore entities. It says AIG never told regulators about its relationships with Bermuda-based Richmond Reinsurance Co. or Barbados-based Union Excess Reinsurance Co., even after it was ordered to stop buying reinsurance from a similar entity, Coral Re, because it controlled that company and so was "effectively reinsuring itself."

The lawsuit also accuses AIG and the defendants of disguising auto warranty losses and Brazilian life insurance losses as investment losses and of creating false underwriting income, in part to disguise its role in a business in which it made a profit by buying life insurance policies from the elderly (see related stories).

AIG's published underwriting results regularly beat the competition

Combined ratio of AIG compared with the average combined ratio of major commercial property/casualty insurers.



Source: *BI* survey

Suit charges AIG and execs with hiding underwriting losses

By JUDY GREENWALD

NEW YORK—American International Group Inc. disguised losses in two widely different types of business—auto warranty and Brazilian life insurance—as investment losses in an effort to protect its reputation as an underwriter, the lawsuit filed last week by New York State authorities charges.

The lawsuit names AIG, former Chairman and Chief Executive Officer Maurice R. Greenberg and former Chief Financial Officer Howard I. Smith as defendants.

The lawsuit said that Mr. Greenberg "considered underwriting results to be the key measure of AIG's success" and in order to "preserve AIG's image in this area," defendants participated in two separate, although similar, schemes to disguise underwriting losses.

According to the lawsuit, AIG's entry into the auto warranty business in the mid-1990s proved to be "disastrous" and by 1999, it had generated a $210 million loss.

In response, Mr. Smith, with Mr. Greenberg's approval, decided to turn this underwriting loss "into a less embarrassing investment loss," says the lawsuit.

It found an offshore vehicle, Barbados-based CAPCO Reinsurance Co. Ltd., to use as a shell corporation to take on the losses. "AIG, however, had to take control of CAPCO without appearing to do so," said the lawsuit. If AIG overtly controlled CAPCO, under New York law, AIG would have to consolidate CAPCO's underwriting results on its books, "when the whole point was to get them off AIG's books."

This involved several steps, including dispatching Senior Vp Joseph Umansky to Switzerland to find "investors" to participate in the deal. AIG financed these investors' purchase of CAPCO's voting common shares through nonrecourse loans, which it did not expect to be repaid. An AIG unit purchased nonvoting CAPCO shares.

Once it was set up, CAPCO reinsured the $210 million in losses for a premium of only $20 million and began paying out on reinsurance claims on the auto warranty losses. By the end of 2001, with CAPCO's assets nearly depleted, AIG sold $68 million of its CAPCO shares back to the company for pennies on the dollar, "realizing an enormous investment loss," says the lawsuit.

"The final result of this complex series of transactions was that AIG had moved its underwriting losses to an off-balance sheet entity where AIG investors could not see them. Instead, AIG reported a far less noticeable investment loss," says the lawsuit.

Similar transactions were involved with AIG's Brazilian life insurance business, which had unfavorable underwriting results that were magnified by currency exchange losses. Under a complex arrangement involving Union Excess Reinsurance Co. Ltd., a Barbados-domiciled reinsurer that is one of AIG's off-balance sheet affiliates; a Taiwanese-based AIG-owned company; a Bermuda-based AIG unit; and a swap transaction, the underwriting loses were converted to investment losses in 1999 and again in 2000.

AIG UNDER PRESSURE

Impact: Buyers foresee industry changes

Continued from page 1

Betterley said. In some cases, he said, it could "bias your analysis."

For example, Mr. Betterley said, "if you were thinking about using an offshore vehicle for some kind of insurance transaction, now you might edge away from that a little bit if it's not a big advantage. Because it's hard to understand, it's hard to defend."

Jim Crockett, manager of risk and benefits at Denver Water, agreed that many of the more complex insurance transactions will undergo greater scrutiny by chief financial officers and chief executive officers "just because of the publicity" from the AIG and other lawsuits involving major industry players.

"Because of publicity and public awareness, accounting practices and reporting procedures are going to be reviewed," he said. For example, "when you get into areas where illegal activity has been cited, such as finite reinsurance, there will be the concern 'Are we doing finite insurance that might be questionable?' " he said.

In addition, "I think external auditors might explore more fully those transactions," he said.

"All of us have been aware of the greater scrutiny after Sarbanes-Oxley, and certainly all of us are going to be more careful, especially with offshore," said Ed Godwin, director of administrative services at Riverside Community College in Riverside, Calif.

In addition, it could have some impact on the availability of reinsurance for joint-power authorities used by the public sector.

"This is going to have a lot of effect because, while we don't use the offshore markets directly, indirectly they offer capacity to ourselves and other people in need of risk finance. It's going to tighten up our ability to get risk financing, especially in the work compensation area," Mr. Godwin said.

Other industry experts say that, as a result of the allegations, risk managers will be forced to become more discriminating in selecting business partners.

"Buyers should act like buyers, instead of partners in the insurance business," said Eugene Anderson, a partner at policyholder law firm Anderson, Kill & Olick in New York.

"Risk managers need to re-evaluate all the insurance intermediary relationships…not just from a financial standpoint–that they're going to be there for the future–but with respect to business practices," said Jeff Pettegrew, executive director of the California Self Insurers' Security Fund in Lafayette, Calif., which provides workers compensation coverage for more than 650 self-insured entities in California.

> "Why they thought they would get away with this displays a kind of an arrogance…that I didn't know existed."
>
> **Eugene Anderson**
> **Anderson, Kill & Olick**

"I think it's critical for our continuation of the integrity of our business to strengthen relationships with players who have shown integrity and to eliminate relationships, where possible, with insurers or brokers who have not stepped up to the plate," he said.

Risk managers will also have to dig deeper if they are to uncover potential conflicts of interest and dishonesty like those alleged in the AIG lawsuit, said Mr. Pettegrew.

"They're going to have to spend more due diligence in the process to ensure some of these back-door relationships and deals are not being done" and "so that their companies are aware of all of the hidden costs associated with these programs–where the money's going," he said.

Mr. Anderson, whose firm represents commercial policyholders in coverage litigation and who has been a longtime critic of AIG's claims paying practices, said he was surprised by the extent of the alleged dishonesty.

"Why they thought they would get away with this displays a kind of an arrogance or an indifference to the rules that I didn't know existed," he said.

The charge that AIG was booking workers compensation revenues as general liability and other lines of insurance to avoid paying assessments to guaranty and workers comp funds is "particularly disconcerting" for buyers in California, according to Mr. Pettegrew.

"The California Insurance Guarantee Assn., CIGA, collects those assessments and is billions of dollars underfunded because of the many insurance company insolvencies," he said. "If AIG didn't contribute its fair share, then they've contributed to that huge deficit, and companies, and even individual self-insureds, have been negatively impacted. So, I'm hoping for full restitution of any and all assessments that would be owed to California and to other states."

Mr. Pettegrew also said the ongoing industry investigations could prompt lawmakers to rethink insurers' limited exemption from federal antitrust laws under the 1945 McCarran-Ferguson Act. That law grants states the right to regulate insurance.

"The way that we've treated insurance and the way we've looked on insurance, there may be a paradigm shift occurring from this. To that degree, it may be a challenge for us to see if there's a better model out there," he said.

Connecticut Attorney General Richard Blumenthal already has testified before Congress that he welcomes ratcheting up antitrust enforcement to rein in abusive practices such as bid rigging between brokers and insurers (*BI*, Nov. 22).

"If, in fact, they take advantage of hiding behind McCarran-Ferguson, they could very well jeopardize the protection they've had," Mr. Pettegrew said.

AIG structured trust to improve results in life settlements: Suit

NEW YORK—American International Group Inc. created false underwriting income both to boost its financial results and protect its public image when it became involved in a specialized area of the life insurance business in 2001, a lawsuit filed last week by New York Attorney General Eliot Spitzer and New York State Insurance Superintendent Howard Mills charges.

The suit names AIG, former Chairman Maurice R. Greenberg and former Chief Financial Howard I. Smith as defendants.

According to the lawsuit, AIG in 2001 decided to enter the life settlements business. In this business, an investor purchases an insurance policy from a policyholder who is near the end of his or her life, for a price that is higher than the policy's cash surrender value. The policyholder gets a payout that is less than the full value of the policy. The investor continues to pay premiums on the policy and collects the full policy amount once the policyholder dies.

"The investor is making a simple bet that the death benefits will exceed the sum of the cash paid to the policyholder and any premiums the investor pays while waiting for the policyholder to die," says the lawsuit.

This "amounted to purchasing life insurance policies—often from sick or elderly persons with a life expectancy greater than two years—as a bet that they would die sooner rather than later," it says.

AIG was concerned both about adverse public relations stemming from its involvement in the business and the fact that, under generally accepted accounting principles, purchasers of life settlements must carry the investment at a loss.

In a note on the matter, Mr. Greenberg wrote, "It seems to me that anybody doing anything in the field stands the risk of adverse PR. … I am uneasy about this."

To avoid these issues, AIG set up a third-party trust, Coventry Life Settlement Trust. Under a complex scheme, Coventry borrowed funds from an AIG affiliate, then used those funds to pay a premium to yet another AIG subsidiary, Alaska-domiciled American International Specialty Lines Insurance Co., in exchange for a "fake" surety insurance policy, the lawsuit says.

Coventry would then file a "claim" with AISLIC for the same amount it had just paid it as premium. AISLIC would pay the amount back to Coventry, which would use the same funds to purchase the life settlements and pay its other expenses, says the lawsuit.

When the death benefits were ultimately paid under the life settlements, Coventry would pay the benefits to AISLIC as a further premium on the fake policy. AISLIC would then be able to report the life settlement income as underwriting income on its surety policy.

By 2003, Mr. Smith reported to Mr. Greenberg that the business had generated a $76 million underwriting profit. "AIG has continued to falsely report this investment income as underwriting income to the present day, contributing to AIG's highly touted underwriting results," the lawsuit says.

In 2004, when the Alaska Insurance Department determined that AISLIC's policy with Coventry did not constitute insurance, AIG moved its life settlement business to another Bermuda-based AIG subsidiary, American International Reinsurance Co. "AIG continues to account for this investment as if it were insurance," says the lawsuit.

—By Judy Greenwald

Focus on Greenberg may be a help to AIG

By JUDY GREENWALD

NEW YORK—The civil lawsuit filed last week against American International Group Inc., its former chairman and another official is, in some respects, good news for the insurer, analysts say.

That is because the primary focus of the lawsuit is former Chairman Maurice R. Greenberg and former Chief Financial Officer Howard I. Smith, and not AIG itself or its current management, they say.

Furthermore, they note that the lawsuit provided little significant new material about the company's alleged misdeeds, essentially filling in details about information that already was public.

Observers generally expect that the lawsuit will eventually be settled, and that AIG will emerge as a strong company.

Cincinnati-based independent insurance analyst John L. Ward said, "Although AIG was named in the suit, as well as Greenberg and Smith, clearly, Spitzer is targeting" those two individuals.

"The lawsuit and the accompanying press release were squarely directed at former management, including Hank Greenberg and

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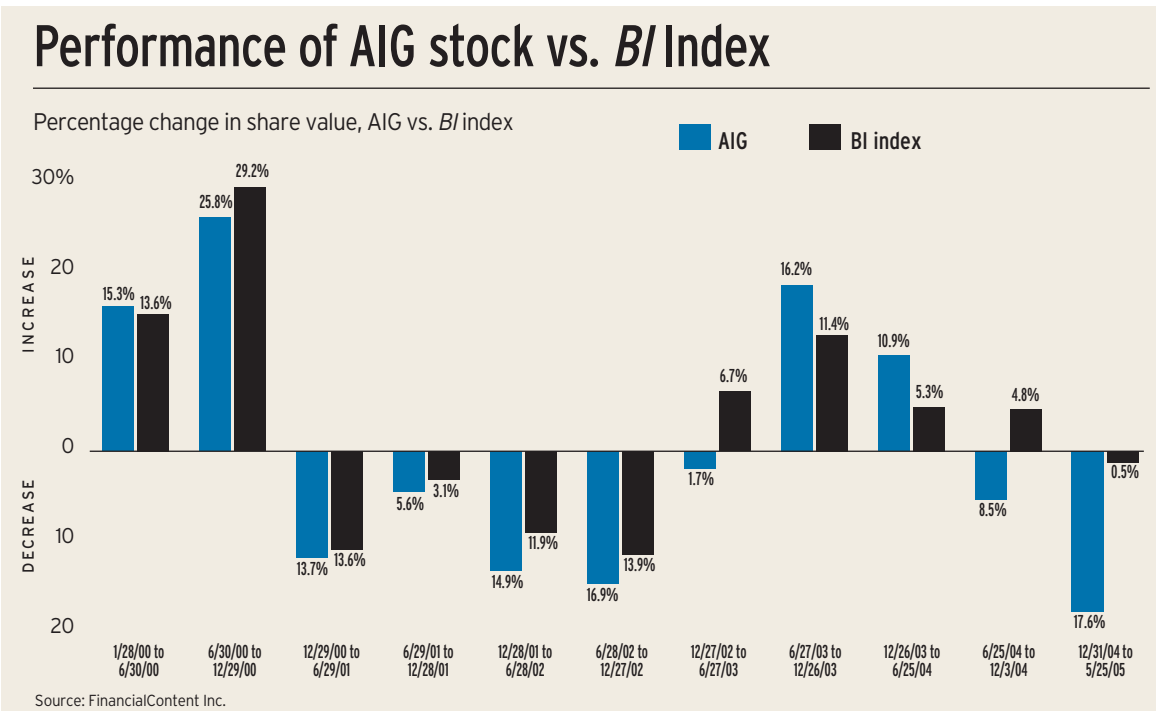
Performance of AIG stock vs. *BI* Index



Source: FinancialContent Inc.

VEBA: Groundbreaking program for academic retirees

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gible can withdraw funds tax-free to pay health care-related expenses.

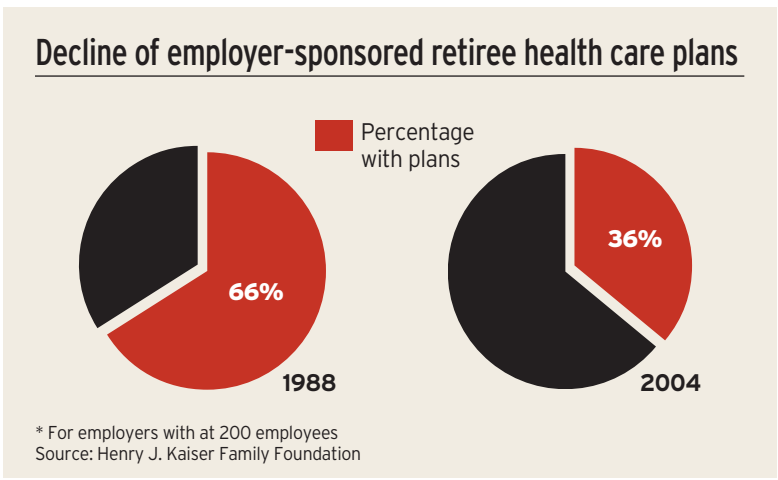
The program, known as Emeriti Retirement Health Solutions, is the result of several years of work by academic institutions, aided by grants from the New York-based Andrew W. Mellon Foundation. It is enabling some academic institutions to offer their retirees health care plans for the first time.

"We wanted to provide retiree health care coverage but did not want to commit to a program that would put a post-employment liability on our books. This is a program where we can control our cost" and still provide employees with significant financial help in funding retiree health care coverage, said Annette Parker, treasurer at Dickinson College in Carlisle, Pa.

"This is allowing us to offer a retiree medical program that is professionally managed and that we are comfortable with the cost. It is something we could not afford if done in a traditional way," said Chip Moore, chief human resources officer for Pepperdine University in Malibu, Calif. Pepperdine is contributing about $1,200 a year to the VEBA on behalf of each employee age 40 and older who has completed three years of service.

Other schools joining the program say offering a retiree health care plan should help them to attract top educational talent.

"It is another tool in our benefits toolbox to attract and retain the best faculty and staff," said Kevin Kerwood, human resources manager at Smith College in Northhampton, Mass. Smith is contributing $418 annually to the VEBA for each eligible employee.



Need for alternatives

Schools that currently offer traditional retiree health plans say those programs have ceased to be affordable, leaving them searching for plans in which their liability would be limited to a fixed contribution amount.

With a traditional plan, "you just don't know what your costs are going to be. They just are not affordable. This is a new concept for health care," said Debby Kelly, director of human resources at Saint Mary's College in Notre Dame, Ind. Saint Mary's is contributing $1,100 a year to the VEBA for each eligible employee.

Outside experts applaud the new program as a creative approach that is a middle ground between the extremes of providing traditional—and increasingly unaffordable—defined benefit type coverage and offering no coverage at all.

"This has a lot of merit for organizations looking for that middle ground," said Michael Thompson, a principal with Pricewaterhouse Coopers L.L.P. in New York.

"We need new approaches that avoid the extremes," added Tom Beauregard, a consultant with Hewitt Associates Inc. in Norwalk, Conn.

For the academic community, providing financial support for retiree health care coverage also could help the institutions address an increasingly common problem in academia: the reluctance of tenured faculty to retire at normal retirement age.

"If you can't move up younger faculty because older professors aren't retiring, you are going to have a problem," said Dave Osterndorf, a principal and senior health care consultant at Towers Perrin in Milwaukee.

But providing retiree health care coverage ameliorates that problem, according to Emeriti. Individuals at institutions that provide substantial financial support for retiree health care coverage typically retire between 18 and 36 months earlier than do those at institutions that do not provide coverage, Emeriti found.

Providing coverage—and reducing fears that faculty members won't be able to afford to retire "creates an environment that promotes institutional renewal," said Mike Clark, a vp and senior health care consultant with The Segal Co. in New York.

While experts applaud the program, they also caution that its applicability—without a change in tax law—could be limited to the tax-exempt world. That is because tax legislation Congress passed in the mid-1980s curbed the ability of many private employers to use VEBAs on a tax-effective basis to prefund retiree health care liabilities, explained Mark White, a senior consultant with Watson Wyatt Worldwide in Washington.

Pay: Increases for risk pros

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pay more for positions that are management level and above," she said.

There is increased attention to risk management these days, Ms. Cain noted, and salary increases could in some cases reflect the value employers are now placing on positions in the field of risk management.

"In different environments, the functions within an organization will attract more focus than in other times," she said.

"Certainly, we now have a business environment that encourages careful risk management," Ms. Cain added.

Karen Banks, a member of the RIMS board of directors, said in a statement that the survey indicates that "risk management remains a lucrative field, as salaries increase and professional recognition continues to expand." Ms. Banks is vp-risk management at Shaklee Corp. in Pleasanton, Calif.

RIMS members who contributed information to the report can purchase it for $125 at *www.rims.org/2005comp*. The cost for nonmember contributors is $500. Members who did not participate can buy the survey for $300, and the cost for nonmembers that did not contribute is $700.

More information is available from RIMS at 212-655-6032 and at *mercer@rims.org*.

Acordia: Middle-market brokerage sued over contingent commissions

Continued from page 3

next," Mr. McGraw said in a statement announcing his civil suit.

In his suit, Mr. McGraw alleges that the contingent commission contracts Acordia has been using since at least 1999 constitute "unreasonable restraints of trade and commerce in the market for insurance services and coverage in the state."

By entering into such contracts, Acordia has caused West Virginia policyholders to "purchase insurance and insurance services at prices higher than they would have paid, and on terms less favorable than would have been available, in a competitive market," the suit states.

Acordia also "repeatedly and willfully" engaged in unfair methods of competition and unfair and/or deceptive practices by, among other things, steering customers to those insurers paying it the highest contingent commissions, manipulating the bids for insurance contracts and fixing the prices of insurance and insurance services, the suit alleges.

Although Acordia disclosed some commission payments to clients, it did not "fully disclose the nature, terms and amounts of the contingent commissions," the suit alleges.

A spokeswoman for Acordia said: "We believe contingent commissions, properly administered, are not inconsistent with the responsibility of our brokers to their customers.

"At this time, Acordia will continue to accept certain contingent commissions, subject to our process and procedures for customer disclosure, which are based on the recommended model provided by the National Assn. of Insurance Commissioners."

Acordia of West Virginia maintains offices in 14 cities in West Virginia. The suit pertains to personal lines, commercial lines and employee benefits policies.

Certain information, including the amount of money Acordia has collected in contingent commissions over various periods, was blacked out in the complaint due to a protective order Acordia was granted, said West Virginia Assistant Attorney General Douglas L. Davis.

The suit seeks compensatory and other damages and to enjoin Acordia from the alleged practices.

Acordia's spokeswoman said the company does not comment on pending litigation. She noted, though, that "Acordia does not condone or tolerate improper or unethical behavior."

One analyst said it is still unclear what impact the suit against Acordia is likely to have on middle-market brokerages, most of which continue to collect contingent commissions.

"My view had been that the middle-market brokers like (Brown & Brown Inc.) and (Hilb Rogal & Hobbs Co.) would potentially be spared or at least find a mutually agreeable way to restructure existing arrangements that would allow them to do substantially what they've been doing, perhaps with some different words attached to it," said Mark Dwelle, an analyst with Ferris, Baker & Watts Inc. in Richmond, Va. "I would continue to believe that's how it will eventually come out, but it's definitely a factor if (states) start going after Acordia," he said.

Acordia's ultimate parent, Wells Fargo & Co., reported $800.5 million in 2003 brokerage revenue (*BI*, July 19, 2004).

HRH exec resigns amid payments probe

By GAVIN SOUTER

GLEN ALLEN, Va.—Hilb Rogal & Hobbs Co.'s president and chief operating officer, Robert B. Lockhart, resigned last Wednesday after it was revealed that employees at the brokerage may have received or made illegal payments in connection with the placement of professional liability coverage.

In a May 26 filing with the Securities and Exchange Commission, the Glen Allen, Va.-based brokerage stated that Mr. Lockhart resigned after HRH determined that: "beginning in 1998, an employee in the company's Hartford, Conn., office arranged or attempted to arrange for payments to be made to the company, or by the company, in connection with the placement of professional liability insurance policies for three different organizations, which may have been improper."

At the times of the payments, Mr. Lockhart was president of the Hartford office or Northeast regional director.

Hilb Rogal & Hobbs also said that the company had terminated the employee who was "involved with the three accounts" and that another employee of the brokerage had been placed on administrative leave.

The matter came to light during the company's review of its practices, which was prompted by investigations into brokerage compensation by various state authorities, HRH said.

In a letter to employees, HRH Chairman and CEO Martin L. Vaughn III said that the brokerage is continuing to investigate the matter and that "If these payments were improper, we will of course make full restitution to the clients who were harmed."

HRH has provided information on the payments to state and federal prosecutors and the Connecticut insurance commissioner.

"Our lawyers have advised us that we cannot comment beyond what was in yesterday's filing, which included the letter to employees," a spokeswoman for HRH said Friday.

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Analysts: Some good news seen in lawsuit

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Howard Smith, which I think reduces the risk of any other forced changes in AIG's senior management," said Mark Lane, a principal and research analyst with William Blair & Co. in Chicago.

"The fact that no current employees of AIG are mentioned is positive for the company," said Steve Dreyer, managing director at rating agency Standard & Poor's Corp. in New York. "The fact that we're not talking about criminal charges, we're talking about civil charges, all of that does not spell a good situation, but certainly it's a better situation than might have been the case."

Mr. Spitzer seems to have gone out of his way to suggest that the company "was well run and in good shape, and it was really a problem with individuals at the company," said J. Paul Newsome, vp and senior equity analyst with A.G. Edwards & Sons Inc. in St. Louis.

Mr. Ward noted that Wall Street reacted to the lawsuit by boosting AIG's stock 3% on Thursday, the day it was filed. "There were some new details that came out, but for the most part the essence" was already known, he said.

Observers widely expect AIG to eventually resolve the suit.

"Our expectations are that it will be settled with a fine," said Joyce Sharaf, managing senior financial analyst at A.M. Best Co.

The pattern with these investigations has been that they ultimately lead to a settlement, said Mr. Dreyer.

The situation may be more complicated, though, in the case of Messrs. Greenberg and Smith, at least in part because a grand jury is reportedly considering criminal charges against them.

"I don't think things with them are going to be settled so quickly or so easily," said Ms. Sharaf.

"This is (Mr. Greenberg's) vindication. It's all he has to shoot for at this point, so while a settlement is a possibility, it seems to me it'll be a fight to the bitter end," said Mr. Ward.

AIG, though, will ultimately weather the scandal, say observers. "I think the company for the most part will be fine," said Mr. Newsome.

Cliff Gallant, analyst with Keefe, Bruyette & Woods in New York, said: "I don't believe the impact will be too dramatic. I think the people who were buying AIG policies a year ago are still buying them," AIG's financial stability has not been questioned, and the insurer's service quality remains intact, he said.

AIG still provides a unique product based on the lines of business it writes and the technical expertise within the company "that does continue to differentiate them," said Mr. Dreyer.

Business Insurance redesigns Web site

Business Insurance has redesigned its Web site, *www.businessinsurance.com*, to better display the depth and breadth of news and information on the site, and to offer new features and tools to help readers stay informed.

In addition to breaking news, the site offers a comprehensive online archive from the weekly newsmagazine, as well as a searchable database of *BI* directories of industry vendors.

Key site enhancements include:

- Updated design and graphics.
- Deeper news resources, with breaking news from *Business Insurance* and Reuters Ltd. throughout the day.
- Multiple new e-mail products, including custom news alerts that enable readers to select news on companies and topics that matter most.
- Expanded highlights from each new issue of the weekly newsmagazine displayed online.
- Enhanced cross-references of related articles, so readers can pursue additional information.
- A new career center for listing and seeking industry jobs, powered by CareerBuilder.com.
- Reorganized news content and information tools specifically for risk managers and benefit managers.
- Ranking data of all the *Business Insurance* vendor directories published online.

Subscribers to *Business Insurance* who register online can access all of these and other features, while nonsubscribers can sign up for free e-mail news alerts. Visit *www.businessinsurance.com* to explore the new features, and stay tuned for additional features in the near future.

BI Stock Index [5/23 - 5/27]

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

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

***BI* Stock Index**	**2391.19**	**1.79**
Dow Jones	**10542.55**	**0.67**
S&P 500	**1198.78**	**0.80**

Largest gains

Tower Group Inc.	7.03%
Axis Capital Holdings Ltd.	5.85%
American International Group	4.91%
PMA Capital Corp.	4.29%
Harleysville Group	4.04%

Largest losses

Hilb, Rogal & Hobbs	-9.44%
Gainsco Inc.	-8.33%
Unico American Corp.	-5.46%
USI Holdings Corp.	-3.51%
Marsh & McLennan Cos. Inc.	-3.11%

Weekly change by market segment

Brokers	-1.21%
Insurers/Reinsurers	0.71%
Managed Care Organizations	1.62%

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

Late News

Continued from page 1

be legally reimported from Canada and Europe. In a letter to House Speaker Dennis Hastert, R-Ill., 221 representatives asked him to schedule a vote on a bill proposed by Rep. Gil Gutknecht, R-Minn., that would allow consumers, pharmacists and wholesalers to reimport prescription drugs from facilities approved by the U.S. Food and Drug Administration in 25 industrialized countries. A companion bill has been introduced in the Senate.

Texas lawmakers reach deal on comp

A House-Senate compromise workers compensation reform measure forged last week in Texas will allow insurers and self-insured employers to direct injured workers into doctor networks. The legislation, praised by Texas Gov. Rick Perry for its potential to lower employer costs, also will increase weekly indemnity benefits by 12% and place the state's workers comp system under the direction of a single appointed commissioner in the Texas Department of Insurance. A comp reform bill also passed in Alaska. That bill would: create a Workers' Compensation Appeals Commission to hear disputes; cap provider fees; and set up a task force to study further changes.

Ohio comp fund exec leaves amid coin scandal

The head of Ohio's Bureau of Workers' Compensation is resigning amid a growing scandal over millions of dollars allegedly missing from a bureau investment fund specializing in rare coins. James Conrad, the bureau's administrator and chief executive officer, tendered his resignation, effective June 3, after Gov. Bob Taft expressed his concern about millions of dollars that are allegedly missing from the state fund's $55 million rare coin-related investment account.

JLT U.S. unit launches emerging markets division

Jardine Lloyd Thompson L.L.C., a U.S. unit of London-based broker Jardine Lloyd Thompson Group P.L.C., has set up a division to help U.S. clients place risks from exposures in emerging markets. The new unit will be headed by John M. Minor, formerly national director of political risks at Aon Trade Credit, a unit of Aon Corp. Mr. Minor will be president of the division, which will be known as Emerging Markets.

Blues plan settles over tobacco funds

Blue Cross & Blue Shield of Minnesota has settled a lawsuit with employer groups challenging its plans for distributing more than $400 million of the proceeds the insurer received from a lawsuit it filed against several tobacco companies. The groups alleged that proceeds from the settlement should go directly to Blue Cross members. Under the settlement, about 38,000 fully insured employer groups that had Blue Cross coverage at any time from Jan. 1, 1978, through June 15, 2001, will receive a share of $41 million, minus attorney fees. Other funds will go to individuals and to pay for anti-smoking initiatives and community clinics serving the uninsured and underinsured, among other things.

Hartford, MetLife get finite subpoenas

The Hartford Financial Services Group Inc. and MetLife Inc. last week reported receiving separate subpoenas from Connecticut Attorney General Richard Blumenthal seeking information on their participation in finite reinsurance deals. Both insurers said that they plan to cooperate with the subpoenas.

Coca-Cola workers strike over health benefits

The more than 2,000 workers at Coca-Cola Co. and Coca-Cola Enterprises who went on strike last week in Connecticut and Los Angeles to protest a proposal by management that they make a larger contribution to the cost of their health benefits returned to work Friday. The four-day strike, which began Monday morning and ended at 5 p.m. EDT on Thursday, was called by the Teamsters Brewery & Soft Drink union, said Chris Roos, president of the union's Local 1035 in East Hartford, Conn. Management had proposed that all but 95 cents of each employee's wage increases over the next six years go into a fund to help pay for workers' health benefits, he said. However, the strike ended when the parties agreed not to require larger health care contributions from workers, according to Mr. Roos. No further details of the tentative agreement were available at press time.

At *BusinessInsurance.com*

New Online Poll: How likely do you think it is that both houses of Congress will approve legislation curbing frivolous lawsuits this year?

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