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Business Insurance

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\$4

High court lowers hurdle for 'mixed-motive' claims Job bias suits may grow

By SALLY ROBERTS

WASHINGTON—Employers are likely to face more so-called "mixed-motive" discrimination suits—as well as a much tougher time defending such claims—because of a Supreme Court decision handed down last week.

The high court on June 9 unanimously ruled in *Desert Palace Inc. vs. Catharina F. Costa* that direct evidence of discrimination is not required for a plaintiff to bring a mixed-motive case under Title VII

of the Civil Rights Act. In such cases, adverse employment decisions are allegedly motivated by both legitimate and discriminatory reasons.

In defending mixed-motive discrimination cases, employers must prove that the adverse action would have been taken even absent the discriminatory motive. Following the high court's ruling, though, plaintiffs in such suits need not produce direct evidence of discrimination and can rely on circumstantial evidence. Such an evidentiary

standard will make it much easier for plaintiffs to sue their employers, which will lead to an increase in the number of mixed-motive cases, attorneys say. Opinions vary, however, on the prevalence of such suits.

"What the Supreme Court appears to have done here is to declare that from now on employers accused of discrimination are guilty until they can prove themselves innocent," said a spokesman for Las Vegas-based Park Place Entertainment Corp., which owns Desert

Palace Inc. Desert Palace does business as Caesars Palace Hotel and Casino.

"They have set a much higher standard and one that, in our view, is unreasonable for employers," the spokesman said.

The case stems from a discrimination suit filed against Desert Palace by Catharina F. Costa, who at one time was the only woman warehouse worker and heavy equipment operator working at Caesars. Ms. Costa had a history of

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Governance law hasn't fueled big EIL interest Demand growing, but pace is slow

By DAVE LENCKUS

In their latest financial statements, petroleum refiner Premcor Inc. and check printer Deluxe Corp. informed investors that the companies recently purchased environmental insurance to help cover their pollution remediation and third-party liabilities.

Insurers, brokers and consultants had expected many other publicly traded companies besides Premcor and Deluxe to turn to the environmental insurance market in the past year to cap their liabilities and calm investors, especially in light of financial disclosure pressures that Corporate America's senior management now faces.

But while demand for environmental insurance products

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Alternative Medicine



A new cost-control therapy?

Coverage of unconventional care likely to increase

By JOANNE WOJCIK

Got a cold? Take two echinacea tablets and call your shaman in the morning.

If that sounds strange, it might not for long, because it's only a matter of time before such unconventional treatment is covered by employer-sponsored health plans, health benefits experts say.

The growing emphasis on consumer-driven health care, which focuses on wellness programs and the

need to keep health care costs under control, could lead to enhanced coverage for alternative therapies such as acupuncture, massage and Chinese herbal medicine, the experts say.

Complementary and alternative medicine could get an even further boost if ongoing federal government-sponsored clinical research, a study by the American Society of Actuaries, and a two-year demonstration project of alternative therapy procedural codes produce favor-

able outcomes, experts say.

Estimates of the percentage of employer-sponsored health plans that currently provide some coverage for alternative medical procedures vary widely. According to the most-recent data available, a 1999 survey by the International Society of Certified Employee Benefit Specialists, 19% of employers offered one or more benefits for alternative care. Also in 1999, Landmark Healthcare Inc., a Sacramento,

See **ALTERNATIVE**/page 22

Late News

House approves class-action reform

The House of Representatives gave its approval to a class-action reform bill last week by a vote of 253 to 170. The

bipartisan Class Action Fairness Act, H.R. 1115, would, among other things, allow large, multistate class actions filed in state

courts to be transferred to federal court in situations where plaintiffs and defendants are from different states and where the aggregate amount at stake is at least \$5 million. Similar legislation won the approval of the Senate Judiciary Committee in early April but has yet to reach the Senate floor.

Benfield raises \$258 million in IPO

Reinsurance brokerage Benfield Group Ltd. raised £157 million (\$258.3 million) through an initial public offering on the London Stock Exchange last week. In the IPO, Benfield sold about 62.8 million shares priced at £2.50 (\$4.11). Last year, Benfield redomiciled to Bermuda and said it was considering listing on the New York or London stock exchanges. The brokerage said that a dual listing is not being considered at the moment but remains an option.

Insurers urge regulators to keep collateral rules

A group of major insurance industry organizations have written a joint letter to U.S. insurance regulators urging them to reject any reduction of collateral requirements for

nonauthorized reinsurers doing business in the United States. The insurer groups hold that any reduction in collateral requirements could erode the security of reinsurance coverage for U.S. cedents. The group addressed their concerns in a letter to John Oxendine, head of the National

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International

U.K. EMPLOYERS BLAST PENSION INSURANCE

Begins on page 17

AON Focus

Advertisement

www.aon.com/focus

Noteworthy

Report explores insurance coverage possibilities for SARS
Buyers of event-cancellation insurance have to be flexible and may need to consider new alternatives, as Joe Addison describes in today's Views column. He and his colleagues are helping clients cope with the uncertainties of terrorism and severe acute respiratory syndrome (SARS), in addition to the usual concerns of spectator events. Aon's specialists are working on multiple fronts to gain a better understanding of the risks and help clients reduce their exposures and obtain insurance for financial protection against losses. In a recent report, Aon explores the possibilities of using environmental impairment insurance to collect on claims of bodily injury or property damage related to SARS. Payment will hinge on how the insurer defines SARS, according to the report, "Environmental Insurance Coverage for SARS." It's available on Aon.com.

www.aon.com/focus/sars22

Get a jump on hurricanes with free storm-tracking resources
Experts are predicting a busy Atlantic hurricane season, and Aon is helping clients stay on top of severe weather warnings. The National Oceanic and Atmospheric Administration is forecasting 11 to 15 tropical storms, with six to nine reaching hurricane strength. The average is 10 tropical storms and six hurricanes for the season, which runs from June through November. Aon offers real-time monitoring services and e-mail alerts as part of its suite of catastrophe modeling services. Aon's catastrophe modeling experts help clients analyze the financial impact of natural disasters and select the right risk management options to protect their property. Several resources, including natural hazard maps for hurricanes, tornadoes, earthquakes and severe weather, are available for free on Aon.com. To download the maps and learn more about Aon's catastrophe modeling services, please visit Aon.com.

www.aon.com/focus/storms22

Coalitions multiply benefits buying power
Aon's work with coalition purchasing groups is paying big dividends for participants. With each benefit season, more and more Fortune 1000 employers are discovering the significant bottom-line advantages of Aon's industry-leading group buying arrangements. Coalition purchasing is a growing trend as more companies forge partnerships to combat escalating costs and simultaneously improve the quality of their benefit programs and boost employee satisfaction. Employers regain negotiating clout and achieve better features, pricing and service from vendors by combining their employee populations. The seven companies in the National Prescription Drug Coalition, for instance, achieved an impressive average annual drug spend increase of only 10 percent last year – compared with the national average of 17 percent. And Aon's National Long-Term Care Coalition has doubled in size in less than 24 months, making it the largest employer organization of its kind in the country. In addition to prescription drugs and long-term care, Aon has created purchasing coalitions for homeowners' and auto insurance, dental plans and group legal assistance. To learn more about Aon's coalition purchasing services, please visit www.aon.com/coalitionpurchasing.

www.aon.com/coalitionpurchasing

European captives forewarned on new accounting rules
Captive insurance companies would do well to heed the debates over accounting rules under way in Europe. Companies resident in the European Union are due to adopt International Accounting Standards by 2005, but the standard-setting boards have said they need more time to sort out how to account for insurance contracts. The outcome could significantly affect the balance sheets of captives, particularly those in countries that permit reserves to cover fluctuations in claims. Praveen Sharma, a senior consultant with Aon's captive consulting company IRMG, explains the issues and the implications in a new white paper, "Accounting for Insurance Contracts: An Uncertain Future for Captives?" He recommends that captive owners begin assessing now the potential impact of the proposed international standards so that they can better manage the expected volatility in earnings. The paper is available on Aon.com.

www.aon.com/focus/captives22

Views

High profile equals higher risk

The entertainment industry has been especially hard hit by radical changes in the insurance marketplace, due primarily to high profile events and the large audiences they serve. The combination of dramatically rising insurance premiums, a faltering economy in the wake of September 11th and the recent SARS scare has created a climate in which entertainment organizations are challenged to find new ways to stabilize their cost of risk while protecting revenue streams. In other words, entertainment companies must change their insurance focus to one that is more concentrated on the severity of risk.

Having long enjoyed a soft, competitive market for insurance, the entertainment industry is still feeling the impact of difficult pricing. Reinsurers are especially concerned with the concentration



Joe Addison

of large groups of patrons or employees at a single event, the use of high-profile facilities, and the risk of event cancellation. As a result, the majority of reinsurers are choosing to provide capacity to other industries with less risk. This leaves very little choice for entertainment industry buyers and requires entertainment risk managers to consider alternatives that they are unlikely to have evaluated in the past, such as significant risk retention or the use of captives. The days of options from multiple insurance carriers and little or no risk assumption by the insured are virtually gone.

Determining the proper type of terrorism coverage is especially challenging, as is the assessment of adequate coverage amounts for high-profile events. Further complicating the process, an insured must balance the cost versus benefit associated with purchasing terrorism coverage. With the Department of Homeland Security's terror

level constantly fluctuating, it is necessary for all organizations that cater to spectators to constantly and thoroughly evaluate the rapidly changing marketplace.

Changes to the insurance marketplace necessitate that entertainment companies alter their buying posture. They can achieve this through a comprehensive loss analysis coupled with specific industry peer comparisons of both potential loss frequency and severity for similar entertainment-related exposures. A strong knowledge of entertainment industry insurance practices and the use of benchmarking information benefit the overall buying decision and are the key components in determining the optimal risk transfer point for your company's unique exposure.

Joe Addison is co-managing director of Aon's entertainment practice group along with Peter Robey. They can be reached at joe_addison@aon.com and peter_robey@aon.com.

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Suit says denials lowered sale price

Former Clarendon owners in dispute with reinsurers

By DOUGLAS McLEOD

TALLAHASSEE, Fla.—Two reinsurers of Clarendon Insurance Group Inc. forced a \$25 million reduction in the insurer's 1999 sale price by wrongfully refusing to pay claims on a book of workers compensation carve-out business, Clarendon's former owners contend.

Retired Clarendon Chairman Ralph Milo and other former shareholders charge in a lawsuit that the refusal of John Hancock Life Insurance Co. and Lincoln National Life Insurance Co. to pay claims led to a \$25 million discount in the price Hanover Reinsurance Co. paid to acquire Clarendon four years ago.

Arbitration proceedings begun after the sale showed that Hancock and Lincoln National had no grounds to refuse payment, according to the suit, filed in U.S. District

Court in Tallahassee, Fla. Hancock earlier this year paid Clarendon \$14.4 million to commute its reinsurance contracts and settle the coverage dispute while an arbitration was still pending, the complaint says.

Mr. Milo and the other former Clarendon shareholders are demanding that Hancock and Lincoln National make up the \$25 million allegedly lost in the sale, and that Hancock pay \$800,000 in legal fees the former owners incurred in the reinsurance disputes.

Neither Hancock nor Lincoln National has answered the complaint.

A spokeswoman for Boston-based Hancock said the insurer "denies each and every allegation, believes the complaint to be lacking totally in factual and legal basis and intends to defend the suit vigorously." Representatives of Philadelphia-based Lincoln National and Swiss

Reinsurance Co.—which acquired Lincoln National's reinsurance operations in 2002—declined to comment.

The lawsuit is one strand in the tangle of litigation and arbitrations that resulted from the late 1990s debacle in the workers comp carve-out market, where the accident and health portion of comp risks was separated from the employers liability portion and ceded to life insurers. Starting with the collapse of reinsurance pools managed by Unicovert Managers Inc., a growing number of reinsurers halted payments to ceding companies, arguing that they had been misled about the nature of the business. Among other things, reinsurers claimed they were unwittingly drawn into reinsurance spirals, assuming and ceding the same business several times over.

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RIMS on the Hill

House holding off on asbestos until Senate moves on its bill



By MARK A. HOFMANN

WASHINGTON—The House of Representatives will continue to hold off action on an asbestos liability reform bill until the Senate acts, at least for the time being, according to the author of a House reform bill.

Asbestos reform is on "the top five list of what to do in this Congress" as far as the House leadership is concerned, said Rep. Mark Kirk, R-Ill.

But with the Senate Judiciary Committee likely to mark up reform legislation in the next few days, the speaker of the House—Rep. Dennis Hastert, R-Ill.—will

likely wait a "respectful" amount of time before the House proceeds, Rep. Kirk told risk managers attending the Risk & Insurance Management Society Inc.'s fifth annual RIMS on the Hill event on June 10. RIMS on the Hill brings risk managers from across the country to Washington to discuss with lawmakers issues and legislation of interest to risk managers.

Rep. Kirk's Asbestos Compensation Act of 2003, H.R. 1114, would set medical criteria and other standards and procedures to compensate victims of asbestos-related diseases. The measure, which was in-

See **BILL**/page 6



PHOTO: AGENCE FRANCE PRESSE

President Bush expressed his support for the creation of a Medicare prescription drug benefit during a speech last week in New Britain, Conn.

Senate committee OKs drug benefit for Medicare program

By JERRY GEISEL

WASHINGTON—Landmark legislation headed for a Senate vote this week that would add a prescription drug benefit to the Medicare program would provide a financial windfall for employers with retiree health care plans, while providing a federally subsidized benefit to tens of millions of retirees.

Last week, the Senate Finance Committee approved on a 16-5 vote the legislation, S. 1, providing for the biggest expansion of Medicare since its enactment in 1965.

Beginning in 2006, the program's 40 million beneficiaries could opt for a new Medicare Part D prescription drug benefit, which would be offered by providers, such as HMOs, PPOs and prescription drug benefit

managers, that would contract with the government.

The coverage would be heavily subsidized by the government at a cost of about \$400 billion over 10 years. Beneficiaries would pay monthly premiums averaging about \$35 a month.

The benefit would be structured with a \$275 annual deductible. Above that, beneficiaries would be responsible for 50% of costs between \$276 and \$4,500. Beneficiaries would pay all drug costs from \$4,501 to \$5,813. Catastrophic coverage would kick in when beneficiaries' out-of-pocket costs hit \$3,700. Above that limit, beneficiaries would be responsible for 10% of expenses.

After years of congressional bickering over the proposal, the historic Medicare expansion is

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Inside Business Insurance

Employers cutting 401(k) matches

A growing number of employers are suspending 401(k) matches as they work to control costs. **Page 4**

Caps on damages vital to med mal reform

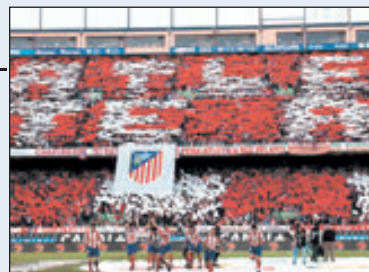
Capping noneconomic damages is the key element in malpractice reform, says a lobbyist for the American Medical Assn. **Page 6**

Risk managers gaining clout in Washington

The annual RIMS on the Hill event shows that risk managers are becoming an ever more recognized force on Capitol Hill. **Page 8**

Sarbanes-Oxley brings changes in liability risks

The Sarbanes-Oxley Act created numerous professional liability exposure changes. **Page 12**



Reinsurers win dispute over earnings policy

A policy designed to cover a Spanish soccer club's loss of earnings involved misrepresentations, the U.K. High Court ruled. **Page 17**

Online

• The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info on your own event.

• Searchable **directories** of all the listings of industry vendors found in *BI's* Market Sourcebook.

• New **Opinion Poll** for readers: Do you think the House of Representatives approval of class-action reform legislation is likely to encourage action on other liability issues such as asbestos and medical malpractice reform?

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Ride Along Enclosed in Editions 3 and 6

401(k) matches hit by poor economy

By JUDY GREENWALD

A growing number of employers are suspending their 401(k) plan matches as they struggle to contain costs in a difficult economic environment.

Observers disagree, however, as to whether many more employers will follow.

Meanwhile, some observers warn that lower-paid employees are more likely to stop participating in 401(k) plans when matches are suspended, which could make it more difficult for the plans to pass nondiscrimination tests.

Many of the companies that have made cuts say they are only temporary, and some have already at least partially restored their matches. "During tough economic times, companies will probably cut back on the match temporarily, but I

think once the economy gets back you're likely to see more companies offering matches again," said John Scott, director of retirement policy at the American Benefits Council in Washington.

"These programs are designed to attract and retain employees, so whenever we get down to periods of low unemployment gains—and I think we will—you're going to see matching contributions go up as companies compete for talent in the labor pool," he said.

Employers that have announced suspensions or reductions in their 401(k) matching programs include: San Francisco-based Charles Schwab Corp.; New York-based Prudential Securities Inc.; Dearborn, Mich.-based Ford Motor Co.; Auburn Hill, Mich.-based Chrysler Group; Jackson, Mich.-based CMS

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PHOTO: REUTERS



PHOTO: REUTERS

Among the U.S. employers that have temporarily suspended their 401(k) plan matching contributions are Ford Motor Co., Goodyear Tire & Rubber Co. and DaimlerChrysler unit Chrysler Group.

Feds indict Near North

Brokerage, former bookkeeper added to case against Segal

By SALLY ROBERTS

CHICAGO—A federal grand jury last week added Near North Insurance Brokerage Inc. and a former bookkeeper as defendants to its case against Michael Segal, owner of Near North National Group.

The 17-count second superseding indictment charges Near North Insurance and Daniel E. Watkins in connection with the alleged theft of more than \$20 million from the broker's premium fund trust account.

In November 2002, Mr. Segal was indicted on seven counts of insurance fraud, seven counts of mail fraud, one count of wire fraud and one count of racketeering. The government alleges that, over at least 12 years, Mr. Segal caused more than \$20 million in insurance premiums to be diverted to his own and his companies' use.

Mr. Segal, who has denied wrongdoing, stepped down as Near North's chairman and chief executive officer last year. His June 16 trial date has been postponed.

In a statement, Near North said that it is "disappointed" with the government's actions.

"The company will fight vigorously against these charges and do everything in its power to preserve the future of Near North," the broker said in its statement.

The pending acquisition of Near North's brokerage operations by Chicago-based private equity investment firm Fron-

tenac Co. L.L.C. is continuing to move forward despite the indictment, said Rodney Goldstein, managing partner at Frontenac.

"We are moving as quickly as we can to complete our work, and we are hopeful that a transaction can close," he said. "We continue to have enormous respect for the depth and breadth of the management organization at Near North."

In the new indictment, federal prosecutors charge that Mr. Watkins, a former Near North accountant and bookkeeper, handed over large sums of cash to Mr. Segal at his request from the brokerage's accounts, concealing them as postage purchases or in envelopes addressed to a Mr. Johnson.

Prosecutors also charge that Mr. Watkins similarly handed over funds to Mr. Segal's family members.

In addition, the government charges that Mr. Watkins embezzled more than \$5,000 from Near North.

The indictment also charges that Mr. Segal and Near North defrauded customers by not disclosing that DMI Brokerage L.L.C. is an affiliate of Near North.

The government alleges that Near North collected fees from certain customers for negotiating insurance coverage while, unbeknownst to the customers, DMI collected commissions from insurers for placing the business. By doing this, DMI obtained an additional \$500,000, the government charges.

Legislators seeking to block corporate-owned life insurance

By ROBERTO CENICEROS

SACRAMENTO, Calif.—A bill moving through California's Legislature would ban employers in the state from buying corporate-owned life insurance policies.

If the measure were to become law, it would deprive employers of a conservative investment tool that some employers use to help finance employee benefits, say opponents of the bill. It could also expose them to a substantial tax burden, they say.

A.B. 226 would prohibit insurers from issuing or delivering COLI policies that designate employers as the beneficiaries for life insurance on nonexempt employees. It would also void existing policies on their next anniversary or on the premi-

um payment due date.

The bill was approved by the state assembly on May 19 and has been sent to the Senate Committee on Insurance.



The legislation was proposed in response to widespread criticism of

COLI policies over the past several years.

Critics have vilified COLI policies as "dead peasant" policies because employers, not the insured employees' survivors, receive the life insurance proceeds. In some instances, employers have purchased the coverage and not informed their employees.

More than a dozen states now have so-called "advise and consent" laws that require employers to inform their employees about COLI policies and require the employers to obtain the consent of employees before insuring their lives.

Legislators in Texas and now California, though, are seeking to pass more stringent laws.

During a legislative session that

See COLI/page 15

NYBGH

Efforts on care quality urged

By MICHAEL PRINCE

NEW YORK—Employers need to work together to foster greater quality in health care, says a leading consultant and buyer group executive.

Through a unified effort to improve quality, employers can ensure a reduction in deaths and injuries from medical errors, as well as achieve considerable savings in their health care costs, said Dr. Arnold Milstein, medical director of the Pacific Business Group on Health in San Francisco and national health care thought leader at Mercer Human Resource Consulting.

By working together, employers can create the leverage needed to "transform the market," he said.

The current U.S. health care sys-

tem is plagued by "an impossibly disproportionate ratio between muscle and brain," Dr. Milstein told attendees at a conference in New York this month sponsored by the New York Business Group on Health.



While the current system has the "muscle"—the technology and medical tools—it is lacking in "brains," or the knowledge about how best to use those tools. This disparity results in a great deal of inappropriate medical treatment, Dr.

Milstein said.

Correcting this imbalance, he said, would require changes in the ways physicians and hospitals are evaluated and paid for services.

The first step is the creation of quality scorecards for doctors and hospitals. Several organizations are working on such projects to measure the quality of care, and employers wisely have embraced those efforts, he said. One such organization is The New York State Health Accountability Foundation, which is working with New York-based employers to measure health care quality.

Once standards for measuring quality have been established, the next step is to make providers more sensitive to their performance. And the best way to do this, Dr. Milstein

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RIMS on the Hill

Lower noneconomic damages key to med mal reform

By MARK A. HOFMANN

WASHINGTON—Limiting the amount of noneconomic damages that can be awarded in medical malpractice liability cases is the key element in malpractice reform, according to a lobbyist for American Medical Assn.

Capping noneconomic damages should rein in medical malpractice insurance premium hikes, said Margaret Carvin, assistant director-division of congressional affairs in the AMA's Washington office.

"Carriers are very interested in this—they're not interested in gouging physicians," Ms. Carvin said during a panel discussion of tort reform legislation at the Risk & Insurance Management Society Inc.'s RIMS on the Hill lobbying visit to Washington last week.

The panel, which was moderated by Janice Ochenkowski, RIMS' vp-external affairs and vp-risk management for Chicago-based Jones Lang LaSalle, also discussed reform efforts related to asbestos liability and class-action lawsuits.

The AMA's Ms. Carvin said the current medical malpractice liability situation is characterized by both good and bad news. The good news is that an increasing number of people are interested in the issue; the bad news is that the interest stems from a crisis in health care access and cost.

She noted that the House of Representatives has already passed a measure—The Help Efficient, Acces-

sible, Low-Cost, Timely Healthcare Act of 2003—that would reform the malpractice liability system. The bill, which is modeled on a 1975 California law, would cap noneconomic damages at \$250,000 and limit punitive damages to the greater of \$250,000 or twice economic damages.

Citing the experience of states such as California that already have imposed limits on noneconomic damages, "as far as we can tell, noneconomic caps are the key," said Ms. Carvin.

Another speaker was sanguine that a separate matter of interest to risk managers, class-action reform, would see congressional action.

Matt Webb, director-legal reform policy for the U.S. Chamber Institute for Legal Reform in Washington, said he's "optimistic" that supporters of S. 274, the Class Action Fairness Act approved by the Senate Judiciary Committee in April, have the 60 votes necessary to halt any filibuster and bring the measure up for a full Senate vote.

Mr. Webb added that he's "very optimistic" that similar legislation that won the approval of the House Judiciary Committee last month will get even more votes in the full House than an earlier measure did when it passed the House last year. That indeed happened last Thursday.

The third tort reform issue discussed, asbestos liability reform, also enjoys an "optimistic" outlook, according to Jan Amundson, senior

vp and general counsel of the National Assn. of Manufacturers in Washington. "Labor still hasn't shut the door" on a reform bill drafted by Sen. Orrin Hatch, R-Utah, she said. Ms. Amundson noted that more than a dozen asbestos liability reform bills have been introduced since the early 1980s and that none has moved as far as Sen. Hatch's.

That bill would replace the current litigation-based system for compensating victims of asbestos-related diseases with a \$108 billion national trust fund paid for primarily by major defendants in asbestos liability cases and their insurers.

"You cannot squander this opportunity," she said, noting that business has rallied behind the bill even though some individual companies are not happy with the proposed trust fund.

"I'm very optimistic something will happen" during the current Congress, said Ms. Amundson, adding that she might be being a little "Pollyannaish" in her assessment.

In a separate presentation at RIMS on the Hill, Joel Wood, senior vp-government affairs for the Council of Insurance Agents & Brokers in Washington, expressed guarded optimism than Congress would amend the Liability Risk Retention Act of 1986 to allow RRGs to underwrite property coverage. Currently, RRGs can write only liability coverage for their members.

Mr. Wood said that although no bill amending the Risk Retention Act has been introduced in this Congress, legislation is likely in the near future.

"I hate to say it, but it takes a little pain to get something like this done," he said, with the pain being the spike in commercial property

rates seen in the wake of the Sept. 11, 2001, terrorist attacks.

He said that "the immutable law of physics in Washington" is that it is always easier to block legislation than to pass it, but if risk managers and others can get Capitol Hill interested in the issue, "I think we've got a shot" of amending the act.

RIMS on the Hill

Private insurers urged to develop terror capacity

By MARK A. HOFMANN

WASHINGTON—The Bush administration believes that terrorism is a manageable risk that the private insurance sector can cover, according to the official overseeing implementation of the federal Terrorism Risk Insurance Act.

And, warned Assistant Treasury Secretary Wayne A. Abernathy, "I don't think people should be sanguine about the ability to reauthorize" the federal government's backstop program for coverage for catastrophic terrorism losses. He told an audience of risk managers to bear in mind that it took Congress more than a year after the Sept. 11, 2001, attacks to enact TRIA in the first place.

Speaking at the Risk & Insurance Management Society Inc.'s RIMS on the Hill event last week in Washington, Mr. Abernathy said he hopes that adequate private capacity is in place by the end of 2005, when the TRIA program is slated to expire. He noted that he has "faith" that the program's current structure will encourage the development of that capacity.

Under TRIA, the federal government and private insurers would

share the costs of future catastrophic attacks, with insurers' share of the exposure increasing as the program continued. The project's aim was to give the industry time to build up capacity.

Mr. Abernathy rebutted the notion that terrorism risk cannot be insured.

"We continually hear from a number of sources" that terrorism risk is unmanageable, said Mr. Abernathy.

Terrorists aim to use very limited resources in an attack that causes the greatest number of people to feel threatened, he said, stressing his belief that such risks are insurable.

He suggested that insurers form their own pools to deal with such exposures. Even high-risk "trophy properties" should be able to be insured, he said. Terrorists would not be able to hit all of those properties at the same time, said Mr. Abernathy.

He said he had "great confidence" that new risk-bearing mechanisms could be developed to meet the terrorism exposure. For the time being, "the capacity's being built, it's not there yet," he said.

Bill: Asbestos reform

Continued from page 3

roduced in March, currently has more than 40 cosponsors and has been referred to the House Judiciary Committee.

"I'm looking minute by minute" at what Sen. Orrin Hatch, R-Utah, is doing, said Rep. Kirk. He said any bill that can pass the Senate could be changed with input from House lawmakers in conference. Because any Senate bill would have to gar-

ner the support of at least 60 senators in order to survive a filibuster, the final Senate bill will likely be a compromise piece of legislation.

According to Rep. Kirk the enactment of asbestos reform legislation could stimulate the economy. He said about 6,000 stocks are depressed because of asbestos liabilities they must disclose. "My best wishes go to Sen. Hatch," he said. "We're ready to roll."

Paul Winston



Editor Paul Winston's weekly column will resume in the June 23 issue

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Editorial

PBGC is a model worthy of emulation

WILL THE UNITED KINGDOM soon follow the United States model and adopt an insurance program to protect the benefits of employees and retirees whose pension plans collapse with insufficient assets to meet their promises?

That is an issue U.K. lawmakers will be taking up in the months ahead, and early indications are that its government will adopt a program that is modeled after the Pension Benefit Guaranty Corp.

The PBGC is the U.S. government agency that has been protecting the pension benefits of workers in the United States for nearly 29 years.

On balance, despite the criticisms of U.K. business groups, we think the PBGC model is a good one for the United Kingdom to consider. During its nearly three decades of existence, the PBGC rescued well

over 3,000 pension plans from failed or financially distressed employers, ensuring the continuation of a basic level of benefits promised to nearly 1 million participants in those plans.

Without the PBGC, those individuals, many of them elderly retirees, would have lost billions of dollars in benefits they earned for decades of work at their employers. Imagine the uproar and cries for government intervention that would have been heard if all those individuals had been left high and dry, as participants were prior to the establishment of the PBGC.

In sum, the PBGC has helped to instill greater public confidence in the security of employer-provided pension benefits by increasing the likelihood that plan participants would receive—even if their companies were to fail—their promised

benefits, or at least a portion of them. That is no small achievement.

As the U.K. government looks to bolster private pensions, it could see similar gains from the creation of a benefit guarantor.

Nevertheless, U.K. lawmakers would be wise to study some of the mistakes U.S. legislators made in setting up the PBGC to avoid repeating them.

The first mistake was establishing a premium payment structure in which all employers—regardless of the funding levels of their plans and the risks their plans posed to the PBGC—paid the same premium rate. That, of course, was completely unfair to employers with well-funded plans, because their premium dollars were unduly subsidizing the PBGC insurance program. It took Congress years to rectify that un-

fairness.

In addition, the PBGC's insurance program, in its early years, was filled with loopholes that made it relatively easy and inexpensive for employers to walk away from their pension plans and dump the liabilities onto the PBGC. Again, it took time to close those loopholes so that the only employers that can terminate underfunded pension plans and pass the plans' obligations onto the PBGC are those in truly desperate condition and whose pension plan obligations would prevent any chance of those organizations staying in business.

By avoiding such mistakes, the United Kingdom should be able to set up a pension insurance program that will provide valuable benefit protection to participants at a relatively low cost to the private employers funding the program.

RIMS on the Hill efforts are on the mark

THE FIFTH ANNUAL RIMS on the Hill serves as a reminder that risk managers are becoming an ever more recognized force on Capitol Hill.

When the Risk & Insurance Management Society Inc. drew members to Washington to speak out on issues of interest back at the first RIMS on the Hill, in 1999, it was a pretty safe bet that many lawmakers had no idea what a risk manager did. There was a lot of educating to be done, both for risk managers

who needed to present their cases on Capitol Hill and for the members of both houses of Congress who would hear those concerns.

The tragic events of Sept. 11, 2001, thrust RIMS and risk managers into a high-profile advocacy role as they joined with other businesspeople, including insurers, agents and brokers, to push for enactment of a federal terrorism insurance backstop.

The effort took more than a year to realize, but in the end, President

Bush received the Terrorism Risk Insurance Act that both he and the risk management community sought.

Risk managers who attended this year's RIMS on the Hill focused on the importance of passing liability reform on a variety of issues, including asbestos, medical malpractice and class-action lawsuits. The agenda was a timely one, for scarcely a day after RIMS on the Hill ended, the House of Representatives gave its approval to a balanced

class-action reform bill.

The risk management community's growing political sophistication was evident last week and is paying off handsomely. If that sophistication continues to grow to the same degree it has over the past half-decade, the rewards of continued political engagement should be even greater in the future.

Schillerstrom



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Ask a risk manager

Buyers have a role in quality-boosting efforts

Q: How can risk managers more effectively address the quality and performance issues of their partners in the industry?

A: While it is no small issue, the situation can best be summed up as such: too little attention to details, commitments and customer expectations and too much focus on the problems of the moment. Those problems tend to concern rates and risks deemed too risky to underwrite.



But there is another side to the equation that is often overlooked. That is the role the buyer—the risk manager—plays in the process of insurance purchasing or, more broadly, risk financing. Quality is a two-way street

and cannot be achieved to any meaningful degree unless all parties to transactions actively participate. Buyer participation means as much attention to detail, commitment and mutual understanding as would be expected of the seller.

Too often, risk managers think solely in terms of what the seller will do for them, when the ability to deliver service is significantly affected by what the buyer must do to produce a quality transaction. Only through mutually understood expectations can the parties hope to achieve a quality result. And only through clear and regular communications can both parties expect to achieve a high degree of mutual understanding.

While some parties to these transactions use contracts in addition to the insurance contract to define these expectations, in most cases there are no written expectations beyond the insurance contract. Similarly, there are few examples of contracts that define the buyer's relationship with the intermediary. Too many of us just take it for granted that the roles assumed by these parties are understood, often as a function of tradition.

That's a big mistake. I would suggest that even when contracts exist, they often obscure the real meaning of mutual understanding with legalese. They may be useful when it comes to litigation, but if real mutual understanding is sought, there is a better way.

One better way is to use a specific agreement—aside from the formal contract—that is designed to detail the actual behaviors expected of both sides that would define the quality of results. This could take many forms, but the Guidelines for Performance Expectations at www.rims.org, designed by the Risk & Insurance Management Society Inc.'s quality committee, is a great example of a document that can help you achieve better performance results and a high degree of mutual understanding. Buyers and sellers make up the committee.

One reason for the success of guidelines is the customization possible in defining what is important to each party. Using a basic template that sets forth major performance categories that are understood to exist in the relationship with different types of providers, the guidelines allow users to specify those things that are most important to them to achieve desired outcomes. Once the expectations are defined, the other party has a chance to either agree or negotiate a set of expectations that are more in line with its view and ability to deliver on the

commitments. Establishing priorities and weighing options is central to identifying what matters most to both parties.

Ideally, the guidelines could then be tied to incentive compensation schemes that can raise the probability that actual expectations will be met or exceeded. In the same way that incentive compensation, in the form of bonuses and stock options, has successfully driven company results by more effectively directing the energies of management and employees, financial incentives can drive partner performance if designed effectively. The key aspect of effective design is tying the incentive specifically to desired outcomes and using penalties for nonperformance. One version of this that I've found effective is using a "deposit" payment up front and a making another payment later that depends on performance.

For example, let's say your broker's services are valued at \$200,000 on a high-performance basis. If you use an incentive range of plus or minus 25%, then the broker would have \$50,000 in the balance that is based on performance. Using this model, you would pay \$150,000 in deposit fees and up to \$50,000 for performance above the "average" and deduct as much as \$50,000 for performance below the "average." It's a pretty simple concept but a very powerful one in producing desired behaviors.

Whether you use an agreement such as the RIMS guidelines or some other form, the key is to get mutual agreement among the parties as to the expectations of each. No partnership can be optimized without such understanding. Furthermore, you can't effectively measure outcomes without applying such discipline to the partnership relationship. In the end, all parties will be more satisfied, even if performance falls short, because performance expectations will be

clearly documented and the consequences of the shortfall will be known. It might even save you some litigation.

Obviously, there are many other ways the insurance industry can address the quality of its work and products, but because it is such a relationship-driven business, measuring outcomes can go a long way toward minimizing friction and maximizing the outcomes that make doing business much easier and more rewarding.

With various entities having pursued insurance industry quality now for several years, we are at a critical juncture for all affected. While RIMS has provided a valuable set of tools—including a broker partner tool—to facilitate better results for its members, it is now up to risk managers to take the initiative and insist that their insurance industry partners work with them more formally toward mutually accepted performance goals that will then drive better outcomes. Ask your broker, underwriter, third-party administrator or consultant to enter into an agreement for evaluating performance. Everyone will be better off for it and, just maybe, we can move quality up to the next level.

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

This month's column on risk management issues was written by Christopher E. Mandel, assistant vp-enterprise risk management at USAA Group in San Antonio and current chief risk officer of RIMS.

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

Industry needs to clean its dirty laundry

By Corby Pelto

There has been a lot of attention given to rising insurance premiums and claim costs since Sept. 11, 2001, and much of that attention has rightfully focused upon the external factors that have had a major impact upon rising insurance claim costs and exposures.



While increasing attention has been given to the external factors, not enough attention has been paid to the industry's internal

problems. It is time for both the industry and its clients to play a role in cleaning up the insurance industry's dirty laundry.

Just as recent scandals have cast a shadow on the accounting industry for its professional and ethical lapses, the insurance industry has issues relative to its own practices.

Among the insurance industry's dirty laundry are a lack of aggressiveness in attacking weak links in claim operation models, a lack of enforcement of appropriate ethical standards and a lack of effort in applying independent and unbiased auditing

practices—particularly to third-party claims administrators.

As a result, the insurance industry has inadequately challenged the status quo over the years, and it has contributed to rising costs by enabling self-interest and personal relationships to play too large a role. The current insurance arena serves as both an enabler and protector of the status quo.

Claims administrators, brokers and risk managers all carry some burden of responsibility for improving the insurance industry problems that we experience today.

Today's claim operations are too often challenged by factors including excessive workloads, inexperience, employee turnover, inadequate training, multistate adjusting challenges, adjuster licensing noncompliance and other adjuster frustrations.

From a process standpoint, the claims industry has not focused enough attention on deploying effective task management processes, and it has shortchanged critical factors that drive claim costs, such as front-end claim investigations. The claims industry is now facing a very real challenge in overpromising and underdelivering results.

Because the industry's measurement and benchmarking efforts have been hampered by data conversion problems and the undisciplined use of statistics, the claims industry has also found itself battling the issue of demonstrable value.

Chief financial officers at insurance industry client companies need to

understand that when a claim operation model is poorly designed or managed, it can lead to bad financial results that can have both a short- and long-term impact on their organizations.

These trends not only can result in higher premiums or claim costs to the customer but also increase the insurance industry's exposure to lawsuits, bad publicity, and errors and omissions and bad-faith claims.

Brokers often play a role in influencing risk managers' purchase of insurance or claims administration services.

However, insurance buyers should understand that the same type of cozy business relationships that got certain accounting firms into trouble with government regulators can be a problem at insurance brokerages as well.

Although risk managers certainly would be expected to rely on their brokers for advice, this relationship isn't immune to potential bias or self-interest. The influence of career positioning, broker financial incentives and other perks and favors is visible in the industry today. These influences can create bias and can inhibit progress by protecting the status quo.

CFOs would be well-served by ensuring that potential areas of self-interest and bias are addressed in their insurance programs and by ensuring that sufficient external audits and monitoring are in place.

Along with maintaining neutrality in the insurance programs, risk managers should

ensure that competent expertise is brought to the table when evaluating their claim programs. When there is a lack of claim management experts involved in the selection committees of prospective TPAs, it can result in inadequate challenges to the process, and it enables personal relationships and other biases to influence the decision.

Risk managers should take greater risks in attacking industry shortcomings. CFOs should know that there is certainly a risk to stockholders and organization leaders by not taking calculated risks.

CFOs and their companies need to understand that rising insurance premiums and rising claim costs are not attributed solely to external challenges. The insurance claims industry carries some responsibility for delivering better claim operation models, better accountability practices and more aggressive efforts to attack weaknesses.

If the insurance industry is to curb the rising cost of insurance, it will need to embark upon a targeted, broad-based and ethical pursuit of quality improvements both in its practices and operation models.

Risk managers have a role to play by demanding improved industry practices. If they do this, the insurance industry will likely deliver far better results.

Corby Pelto is president of Pelto Group Inc., a Golden Valley, Minn.-based independent claims management consultant.

Cutting costs of business interruption cover

By Christopher M. Lewis
and Elizabeth V. Walles

In the wake of the Sept. 11, 2001, terrorist attacks, businesses have found it increasingly challenging to obtain business interruption coverage at attractive rates and limits. Barring an immediate softening of the commercial insurance market, we believe that businesses' best



opportunity for obtaining business interruption coverage would be through a narrowing of the risks covered by these policies.

But how can businesses obtain adequate coverage while narrowing the effective risk transfer in business interruption contracts?



We believe that a switch to activity-based or indexed-based contracts can provide part of the answer, helping to expand capacity in the business interruption

market.

Underwriting capacity in the commercial property/casualty insurance market has declined nearly \$100 billion in the past three years, according to a January 2003 Insurance Information Institute report. The market's

contraction following the Sept. 11 attacks has primarily been attributed to the resulting reduction in insurer capital, as well as the increase in insurers' assessment of the probability of terrorist attacks.

Another important element in the continuing market contraction, however, is the revelations emanating from 9/11 business interruption claims that the current structure of business interruption policies exposes the insurer to considerable unintended risk shifting—causing insurers to further reduce exposure to the business interruption market.

This unintended risk shifting is due to the broad coverage terms currently in standard business interruption policies. For example, a typical business interruption policy provides coverage for income lost and extra expenses incurred due to the disruption of a firm's physical assets. Policies also may include contingent business interruption coverage for losses incurred due to physical disruption to a supplier or customer. However, ambiguous terms within business interruption policies typically do not specify how losses should be computed.

As evident in some financial institutions' recent claims, the magnitude of potential business interruption exposure is highly dependent on the nature of the insured activities. Banks filing business interruption claims following the Sept. 11 attacks have claimed lost revenues associated with their inability to transact, process and settle transactions across a wide variety of markets and activities.

Notably, the losses on these policies depend critically on the specific activity being insured. For example, an investment bank knows how much of its trading business revenues typically derive from customer transactions vs. gains on securities

held in its own trading portfolio. Although they may be within the same business unit, these two revenue sources are impacted differently by physical disruption and impart a different business interruption loss.

The insurance company's issue is that the policyholder has more information than the insurer about the risk being transferred through the business interruption contract. This superior position leads to concerns over risk shifting from moral hazard or adverse selection. Before Sept. 11, pure indemnity contracts for business interruption coverage provided policyholders with low-basis risk in coverage but lacked transparency in protection and did not allow insurers enough control over ex-post moral hazard. Since insurers did not sufficiently charge for the risks being transferred, policyholders preferred these indemnity contracts. A key lesson from Sept. 11 claims adjustment, however, was the substantial cost of ex-post moral hazard and broad coverage standards.

One option addressing this issue is to offer activity-based coverage on a business unit level, similar to unauthorized-trading policies on individual traders. With activity-based business interruption coverage, a business could obtain protection against specific losses from individual business units based on the nature of the loss that would be incurred with a qualifying event. For the policyholder, the additional cost of this type of contract would be reduced per-activity limits and possibly higher underwriting fees.

Another alternative would be to offer index-based contracts. Under an index-based contract, the actual loss payout would be determined using a predefined formula based on the number of days of physical disruption, a preset transaction fees schedule and an index of market activity based on

market volumes and the policyholder's market share, less any offsets.

For example, a power generator selling capacity to the market would purchase a business interruption policy that reimbursed the company using a payment linked to a fixed market share of the generation volume in a given market, the market's actual volume during the outage and the market prices that prevailed during the indemnity period.

For a brokerage institution, a similar contract could cover losses based on a fixed market share of the brokerage market, actual market volumes and an agreed-upon schedule of net commissions by product type. The business interruption loss then is calculated as projected revenues minus actual revenues.

In both examples, the payment on the business interruption contract would be closely—though not perfectly—linked to the actual loss incurred. For the policyholder, insurance payments and actual losses would slightly differ due to such factors as product mix changes, customer behavior and potential saved expenses. But the contract's transparency would give more confidence to the insurance community that the contracts protect against unintended risk shifting.

Using these approaches, insured businesses would assume higher-basis risk on the underlying coverage but benefit from greater access to affordable business interruption policies in the marketplace.

Christopher M. Lewis is chief operating office and managing director of Fitch Risk Advisory in Greenwich, Conn., where he oversees NetRisk Insurance Services practice. Elizabeth V. Walles is a vp in NetRisk Insurance Services.

Sarbanes-Oxley will keep risk managers busy

By David Golden

The Sarbanes-Oxley Federal Corporate Accountability Act has received significant attention from insurers as they struggle to comply with Securities and Exchange Commission rules to implement the new law. Hidden beneath the early compliance efforts are numerous professional liability exposure changes that risk managers



will have to understand and minimize.

On the surface, Sarbanes-Oxley and its resulting regulations implement some fairly logical controls on how corporate financial statements are developed and justified. Audit

firms are not permitted to audit their own work. Auditors cannot act in a management role. Auditors cannot advocate for their own audits or represent clients before the Internal Revenue Service during tax audits. An audit firm's partners must rotate on and off each client. The client company's audit committee must comprise independent directors rather than company executives. The audit committee will have the sole authority to hire an outside audit firm.

The changes start with accountants; after all, this is an accountability law. They must update their professional knowledge to make sure that the statements they create comply

with the new law and with the SEC regulations that keep evolving and changing.

Accounting firms must also be aware of the restrictions on additional services that audit firms may provide. Internal coordination will have to be flawless, while maintaining the appropriate distance and protecting privacy of information. It will be a challenge for the marketing department. It could also be a risk management nightmare.

Coordination of professional liability coverage and underwriting needs among the professions could get even trickier than they are already. Some firms might decide to get out of the consulting or other businesses altogether to concentrate on auditing. The opposite is also true; some firms might decide to drop their accounting and audit services to concentrate on building their consulting incomes. Any change in operations will produce risk management challenges: what coverage to add, what coverage to drop, what claims-made tail to buy and the like.

Directors and officers liability coverage is certainly at risk. The requirement that the chief executive officer certify accounting statements may have received the most press, but it certainly is not the only change. The requirements of the new law likely add numerous exposures to D&O lawsuits. This line has seen an explosion of litigation that started several years before anyone heard of Enron. There will be more litigation as various corporate excesses are uncovered. The best hope for a slowing of D&O litigation is probably a recovery of the stock market. But this may not happen any time soon, leaving

this particular line of insurance even more vulnerable to continuing changes in coverage and limits for some time. Risk managers will have to track, understand and adjust risk management tools on an ongoing basis.

Insurance agents and brokers will be part of the complicated legal scene. Producers need to be knowledgeable about the latest changes, good at explaining them and the consequential changes in insurance coverage, and excellent at documentation if they want to stay out of the courthouse. Errors and omissions exposures for insurance agents and brokers will be heightened as they become exposed to allegations that they did not properly explain coverage options or did not recommend appropriate coverage and/or limits. They will have their own risk management exposures as they work with client risk managers and business owners.

Insurers, especially stock companies, will be part of the D&O mix, too. Beyond their own underwriting results from providing all of these coverages, insurers will have their own D&O exposures to manage. The twist will be that they could see D&O allegations that company leaders did not properly oversee insurance operations in the professions subject to Sarbanes-Oxley if those underwriting operations lose money over time. Major decisions, such as bulk reserve adjustments, might be second-guessed by stockholders and attorneys looking for class actions to assemble.

Even lawyers can be stung by Sarbanes-Oxley. Corporate attorneys have a positive responsibility under the new law to progressively report accounting concerns to

the chief financial officer, the chief executive officer and, ultimately, to the board of directors' independent audit committee. This calls for subjective judgment, more knowledge of audit and accounting standards and successful balancing of ethical standards by corporate attorneys.

Just to make things a little more complicated for risk managers and insurers, rumors are flying that states may enact similar laws that are even stricter. Such laws might go beyond publicly traded companies. These could have even wider consequences for the insurance industry. There are also rumors circulating that some plaintiff law firms are creating Sarbanes-Oxley specialties within their firms, so more litigation is almost a certainty.

Finally, the big unknown is what the courts will do with the new law and the causes of action that it creates or changes. It will be years before we have real confidence in how exposures have really changed as a result of Sarbanes-Oxley.

Coverage implications will vary from profession to profession and from one coverage form to another. One thing is certain: risk managers, underwriters, and insurance agents and brokers will all be busy keeping current on both the federal and the possible state laws, as well as new regulations and emerging case law, in order to comply with this complex new law. If you are one of them, think of it as job security.

David Golden is director of commercial lines for the National Assn. of Independent Insurers in Des Plaines, Ill.

INSURER TOPICS

Urban markets merit fair, consistent treatment

The only discrimination allowed is that on a sound actuarial basis

By MARK A. HOFMANN

Consistency may be the hobgoblin of little minds, as Ralph Waldo Emerson put it, but it can also help insurers and agents alike to avoid allegations of redlining.

Like many other things bad and good, redlining can be in the eye of the beholder. What insurers may view as sound underwriting can look like illegal discrimination to those who cannot find affordable coverage.

To avoid such charges, insurers and producers must treat customers fairly and consistently, say industry experts. To do so is not simply a legal matter; it's a matter of good business sense as well, they say.

Fortunately, redlining appears to be fading as an issue, say observers.

"Overall, we're hearing very little about it. It doesn't seem to be of widespread concern," said Madelyn Flannagan, vp-education and research for the Independent Insurance Agents & Brokers of America in Alexandria, Va.

"It's an issue that's ebbed and flowed over the past decade or so. It was certainly a more-prominent issue seven or eight years ago," said Chuck Chamness, executive vp of the National Assn. of Mutual Insurance Cos. in Indianapolis. "We think there is good business being done in urban markets, and many of our companies are participants in that market," he said.

"Insurance agents, brokers and insurance companies should know that urban business can" bring in above-average returns, said Suzanne Reade, president of the Chicago-based Urban Insurance Partners Institute, an insurance industry-supported nonprofit group that helps insurers understand the urban marketplace.

"The legal and regulatory climate is evolving. Availability and affordability continue to be issues," but insurers are taking an increased interest in urban markets, and local business development leaders are interested in working with insurers, Ms. Reade said.

Misunderstanding can be avoided, industry experts say, but only if there's a common understanding of the problem and a commitment to treat all policyholders fairly.

Redlining as it is usually understood—discriminating unfairly against a potential policyholder simply on the basis of location—is illegal in all 50 states and the District of Columbia, noted Rey Becker, vp-property/casualty for the Alliance of American Insurers in Downers Grove, Ill.

"From the insurance industry perspective, our definition of redlining tends to be a bunch of middle-aged white guys sitting around in a room drawing a big red circle around a city," said Mr. Becker. "Having said that, the industry, certainly the membership of the Alliance, does not engage in

that kind of conduct," he said.

He said housing and community activists' definition "is if you live in a certain city you might not be able to get access to every single product an insurance company writes for the premium you are willing to pay. So when you have rather polar definitions of the issue like that, sometimes it's difficult to find common ground."

Mr. Becker said that some housing advocates and community advocates tend to view redlining

under a theory called disparate impacts. The concept is that the insurance company's motive and conduct are irrelevant; "the only relevant issue is what is the impact on a certain minority group, a certain income group or a certain neighborhood," he said.

The insurance industry's view is that "federal and state law prohibit unfair discrimination based on race or gender or other factors that of the sort, so as long as you're not underwriting on factors based on

that criteria, you're within the law."

The Sept. 11, 2001, terrorist attacks have added a new wrinkle, as regulators and some businesses in areas deemed to be at high risk of attack have charged that insurers are unfairly discriminating against them. Earlier this year, a District of Columbia official blasted a preliminary Insurance Services Office Inc. rating analysis for commercial properties in Washington as grossly unfair.

Eric Goldberg, assistant general counsel for the American Insurance Assn. in Washington, said it would be impossible to engage in redlining under the Terrorism Risk Insurance Act of 2002, which provides a federal backstop to help cover the losses of future terrorist attacks.

TRIA requires insurers to make available terrorism coverage "to the same extent that coverage for other covered perils is available," he

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No. 2 in a Series

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INSURER TOPICS

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noted. "Because, as a prerequisite of participating in the federal program, you have to make this coverage available to your policyholders, how could there be an allegation of redlining?" he asked. "The ISO rate filing underscores the problem insurers have with pricing this product. Since past losses are predictive of future losses, thank God we don't have this history of past losses to come up with an actuarially justified basis for pricing the product."

But for more-standard perils, those with a history of losses, insurers and agents can try several approaches to avoid the taint of

redlining, experts say.

"Two very important things they need to have are documentation and standards for permissible underwriting guidelines that they follow," said Bruce W. Foudree, an attorney with Lord Bissell & Brook in Chicago and a former Iowa insurance commissioner.

"The underwriting criteria have to be based on an accurate measurement of the risk. That's what actuaries are doing; they're trying to measure the risk," said Mr. Foudree.

"The reason redlining is prohibited by statute is the whole concept of unfair discrimination. You can discriminate in insurance, but you have to have a sound

actuarial basis for doing so," he said.

Review underwriting guidelines and make sure they're consistent with industry best practices and make sure they have a sound actuarial basis, advised Ben Klubes, a partner in the Washington law firm Skadden, Arps, Slate, Meagher & Flom L.L.P. "With respect to customer interaction, it's important to treat everyone professionally, courteously and equally."

He noted that people seeking examples of unfair treatment often use "pairs testing," where two otherwise similar people of different races seek quotes by phone.

NAMIC's Mr. Chamness said insurers and agents "should be

aware there are groups testing for unfair discrimination in various markets. Those fair-housing groups, as they're called, do pairs testing that evaluate how prospective customers with different profiles are treated by agents," he said.

"Having a good business plan for urban areas is absolutely essential," said Mr. Chamness.

"We strive for uniformity. It might be nice to see some model regulations in each state dealing with collecting data, in order to base the rates on. As we look at other model regulations, they seem to work and, as an industry, we are striving for uniformity," said IIABA's Ms. Flannagan. "I think the majority of agents would be hard-

pressed to understand all the implications and definitions of redlining. I think that agents and companies need to work more closely together on a more-uniform definition that works for the consumer, who is their ultimate customer."

Ms. Reade suggested that the most important thing for agents is to ask questions of the insurance companies with which they work.

"Try to make sure that you both have a common understanding of the legal framework as well as the company's specific underwriting and marketing direction. Asking questions now can prevent costly misunderstandings later," Ms. Reade said.



When the President signed the Terrorism Risk Insurance Act of 2002 on November 26, insurers had 90 days to meet the requirements of the bill. Ninety days to develop and file loss costs, rules, and forms. Ninety days to disclose federal involvement and offer coverage in all states. Ninety days to do the impossible. Thanks to the team effort at ISO, information began flowing to ISO's customers within a week of the President's signing. • ISO. Thorough, insightful analysis. Strong decision-support tools. Dedication to improving your profitability.

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IT briefs

Educational organization to honor industry CSRs

AUSTIN, Texas—The National Alliance for Insurance Education & Research has named the state winners of its 2003 Outstanding CSR of the Year Award.

The award, created in 1991 to recognize the contributions of outstanding customer service representatives in the insurance community, this year recognizes individuals in 41 states and Puerto Rico. From the state winners, a national winner of the award will be selected.

To qualify for the honor, candidates submitted an essay on customer service skills, and demonstrate commendable service to their agencies, their industry and their community. A candidate must be an insurance customer service representative or have primary responsibility for insurance customer service duties.

The National Alliance for Insurance Education & Research, based in Austin, Texas, offers advanced professional education for insurance and risk management professionals.

For the names of the state winners and information about the award, visit www.scic.com.

IEF recognizes insurance educator

INDIANAPOLIS—The Insurance Education Foundation has named Marcia E. Allen, a teacher at Murphysboro High School in Murphysboro, Ill., as this year's James L. Osborne Insurance Educator of the Year award.

The national award is named for the Indianapolis-based IEF's founder and is presented each year to a high school teacher who demonstrates excellence and creativity in providing insurance education to high school students.

Eligibility was limited to the 2,130 high school teachers who have graduated from one of seven insurance education institutes sponsored by IEF over the past 15 years and who have taught insurance during the past school year in a course leading to a high school diploma.

INSURER TOPICS

Entrepreneur breaks gender, race barriers, creates opportunities for minority communities

By JOANNE WOJCIK

If she were a betting woman, Ernesta Procope would probably say she was a long shot.

The odds were certainly against a black woman succeeding in business in the poverty-stricken Brooklyn neighborhood of Bedford-Stuyvesant in the 1950s, long before the civil rights and women's movements.

But Ms. Procope isn't one to listen to conventional wisdom.

"I've never operated with a complex whether I'm a woman or a black woman or black," says the founder, president and chief executive officer of E.G. Bowman Co. Inc. "To me, it doesn't matter. I'm out there trying to make a buck. And if you don't like me because of what I am, that's your problem. That's the only way to look at it. Otherwise, I'd go crazy."

Indeed, this tough-girl attitude, developed early in life in a family with three older brothers, has been Ms. Procope's driving force.

Upon the death of her first husband in 1952, Ms. Procope, formerly Ernesta Bowman, opened a homeowners and auto insurance agency in a Brooklyn storefront.

'I've never operated with a complex whether I'm a woman or a black woman or black....To me, it doesn't matter. I'm out there trying to make a buck. And if you don't like me because of what I am, that's your problem.'

*Ernesta Procope
E.G. Bowman Co. Inc.*

Her background? She was a pianist who attended New York's prestigious High School of Music & Art and majored in music while in college.

But, in true entrepreneurial spirit, she saw a need and filled it.

"It was a terrific homeowner location," she recalled. The area had an absolute "need for property and auto insurance for homeowners."

Furthermore, "when I started, there was only one other insurance broker in the area. So I had an open market," she said.

Fifty years later, Ms. Procope's inner-city insurance agency has grown to become one of the nation's largest minority- and woman-owned insurance brokerages.

And while nurturing her business, Ms. Procope also helped improve the economic conditions of minority communities throughout New York state.

She has received many awards, including the Trumpet Award in

2002 from Turner Broadcasting System. She was named one of Network Journal's 25 Influential Black Women in Business and one of *Business Insurance's* 100 Leading Women of the insurance industry. In 1972, First Lady Patricia Nixon named her "Woman of the Year."

Ms. Procope considers her greatest accomplishment to be her contribution to the creation of the New York Property Insurance

Underwriting Assn. in 1968. The property insurance pool covers homeowners who cannot obtain coverage in the voluntary market.

"We were the ones who instigated it. We started discussions with Gov. Nelson Rockefeller. The governor then ordered the Insurance Department to hold hearings throughout the state to determine the state of the insurance market for minority

homeowners," she recounted. The outcome of those hearings led to the introduction of legislation that created the association.

Ms. Procope's list of achievements goes on.

In the early 1960s, when President Lyndon B. Johnson declared war on poverty in urban America, Ms. Procope also was there, providing assistance to

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INSURER TOPICS

Continued from previous page

minority-owned businesses seeking both property/casualty insurance and employee benefits coverage.

In the late 1960s, using tools many benefit consultants had yet to discover, Ms. Procope's brokerage developed a benefit education program for employees of the community corporations formed by the New York City Community Development Agency to stimulate business growth in the city's urban areas.

"Not only did we create the insurance coverages, but we administered them on a daily basis," she said. "And it was almost like taking people to school, people who were in charge of insurance

but who knew nothing about it. We had to educate them."

The brokerage also held seminars for employees to teach them how to use their benefits to keep healthy, according to Ms. Procope.

This initial venture into commercial lines provided the springboard that launched E.G. Bowman into the broader commercial market. In 1969, Ms. Procope landed the account of Purchase, N.Y.-based PepsiCo Inc., which is still a client today.

"There aren't that many minority businesses that you can depend on to write insurance for. So, therefore, you must try to get straight into the economic mainstream," she said. "That is

what we attempted to do beginning in the early 1970s."

'There aren't that many minority businesses that you can depend on to write insurance for. So, therefore, you must try to get straight into the economic mainstream.'

*Ernesta Procope
E.G. Bowman Co. Inc.*

To solidify her position in the commercial insurance market, Ms. Procope moved her growing brokerage out of Brooklyn and

onto New York's Wall Street, the nation's financial center, in 1979.

"In Bedford-Stuyvesant, we owned our own building," she said. However, "we found it difficult for risk managers from various parts of the country, or even in the city of New York, to come to Bedford-Stuyvesant. They were just afraid of the name. They thought that perhaps something would happen to them, which was untrue.

"The second thing was, we wanted to be close to the insurance marketplace. And downtown Manhattan, at that time, was where many of the insurance companies were based. So it would be easy for my people to go over to get a binder signed or go pick up a policy

or whatever was necessary. It was more convenient on Wall Street than in Bedford-Stuyvesant," she added.

When the World Trade Center was attacked on Sept. 11, 2001, Ms. Procope's brokerage, just four blocks from Ground Zero, was closed for two weeks. But it reopened with all 40 staff members returning to work.

In keeping with her entrepreneurial spirit, Ms. Procope is responding to business needs that arose out of the event by developing risk management consulting services focusing on evacuation and crisis management. The product will be introduced by E.G. Bowman on July 1.

"Being a small agency, you've got to find a niche," she said. "So we're trying to develop this area. We have eight full-time safety engineers on staff."

And Bowman Specialty Services L.L.C., the risk management consulting division, has been providing loss control and safety engineering to New York's public universities since 2000 under a contract with the Dormitory Authority of the State of New York.

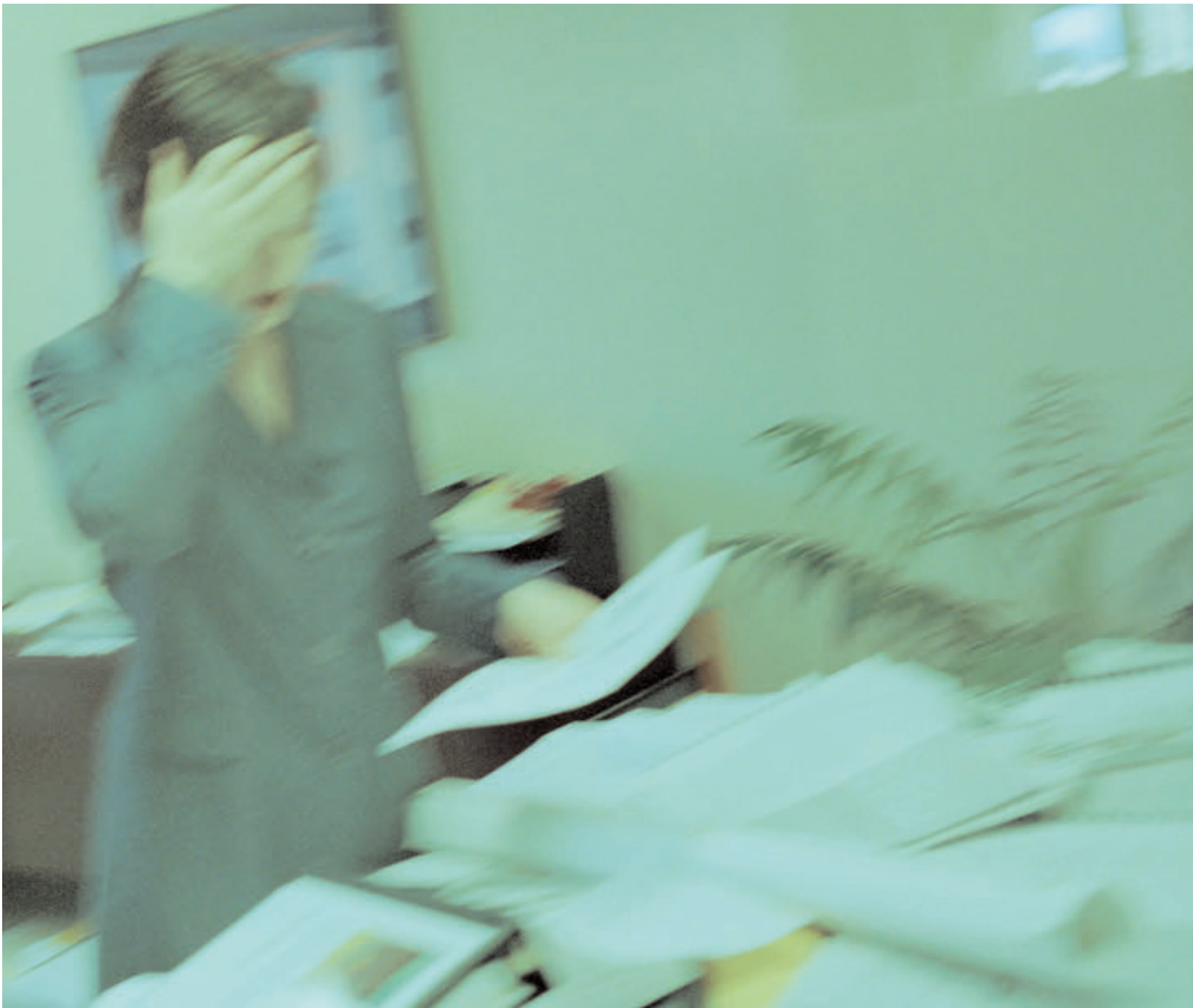
Even though Ms. Procope's tenacious spirit has enabled her to break through gender and racial barriers over the past five decades, she still occasionally struggles with discrimination.

"People haven't changed," she said. "Let's assume we acquired somebody because we needed the talent that they had, and the owner would like to leave. But many of his clients might not want to stay with us because we are a minority."

So what's more detrimental, being a woman or being a minority? "One's as bad as the other," she said.

Even so, Ms. Procope remains undaunted as she prepares her brokerage for the next 50 years.

"I had three brothers older than me. And they were much older. They slapped me around, knocked me down. I was the baby. And there were these three older men who were my brothers. I think I got a lot of my strength from them, not only physically, but mentally."



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INSURER TOPICS

Insurance Accounting & Systems Assn. Inc.

Benchmarking can change direction of company

By SALLY ROBERTS

Although benchmarking has been used for years by companies in a variety of industries, it is now emerging as an important analytical tool for the insurance industry, according to a benchmarking expert.

"At many insurance companies, benchmarking departments have been established or benchmarking techniques have been integrated into the strategic business planning process," said Jeffrey J. Rieder, a manager with Cincinnati-based Ward Group.

Mr. Rieder said that benchmarking involves comparing a company against its peers in a "search for those best practices that will lead to the superior performance of a company." Key to this definition, he said, is the combination of measurable financial comparisons and best practices.

One insurer, Penn National Insurance, recently used benchmarking as a tool to increase its financial performance and to achieve a ratings upgrade from A.M. Best Co.

Christine Sears, senior vp and

chief financial officer of the Harrisburg, Pa.-based insurer, discussed Penn National's success story during a session at the recent Insurance Accounting & Systems Assn. Inc. annual conference in Denver.

"Our results in the mid- to late 1990s were not very good," Ms. Sears said. The insurer's statutory combined ratios were higher and its return on revenues was lower than industry averages.

In 1998, the insurer cleaned house in its executive ranks and charged the new executives, including Ms. Sears, with improving the company's results, she said.

The company decided to conduct a benchmarking analysis, Ms. Sears said, because the board of directors and management were asking such questions as:

- How does Penn National compare with its peers?
- Where does the company need to improve in order to improve its B++ rating with Best?
- What are the company's strengths?
- What best practices are others using?

"We had done limited

benchmarking before, but we started the process over," she said.

The first thing Penn National did was to determine what to benchmark, Ms. Sears said. The

Benchmarking involves comparing a company against its peers in a 'search for those best practices that will lead to the superior performance of a company.'

*Jeffrey J. Rieder
Ward Group*

company ultimately decided to benchmark expenses, combined ratios, return on revenue, asset allocation and investment returns, reserve development, surplus and A.M. Best ratios, she said.

"Once we knew where to look, we needed to see whom to benchmark with," she said. The peer groups were broken down into four groups: current companies with similar structure and ratings; competitors; public companies, because Penn National's goal is to eventually go public; and

companies the insurer would like to emulate in the future, she said.

The insurer then developed data sources to obtain financial statements and other public information about its peer groups, Ms. Sears said. Such data sources include financial information from Concord, Mass.-based OneSource Information Services Inc.; A.M. Best insurance reports; Ward Group's annual analysis of the insurance industry; and the Internet, she said.

After studying and analyzing the results of its benchmarking analysis, Penn National discovered it ranked eighth out of 11 in its competitor peer group in 1999 combined ratio comparisons, Ms. Sears said. It also discovered that, compared with its competitors, the insurer's expense structure was high and its average premium per agent was low. In addition, the study showed that the insurer's process costs were higher than those of its peers, as were its outside legal costs.

Over the next couple of years, Penn National took certain steps it determined to be best practices to reduce its expense ratio. Among other changes, the insurer began requiring minimum premiums from its independent agent sales

force, Ms. Sears said.

By 2001, the insurer reduced its total expenses, as a percentage of direct written premiums, to 42.2% from 43.3% in 2000 and 44.7% in 1999.

And by the end of the third quarter of 2002, Penn National ranked No. 3 in the same combined ratio peer group of 11 companies, Ms. Sears said.

It also brought its return on revenue and operating performance in line with its peers and achieved its goal of obtaining an A- rating upgrade from Best in March, Ms. Sears said.

Among the lessons that Penn National learned, Ms. Sears said, is to "know your data" and "understand your peer group's corporate structure."

In addition, "benchmarking cannot be a finance-only project," she said. "We tried that in the early '90s and it died. Once senior management is involved, it will be more successful."

Ms. Sears also advises companies to "educate, educate, educate" by, among other steps, attending staff meetings going before the board to explain what benchmarking means.

Insurance Accounting & Systems Assn. Inc.

M&A deals take longer in today's corporate climate

By SALLY ROBERTS

While the sluggish economy and the fallout of corporate scandals may have lowered the overall number of insurance-related mergers and acquisitions over the last few years, there is still much activity in that area, according to a consultant.

There are numerous insurance transactions that have "colored the M&A marketplace" over the last few years, said Nadine A. Mirchandani, transaction support for the New York financial services office of Ernst & Young L.L.P.

Although statistics may show declining numbers of closed deals, they do not take into account the time it takes to close a deal today, Ms. Mirchandani said. "There were many deals in the works in the fourth quarter of 2001 that did not close until 2002," she said.

Nor do the numbers reflect the size of the deals, she said. There is a difference between completing many small deals and one large deal.

"The stats are what they are, but I hesitate, because it does not necessarily tell the whole story," Ms. Mirchandani told attendees at a session during the annual

conference of the Insurance Accounting and Systems Assn. Inc., held recently in Denver.

Nevertheless, Ms. Mirchandani said, the softening economy, the fallout from the corporate scandals and new regulations—especially the Sarbanes-Oxley Act—have all converged to slow the flow of deals being completed.

According to M&A statistics compiled by Hartford, Conn.-based Conning & Co., among property/casualty insurers, 41 deals were completed in 2001, compared to 53 in 2000 and 63 in 1999. On the distribution side, 160 deals were completed in 2001, up from the 145 completed in 2000 but down from the 203 deals completed in 1999.

"The financial services sector is luckier than most," Ms.

Mirchandani noted. "It's much more stable than other industries, like telecommunications and manufacturing."

Despite a decline in the number of M&A-closed deals, numerous other insurance transactions have

'The financial services sector is luckier than most. It's much more stable than other industries, like telecommunications and manufacturing.'

*Nadine A. Mirchandani
Ernst & Young L.L.P.*

taken place recently, she said.

Spinoffs are just one example of this trend, the most obvious being Citigroup Inc.'s divestiture of Travelers Property Casualty Corp. in late 2001, she said.

Companies also are repositioning themselves, she said. For example, a company with multiple lines of business that does not necessarily want to sell might enhance a line of business by building it as a stand-alone company, she said. St. Paul Cos. Inc.'s spinoff of its reinsurance operations into Platinum Underwriters Holding Ltd. is such an example, she said.

There also are new company formations taking place, Ms. Mirchandani said. Endurance Specialty Insurance Ltd. and Allied

World Assurance Co. Ltd. are just two examples of recent formations in Bermuda.

Companies also are purchasing renewal rights from others, she said. Kemper Insurance Cos., which recently sold the renewal rights to its middle-market business to St. Paul, is one example.

And private equity firms "are willing to ante up capital if there is a solid business model," she said. And while initial public offerings "are few are far between," she said, "they are happening out there."

All this is contributing to a stable base of transactional activity within the insurance industry, Ms. Mirchandani said.

As for the mergers and acquisitions that are taking place today, several trends have developed, she said.

The markets and shareholders no longer tolerate bad deals. Therefore, "due diligence has increased substantially," Ms. Mirchandani noted. "Whereas it used to be due diligence was a financial and numerical exercise, it's clearly business due diligence now," she said.

As a result of this, "bad deals are dying quicker and good deals are taking longer to close," she said.

Ms. Mirchandani said that while forecasts indicate a stable M&A environment for the property/casualty insurance and distribution sectors for the near term, the pace is predicted to pick up longer term, perhaps 18 months from now.

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Quality: Creating standards

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said, is to link provider pay to performance.

Some employers already have begun such efforts. For example, a coalition of large employers and health plans recently launched a project, Bridges to Excellence, that will pay bonuses to physicians who implement quality-improvement measures (*BI*, April 28).

In addition, a program in Florida is seeking to tie physicians' pay to their performance (see related story).

Furthermore, Dr. Milstein said, individual consumers need to be

given financial incentives, such as lower co-payments, to seek out higher-quality providers.

Employers and consumers, he said, need to stress the importance of quality to the point that it becomes "a stay-in-business issue" for doctors. Once providers recognize the importance of quality, Dr. Milstein said, they will make fundamental changes to their practices.

And now is the time take action, Dr. Milstein said, as sharply rising costs have prompted employers to explore their options, creating an environment in which change

can occur.

But employers need to rally around the issue of improving health care quality, Dr. Milstein said. "You can't get there without critical mass," he said.

Efforts to improve the quality of health care delivery will slow cost increases, saving employers money, Dr. Milstein said.

But the transformation of provider practices won't be easy and could take a decade or longer to complete, Dr. Milstein cautioned.

"It's easier said than done," he said.

NYBGH

Program promotes evidence-based care

By MICHAEL PRINCE

NEW YORK—In Florida, a health care coalition wants to promote health care quality and is willing to pay for it.

The Central Florida Health Care Coalition will soon introduce a new program that will reward doctors who provide quality care, said Becky Cherney, president and chief executive officer of the Central

Florida Health Care Coalition in Orlando.

The guiding principle of the program is that employers need to push doctors to improve quality, Ms. Cherney said. This will not only save lives but also reduce costs, she said, because fewer people will require hospital stays and other medical treatment as a result of doctors' mistakes.

Ms. Cherney said that, under the coalition's program, doctors will be ranked on their willingness to practice evidence-based medicine. Quality declines, she said, when doctors treat patients in their own fashion and do not follow proven treatment guidelines.

'The enemy is variation in care, and that's what we have to squeeze out.'

Becky Cherney
Central Florida Health
Care Coalition

"The enemy is variation in care, and that's what we have to squeeze out," Ms. Cherney told attendees this month at a conference in New York sponsored by the New York Business Group on Health.

Under the program, each doctor will be placed in one of three categories based on his or her performance with regard to the evidence-based practices.

Those in the top rank will receive a higher reimbursement level than they now do and will be paid more money for treating chronically ill patients, while being given more freedom in how they treat patients.

In addition, employees with employers participating in the program will have lower co-payments to see these doctors, providing a financial incentive for patients to seek out their services.

In exchange, the doctors agree to write all their prescriptions electronically in order to reduce prescription errors. The doctors also agree to participate in a one-week training program every year.

Those doctors in the middle tier will see a lower reimbursement rate than the highest tier, and employees will pay a higher co-payment to see them.

Doctors in the lowest tier will have the lowest reimbursement rate and their patients will pay the highest co-payment. In addition, the program will undertake efforts to train these doctors to improve their performance.

"Our job is to build a better physician, one physician at a time," Ms. Cherney said.

She said that a doctor in the top tier could typically see a 7% jump in fees in the first year, providing an incentive for doctors to improve their quality and join this select group.

"That's exciting to physicians," Ms. Cherney said.



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COLI: California measure would ban policies

Continued from page 4

ended June 2, Texas legislators attempted to pass bills that would have banned COLI policies. Although the legislation, S.B.137, was passed by the Senate, where it was introduced by Sen. Rodney Ellis, D-Houston, the session ended without the Texas Assembly passing the bill.

New COLI legislation likely will be introduced again when Texas legislators convene in 2005. But any new legislation probably will seek advise and consent requirements rather than elimination of COLI policies, according to Sen. Ellis' office.

'The people who ultimately pay the price for this legislation are the employees and their families who have their benefits cut.'

*Eric Wittenmier
Aon Consulting*

Advise and consent laws enjoy wider support from industry groups.

The Kansas City, Mo.-based National Assn. of Insurance Commissioners last fall announced new guidelines for COLI policies. The guidelines call for state laws requiring employers to obtain the consent of employees before the purchase of a COLI policy.

The Washington-based American Council of Life Insurers supports the NAIC's model law. But it opposes California's A.B. 226, which was introduced by Assemblyman Juan Vargas, D-Chula Vista, and was sponsored by the California Labor Federation AFL-CIO.

"We are in an age where providing employee benefits is growing more difficult for employers, and it certainly doesn't help the situation," an ACLI spokesman said of the California measure.

COLI policies provide predictable investment returns, which helps assure employers that they will be

able to meet future benefit obligations, the spokesman said. Employers often invest in COLI policies to pay for post retirement health, pension and life insurance benefits as well as to make disability payments, he added.

It is unusual for companies to purchase COLI policies for reasons not related to benefit funding, according to Eric Wittenmier, a senior vp for Aon Consulting in Chicago.

Mr. Wittenmier estimated that less than 20% of large companies purchase COLI. Most employers that purchase the policies have al-

ways informed their employees of the practice, he added.

Given the negative publicity surrounding COLI policies and the passage of advise and consent laws in more states, employers have stepped up their efforts to inform their employees about the policies, consultants say.

A law stripping employers of the ability to use COLI policies would likely increase benefit costs and hurt employees, Mr. Wittenmier said.

"The people who ultimately pay the price for this legislation are the employees and their families who

have their benefits cut," Mr. Wittenmier said.

Entirely eliminating COLI would force employers to drop health coverage or fund it by cutting wages or other benefits, according to the Sacramento, Calif.-based California Chamber of Commerce, which is opposing the legislation.

Forcing employers to surrender the policies earlier than expected could result in an unforeseen tax obligation, said Anna Mulholland, a Watson Wyatt Worldwide consultant in Boston who specializes in executive nonqualified plan design and funding.

The proceeds from life insurance policies generally are not taxable if paid out after the insured dies. But surrendering the policies before then can result in a tax bill for any gain in value the policies have accumulated.

Policies that employers have held over a long period, say 15 years, would have accumulated a substantial amount of cash value, Ms. Mulholland said.

"There are a lot of policies that have gain in them," Ms. Mulholland said. "That would be very damaging to a lot of companies."

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Commentary

New environment for risk managers

There is an unfortunate risk management "disconnect" from environmental issues in Corporate America, some insurance professionals say.

This "disconnect," they say, is partly why environmental insurance products designed to cap pollution remediation and third-party liabilities are not generating quite as big a demand as expected by now.

The market's expectations were fueled by the Sarbanes-Oxley Act of 2002, which requires top executives to certify their organizations' financial statements. Insurance professionals theorized that those certifications would mean more organizations would err on the side of accounting conservatism and detail their environmental liabilities. To calm investors, organizations were expected to ringfence their liabilities with various finite risk and risk-transfer products (*BI*, June 10, 2002).

But, the demand for environmental insurance increased only modestly over the past year, market experts say. They say one big reason is that risk managers often are not responsible for their organizations' environmental issues, forcing insurance professionals to market their products to others who are not insurance savvy.

So, what are insurance professionals really getting at when they talk about this "disconnect"?

Is this just a ploy to boost their own revenues by goading risk managers into charging into an area typically outside of their corporate domain and acting as shills for insurers?

Or, do many risk managers have a potentially career-enhancing opportunity to help guide their organizations toward a well-reasoned approach in handling their environmental liabilities?

As much of a cynic as I am, I believe that the mind-numbing pounding that is dogging many risk managers today is more than a hard market-induced headache. Open your doors to an opportunity struggling to get in.

Like a bull-riding cowboy who doesn't have a single friend among the rodeo clowns in the ring, risk managers certainly would face a huge challenge if they ventured uninvited into the environmental arena. Plus, what risk manager has the time?

But, anyone who has read Risk Manager of the Year profiles has come across story after story

about risk management's top professionals embracing such challenges and helping their organizations address one enterprise risk or another that was not within their purview.

Here are a couple other observations that risk managers ought to keep in mind.

Larry Schnapf, a New York-based environmental attorney who specializes in assisting corporations with mergers and acquisitions and other transactions, said he often finds that many organizations' environmental attorneys—probably veterans of the general liability pollution insurance wars—are biased against insurers.

Nevertheless, insurance

professionals still are getting their message across to corporate decision-makers by going directly to them. And that could result in negative consequences for risk managers—regardless of whether they have any authority over environmental issues.

Consider this observation from attorney Andrew Davis, a Boston-based partner at LeBoeuf, Lamb, Greene & MacRae L.L.P. He said chief executive and financial officers at even sophisticated companies often are "shocked" when they learn about the environmental insurance products that are available. And—this should shock risk managers—he said many of those executives then wonder aloud: "Why is my risk manager not aware of this?"

Before you start accusing me of being a shill for environmental insurers, let me be clear: I am neither recommending nor panning those coverages. But what seems clear to me is that risk managers have a golden opportunity now to help steer their organizations in the direction that is best for them.

Kenn Anderson, managing director-environmental in Chicago for broker Arthur J. Gallagher Risk Management Services, a division of Arthur J. Gallagher & Co., summed it up best. He noted that if an organization is going to self-insure environmental risk, that decision should be reached after a well-defined evaluation process. That's quite different from being forced to self-fund a loss that an entity just "gets stuck with," he said. "That's not the right way to finance risk."

Senior Editor Dave Lenckus' commentary appears periodically in *Business Insurance* and at www.businessinsurance.com. He can be reached at dlenckus@crain.com.



Dave Lenckus

Comings & Goings



Mr. Dangler



Mr. Toon



Ms. Martinez

Brokers:

G. Randolph Jones has joined Aon Risk Services in New York as executive vp-business development. Mr. Jones previously was managing director of private equity and M&A services for Marsh Inc.

Michael P. Dangler has been appointed a national practice leader in the New York office of London-based Willis Group Holdings Ltd.'s new Specialty Benefits Practice Group. He previously was an assistant vp in New York for Aon Corp.

Chicago-based Near North National Group has named **Patty Flando Babcox** senior vp in charge of its fine arts practice, a unit she helped found in 1987 before leaving the broker. She most recently was a senior vp at Washington-based Huntington T. Block Inc.

Insurers:

Eugene B. Kelly has been named senior vp of field operations at Southfield, Mich.-based Meadowbrook Insurance Group Inc. Previously, Mr. Kelly served as resident vp in the New York branch of Kemper Insurance Cos.

Reinsurance:

New York-based reinsurance intermediary Gill & Roeser Inc. has

named two new senior executives:

• **Kevin Kennedy** has been appointed senior vp. He previously was senior vp/program manager for Guy Carpenter & Co. Inc.

• **Edward R. Santos** also has been named senior vp. He is a former senior vp for Towers Perrin Re.

Linda DiFolco has been named North America casualty facultative product leader for Overland Park, Kan.-based Employers Reinsurance Corp. Previously, she was vp-excess and surplus lines with Partners Specialty in Kansas City, Mo.

New York-based Folksamerica Reinsurance Co. has named **George Stoffel** as senior vp. Previously, Mr. Stoffel was head of XL Re's casualty catastrophe and clash portfolio.

David Kalainoff has been named executive vp and chief underwriting officer of Hamilton, Bermuda-based Max Re Capital Ltd. Before joining Max Re, Mr. Kalainoff was head of the specialty casualty treaty operations at Transatlantic Reinsurance Co.

Managed care:

Delta Dental of Pennsylvania and Delta Dental Insurance Co. have made two senior-level appointments:

• **Thomas Toon** was promoted to chief operating officer for Me-

chanicsburg, Pa.-based Delta Dental of Pennsylvania. Mr. Toon most recently served as vp of underwriting, actuarial and operations for Delta Dental Insurance Co.

• **Belinda Martinez** was promoted to COO of Alpharetta, Ga.-based Delta Dental Insurance Co. She will continue in her role as senior vp and COO for Cerritos, Calif.-based PMI Dental Health Plan.

Lansing, Mich.-based Accident Fund Insurance Co. of America, a subsidiary of Blue Cross & Blue Shield of Michigan, has named **Steven C. Hess** as executive vp and general counsel. Previously, Mr. Hess was a general counsel at the Michigan Blues organization.

Other suppliers:

Robert L. Natt has been named chief executive officer of Waltham, Mass.-based mbi, a provider of health care debit cards for flexible spending accounts and other pre-tax plans. Mr. Natt was previously an executive vp for the New England region of Oxford Health Plans.

Farmington, N.Y.-based Subrogation Partners Inc. has named **Edward Holleran** executive vp. Mr. Holleran will also serve as executive vp for Subrogation Capital Group L.L.C. Previously, he was a principal in the consulting firm Alexander Browning L.L.C.

Stroock & Stroock & Lavan L.L.P. has named **James E. Fitzgerald** as a partner in the Los Angeles office. Mr. Fitzgerald previously was a partner in the insurance group of Luce, Forward, Hamilton & Scripps 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; or to jwalker@crain.com. Photos should be sent to Kathy Barnes at the same address or to kbarnes@crain.com.

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International

17

U.K. fund criticized as 'last nail in coffin' for defined benefit plans Pension protection panned

By SARAH VEYSEY

LONDON—U.K. business groups are wary of a government plan to create a program to protect pension participants' benefits against employer insolvencies, fearing that it could involve huge additional costs and place an unfair burden on employers with well-funded plans.

In addition, the government has changed pension rules—effective immediately—to close a regulatory loophole that let solvent companies terminate underfunded defined benefit pension plans without making good the funding shortfall.

The Department of Work and Pensions last week proposed a program, similar to the Pension Benefit Guaranty Corp. in the United States, that would guarantee the pension benefits of defined benefit plan participants at insolvent companies. The program, known as the Pension Protection Fund, forms part of a set of government proposals aimed at strengthening protections for plan par-

ticipants and making it easier for employers to operate pension plans.

The fund would be financed by premiums paid by all employers operating defined benefit pension plans, which are known in the United Kingdom as final-salary schemes. Plans that are underfunded would pay a higher premium to the fund, though premium levels have not been determined.

Under the current proposal, when an employer becomes insolvent, the Pension Protection Fund would pay 100% of pension benefits owed to the company's retirees and 90% of the benefits promised to participants who are still working, according to the Department of Work and Pensions.

"The new Pension Protection Fund will ensure that where company pensions have been promised, pensions will be delivered," Andrew Smith, secretary of state for work and pensions, said in a statement.

See PENSIONS/next page



PHOTO: BBC/NEWSCAST

Secretary Andrew Smith's Department of Work and Pensions proposed the Pension Protection Fund program last week.

Asbestos uncertainties weaken runoff balance sheet

By NEIL HODGE

LONDON—Equitas Ltd. has again boosted its asbestos reserves following a review of potential asbestos liabilities, mainly in the United States.

Equitas, which is the runoff reinsurer for Lloyd's of London's pre-1993 long-tail liabilities, said it had increased its asbestos reserves by £399 million (\$663.2 million), bringing its gross undiscounted asbestos reserves to £5.3 billion (\$8.81 billion).

The boost in asbestos reserves marked the third such move in four years.

Asbestos, pollution and health-hazard claims account for 80% of Equitas' net discounted liabilities, the

company reported. And "asbestos remains the greatest single threat to Equitas," Hugh Stevenson, chairman of Equitas, said in a statement announcing the reinsurer's results for its most recent fiscal year. He added that "the balance sheet of Equitas is weaker than it was a year ago, and we still face uncertainties arising from matters over which we have little or no control."

Michael Crall, Equitas' chief executive officer, said that the reserve boost was prompted in part by a review of U.S. companies' filings to the Securities and Exchange Commission.

Equitas has taken steps to reduce its exposure to asbestos claims, including requiring medical documentation for asbestos injury claimants (*BI*, Sept. 10, 2001).

In its financial results for the year ending March 31, 2003, announced June 11, Equitas said that its aftertax accumulated surplus had fallen by 22.4% to £527 million (\$832.1 million), compared with a year earlier.

Gross claims paid for all types of coverage

See **EQUITAS**/page 20

PHOTO: AP/WIDE WORLD

Spanish soccer club Atletico de Madrid takes the field at Madrid's Vicente Calderon stadium earlier this year.

Reinsurers score a win in soccer TV rights suit High court finds insurer misrepresented policy

By CAROLYN ALDRED

LONDON—A contingent reinsurance policy written to cover Spanish soccer club Atletico de Madrid's loss of earnings on its demotion from Spain's top soccer league was misrepresented and the insurer was in breach of a warranty in the contract, London's High Court has ruled.

The dispute centered on the payment of broadcasting rights for Atletico de Madrid. By the start of the 1999/2000 season, Atletico was entitled to receive a minimum of 3 billion pesetas (\$18.2 million) for broadcasting rights from Audiovisual Sport SA, contingent on the soccer club staying in the top league. Under the arrangements with the soccer club, Audiovisual was required to produce a bank guarantee to cover loans given to the club by Atletico's bank, Banco Pastor, and Audiovisual issued promissory notes totaling 2.9 billion pesetas (\$17.6 million) that were due to mature during the 2000/2001 season. Audiovisual was potentially exposed if Atletico was relegated and if Atletico then defaulted on paying back the loans. As a result, Audiovisual required that the soccer club purchase insurance that would cover the loss in the event of the club's relegation.

Vitalicio de Espana S.A. de Seguros y Reaseguros wrote an insurance policy for 2.9 billion pesetas and reinsured 98% of the risk in the continental European and London markets. The facultative reinsurance named Atletico de Madrid as the insured and Vitalicio Seguros as the rein-

sured and provided a limit of 2.9 billion pesetas for loss of contracted television rights if the club was relegated.

Although most of the reinsurers paid the claim following Atletico's relegation at the end of the 1999/2000 season, several reinsurers, representing 31.54% of the risk, disputed the claim. The reinsurers alleged that Vitalicio had agreed to indemnify not Atletico but Audiovisual, and that the underlying insurance did not provide for a loss with a limit of 2.9 billion pesetas but had an agreed value of 2.9 billion pesetas, which would be paid regardless of the value of the actual loss in profits. The reinsurers claimed that Vitalicio was in breach of a warranty in the reinsurance policy and that Vitalicio had misrepresented the terms of the original policy and that had induced them to write the risk.

The disputing reinsurers were Lloyd's of London syndicates 2021 and 102, managed by Goshawk Syndicate Management Ltd.; the Tyche Consortium, which through ASU International acted for Lloyd's underwriters and Reliance National Insurance Co. (Europe) Ltd.; Lexington Insurance Co. Ltd.; and Global Specialty Risk.

Mr. Justice Andrew Smith agreed that the insurance was written on an agreed predetermined value of 2.9 billion pesetas and accepted that some of the reinsurers would not have written the risk had they known that it was not for an indemnity for loss actually suffered by Atletico.

The judge also agreed that because the sum in-

See **MADRID**/page 20

World Updates

Alleghany purchases RSA surplus lines unit

Royal & SunAlliance Insurance Group P.L.C. has sold its U.S. surplus lines unit, Royal Specialty Underwriting Inc., to Alleghany Insurance Holdings L.L.C. for £72 million (\$119.7 million). RSUI recorded net written premiums of about £320 million (\$531.9 million) in 2002, according to RSA. The sale is part of RSA's turnaround plan, announced last fall (*BI*, Nov. 11, 2002). RSA also announced the sale of its Puerto Rican operations to San Juan-based Cooperativa de Seguros Multiples de Puerto Rico for £38 million (\$63.2 million).

Marsh shifts executives in regional division

William Malloy has been appointed president and chief executive officer of Marsh Inc.'s Europe/Middle East Region. Mr. Malloy, currently president of Marsh's Western European regional arm in Paris, will succeed Daniel Jones, who is moving back to the United States. Mr. Malloy will remain in Paris in his new role.

Berkley, Kiln to form specialty liability insurer

Berkley London Holdings Inc., a subsidiary of W.R. Berkley Corp., is setting up a London market company in conjunction with Lloyd's of London company Kiln P.L.C. W.R. Berkley Insurance (Europe) Ltd. will be a specialty casualty insurer in the United Kingdom, initially focusing on the professional indemnity market, Kiln said in a statement. WRB Insurance will be capitalized at £80 million (\$133.0 million), of which Kiln will have a £16 million (\$26.6 million) interest.

Promina CEO to head insurance council

Mike Williams, managing director and chief executive officer of Promina Group Ltd., has been appointed president of the Insurance Council of Australia. Mr. Williams succeeds Raymond Jones, managing director of QBE Insurance (Australia) Ltd., who has been the council's president since 2001.

Aon Risk Consulting makes appointments

Steve Barnett has been appointed chairman of Aon Risk Consulting in London, while Hans-Kristian Bryn has been named as the division's new deputy chairman. Mr. Barnett was formerly a partner in the financial services practice at Deloitte Consulting in London. Mr. Bryn was formerly a partner in the financial risk management practice of PricewaterhouseCoopers in London.

Pensions: Business groups pan protection program

Continued from previous page

The proposals, which Parliament must approve, likely would not take effect until at least 2005.

Estimates of the program's cost to employers differ, and some business groups are concerned that it could be considerable.

Indeed, some employers fear "that this is, in effect, going to be quite a high additional cost," said Mike Hammer, a consultant at Towers Perrin in London.

Although it has not established specific contribution levels, the Department of Work and Pensions estimates that the program's aggregate cost to U.K. companies would be between £300 million and £400 million (\$493.6 million and \$658.1 million) per year.

But Tim Keogh, a consultant at Mercer Human Resource Consulting in London, said Mercer estimates that the annual cost to business in the longer term could be

closer to £1 billion (\$1.65 billion).

In the United States, employers paid nearly \$800 million to the PBGC in 2002, though the PBGC guarantees are substantially less than what the U.K. program would provide. The PBGC insures more than 32,000 pension plans.

Business groups and consultants warn that if the U.K. program's costs are too great, some employers may decide to close or terminate their defined benefit plans.

Many employers in the United Kingdom in recent years have sought to reduce their costs and liabilities by closing final-salary plans to new entrants and setting up lower-cost defined contribution plans.

The government's proposal would add to the cost burden that pension plans have become to some employers, contends Kenneth Donaldson, a consultant at London-based consulting actuaries Hazell Carr. "The concept smacks of

robbing Peter to pay Paul," he said.

Simon Martin, head of research at Aon Consulting in London, said the proposed fund "could be the last nail in the coffin for final-salary pension schemes."

John Cridland, deputy director general of the London-based Confederation of British Industry, said that if the proposal added greatly to the cost of providing occupational pension plans, some employers would no longer be able to provide defined benefit plans.

And Derek Brownlee, pensions executive at the London-based Institute of Directors, said that although the organization welcomes the idea of a fund to protect pension participants' benefits, it is concerned about the consequences of the attendant costs to employers. If the "burden of financing the fund falls on employers, some may be forced to close their final-salary schemes altogether," he noted.

In addition, Mr. Cridland said it is "important that employers with good schemes do not subsidize those with weak schemes." He noted that employers with strong plans "will be reluctant to pay for those without."

The government also has introduced—with immediate effect—a rule to prevent solvent employers from shutting down underfunded defined benefit plans without fully funding the benefits owed to members.

Previously, a loophole in pension regulations enabled solvent employers to close their plans without making up the shortfall. This was highlighted last year when Danish shipping company Maersk & Co. decided to terminate its U.K. defined benefit plan, which was underfunded by about £3.5 million (\$5.4 million). The company was able to do so because, although its plan was underfunded, it still met the minimum funding requirement

(BI, Oct. 28, 2002).

Under the new rules, however, employers must provide all benefits promised to plan members before they can close a plan.

Mercer's Mr. Keogh said the move sends a message to employers that may have been considering closing their underfunded defined benefit plans. "This will be unwelcome news for employers who have sought to exploit the availability of the option of walking away from their pensions—even if few have actually taken this step," he said.

Aon's Mr. Martin said that, as a result of the new rule, "the only real way out for companies looking to close their schemes may end up being bankruptcy."

Brendan Barber, general secretary of the London-based labor federation the Trades Union Congress, welcomed the move, saying it would "help to restore the pension promise made by employers."

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Equitas: Balance sheet weakens

Continued from page 17

totalled £1.1 billion (\$1.74 billion), down from £1.4 billion (\$2.00 billion) in the previous year.

The company reported investment losses of £72 million (\$113.7 million), compared with an investment profit of £95 million (\$135.4 million) as of March 31 last year. Equitas attributed the losses chiefly to lower equity prices in markets worldwide.

The accumulated losses also hit Equitas' solvency margin, which is

its accumulated surplus expressed as a percentage of its net claims outstanding. Equitas' solvency margin last year fell from 8.7% from 10.3% a year earlier. At its launch in 1996, Equitas' solvency margin was 5.6%.

Although asbestos remains the biggest threat to Equitas, Mr. Crall said that the company's three-year asbestos "survival ratio"—an impressive measure of an insurer's reserve adequacy—would allow the reinsurer to pay asbestos claims at

its present rate for the next 24 years. Mr. Crall said that the average for most other insurers is just 11 years.

Equitas continued its policy of commuting reinsurance contracts where possible throughout the 2002/03 fiscal year and completed a total of 83. In addition, as of April 1, Equitas combined its reinsurance recovery activities into one department covering loss-by-loss collections and commutations, which it expects will further reduce costs.

Madrid: Soccer suit

Continued from page 17

sured in the original contract was on an agreed basis and the description of the sum insured in the reinsurance contract amounted to a warranty that had been breached, the reinsurers were entitled to void the policy.

"The reinsurance was written to indemnify for a loss in profits, whereas the direct insurance was written as an agreed value. It is a case of misrepresentation," said Danny Burns, contingency under-

writer for syndicate 2021. Mr. Burns claimed in court that he had never written demotion coverage on an agreed-value policy and would not have underwritten the risk had he known that it was written as such.

Mr. Burns told the court that Goshawk does not cover risks written on an agreed-value basis because there is a perceived risk of moral hazard and a belief that the insurers, rather than the insured, should benefit from any savings made.

Pollute: Governance law not fueling big EIL interest

Continued from page 1

continues to grow, publicly traded companies with environmental liabilities are not flocking to the products in near the numbers that market experts had anticipated, those experts acknowledge.

"We're seeing a slight increase in business," said Joseph Boren, president of AIG Environmental, a unit of American International Group Inc. of New York.

Market experts attribute the lower-than-expected demand to several factors, including a "disconnect" between risk management and corporate environmental matters, rather than a lack of capacity or range of products.

Estimates of annual environmental insurance premium volume range between \$1.6 billion and \$1.8 billion, up from around \$1.3 billion in the mid to late 1990s.

Market capacity could exceed \$500 million, which is ample, experts say.

Unlike the pre-1986 general liability policies that have been at the center of innumerable pollution coverage disputes in courts across the country, most current environmental insurance policies are designed specifically to cap policyholders' pollution remediation costs and third-party liabilities. Insurers offer a variety of finite risk, pure risk transfer and blended products, which vary tremendously in price and applicability to each risk (BI, June 10, 2002).

Environmental insurers had expected a greater demand for their products when the Sarbanes-Oxley Act of 2002 was passed. In the wake of several high-profile corporate failures, Sarbanes-Oxley requires chief executive officers and chief financial officers to certify their organizations' financial statements.

Although Sarbanes-Oxley did not change disclosure rules, insurance professionals believed that the certification requirement would mean that more organizations would err on the side of caution and detail their environmental liabilities. To calm investors when those liabilities appeared, organizations were expected to ringfence their liabilities with environmental insurance products.

Other pressures also are bearing down on corporate executives to more fully disclose environmental

liabilities.

For example, on its Web site, the U.S. Environmental Protection Agency has begun identifying companies that face environmental enforcement actions totaling \$100,000 or more. If those companies, as accounting standards require, have not disclosed the environmental problems leading to those actions, they can expect Securities and Exchange Commission action, said Andrew Davis, a Boston-based partner at the law firm of LeBoeuf, Lamb, Greene &

Significantly, many companies believe they cannot quantify their environmental liabilities with the degree of certainty that would require full disclosure to investors.

MacRae L.L.P.

"I think a lot of companies are running afoul" of that disclosure requirement, Mr. Davis said.

Additional pressure to disclose environmental liabilities soon may be emanating from companies' own environmental attorneys. The SEC has determined that Sarbanes-Oxley's attorney code-of-conduct provision requires any attorney working on a company's environmental matters to press for fuller disclosure when the attorney feels it is warranted, said Larry Schnapf, a New York-based environmental attorney.

But even if companies avoid running afoul of the SEC by disclosing their environmental liabilities, those disclosures could anger investors, who might file securities-related claims against directors and officers for failing to disclose those liabilities sooner.

"If the new numbers are sufficiently alarming to the financial market that there's a significant drop in stock price, that potential action exists," observed insurance attorney Dan A. Bailey, a partner at Arter & Hadden L.L.P. in Columbus, Ohio.

With that potential development in mind, directors at companies that disclose their environmental liabilities for the first time may push

for environmental insurance in hopes that the coverage will calm investors, AIG's Mr. Boren observed.

"By putting one more loss mitigation method out there, it could only help," said David Bennink, a New York-based director of Aon Environmental, a division of Aon Risk Services Inc.

D&O policyholder attorneys at Sachnoff & Weaver Ltd. in Chicago agree.

Purchasing sufficient environmental insurance to cap newly disclosed environmental liabilities "would provide some protection to the company and its directors and reduce their potential liability to shareholders and minimize or undercut shareholders' ability to complain" about the disclosure, said attorney Jeffrey Schumacher, a partner at Sachnoff.

The coverage may not help, though, if the organization's own reserve still will have a material impact on its financial wherewithal, he noted.

And, even disclosures of immaterial liabilities may not prevent frivolous lawsuits, observed attorney Carolyn Rosenberg, another partner at Sachnoff.

Several factors, however, are offsetting those pressures, market experts say.

Significantly, they say, many companies believe they cannot quantify their environmental liabilities with the degree of certainty that would require fuller disclosures to investors.

But, some investors are pressuring the SEC to adopt environmental liability disclosure standards, Mr. Schnapf noted.

The lower-than-expected demand also is attributable to buyers' unfamiliarity with the products, market experts say. Because risk managers often have little or no say on corporate environmental issues, environmental insurance products typically are pitched to executives with little or no insurance background, the experts explain.

"It takes a while for consultants to get to all of their clients and educate them on how to cover their liabilities," said Alan Brassler, a senior vp at Marsh Inc. in Atlanta.

While insurers, brokers and consultants will continue to market environmental insurance coverages to



On its Web site, the U.S. Environmental Protection Agency has begun identifying companies that face environmental enforcement actions totaling \$100,000 or more.

whoever oversees corporate environmental matters, they contend that many risk managers who do not make their services available to their senior management are missing an opportunity to help their organizations deal with their environmental matters and, in turn, bolster their careers.

Right now, the risk manager often is "the last guy to know" that their organizations are examining how to handle their environmental liabilities, said Michael Murphy, the New York-based president of Chubb Environmental Solutions, a unit of Chubb Corp. "Senior executives look at them as insurance purchasers, not strategic partners" at all but the most sophisticated companies, he said.

"It's an opportunity for a risk manager to add value to the bottom line of the firm through innovative insurance products," said David J. Dybdahl, a senior consultant with American Risk Management Resources Network L.L.C. of Madison, Wis.

Risk managers could have "a meaningful impact" on their companies' handling of environmental matters by either alerting senior management to insurance options or developing a self-insurance plan, said Kenn Anderson, managing director-environmental in Chicago for broker Arthur J. Gallagher Risk Management Services, a division of Arthur J. Gallagher & Co.

If only by being "a squeaky

wheel" initially rather than waiting for formal authority over environmental matters, risk managers should get involved in various corporate environmental issues to fulfill their professional obligation "to reduce the cost of risk to the organization," Mr. Anderson said.

Gallagher's Mr. Anderson noted that a risk manager at a Fortune 250 company recently secured authority over corporate environmental matters after showing his organization how it could resolve some environmental problems that were hindering the divestiture of some properties.

Other risk managers also are beginning to assert themselves in environmental matters, market experts say.

"I do see an increasing number of risk managers taking authority" over environmental matters or at least offering assistance to whomever has authority in that area, Mr. Brassler said.

Risk & Insurance Management Society Inc. President Lance J. Ewing said that risk managers have "got to sell themselves" to senior management but that they need some help.

"Brokers have an obligation to help risk managers get that authority" by inviting them into discussions with corporate officials on environmental matters, said Mr. Ewing, executive director of risk management at Park Place Entertainment Corp. in Las Vegas.

Medicare: Expansion expected to benefit employers

Continued from page 3

on a fast and seemingly unstop-able path to passage. The Senate is expected to approve the Finance Committee bill this week, while the House Ways and Means Committee also could act this week on a somewhat similar bill that was unveiled last week. Congressional leaders want to send a final measure to President Bush for his signature by July 4.

That swift pace—by traditional

congressional standards—comes as Republicans and Democrats, sensing enormous public support for the new benefit, have largely put aside partisan differences to work together.

"What a difference a year makes," said Sen. Orrin Hatch, R-Utah, referring to last year's unsuccessful efforts to pass a bill when congressional Republicans and Democrats developed separate proposals and then refused to work to-

gether to bridge the differences.

But as Finance Committee Chairman Charles Grassley, R-Iowa, noted at the start of last week's committee consideration of the bill he and ranking minority member Sen. Max Baucus, D-Mont., put together: "Not a lot gets done in the United States Senate unless it is done in a bipartisan way."

"The highway or my way will not work in a 51-49 Senate," said Sen. Olympia Snowe, R-Maine, referring to the political composition of the Senate.

Still, there were some doubts. Sen. Don Nickles, R-Okla., warned that the \$400 billion price tag is unrealistically low. "I'm concerned that it will cost twice as much. I want our kids to be able to afford this as well."

But all senators agreed that the expansion would ensure a level of prescription drug benefit coverage that millions of beneficiaries now lack.

"What we have done today will affect every single American," said Senate Majority Leader Bill Frist, R-Tenn.

The congressional action would have a huge and positive impact on the dwindling number of employers offering health care coverage to their Medicare-eligible retirees.

With employer prescription drug benefit plans costing roughly \$1,400 to \$1,800 per retiree, depending on the scope of the benefits, the government's assumption of a big chunk of those costs would dramatically cut employers' liabilities.

'I'm concerned that it will cost twice as much' as the estimated \$400 billion price tag. 'I want our kids to be able to afford this as well.'

*Sen. Don Nickles
R-Okla.*

"Would this be helpful? Certainly," assessed Paul Dennett, vp-health policy for the American Benefits Council in Washington.

"It would be good news, at least in the short run, as employers" could eliminate benefits that would duplicate those provided through Medicare, said Harvey Sobel, a principal with Buck Consultants Inc. in Secaucus, N.J.

In all, the Medicare expansion would result in employers eliminating all or part of retiree health care

plans affecting about 3.7 million retired workers and their dependents, government actuaries estimate.

Still, even with the government prescription drug expansion, employers still would play a vital role in providing retiree health care coverage.

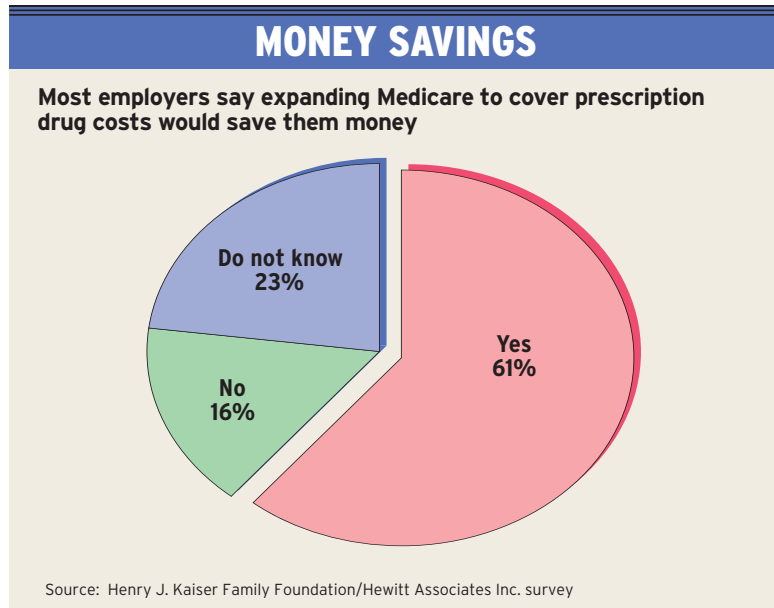
Employer-sponsored plans, for example, could provide coverage for prescription drug costs not covered by Medicare, much as they now do for hospital and physician expenses the federal program does not cover.

"You could see wraparound plans," said Frank McArdle, a consultant with Hewitt Associates Inc. in Washington.

"Employers could fill in the gaps," added Joe Martingale, national leader for health care strategy at Watson Wyatt Worldwide in New York.

While employers—depending on the shape of the final legislation—could save billions in dollars in retiree health care costs, some experts say it isn't fair to describe those savings as a windfall.

"These are good guys who are voluntarily providing the plans," Mr. Martingale said, noting that employers, through taxes they pay, will help fund the expanded Medicare program.



401(k) match: Employer match hit by poor economy

Continued from page 4

Energy Co., Charlotte, N.C.-based Goodrich Corp.; Akron, Ohio-based Goodyear Tire & Rubber Co.; and Providence, R.I.-based Textron Inc.

"Most of these companies are not necessarily in Chapter 11, but they've had severe economic situations in their businesses," said Joe Hesselthaler, Philadelphia-based principal with Towers Perrin.

A 401(k) match "may be deemed to be inappropriate if the company's experiencing some real financial challenges," said Ann M. Longmore, New York-based senior vp and global financial/executive risks practice leader for Willis of New York Inc.

With many employers already cutting health plan benefits, observers say suspending 401(k) matches is a natural cost-cutting move. In addition, defined benefit plan obligations have "a lot to do with past accruals and past investment results" that are smoothed out over a period of years, which means cutting these plans temporarily would not have the same immediate financial impact that eliminating the 401(k) match accomplishes, said Michael Weddell, Southfield, Mich.-based retirement consultant with Watson Wyatt Worldwide.

Paul Gewirtz, a Cleveland-based partner with Ernst & Young's Human Capital Group, said, "I think that a lot of large companies were not fully aware before that they had the freedom all along in their 401(k) plans to cut back on the match.

"Many companies have always traditionally considered the match as a fixed obligation. Once hard times came in the last few years, it was, I think, a pleasant surprise to company treasurers that this could be a reasonable short-term—and I will emphasize short-term—solution to additional downsizing" that allows some larger companies "to save very substantial amounts of cash."

Mr. Gewirtz said more cutbacks can be expected.

Others agree more employers will suspend matches as long as the economy remains troubled.

Mr. Weddell said, "I think it started off as not that big a trend, but I think it kind of surprisingly became one."

Tom Clough, managing director of Norwood, Mass.-based NYLIM Retirement Plan Services, which administers retirement programs, said, "It wouldn't surprise me to see it continue for a little while longer until everyone is in that economic rebound that we're all waiting for."

An informal NYLIM survey conducted in March of 300 companies with 500 or more employees found that 2% had eliminated their matching programs since the beginning of 2002.

Alicia Munnell, Chestnut Hill, Mass.-based director of the Center for Retirement Research at Boston College, said that "if the economy doesn't recover within the next year or so, then I think we may see more companies pulling away from the employer match."

David Wray, president of the

Chicago-based Profit Sharing/401(k) Council of America, said, however, "I wouldn't expect to see too many more" publicly held companies suspend their matching programs. "The market is turning, the economy is turning, and historically we would expect to see the (employer) contributions return as well," he said.

'I think it started off as not that big a trend, but I think it kind of surprisingly became one.'

*Michael Weddell
Watson Wyatt Worldwide*

Others agree. Lori Shapiro, a principal with Mercer Human Resource Consulting in Philadelphia, said she does not see this as a big trend. Most clients believe eliminating the match "is going to look bad with employees because 401(k) plans are so highly valued," second only to health care plans.

Susan Alford, Atlanta-based senior vp with Aon Consulting, said that "although companies were talking about it, not many had actually done it."

Meanwhile, some observers say they are concerned that suspension of matching programs could discourage employees from participating in 401(k) plans altogether. Whenever there is an in-depth study of the issue, "the match is always the primary, and most power-

ful, inducement to participate in a plan and companies are aware of it," said Rich Koski, a principal with Buck Consultants Inc. in Secaucus, N.J. "I think the employee relations issue and the (human resources) issue is a pretty strong argument not to do it."

The NYLIM survey found that as many as 10% of plan participants stop participating when matches are suspended, and these are more likely to be lower-paid employees, who are those that most need to save, said Mr. Clough, though he added that other factors, such as employees' desire to put away a personal nest egg in anticipation of layoffs, may account for this too.

This trend also has repercussions on employers' ability to pass Internal Revenue Service nondiscrimination tests, said Mr. Clough. These tests are used to determine whether average deferrals of highly compensated employees do not exceed those of rank-and-file employees by more than a permitted amount.

Ms. Munnell agreed this is a concern. "I think the reason the match was there in the first place was because the plans have nondiscrimination requirements. The goal is to get broad participation" and employers are going to have to worry that if low-income employees do not contribute to their plans "they're not going to satisfy the IRS requirements."

Ernst & Young's Mr. Gewirtz said, "Most forward-looking managements really understand that two things happen when they eliminate the match: One is that substantially

less money is being put away for an employee's retirement, and number two, even worse, a lot of people are going to stop their own contributions to the 401(k) plan if there's no match, and that would be really unfortunate." This is why many companies approach cutting their matches as only a short-term solution, he said.

Many companies say, in fact, their matching program's suspension is only temporary. CMS Energy, for instance, which suspended its match in September 2002, plans to reinstate it in 2005, said a spokesman.

Some have already restored it. Clearwater, Fla.-based Tech Data Corp. suspended its match in April 2002 and restored it in January, said Dave Francis, director of compensation and benefits. Instead of reinstituting its previous program of a 50% fixed match in company stock for up to 6% of employees' salary, however, "we anchored the match based on company performance relative to goals that will be assessed at the end of the year, when the financial results are finalized," said Mr. Francis. The idea is to build a partnership with employees and "to recognize the current economic times, but also to balance that with the real needs of our employees," he said.

In addition, Detroit-based General Motors Corp., which in March 2001 cut its match for every \$1 that employees defer from 80 cents to 60 cents and then to 20 cents, raised it back to 50 cents in January, said a spokesman.

Motives: Employers face increase in job bias suits

Continued from page 1

disciplinary sanctions against her arising from problems with management and co-workers. After a physical altercation with a co-worker in 1994, Ms. Costa was terminated, while the other co-worker, who had a clean disciplinary record, was given a five-day suspension.

Ms. Costa subsequently filed a sexual discrimination suit in Nevada district court, alleging that she had been stalked and treated differently because of her gender.

A jury found in favor of Ms. Costa and awarded her back pay and compensatory and punitive damages.

On appeal, a three-judge panel of the 9th U.S. Circuit Court of Appeals in San Francisco initially vacated and remanded the decision, holding that the district court erred in giving the jury a mixed-motive instruction because Ms. Costa failed to present "substantial evidence" of discrimination. A year later in 2002, the full Court of Appeals reinstated the district court's judgment after rehearing the case.

Other courts are divided on the issue.

Writing for the high court, Associate Justice Clarence Thomas said

that the amended Civil Rights Act of 1991 does "not mention, much less require, that a plaintiff make a heightened showing through direct evidence."

Furthermore, he said, had Congress intended to require a standard of direct evidence, it would have made that intention clear.

"Its failure to do so is significant, for Congress has been unequivocal when imposing heightened proof requirements in other circumstances," Associate Justice Thomas wrote.

Employment attorneys differ on the significance and scope of the decision, although they generally agree that the number of mixed-motive cases is likely to rise because plaintiffs' evidentiary standard has been lowered.

"I think it's bad news for employers," said Brian Ashe, an attorney with Seyfarth Shaw in San Francisco. "Historically, the mixed-motive formula for employment discrimination cases required a showing of direct evidence of discrimination coupled with a nondiscriminatory motive for the termination," he said.

The Supreme Court "has made it

much easier for these plaintiffs to bring these sort of claims against their employers."

And "it makes it harder for employers (to defend these suits) because, quite frankly, in many situations there are a lot of reasons for firing an employee," he said.

'It makes it harder for employers (to defend these suits) because, quite frankly, in many situations there are a lot of reasons for firing an employee.'

Brian Ashe
Seyfarth Shaw

In mixed-motive cases, "the decision significantly lightens the plaintiffs' burden of proof...and that's significant," said Richard D. Tushman, a labor attorney with Becker & Poliakoff P.A. in Fort Lauderdale, Fla., who noted that mixed-motive cases are "fairly routine."

"Even where there appears to be a legitimate, nondiscriminatory rea-

son for the employers' actions, more plaintiffs will now say there... was also an impermissible factor," he said. "And they will be able to get to a jury on that issue because they will be able to present such proof through circumstantial evidence rather than having to produce direct evidence."

"It's a victory for employees," said Albert J. Solecki, a labor attorney with Goodwin Procter L.L.P. in New York. "In mixed-motive cases, I think employers will have a higher likelihood to settle these cases before they go to trial because of employees' ability now to win these cases on circumstantial evidence."

But Jeremy Glenn, an employment attorney with Meckler, Bluger & Tilson in Chicago, pointed out that plaintiffs still must prove discrimination through circumstantial evidence.

"There's no reason to doubt the credibility of circumstantial evidence," he said. "It goes through the same filters as direct evidence, and once it's allowed as evidence in a courtroom, circumstantial evidence is used to support liability in all kinds of different contexts."

Mr. Glenn said that the high

court's decision will likely have limited impact.

"It changes the plaintiff's burden to get a jury instruction on a mixed-motive case, but in reality, these cases just don't arise very often," Mr. Glenn said. "What you see more of is single-motive cases where a plaintiff argues that the single motivation for the adverse action was because of a protected characteristic."

Chris D'Angelo, an employment attorney with Nixon Peabody L.L.P. in New York, agrees.

"It really doesn't change the landscape a whole heck of a lot for employers in discrimination cases," he said. "While it does make it easier for plaintiffs to establish a mixed-motive if they plead the case as a mixed-motive, I don't think that it impacts a large majority of cases that employers are faced with on a regular basis."

Mr. D'Angelo said, however, that he does think more mixed-motive cases will be filed as a result of the decision. "And what that does is shift the burden to the employer to establish that the adverse employment action would have been taken even absent the unlawful motive," he said.

Alternative: More coverage of unconventional care

Continued from page 1

Calif.-based alternative healthcare services provider, found that two-thirds of health plans nationwide offered coverage for at least one form of alternative care. In addition, benefits mandates in several states require health plans to provide some forms of alternative therapy, such as chiropractic treatments and acupuncture.

Health plans that cover alternative therapies commonly do so in one of three ways:

- As a discount program, such as CIGNA Corp.'s "Healthy Rewards" program, which gives members discounts on alternative medicine services, vitamins and herbal medicines.

- As a rider or carve-out with limited benefits, such as Oxford Health Plan.

- As part of the standard benefit plan, such as HMO Illinois, a subsidiary of Blue Cross & Blue Shield of Illinois that allows members to choose complementary and alternative medicine providers as their primary care physicians.

While only a handful of employer-sponsored health plans currently provide alternative therapy coverage, benefits experts predict more will do so in the future for a variety of reasons, including as an attempt to reduce health care costs.

"What's really driving the change is the utter inability of conventional medicine to improve both control costs and improve clinical outcomes," said Dr. Richard Sarnat, co-founder and president of Alternative Medicine Inc., the Highland Park, Ill.-based independent practice association that provides alternative therapy providers to HMO Illinois.

"Everything we're been doing in the box is not working. And managed care is now 25 years old. And so, if the decision makers who do purchase health care in large volumes do nothing new, they are going to never control health care costs," Dr. Sarnat said.

The move toward a consumer-driven health plan model also could lead to the expansion of alternative medicine, predicted Ben Haas, senior consultant at Watson Wyatt in Boston.

"I do think the more-holistic approach to medicine that we see in the alternative medical delivery model does resonate to some extent as we move to a greater focus on health and health improvement," which is emphasized in the consumer-driven model, he said.

Just as "chiropractic care has moved from being alternative to being a fairly standard part of most benefit programs," he said, "I think we'll see more coverage for things like nutrition counseling, smoking cessation, weight-loss programs," and many other programs that incorporate the use of alternative medicine.

Broader coverage for alternative medicine also could come in the form of allowing participants in consumer-driven health plans to use employer-provided funds in health reimbursement accounts to pay for it, predicted Mary Harrison, an associate principal at Buck Consultants in New York.

If employees are responsible for paying for more of their own health care, they will likely consider alternative medicine, because it is often cheaper than traditional Western medicine, she said.

"People are seeing it as a more

cost-effective way to get treatment," she said. "People are also more interested in things like massage therapy to deal with stress or repetitive motion injuries," or for other conditions for which they are dissatisfied with conventional medical treatment.

'I do think the more-holistic approach to medicine that we see in the alternative medical delivery model does resonate to some extent as we move to a greater focus on health and health improvement.'

Ben Haas
Watson Wyatt

Two out of three people in the United States now use some form of alternative therapy such as acupuncture, herbal medicine and chiropractic therapy, according to a 1998 survey by Stanford University's School of Medicine. They also shelled out some \$27 billion out of pocket for these treatments, according to a 1998 study by Harvard Medical School.

Tim McDonald, corporate health programs manager at General Motors Corp. in Detroit, expects that many employers will offer some forms of alternative medicine as part of their wellness programs, which is what GM has done. The automaker offers yoga and tai chi and all of its health plans cover chiropractic treatment, he said.

"Yoga has gotten the most acceptance, but as far as providing yoga

benefits, I don't see it," he said. Rather, if such benefits are introduced as part of a wellness program, "it offers companies an opportunity to test things out and not codify it as a benefit," Mr. McDonald said.

Scientific evidence supporting the efficacy of alternative medicine will have perhaps the greatest impact on the extent to which employer-sponsored benefit plans cover the procedures, benefits experts say.

"It's somewhat like the wellness problem. It's difficult to quantify," said Jim Crockett, manager of risk and benefits at Denver Water. As a result, "a lot of entities are reluctant to pay for it." But, "if you could quantify it and compare it to traditional medicine," then it may be covered, he said.

Several research projects under way could resolve the debate over the value of alternative medicine.

The National Center for Complementary and Alternative Medicine, a division of the National Institute of Health, is conducting the first large-scale clinical trial of EDTA chelation therapy as a treatment for coronary artery disease. In the therapy, which has been approved by the U.S. Food and Drug Administration to treat lead poisoning and other heavy-metal toxicity, EDTA, a manmade amino acid, is given to patients intravenously. Other clinical trials by NCCAM will study the use of alternative medicines in treating minor depression and severe acute respiratory syndrome, or SARS.

Separately, the American Society of Actuaries is analyzing health care claims data from insurers to determine the cost effectiveness of com-

plementary and alternative medicine compared with traditional medicine.

A lack of coding is one of the reasons that insurers and many employers haven't offered alternative therapies coverage, said Synthia Molina, chief executive officer of Alternative Link of Albuquerque.

"There's a lot of miscoding that is going on right now, then in other areas, no coding at all," she said.

To resolve the coding issue, Alternative Link has been authorized by the U.S. Department of Health and Human Services to lead a two-year demonstration project in which its codes will be used by more than 10,000 organizations, including health plans, insurers, third-party administrators and providers.

Gaining more information on complementary and alternative medicine "will lead to greater coverage and reimbursement," Ms. Molina said.

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Late News

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Assn. of Insurance Commissioners' Reinsurance Task Force. That task force is expected to consider the issue of reinsurance collateral during the NAIC's June 21-24 meeting in New York.

Vice president calls for med mal reform

Vice President Dick Cheney urged Congress to quickly pass medical malpractice liability reform. The current medical liability system is



Mr. Cheney

"broken" and has driven up malpractice insurance rates, forcing some physicians to stop practicing medicine, Mr. Cheney said. "We need to get a bill on the president's desk that will fix the medical liability system, and we need to do it soon," he said at an American Assn. of Health Plans conference last week.

Louisiana drops prior rate change approval

Louisiana insurers will be able to raise or lower rates without prior approval under a new flexible-rating law. The legislation, which applies to commercial and personal lines, would take effect Jan. 1, 2004. Under the law, insurers can raise or lower rates by as much as 10% without obtaining regulatory approval. Insurers must notify policyholders of any rating change, which will take effect 30 days after it is filed with

the Louisiana Insurance Rating Commission.

Hannover Re to get \$587 million capital boost

Hannover Re Group said it plans to raise about 500 million euros (\$587.2 million) through a private placement of shares and a capital injection from its parent, German mutual insurer Haftpflichtverband der Deutschen Industrie. The reinsurer is issuing 9.7 million shares to institutional investors in the United States and Europe, a move it expects to raise about 230 million euros (\$270.1 million). In addition, HDI will boost Hannover's capital base by transferring its Ireland-based subsidiary, HDI Reinsurance Ireland, to Hannover Re.

Vet can pursue claim for Agent Orange injuries

A Vietnam War veteran can pursue a claim against manufacturers of Agent Orange regardless of a 1984 class-action settlement, following the U.S. Supreme Court's failure to agree on the merits of the case. The Supreme Court split 4-4 over the case, *Dow Chemical Co. vs. Stephenson*, thereby allowing to stand a lower court ruling that the veteran could pursue his case because he did not have any symptoms of illness from his exposure to the Agent Orange defoliant until after the funds from the earlier settlement had been depleted.

Former grocery chain owner liable for award

The former owner of a now-defunct grocery chain is liable for a \$5.4 million award to retirees after a federal appeals court ruled an insurer does not have to fund a portion of the award. The appeals

ruled that the \$250,000 deductible on an employee benefits liability policy written for Schwegmann Giant Supermarkets applied to each individual claim and therefore was never exceeded. The lower court had ruled that the insurer was responsible for the award amount minus a single \$250,000 deductible. The lower court's ruling was unusual in that it established that a retirement plan can be protected by the Employee Retirement Income Security Act even if it is funded by noncash benefits. The appeals court agreed that the plan was protected by ERISA.

Employers not changing retirement benefits

Despite the sluggish economy, most employers are not changing the contributions they make to employees' retirement plans, a survey concludes. In a survey of 889 human resources professionals, which was conducted by the Society for Human Resource Management from May 27 through June 3, 72% of respondents said their companies had made no change to retirement benefits. Of the 28% that reported making changes, 4% said they had increased the match they make on employee contributions to retirement plans, while 4.5% said they had reduced the company match.

Pennsylvania governor proposes med mal reform

Wide-ranging reforms aimed at curbing escalating medical malpractice liability insurance premiums were proposed by Pennsylvania Gov. Edward Rendell.

Among other things, the governor proposes requiring state insurance department approval for all medical malpractice policy wordings.

Currently, only policies generating less than \$25,000 in annual premium require approval. Also, under the proposals, the state would pay for three years the premiums



Gov. Rendell

of certain high-risk categories of physicians to the state's Medical Care Availability and Reduction of Error program. The program provides compulsory excess malpractice coverage.

Briefly noted

The House Committee on Education and the Workforce approved the **Small Business Health Fairness Act**, which would allow small businesses to form association health plans, by a vote of 26-21 on Thursday....A.M. Best Co. downgraded the financial strength rating of New York-based **MLMIC Group** to B, or fair, from B++, or very good, and removed the rating from review. Best said the action reflected the medical liability insurer's deteriorating operating performance and marginal capitalization.

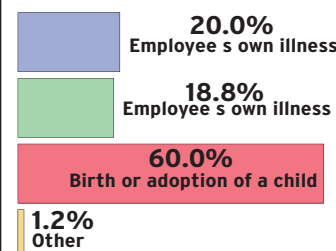
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Online Poll

[6/9 - 6/13]

What is the most common reason your organization's employees take leave under the federal Family and Medical Leave Act?



BI Stock Index

[6/9 - 6/13]

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 **1977.35** **1.36**

Dow Jones **9117.12** **0.60**

S&P 500 **988.61** **0.09**

Largest gains

PMA Capital Corp.	15.83%
Alleghany Corp.	11.12%
Oxford Health Plans	9.93%
Vesta Insurance Co.	8.70%
Humana Inc.	8.57%

Largest losses

CIGNA Corp.	-8.85%
Unico American Corp.	-7.95%
SCPIE Holdings Inc.	-7.88%
SCOR	-6.54%
Argonaut Group	-5.35%

Weekly change by market segment

Brokers	0.71%
Insurers/Reinsurers	1.12%
Managed Care Organizations	1.62%

Source: CNET Investor (investor.cnet.com)

Carve-out: Reinsurers sued over denials

Continued from page 3

Hancock, which reinsured UniCover risks, took a \$133.7 million after-tax charge for unrecoverable reinsurance in 1999 and has been involved in arbitrations with several other participants on the business, including Clarendon.

Lincoln National last year settled a dispute in which Swiss Re sought to reduce the \$2 billion it had agreed to pay for Lincoln National Re by \$770 million, largely as a result of carve-out liabilities. As part of the settlement, Lincoln National agreed to pay Swiss Re \$195 million plus an additional \$100 million under an indemnification agreement covering the personal accident business, according to Lincoln National's first-quarter 2003 financial statement.

The Clarendon owners' lawsuit similarly involves the impact of looming carve-out losses on a pending acquisition deal.

In addition to Mr. Milo and a Milo family partnership, the plaintiff shareholders include former Clarendon president Robert D. Ferguson and the bankruptcy estate of

Finnish insurance holding company Kansa International Corp. Ltd.

According to the suit, Clarendon's owners reached an initial deal in 1998 to sell the company to Hannover Re for \$389.1 million. Before the scheduled year-end closing, though, Hancock and Lincoln National halted reinsurance payments on contracts covering Clarendon personal accident business, with Hancock later claiming misrepresentation in the placement of the risks and Lincoln National charging that it had been drawn into a reinsurance spiral.

Hannover Re then backed out of the deal, asserting that the reinsurance disputes were a "material adverse change" in Clarendon's business. The German reinsurer later agreed to go ahead with the acquisition in return for "substantial concessions," including a \$25 million reduction in the purchase price, the suit says.

Arbitration proceedings involving Hancock later established that neither Hancock nor Lincoln National had any basis for denying liability

under their contracts, the Clarendon owners allege.

Hancock reinsured both Clarendon

Clarendon's former owners are seeking to recover a \$25 million reduction in the company's sale price.

don and Philadelphia-based Legion Insurance Co.—now in rehabilitation—on carve-out business originally produced by Bermuda-based managing general agent Stirling Cooke Brown Holdings Ltd., the suit says. Last year, a Pennsylvania state court affirmed two arbitration awards ordering Hancock to pay Legion \$5.9 million plus \$1 million in interest on carve-out reinsurance claims.

Clarendon itself launched an arbitration with Hancock on the Stirling Cooke business last year and in January 2003 reached a settlement under which Hancock paid Clarendon

\$14.4 million to commute its treaties, the suit reports.

The complaint does not cite any arbitrations involving Lincoln National. The suit charges, however, that evidence from the Hancock arbitrations shows both Hancock's and Lincoln National's denials of liability to be "baseless, wrongful and done with knowing and reckless disregard of their impact on the transaction between plaintiffs and Hannover Re."

Charging the reinsurers with tortious interference with the sale contract, Clarendon's former owners seek to recover the \$25 million reduction in the sale price.

The suit also alleges that Hancock's \$14.4 million arbitration settlement included \$2.7 million for legal fees, part of which was intended to cover legal expenses of Clarendon's former owners. Hancock paid the entire sum to Clarendon, though, despite an agreement to split the amount apportioned for legal fees, according to the complaint, which seeks an \$800,000 reimbursement from Hancock.

INSURER TOPICS

A MONTHLY EDITORIAL SECTION SENT EXCLUSIVELY TO INSURERS AND REINSURERS

Urban Market Opportunities



Cities take on a new attraction for insurance industry

Building the community's confidence in a business is key to its success

By SALLY ROBERTS

With an abundance of opportunity waiting for the insurance industry in the urban markets, just what does it take to be

successful?

Insurance agents in the inner city say success lies in being able to mirror the communities they serve, being flexible, getting involved in the community and building a good reputation.

"I think one of the key ingredients is to have a reputation of being a business that

operates totally with the community's confidence," said Milton E. Moses, president and chief executive officer of Community Insurance Center Inc., an independent agency located in Chicago's predominately African-American Chatham neighborhood. "We have let people know we're a business that can be trusted and that we have quality

products and that we put our customers first," he said.

In addition, "one thing that has contributed to our success is that when we built the facility, we wanted it to be something the community identified with as financial strength in the community," Mr.

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Avoiding accusations of redlining / 12D

Entrepreneur breaks barriers / 12F

Benchmarking as an analytical tool / 12H

Fewer M&As, but plenty of deals / 12H

INSURER TOPICS

Cities: Urban areas take on a new attraction

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Milton said. "Financial strength means security, and security is what we need in any community. We need our kids to grow up secure knowing they have opportunities and that there are jobs available and they don't have to take the wrong road in life in order to be a success," Mr. Milton said.

As such, Community Insurance Center's workplace is a nice professional office where dress codes are strictly enforced, Mr. Milton said. "We feel the initial appearance is your biggest impression," he said. As such,

"everything looks real good when you walk in the door," he said.

But it's not only about looking professional, urban market agents say.

"Our people mirror the community," said Alex Soto, president of InSource Inc., a Miami-based agency. "The fact is a vast majority of the people in my office are bilingual, so if you are a Latin American buying property here in Miami and you're more comfortable speaking Spanish, we'll speak Spanish," he said.

Mr. Soto noted, though, that remaining flexible also is key.

"I have an equal amount of Anglo clients as I do Hispanic clients," said Mr. Soto, who immigrated to the United States from Cuba more than 40 years ago.

"I can do the same thing in Spanish as I can English. If you circumscribe yourself to one or the other, you'll have difficulties" selling in the urban market, he said.

Harold L. Lee & Sons Inc., a fourth-generation family-run insurance agency located in New York's Chinatown, also is a totally bilingual insurance agency, according to Sandra Lee, a principal

in the agency. "We all speak English and several dialects of Chinese," she said. "That certainly has enhanced our relationships with clients. It gives them a comfort level that they are getting a better explanation of the coverages."

In addition to speaking the same language, Ms. Lee said that good insurer partnerships and a long and strong presence in the community have also helped in the success of her agency.

"We're very active in civic affairs in Chinatown and the city," she said. By "being out there in the

center of influence in the community" the agency has been able to pick up business outside of Chinatown, she noted.

Indeed, exposure is one of the key ingredients behind the success of Gary, Ind.-based Haywood & Fleming Associates, according to Roosevelt Haywood III, president and CEO.

"By me getting involved with trade associations and, at the same time, being involved with the National African American Insurance Assn., I've had the opportunity to travel, experience and be exposed to some of the best in the business," he said. "I've learned about agency systems, agency management, sales and positioning," said Mr. Haywood. "That is a tremendous combination when you bring it back home and apply it to your community."

'If you are a Latin American buying property here in Miami and you're more comfortable speaking Spanish, we'll speak Spanish.'

Alex Soto
InSource Inc.

The Urban Insurance Partners Institute, a Chicago-based organization devoted to educating the insurance industry about urban insurance issues, offers the following suggestions for agents who want to penetrate the urban market:

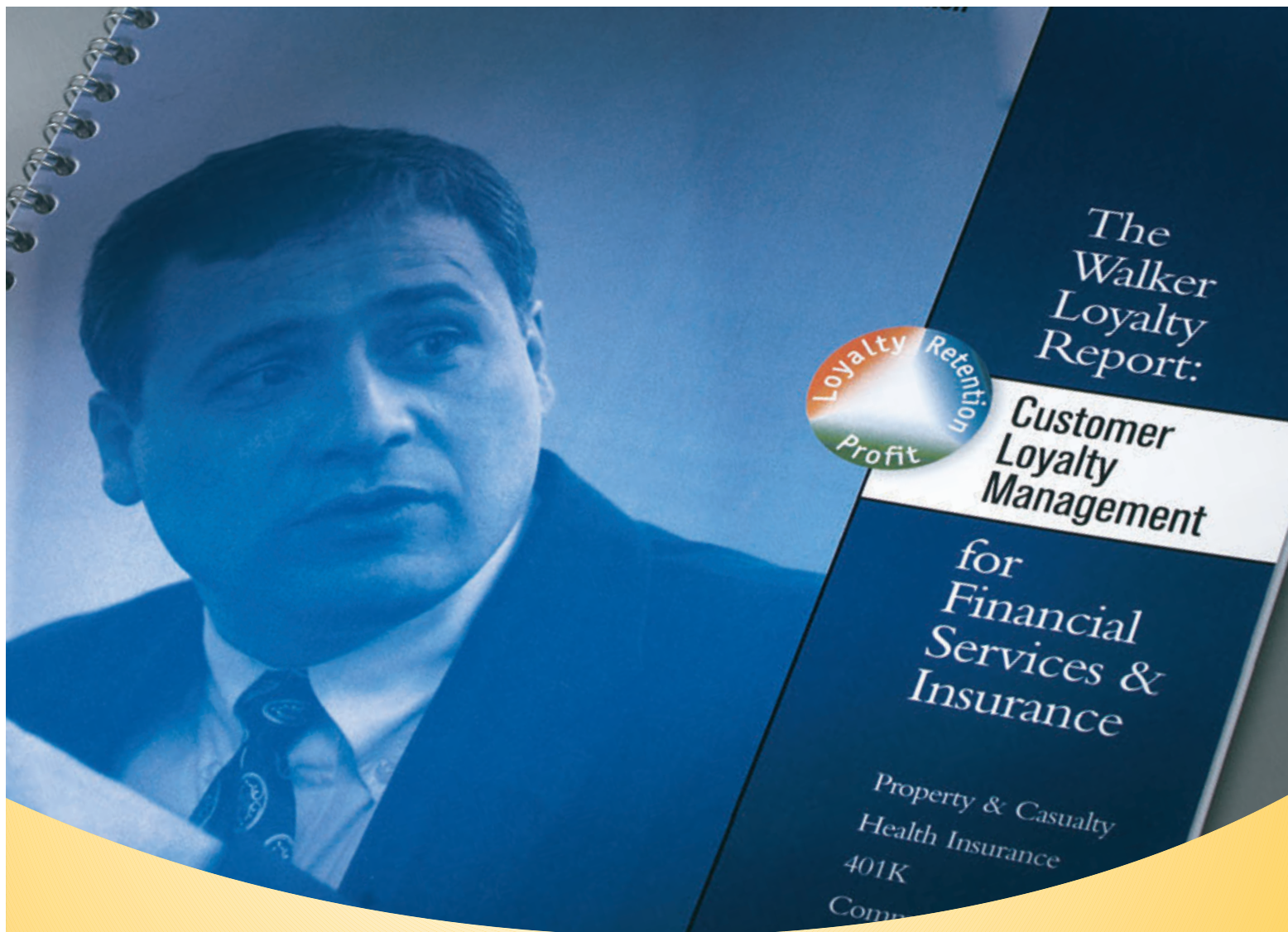
- Know the local market and develop a business plan. If the market area has first-generation immigrants, for example, an agent may face language challenges.
- Work with insurers that have sound urban markets strategies. An insurer that wants to test the waters by appointing just one agent or quickly develops a product without market research is probably not a company that has a sound, long-term strategy for urban market success.
- Do not try to gain credibility in the community simply by sponsoring a local charity or community event. By serving on a local community development board, for instance, agents and brokers can gain real understanding of the area and its economic trends.
- Consumer education is key. Through educational presentations, business owners will better understand the coverages that they need and the value of retaining their coverage.

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