HMO ruling may spur ERISA clarification

High court's decision on state review of coverage disputes could prompt legislative action

By MARK A. HOFMANN

WASHINGTON—A U.S. Supreme Court ruling that federal benefits law does not pre-empt a state's mandated external review of certain medical coverage disputes is unlikely to break the current deadlock in Congress on patient rights legislation, health care experts say.

Some are hopeful, though, that the high court's majority decision in *Rush Prudential HMO Inc. vs. Debra Moran et al.* could prompt federal lawmakers to clarify the scope of the Employee Retirement Income Security Act's pre-emptive powers on health care matters. ERISA preemption of state laws has long been a focus of litigation by health plans.

The case, which was decided June 20, revolved around whether ERISA pre-empted an Illinois law that mandates that health plans provide for an independent external review of certain coverage disputes (*BI*, June 24). By a margin of 5-4, the high court ruled that the Illinois HMO Act—which is similar to legislation in about 40 other states—was an insurance regulation and, therefore, is not subject to ERISA preemption.

The ruling could be taken as a victory by the advocates of federal legislation to reform managed care regulations, but that doesn't mean that it's going to jump-start the stalled debate over such legislation, said Paul Dennett, vp-health policy for the employer-backed American Benefits Council in Washington.

"It raises the visibility of the patients bill of rights legislation in the short term," Mr. Dennett said, because some of the same issues that the court was wrestling with are addressed in competing bills that were passed by the House and Senate last year. A conference committee has

See ERISA/page 22

INCREASES HIT MIDSIZE EMPLOYERS

A national survey found that midsize employers are facing bigger increases in health care costs than are other employers

	10- 199 employees	200-999 employees	Fortune 500
Total health benefit cost per employee	$4,496	$5,144	$5,459
% Cost increase 2000-2001	10.4%	16.8%	11.2%
% Increase expected for 2002	12.5%	12.7%	13.0%
Health benefit cost as % of total payroll expense	11.8%	15.0%	13.9%

Source: Mercer Human Resource Consulting

Midsize firms face highest cost hikes on health benefits

By JUDY GREENWALD

Midsize employers were squeezed the hardest by double-digit health benefit cost increases in 2001, new research shows.

Employers with 200 to 999 employees absorbed a 16.8% increase in total health benefit costs, or an average of $5,144 per employee, according to an analysis of a broader study conducted by Mercer Human Resource Consulting. The full survey was released last December (*BI*, Dec. 10, 2001).

In comparison, small employers with 10 to 199 employees averaged a 10.4% increase, or $4,496 per employee, while Fortune 500 employers surveyed averaged an 11.2% hike, to $5,459 per employee, according to the study, "Mid-Sized Employer Health Plans—2001." The study, which was released by Marsh Inc., looked only at the responses of 1,352 employers with fewer than 1,000 employees.

Roger Edgren, the head of Marsh's Employee Benefits Services Group and one of the study's authors, said midsize employers are in a double bind. "They need to be able to offer a benefit package that is comparable to those offered by large employers with whom they compete for labor, yet they have neither the purchasing power of large employers nor the resources to devote to benefit cost management," he said in a statement.

In response to continuing double-digit cost hikes, 34% of employers with 200 to 999 employees said they planned to raise employee premium contributions for 2002, and 27% planned to raise deductibles, copayments or out-of-pocket maximums. Small employers, with 10 to 199 employees, having made changes in 2001, were only about half as likely to make changes in 2002.

Mr. Edgren told *Business Insurance* that, in recent years, cost shifting had "been less of an issue with rate increases being lower. But now, with the economy the way it is and jobs harder to

See HEALTH COSTS/page 19

State legislature considers corrective measure

California high court rules age-based benefits bias is legal

By JOANNE WOJCIK

SAN FRANCISCO—A California Supreme Court decision allowing employers to deny certain benefits to older workers could become moot if legislation to reform the state's anti-bias statute is enacted.

California's highest court ruled June 24, in *Esberg vs. Union Oil Co.*, that the state's Fair Employment and Housing Act does not prohibit "discrimination in the terms, conditions or privileges of employment on the basis of age."

The ruling notes that two separate sections of the FEHA prohibit various forms of workplace discrimination and identify protected classes. It points out that while Section 12491 specifically prohibits age discrimination in employment—hiring, discharge, suspension, etc.—it does not address the "terms, conditions and privileges of employment." And, the ruling says, Section 12490, the section that addresses such employment terms, bars discrimination on the bases of "race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, sex or sexual orientation," but not on the basis of age.

Legislation pending before the California Senate Judiciary Committee, though, would add "age" to the bases of discrimination in terms, conditions and privileges of employment. The bill, A.B. 1599, which specifically seeks to overturn the circumstances that led to the *Esberg* decision, already has passed the state Assembly.

Similar legislation was passed in 1998, but then-Gov. Pete Wilson vetoed it, saying that older workers already were protected by the FEHA.

California's current governor, Gray Davis, has not taken a position on the bill and has directed his legal staff to review the *Esberg* decision, a spokesman said.

The ruling stems from a lawsuit filed by Dan Esberg of Corona, Calif., a former telecommunications specialist at Union Oil Co. of California who, at the age of 56, was denied reimbursement of tuition paid for a master of business

See AGE BIAS/page 22

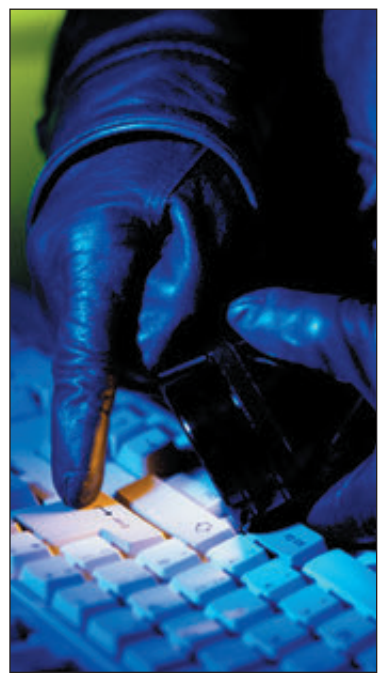
Near North sues ex-IT workers, claiming hacking theft of info

By DOUGLAS McLEOD

CHICAGO—Near North Insurance Brokerage is suing three former employees, charging that they hacked into its computer systems and stole e-mails and other proprietary information that have been passed on to competitors.

The complaint, filed in U.S. District Court in Chicago, names David K. Cheley, Douglas Sikora and Craig Jongsma, all former information technology employees of Near North. The suit seeks, among other things, to recover the $645,000 the brokerage says it has spent in investigating the tampering and re-securing its systems. Near North has a "full complement" of technology insurance coverages that it believes will cover its loss, a spokeswoman said.

Near North client records are kept on separate computer servers and were not tampered with in the alleged hacking incidents, which focused on the broker's internal and external e-mail, personnel records and other files, Near North said.



According to the lawsuit, Mr. Cheley accessed Near North's computer system shortly after his termination in August 2001 using stolen passwords and installed a program that would give him access to all log-ins and passwords in the system. Messrs. Jongsma and Sikora left Near North at different times earlier this year.

Joining a Rosemont, Ill., technology services company after leaving Near North, Mr. Cheley was assigned to work for a Chicago insurer, according to the suit and a Near North spokeswoman. During March

See NEAR NORTH/page 23

Defined benefit revival

Enron debacle fuels support for 'DB/k' hybrid plan

By VINEETA ANAND

WASHINGTON—The collapse of Enron Corp. has given a new impetus to proposals to revive traditional pension plans in which participants usually are assured of receiving a monthly check for life.

The latest information from the Labor Department, which doesn't reflect the stock market's decline in recent years, shows that assets in private and multiemployer pension plans amounted to $1.9 trillion in 1998, and $1.5 trillion in 401(k)-type plans.

In the quintessential lemonade from lemons-type of effort, some organizations representing actuaries, as well as a pension money manager, are floating proposals to combine 401(k) plans with traditional defined benefit pension plans, building on the best features of both.

Now, though, the millions of dollars in lost retirement savings by Enron participants have breathed new life into those efforts, loosely dubbed "DB/k."

The idea isn't new.

Until recently, cash balance plans—defined benefit plans with 401(k)-like features such as hypothetical individual accounts—were all the rage until employee uprisings at companies such as IBM Corp. soured many companies on the concept. The Internal Revenue Service's clampdown on approving conversions from traditional pension plans has also contributed to the dampening of enthusiasm.

The Labor Department data show a continuing decline in pension plan coverage, and experts have grappled with ways of increasing coverage among small employers, where the number of defined benefit plans has decreased sharply. In 1998, an estimated 44% of all participants were in defined benefit plans, down from 84% in 1978. The decrease is, in part, because of huge terminations by smaller employers and the parallel lack of creation of new jobs among unionized firms, which continued to offer traditional pension plans, according to the Department of Labor's data analysis.

The DB/k proposals by the American Academy of Actuaries, a Washington actuarial think tank, and the Principal Financial Group of Des Moines, Iowa, are intended to jump-start the creation of defined benefit pension plans among small and midsize employers by eliminating much of the paperwork and red tape associated with setting up these plans.

"The collapse of Enron has revealed shortcomings in the 401(k) risk borne by employees that had not been looked at in the roaring 1990s," said Rep. Earl Pomeroy, D-N.D. Mr. Pomeroy and Reps. Rob Portman, R-Ohio, and Ben Cardin, D-Md., are contemplating introducing legislation incorporating some type of DB/k proposal into pension simplification legislation later this year.

James M. Delaplane Jr., vp of retirement policy at the Washington-based American Benefits Council, which is studying the various DB/k proposals, agreed. "There is a greater interest in defined benefit plans generally since Enron, and specifically in marrying something of defined benefit and defined contribution features," he said.

And Stuart Brahs, a Washington-based lobbyist for the Principal Financial Group, which also consults to many smaller plans, noted, "This is next generation. We are looking ahead to include it in the mix" of new pension simplification proposals.

The proposals on melding pension and retirement plans got their first public airing at a congressional hearing June 20, held by Rep. Amo Houghton, R-N.Y., chairman of the House Oversight Subcommittee.

The new proposals—which studiously avoid the mention of cash balance plans—would go beyond the run-of-the-mill existing hybrid plans, in which employees receive pensions equivalent to money set aside in hypothetical accounts.

One version, floated by the American Academy of Actuaries, is inspired by the participant-directed cash balance pension plan set up by Bank of America Corp.—then NationsBank Corp.—in 1998, in which participants could roll over their 401(k) balances into a cash balance plan and put the money within the hybrid plan in investment options mimicking the choices they had in the 401(k) plan.

'There is a greater interest in defined benefit plans generally since Enron, and specifically in marrying something of defined benefit and defined contribution features.'

James M. Delaplane Jr.
American Benefits Council

The biggest advantage is that employees would, at a minimum, receive at least the amount of money they had rolled over from the 401(k) plan, as well as their accrued pension and subsequent employer contributions.

Ron Gebhardtsbauer, senior pension fellow at the American Academy of Actuaries, said the DB/k proposal would, in effect, guarantee participants their 401(k) retirement savings—but within a defined benefit plan, so they would be insured by the Pension Benefit Guaranty Corp. The losses of Enron participants' retirement savings has sparked lawmakers' interest in guarantees, but the inherent difficulties of such an undertaking make this proposal attractive because it aims to accomplish that within the existing framework.

The academy's proposal would permit employers to decide how many investment options to offer within the cash balance plan, how much of the rollover assets to guarantee and whether to impose a fee for the guarantee. NationsBank did not charge participants for the guarantee.

The academy's proposal, in essence, would extend many of the rules that apply to 401(k) plans to the combination plan. Thus, participants would be able to make pretax contributions to the DB/k.

The proposal also would let low-income workers collect a government subsidy for contributions to retirement plans, eliminate the typical waiting period for new employees to be covered by the new plan, permit employees to start collecting their retirement savings upon reaching 59 and one-half years of age, and simplify other tedious rules that apply to defined benefit plans.

The proposal also would allow employers to use surplus pension assets to pay for their matching contributions.

"This might motivate some employers, the ones that have overfunded DB plans, to move their 401(k) to the DB side," Mr. Gebhardtsbauer said in written testimony prepared for the hearing.

Moreover, the proposal would allow participants to make use of the current limits on maximum benefits they can receive under both pension and retirement plans. In 2002, participants can receive up to $160,000 in pension benefits and contribute up to $40,000 in combined employer-employee contributions to all types of retirement plans.

"Policymakers have said that participants should have the best of both worlds—a defined benefit pension plan and a 401(k) plan—and it makes sense to keep separate limits for each," Mr. Delaplane said.

The proposal has raised a lot of concern. PBGC officials wonder how to value benefits under a combined plan that has been terminated, if the plan offers participants a range of investment options, according to sources who asked not to be identified.

Because cash balance plans typically are underfunded on an ongoing basis, PBGC officials also worry about the agency's liability if an employer sponsoring a combined plan goes under, the sources said. A spokesman from the PBGC declined to comment.

The DB/k plans also could increase pension plan volatility under current accounting rules, said a pension expert who did not wish to be identified. Participants' asset allocations would be all over the map, increasing the volatility of overall plan returns and thereby making it difficult to predict returns.

"A lot of legislative changes would have to happen for the DB/k to work," noted the expert.

Meanwhile, the second variation of the DB/k proposal being floated by the Principal Financial Group and the American Society of Pension Actuaries of Arlington, Va., is aimed at small employers and would simply overlay a 401(k) plan on a defined benefit plan.

Questions remain, though, about how the proposals would work. And those drafting the proposals have not yet dealt with thorny issues such as whether participants would have to contribute to the DB/k in order to receive the DB benefit.

Vineeta Anand is a reporter for Pensions & Investments, a sister publication of Business Insurance.

Errors & omissions

● An article on retroactive reinsurance in the June 24 issue omitted the fact that Frank B. Hall & Co. Inc. did not become the broker for the MGM Grand until after the 1980 fire occurred.

12 states approve exclusions for excess workers comp

By MEG FLETCHER

ST. LOUIS—Terrorism exclusions for excess workers compensation policies have been approved by at least 12 states, a leading workers comp insurer has revealed.

Safety National Casualty Corp. says that it "has received explicit approvals from 12 states" to impose approved terrorism exclusions on excess workers compensation policies that are purchased by self-insured employers.

While the statutory nature of workers comp coverage prevents a terrorism exclusion from being imposed on primary workers comp policies, such exclusions are permitted in excess comp policies in some states where self-insureds are not required to carry excess coverage, according to several regulatory and industry sources.

The revelation by St. Louis-based Safety National is increasing concern about the impact of a terrorist attack on employers.

"If you exclude terrorism, then all the exposure is back on the employer, which could have severe financial implications if there was a large terrorism attack," said George Pantos, counsel in the Washington office of the Self-Insurance Institute of America Inc.

Illinois, which acknowledged it is one of the 12 states, previously re-

See WORKERS COMP/page 19

Commentary

Paying for quality saves in long run

My blood pressure is still rising since I reported on a new study by the Midwest Business Group on Health that said employers are being penny-wise and pound-foolish when they cut corners on health care.

Business Insurance has published numerous articles over the years that have illustrated how improving quality lowers costs. Time and again, it's been shown that employers that pay for wellness programs, mental health care and other preventive health care services save money in the long run.

It's pretty obvious employers haven't been paying attention, though, if 30 cents of every dollar spent on health care today is being wasted, as the MBGH found. This occurs because of a combination of administrative inefficiencies and misuse of medical services, which is done primarily to circumvent coverage restrictions.

Joanne Wojcik

Like a cancer that grows if it's not detected early, poor-quality health care is metastasizing in this country. One only has to review the research on medical errors by the Academy of Sciences' Institute of Medicine to see that prognosis.

The problem is that too many employers are not focusing on the long-term implications of their health care decisions.

Take wellness programs as an example. Countless benefit managers see no point in investing in health promotion programs because if their employees quit and go to work somewhere else, they won't reap the benefits of improved health. But what if they end up being the employer that hires that overweight 45-year-old smoker who needs a coronary bypass operation?

Employers grousing about having to boost mental health care benefits to bring them into parity with other medical benefits should look at a study by Costa Mesa, Calif.-based pharmacy benefit manager Prescription Solutions that found overall health care costs would decline if depression were properly diagnosed and treated.

Concentrating on the here-and-now might be good advice if you're practicing Zen, but improving the health care system requires that employers prepare for the future while keeping an eye on the past.

That can mean reassessing the benefit tools used in the present.

The continued focus on managed care to contain costs is outdated. It was innovative when it was introduced back in the early 1970s, but now all it's doing is riling employees who can't seem to get the medical care they need and bankrupting doctors who are being forced to accept lower and lower fees.

As for employers that think "defined contribution" will be the panacea to their cost ailments, they may as well be drinking snake oil. All defined contribution does is treat the symptoms by passing the buck—literally—to employees. It doesn't cure the disease. Just because employees have to pay a greater share doesn't mean the health care they buy will be any better. In fact, many will probably forgo expensive but necessary treatments and end up in worse shape.

Rather than tackling problems with the health care system head on, it seems everyone is pointing fingers. By now, we've pretty much blamed everyone: Employees are at fault because they're bad consumers; doctors are at fault because they render more services than are necessary; insurers are to blame because they're bean counters focused on profitmaking; and employers are to blame because they're self-serving and avaricious.

There are a few pioneering employers that do seem to be "getting it," such as the Leapfrog Group, whose members are willing to pay for better-quality health care, and the MidAmerica Coalition on Health Care, which is encouraging employees to seek treatment for mental illness before it manifests itself in physical illness.

But I worry that if these and other initiatives are successful in slowing down the rate of medical inflation that employers will once again become complacent, as they did after the introduction of managed care helped taper off health care cost increases in the 1990s. That's when employers had the chance to do some long-range planning, but didn't.

Throughout the years that I've reported on the U.S. health care system, I've seen history repeat itself too many times. Even though the players and terminology change, the outcome remains the same: Good health care costs money, but bad health care costs even more.

Senior Editor Joanne Wojcik's commentary appears periodically in Business Insurance and on www.businessinsurance.com. She can be reached by e-mail, at jwojcik@crain.com.

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Editorial

New benefit options welcomed

CLARIFICATION BY the Internal Revenue Service of the tax treatment of health reimbursement accounts could expand the options available to employers seeking ways to curb soaring benefit costs.

Without such alternatives, many employers—especially smaller ones—will drop their health care plans altogether rather than pay for the increasingly expensive benefits.

The reimbursement accounts—also called personal spending accounts—form the basis for an increasingly popular example of the defined contribution approach to health care benefits. While vendors and employers have already been using these accounts to reimburse employee medical expenses, the tax status of the approach has been uncertain and other questions have lingered. With the clarification provided by the IRS, these types of defined contribution health plans are poised to grow, and they could form the basis for new benefit funding options.

The attraction of these reimbursement plans for employers is that they limit employers' health care expenditures to a fixed amount; anything over that amount is picked up by the employee.

At a time when health care premiums are increasing at double-digit levels annually, this provides an important new option in employers' cost-containment arsenal. And for some small employers it may induce them to offer a health benefit they previously felt was beyond their financial reach under traditional insurance arrangements.

As reported on page 1, the IRS defined how the reimbursement plans must be structured—such as being solely funded by employers and reimbursing only actual medical expenses—to avoid income tax on the funds set aside to reimburse employees' medical expenses. But the government also provided other guidance that should make the plans even more popular.

For example, the funds can be used to reimburse employees for the purchase of health insurance, rather than merely reimbursing medical care on a fee-for-service basis.

Also, any unused funds can be carried over to subsequent years, rather than forfeited. This should make employers more comfortable about setting funds aside, as well as avoid the wasteful practice of seeking health care services just to use up remaining balances.

The funds also are portable, to the extent that employees can continue to get reimbursement from any remaining funds after they leave an employer. Former employees could use the funds to cover COBRA premiums, or retirees could use remaining funds to pay for medical expenses.

And finally, the health reimbursement accounts can be coordinated with other plans, such as flexible spending accounts, which opens up new benefit design combinations.

The clarification of how these plans can be used will surely spur new interest in the plans. They will not be the answer for all companies, but we are pleased to see that the government is amenable to providing employers with alternatives.

During the current period of health care inflation, having such alternatives may mean the difference between employers offering some form of health care benefit or none.

Schillerstrom

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Letters to the Editor

RRG 'experiment' working successfully

To the editor: In his June 10 letter to *Business Insurance*, Charles A. McAlear states that he has a "little trouble" with my math concerning the rate at which risk retention groups have become insolvent.

Mr. McAlear's difficulty is that he is comparing the percentage of insolvencies in a 10-year period for risk retention groups (14 of 142, or 10%) with the percentage of insolvencies in a single year for 3,000 property/casualty insurers (30 of 3000, or 1%). The appropriate comparison is a single year for both, for which the insolvency rate would be comparable, at approximately 1%.

Mr. McAlear's second point relates to who gets hurt by insolvencies and whether RRG insolvencies are "unaccounted for," withholding the information necessary for "the public to judge the success or failure of the experiment."

Mr. McAlear is perhaps in the best position to shed light on this subject. Can he, as a past president of the National Assn. of Professional Surplus Lines Offices, tell us how many surplus lines company insolvencies are "accounted for"? This information would be helpful, so that the public might "judge the success or failure of the (surplus lines) experiment."

Another interesting fact that Mr. McAlear should consider is that none of the RRGs that have been assigned letter ratings by A.M. Best has become insolvent. In contrast, of the traditional property/casualty companies tracked by A.M. Best that became insolvent from 1992 to 2001, 45% had active ratings, according to a just-published A.M. Best insolvency study.

I think the facts clearly show that the RRG experiment is working quite well.

Also, please note that the number of RRG insolvencies is 14—not 15, as indicated in my previous letter. One RRG was rehabilitated.

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

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Forgoing excess cover requires analysis

Q: *We recently received excess coverage quotes for our self-insurance program. Our old self-insured retention of $250,000 is no longer being offered, and the quotes for higher SIRs are double or triple what we had been paying. In this situation, is it reasonable to consider eliminating excess coverage altogether?*

A: If you decide not to buy any excess coverage, you should significantly increase the self-funding of your programs. Even if you don't carefully analyze how adequately funded your program is, you should probably, at a minimum, increase your self-funding by an amount comparable to your old excess premiums. Think of this as a contingency reserve for large claims.

A more prudent approach, though, is a careful review of your situation.

First, look at your past experience with excess coverage. Was it a good deal or a bad deal? How many claims—if any—did the reinsurer actually pay? Evaluate the total premiums paid to the reinsurer compared with the total losses it paid out. Keep in mind that a reinsurer is due, in addition to administrative costs, a reasonable amount for assuming the risk associated with insuring large claims, regardless of whether it actually paid any out.

Second, explore the mechanisms that are available to you in the event that you suddenly need to increase the assets of your fund or that you incur a large claim. Do you have the means to increase the rate assessed? Are other appropriation methods available? Alternative funding means should be taken into account before you make a change to your program that increases your exposure to sizable losses.

There are several other program-specific factors that you should consider, including:

Size of program: Can your program absorb one or two large losses? A large program has the advantage of greater stability in regard to year-to-year loss costs. Conversely, claims for a smaller program in a high loss year can be five or more times the cost of claims in a low loss year. Generally speaking, the higher your retention, the lower the stability of your year-to-year loss costs.

Types of exposures: What is your overall potential for high-dollar-value claims? For instance, the law enforcement branch of a public entity exposes the fund to a high risk of large claims. A current evaluation of your potential exposures is essential in determining the advisability of raising your SIR.

Variability: How predictable are your costs? The best way to estimate this is to look at the average value and standard deviation of your past claims. Or you can simply compare the value of your largest claims, including those that may have broken into the excess coverage layer, to your average claim size. It is important to be cautious here, though, because you may not have enough historical information to get a definitive answer. Depending on the credibility of your experience, the fact that you haven't had many large claims in the past may not be a reliable indicator as to the number of large claims you will have in the future.

Credibility: Do you have enough past claims to make your historical experience a reliable predictor of your future experience? In general, full credibility, depending on the type of claims included, requires from 1,000 to 3,000 claims. Many smaller self-insurance programs or newer programs fall far short of this number. If this is your case, the experience of a similar program that has more credibility can be considered.

Confidence level: At what confidence level do you maintain your fund? In other words, is your fund balance at a level at which it is 70% probable that your final claims costs will not exceed the balance? Is it at 90%? Or just at the "expected" level of 50% to 55%? If you move to a higher retention level, it is important that the confidence level at which you carry your fund balance is appropriate. The higher the retention, the higher the confidence level should be. This is because the variability of your claims generally increases as you move to higher retention levels, as does the risk of a large claim.

The hardening of the excess coverage market has made decision making with respect to self-insurance programs more difficult. In recent years, excess coverage has almost always been a good deal.

These days, though, that may no longer be true. An objective, unbiased look at your future potential for losses should be the basis for whatever decision you make in this regard.

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four quarterly features in the Perspective section of Business Insurance can give you some answers.

Ask A Benefit Manager, 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 actuarial issues in the casualty field is written by Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore. Dennis J. Nirtaut, managing director of compensation and benefits for Arthur Andersen L.L.P. in Chicago, answers questions for benefit managers. Christopher E. Mandel, assistant vp-enterprise risk management at USAA Group in San Antonio and president of the Risk & Insurance Management Society Inc, answers questions on risk management issues. William J. Miner, an actuary with Watson Wyatt Worldwide in Chicago, answers actuarial questions on benefits issues.

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.

Defendant's response vital to asbestos cover

By Randy J. Maniloff

The New York Times recently reported—front page and above the fold—that U.S. companies and insurers have spent over $30 billion to defend and settle asbestos lawsuits. Moreover, the Times cites industry analyst predictions that the total bill for asbestos could exceed $250 billion. If such predictions come true, or even half-true, the asbestos problem is still in its infancy.

The conventional wisdom is that as more and more traditional asbestos defendants are forced into bankruptcy, the asbestos plaintiffs' bar must cast a wider net in its search for replacement defendants. Thus, while there are many seasoned veterans on the asbestos playing field, there are also rookies that are facing this challenge for the first time.

Even an asbestos newcomer knows, though, that the first thing to do in response to the complaint is to open the file drawer marked "Insurance." Actually, the first thing that will probably happen is that the owner of the defendant company will rant that it never had anything to do with asbestos and that this is simply further proof that lawyers are ruining this country.

For a defendant company, knowing to turn to its insurers is one thing; knowing how to go about it, though, is quite another. There is a prudent way for a first-time asbestos defendant to place its liability insurers on notice of the situation that will benefit both the defendant company and its insurers.

Notwithstanding what the law may be, when a long-tail claim implicates many insurers, they typically share the cost of defense and any eventual indemnity.

The first thing for a new asbestos defendant to bear in mind is that it is a near-certainty that its current liability policy—and perhaps its commercial general liability policies for the past 10 to 15 years—will not be a source of protection, because they will contain the "asbestos exclusion." Without getting into the intricacies of "trigger of coverage" and duty-to-defend law—concepts that are justifiably the subject of entire chapters in insurance treatises—it can be said that, in general, the defendant company should place on notice each of its primary and excess liability insurers from the time of the plaintiff's alleged date of first exposure to asbestos to its last policy without an asbestos exclusion. A chart listing each of these insurers, policy numbers, policy periods and limits of liability should be provided to each insurer being given notice.

It is extremely important that a diligent effort be made to locate these possibly decades-old policies or secondary evidence that may support their issuance. In addition to placing its insurers on notice, the company should convene a meeting of all such insurers for the purposes of discussing its defense and reaching a cost-sharing agreement.

Some defendant companies might scoff at this advice, reasoning that each of its insurers has a complete defense obligation; they argue that as soon as one insurer is placed on notice and accepts the tender of defense, the company has safely washed its hands of the problem. Even if this is a correct statement of the law—and it is in some states but not in others—a new asbestos defendant should not take such a shortsighted approach.

The reality is that, notwithstanding what the law may say, when a long-tail claim implicates many insurers, they typically share the cost of defense and any eventual indemnity. Thus, considering that a new asbestos defendant is about to embark on a long journey with several of its past insurers, it would be well served to get off on the right foot with them. The best way to do that is for the defendant to show its insurers a willingness to assist with the cost-sharing effort.

In addition, the asbestos defendant company that places all of its potentially implicated insurers on notice will not just be making life easier for its insurers, but will likely be providing itself with a tangible legal advantage as well. While it is true that many states impose a high burden, such as proof of prejudice, on insurers that seek to preclude coverage on the basis of "late notice," many of those same states impose no burden on insurers that seek to preclude coverage for "pre-tender defense costs." Considering that the defendant company will likely need to turn to its other insurers eventually, it may be setting itself up for significant uncovered defense costs by failing to place all of its insurers on notice from the outset. Furthermore, a defending insurer may take the position that this notice failure on the policyholder's part has prejudiced the insurer's contribution rights.

While companies probably can do little to keep from becoming involved in asbestos litigation, there is much that they can do to make the process of securing their insurers' involvement as smooth as possible. With liability projections that exceed $250 billion, there are many more relationships between asbestos defendant companies and their insurers that are yet to be forged.

Randy J. Maniloff is a shareholder at the Philadelphia-based law firm of Christie, Pabarue, Mortensen & Young P.C., where he concentrates his practice in the representation of insurers in coverage disputes. The views expressed herein are solely those of the author and are not necessarily those of his firm or its clients.

Hospitals seeing large increases in malpractice rates

Michigan providers protected somewhat by tort reform

By DAVID BARKHOLZ

Soaring rates for medical malpractice insurance are the newest worry for hospitals and physicians.

Detroit-area hospitals are seeing insurance renewals calling for rates that are at least doubled, said Ruth Goodell, senior vp in the Detroit health care practice of Marsh Inc.

That's on the low side. Mount Clemens General Hospital, which buys malpractice insurance in a group with four other hospitals, is bracing for rates to triple at its July 1 renewal What's more, to keep the renewal, even at those levels, the 288-bed hospital in suburban Detroit will have to self-insure a greater portion of claims, Ms. Goodell said.

Like most larger hospitals in Michigan, Mount Clemens General self-insures malpractice claims less than $1 million and buys reinsurance above that.

The additional costs to the hospital next year for malpractice coverage could run into the millions of dollars, said Robert Milewski, Mount Clemens General's president and chief executive officer. "This malpractice liability kind of snuck up on us," he said. "This has the potential to wipe out hospital bottom lines."

Medical malpractice rates have been rising nationally for about a year as insurers that survived a dismal underwriting decade in the 1990s try to firm up their financial positions through increased rates, Ms. Goodell said.

The trend started in states with lenient tort laws that allow for big jury awards for pain and suffering. But eventually it began to wash into states such as Michigan that have tried to keep awards in check through tort reform, she said.

Michigan, for example, caps noneconomic damages and requires claimants to give 182 days' notice to hospitals, physicians and other health care providers before filing a lawsuit. The extra times gives providers and claimants time to settle differences.

Hardening of the reinsurance market also has fueled rising rates, Ms. Goodell said.

One of the more troubling parts of the malpractice rate increases is that they are general in nature and not necessarily tied to a poor claims experience by the insured hospital or physician, she said. "We're telling clients that a 100% increase is about as reasonable as anyone can expect," said Ms. Goodell.

Michigan Insurance Commissioner Frank Fitzgerald said the state's medical malpractice tort reform has helped keep local rates from running at the astronomical levels experienced by other states that have not enacted reforms.

Mount Clemens General is feeling little consolation, however. Its malpractice rates were fairly flat for the past five years, Mr. Milewski said.

Now, the looming malpractice rate increase is a setback for hospitals that have spent those years dealing with rising labor and pharmaceutical costs combined with huge reimbursement cuts by the two largest payers in Michigan: Medicare and Medicaid.

The reimbursement cuts cost Michigan hospitals hundreds of millions of dollars, resulting in job cuts and cost-cutting, especially in urban areas.

Doctors practicing at The Detroit Medical Center have not been immune to rising medical malpractice rates, said Raeann Shepherd, DMC vp of risk management.

Commercial insurers are trying to recover from charging too little for insurance in the 1990s with big increases today, she said. Many insurers once active in Michigan, including the St. Paul Cos. Inc., have stopped writing malpractice coverage altogether.

Increases are ranging from 10% to 100%, depending on how risky the specialty is, she said. Some physicians are having their coverage canceled, with as little as 30 days' notice, Ms. Shepherd said.

The DMC self-insures most of its medical malpractice liability and reinsures major claims through a Cayman Islands-based captive, DMC Insurance Ltd., she said.

Henry Ford Health System is relieved that it is in the middle of a three-year, noncancelable policy for its malpractice reinsurance, said John Mucha, vp of risk finance and insurance services. Without the multiyear contract, Henry Ford Health would face reinsurance premium increases of 200% to 400%, he said.

Henry Ford Health is hoping the market will stabilize by the time its current contract expires in August 2003, Mr. Mucha said.

David Barkholz is a reporter for Crain's Detroit Business, a sister publication of Business Insurance.

AGENT/BROKER TOPICS

A MONTHLY EDITORIAL SECTION SENT EXCLUSIVELY TO AGENTS, BROKERS AND CONSULTANTS

Marketing Strategies

Trusted Choice campaign seeks image change

By NICOLE VOGES

The Independent Insurance Agents & Brokers of America has been hard at work changing the image of its members.

The Big I introduced its new branding program, Trusted Choice, with campaigns in the cities of Seattle and Louisville, Ky. in February, and it plans to go national with the campaign next year.

Talk of a new image for independent insurance agencies began at the IIABA in 1998, and the Alexandria, Va.–based association hired a branding firm the following year. The IIABA supports the new program with funding from 16 regional and national insurance companies and fees from participating agencies.

The IIABA developed the new program out of necessity, said Robert Rusbuldt, IIABA's chief executive officer. The new image comes in response to outside research that revealed that consumers had negative views of the terms "independent," "insurance" and "agent." According to the IIABA Web site, *www.iiaba.com*, consumers viewed the terms as meaning "small," "not affiliated with major brands" and "an agent of the company."

"The Big I logo did not connote anything to consumers," Mr. Rusbuldt said. "Consumers surveyed in the study decided that the Trusted Choice logo was preferred, even over the Big I," he said, though the IIABA plans to keep using the logo for its members.

Over 1,300 agencies have joined the Trusted Choice program, and "we have a goal of 2,500 agents by the end of the year," said Ronald Smith, the chairman of the Trusted Choice campaign and the president of Smith Sawyer & Smith, a Trusted Choice agency in Rochester, Ind.

The IIABA, which represents more than 300,000 agents and agencies nationally, will continue to offer its resources and services to members. The Trusted Choice program is an option for Big I members that want to increase their visibility with customers.

Mr. Rusbuldt acknowledged that, despite an increasing number of participants, some agencies are wary of the image change. "For a lot of agents for a long time, the Big I logo meant a lot to them," he said, "and it still does."

Mr. Rusbuldt said he knew it was time to create a new plan, though, because the competition—some insurers that do not use independent agencies—had been casting independent agents in a negative light.

According to the IIABA Web site, consumers have seen "agents branded as unnecessary 'middlemen' by competitors."

Independent agents "need to define who we are," Mr. Rusbuldt said.

"It's been almost 20 years since the Big I did a major marketing campaign," he said. "A whole generation went by not understanding what independent agents do. We think we're going to regain it through this branding effort."

While the Big I is encouraging its members agencies to join the program, they must meet certain standards. Agents must sign the program's Pledge of Performance, agreeing to, among other things, provide service to customers 24 hours a day, seven days a week; return telephone calls and e-mails promptly; and guide customers through the claims process for prompt, fair resolutions to claims.

"The pledge works, but you would be surprised at how simple it is," said Alex Soto, the former chairman of Trusted Choice and the president of InSource, a Trusted Choice agency in Miami. "That's what consumers directly told us they wanted."

Member agencies must pay an annual fee to participate in the Trusted Choice program: $250 for an agency with nine or fewer employees, and $499 for an agency with 10 or more employees. Agencies must also commit to participate for at least three years.

"Sending your money is not the only part.…We have to put up the logo and have the employees talk up Trusted Choice," said Michelle Rupp, the Trusted Choice committee chair for Washington state and the owner of Nowogroski Rupp Insurance Group of Seattle.

Once an agency has agreed to the standards set forth in the performance pledge, it can take advantage of the Trusted Choice program immediately.

Mr. Rusbuldt said one major benefit of participation is being listed on the agency locator on the Trusted Choice Web site, *www.trustedchoice.com*. "If you're in Topeka, Kan.," he said, the locator "will give you the name and number of the nearest agent."

Another benefit of the Trusted Choice program is that insurers are including the brand in their marketing efforts, directing customers to participating agencies.

Mr. Smith said that though it is hard to gauge where business comes from, Trusted Choice can promise to give agents "the opportunity to communicate exactly what they do."

A press release announcing the choice of Seattle and Louisville as pilot cities for the Trusted Choice campaign noted that both cities' demographics closely mirror those of the national population. Three television ads were aired in the two cities for four weeks, at

See BIG I/next page

Web-based meetings offer cost-effective access

By SALLY ROBERTS

When Providence, R.I.-based GRX Technologies wanted to market the latest version of its software product to the largest agents and brokers in the country last fall, it turned to a unique direct-mail campaign to entice the brokerage decision-makers to attend a breakfast demonstration at the annual Greenbrier industry meeting.

Each of about 300 individuals received a direct-mail card, along with one of a variety of theme-related reproductions of antique toys. In one case, for example, the cards read, "Consider our technology rocket fuel for your large commercial accounts," and prospects received model rocket toys.

Although the mail campaign generated a lot of interest—30%, or 90 people, responded positively to the invitations—the Council of Insurance Agents & Brokers canceled its annual Greenbrier meeting due to the terrorist attacks of Sept. 11.

"We were scrambling a little bit because we'd spent these marketing dollars trying to attract an audience to the show and it only happens once a year," said Erik Dorsey, marketing manager of GRX. "So we decided to pursue other avenues and not let people down if they were interested in hearing about our product."

The other avenue turned what was supposed to be a face-to-face breakfast seminar at the Greenbrier into a "cyberbreakfast" and Web meeting at the prospects' own desks.

Using technology from WebEx Communications Inc., a San Jose, Calif.-based multimedia Web communication services firm, GRX's prospects dialed into the so-called "Webinar" via a phone line and interacted with GRX as it demonstrated its technology via an Internet presentation.

In keeping with its original breakfast theme, GRX also mailed out fresh coffeecakes to the prospects to enjoy during the individual presentations to the 20 individuals that responded to the Webinar invitation, Mr. Dorsey said.

It was a cost-effective way to get GRX's message out, he said. The whole mail campaign, including the original direct-mail cards and toys and the second mailing, cost $3,500. The Web-based presentation cost an additional $500 to $600, he said.

Whereas GRX might otherwise have had to travel to the individual prospects' offices to demonstrate the product, "we were able to touch 20 industry participants directly into seeing our product.…All for the cost of a couple of plane tickets," he said.

In addition, "it was nice because it exposed people to the benefits not only of what we can provide but also what other technology is out there," Mr. Dorsey said.

Indeed, marketing experts say Web-based meetings are a great way for agents and brokers to enhance the insurance sales process.

Although Web-based meetings are more frequently used by insurance companies as training tools, experts say intermediaries also can benefit from such technology.

"From a sales standpoint, (Web-based meetings) give you a very low-cost way to have a sales call that's a step up from a normal telephone contact," said Kimberly Paterson, president of Creative Insurance Marketing Co., a Red Bank, N.J.-based marketing communications firm. CIM assisted GRX in its marketing effort.

For agents and brokers, using the Web to present products and services is extremely helpful, especially "when you're trying to make a sale and you don't have local presence," she said. "It's a cost-effective vehicle that lets you take the sale to the next step and really determine interest before you invest that money and get on a plane."

In addition, "not only is money such a critical thing but the big thing today is time. Brokers don't have a lot of time for selling; they are busy defending their territory," Ms. Paterson said. "This is a huge time-saver, in addition to the cost savings."

"I think (Web-based meetings) can be a great, cost-effective tool for managing existing relationships with clients," GRX's Mr. Dorsey agreed.

In addition, it's "a great tool to introduce yourself to a new client," he said. While "nothing will ultimately replace the face-to-

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AGENT/BROKER TOPICS

Big I: A change in image

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a total cost of about $400,000, Mr. Rusbuldt said.

Ms. Rupp said that consumers in Seattle are "starting to wake up" and take notice of the campaign. "There's a little bit of a buzz going," she said.

Although the Trusted Choice brand has yet to catch on nationwide, Ms. Rupp said she's "waiting for that mad rush." With 120 Trusted Choice agencies in Washington state, Ms. Rupp said she believes the state is "a little ahead of the curve."

Agents outside the pilot areas have also been marketing the brand in their own offices and locations. Garret Ratcliffe, a state national director for IIABA and a principal at Jones Raphael & Oulundsen, a Trusted Choice agency in New Britain, Conn., said that customers are impressed by the Pledge of Performance. "We took that pledge, put it on a card, we hand it to the person and go over it with them," he said.

"We've had fantastic response from the people we've sat down and gone over the pledge with, and we're getting more referrals than we've ever had," Mr. Ratcliffe said. He also called the pledge "a nice affirmation," not only for the customers but also for agency staff.

Mr. Ratcliffe recalled that one man was so impressed with his agency's promise to call customers back within the same day—one step beyond than the pledge's promise of a prompt return call—that he asked Mr. Ratcliffe to take over the business on some condominium property that another agent had been handling.

But it isn't just participating agencies that are involved in the Trusted Choice campaign. Bruce Allenbaugh, senior vp of marketing for Seattle-based SAFECO Corp., one of the four founding insurers funding the brand campaign, said SAFECO saw "a vital need to do this as a national carrier."

SAFECO ran a print ad campaign in several papers around the Seattle area. One of the ads, described by Mr. Allenbaugh as "rather tongue in cheek," states, "Please. Call an agent who doesn't work for us." The ad promotes the Trusted Choice program, saying that its participating agencies "put your needs first. As do we." SAFECO also posted some additional pages its Web site "on why Trusted Choice makes sense."

Mr. Allenbaugh agreed with the IIABA that the most important step during the preliminary stages of the campaign is to inform independent agencies about the program. "We've seen a growing number of agents" joining Trusted Choice, he said. "Their reaction to this is what we're most happy about."

Mayfield Village, Ohio-based Progressive Corp., another insurer partner of Trusted Choice, also extended its commitment beyond financial support. "When these efforts started, we did work with local agents that wanted to be Trusted Choice, getting it kick-started with agents we work with," said Bob Williams, Progressive's agency group resident. "We try to direct business to Trusted Choice agents."

The IIABA's Trusted Choice committee plans to meet soon to discuss the progress of the program. Mr. Soto said that though it's too early to assess the brand's success, he is confident that the Trusted Choice logo will eventually come to signify value to consumers. Mr. Soto noted that while the campaign's advertising expenditures have not been large, "the more value in the product, the less time you have to spend on ads."

Mr. Rusbuldt concurred. "You don't have to have a boatload of money to market something if you have a good product or service," he said. "It might take a while longer, but eventually you will be known by consumers."

Web: Option for meetings

Continued from previous page
face meeting, it is a great way to get your foot in the door in a cost-effective manner," he said.

"It gives you another level of service," a spokesman for WebEx said of its online meetings. "Instead of just talking to someone on the telephone, you can have a video on screen. You can go over documents or insurance policies, and customers can fill out an application together with you online."

Web-based meetings also allow agents and brokers to expand their territories, he said. "Whereas before your territory might have been how far you can travel in one day, this allows you to cast a wider net for your service because you can suddenly work virtually."

The spokesman said that while most of WebEx's insurance clients are insurance companies that use the Web tool for training purposes, he expects the technology to take on more of a sales and marketing role as well.

"Once you start doing WebEx meetings, you get addicted to them," he said. "What happens is people get into a WebEx meeting and they say, 'I should be using this for my business.' That's how it will expand out."

WebEx subscribers pay $100 per data port, per month, for unlimited meetings. Nonsubscribers pay a fee of 45 cents per minute per user for meetings, the spokesman said.

AGENT/BROKER TOPICS

Insurance Marketing Communications Assn.

Web design expert cites pitfalls of sites

By RODD ZOLKOS

In designing a Web site, the most important consideration for a company is ease of navigation, according to one Web design expert.

"Everything in your site revolves around navigation," Redmond, Wash.-based author and webmaster Vincent Flanders said last week at the annual conference of the Insurance Marketing Communications Assn. and the Life Communicators Assn. in Toronto.

"If they can't find it, they're going to leave," said Mr. Flanders, who was webmaster for Lightspeed Net from 1995 to 1997 and in 1996 launched his WebPagesThatSuck.com site as an offshoot of Web design classes he was teaching.

Citing a site that has demonstrated successful design, Mr. Flanders suggested a good rule of thumb in Web site design is "Would Amazon.com do it?"

"Most Web sites out there have some severe problems," he said, suggesting insurance companies "would go broke" if they insured against bad Web site design.

"When you look at a Web site, you should know exactly what it's about," he said. Too often, though, it's difficult to determine from the site what the company behind it actually does.

He suggested attendees apply the "man from Mars approach" to their Web site design. "If a man from Mars came down, would he know what your Web site's about?" he asked.

"Remember, no one is going to write you a check because your Web site has won awards or because it's cool or because it's got a Flash that moves around," Mr. Flanders said. "They write you checks because you solve problems. Your Web site should solve problems."

For insurance industry Web sites, providing information is a key to being truly successful, he said.

"There's only three reasons people go to Web sites," Mr. Flanders said. "They go to buy something, they go to get information or they go to be entertained."

"Nobody goes to an insurance Web site to be entertained," he said. "I'm not sure you can sell insurance on the Web, so the selling angle is kind of out." Instead, he said, people are inclined to visit insurance industry sites because "they want you to 'Solve my problem now.' "

One factor Mr. Flanders said he often sees in unsuccessful Web sites is an excessive infatuation with design elements.

"People think if they add one more design element to their Web site, it's going to be good," he said. "No. Throw out unnecessary design items."

"Just because you can add a design element doesn't mean you should," Mr. Flanders continued. "In Web design, do you need to have the design element? Will anybody write you a check because you're using it?"

Failed Web sites problems often begin at the home page, the Web design expert said. "You've got to remember the home page is the most important page," Mr. Flanders said. "It's the first impression. Most screw-ups come from that."

It's also critical to know your audience, he said, and make sure the content of the page is appropriate for that audience. And the site shouldn't confuse the visitor. "Give them what they expect," he said.

"If you don't give your customers what they expect, they're going to be angry," he said, and that can lead to public relations nightmares.

While certain industries lend themselves to certain Web site characteristics and elements, "one of the problems with insurance company sites is you all look alike, sort of," Mr. Flanders said. "It's really difficult to design a site that's unique enough that people will instinctively recognize it."

Mr. Flanders listed a number of techniques and elements he thinks insurance companies and brokers should avoid.

"There is one technique that is always going to be bad," he said. "It's called 'mystery meat navigation' and that's where you mouse over a link to find out what it is."

That technique "is spreading, unfortunately," Mr. Flanders said. "It's very arrogant to think that your site is so important that people are going to memorize the navigation. They're not."

Another technique he recommended conference attendees avoid is Flash animation.

"If there's one technique your designers are going to want to try on your site and try to talk you into, it's Flash," he said. "There might be a reason for an insurance company using Flash on its Web site. I can't think of it."

Among its drawbacks, Flash uses up considerable bandwidth, and it interferes with site navigation, Mr. Flanders said.

Large Web pages are something else to avoid, he said. "Hold your breath," he advised. "If the page hasn't loaded by the time you gasp, it's too big."

Cheap clip art, three-dimensional logos and a lack of contrast between text and background are other frequently seen problems he recommended that insurers and agents avoid on their Web sites.

AGENT/BROKER TOPICS

Insurance Marketing Communications Assn.

Agents, brokers hold expertise they can take to the bank

By RODD ZOLKOS

The melding of banking and insurance offers insurance companies, agencies and brokerages a chance to co-brand insurance products "with a trusted adviser," while tapping a pool of bank customers who want and need insurance services, according to a group of speakers with experience in bank distribution of insurance products.

Efforts to tap the marketing opportunities offered by integrating banks and insurance have advanced "with fits and starts, successes and failures," noted Nanci Evarts, vp and manager of corporate communications for Aon Services Group, a division of Aon Corp. in Woodland Hills, Calif. Ms. Evarts moderated a session at the annual joint meeting of the Insurance Marketing Communications Assn. and the Life Communicators Assn. last week in Toronto.

But Mark Ogren, director of Aon's Financial Institution Alliance, a division of the brokerage that was formed to sell insurance products to and through financial institutions, cited several reasons that banks offer considerable opportunity for insurance marketers.

"Banking is the one industry that is related to every other industry and has an impact on all of them," Mr. Ogren said.

He said that there are more than 9,000 banks in the United States, 32% of U.S. households have three or more banking relationships, and 60% of households have been with their present bank for five or more years.

Still, when the Gramm-Leach-Bliley Financial Services Modernization Act came along in 1999, "everybody thought it was going to be a panacea for banks in insurance," Mr. Ogren said. "But, frankly, it hasn't worked out the way everybody anticipated."

Banks have marketing leverage, Mr. Ogren said, because their physical location is close to customers, they see customers often and they deal with customer life events such as the purchases of homes and autos, and "those are natural opportunities to sell insurance."

In addition, banks have a wealth of information on customers that can be used to provide marketing advantage. "But it's amazing to find the number of banks today that don't know anything about their customers in detail," he said.

Banks' approach to dealing with insurance products has involved expanding their own operations to address insurance sales, partnering with insurance agencies or purchasing the capabilities by buying an agency, Mr. Ogren said. But, addressing the third option, he said, "I have not run across a bank yet that has effectively integrated that agency into its bank culture."

"Most insurance products that are sold today are sold through a subsidiary of the bank or a third party," he said. "The significance of that is it's not an integral part of the business of the bank."

There are several reasons banks haven't been satisfied with their insurance business to date, Mr. Ogren said. One is that most banks aren't good at developing insurance marketing strategies, he said.

But there is potential for success in those activities, because bank customers want and need the insurance services the bank can provide, he said, and a bank can organize itself to meet those needs.

In trying to market insurance, it's important for banks to remember that "it's not about selling insurance," Mr. Ogren said. "It's about the bank remembering that insurance solutions are an integral part of their customers' lives."

The bank has to leverage insurance marketing as part of its overall banking operation, he said, and it has to present insurance products in an integrated fashion with banking products. "It can't be an add-on," he said.

Lawrie McGill, vp-strategic initiatives at the CIBC Insurance unit of the CIBC Group of Cos. in Mississauga, Ontario, said that while his company has had tremendous success integrating insurance sales into its banking activities, its real success has come from distribution rather than manufacturing insurance products.

In addition to added revenue, distributing insurance products provided the bank with a potential for increasing customer loyalty, he said. "The more contacts we have with the customer, the better," Mr. McGill said.

Jeffrey A. Oster, managing director at Aon Annuity & Insurance Services in San Francisco, suggested that insurance industry companies can develop product marketing strategies like Web-based programs for banks linked to the bank's Web site, "and if you can develop these and turn them over to the bank on a turnkey basis, (banks will) look at you in a whole new light."

"One thing you might want to come to the bank with is" an actual selling site, Mr. Oster said. "This is a lead generation program," he said. "The whole goal of a Web-based program is to feed the brokers and agents."

And, he said, "If you are fortunate enough to have a bank that has 1 million e-mail addresses…you can effectively use that," using e-mail to draw customers to the selling site.

Agent/Broker Topics

ADVERTISER INDEX

Issue of July 1

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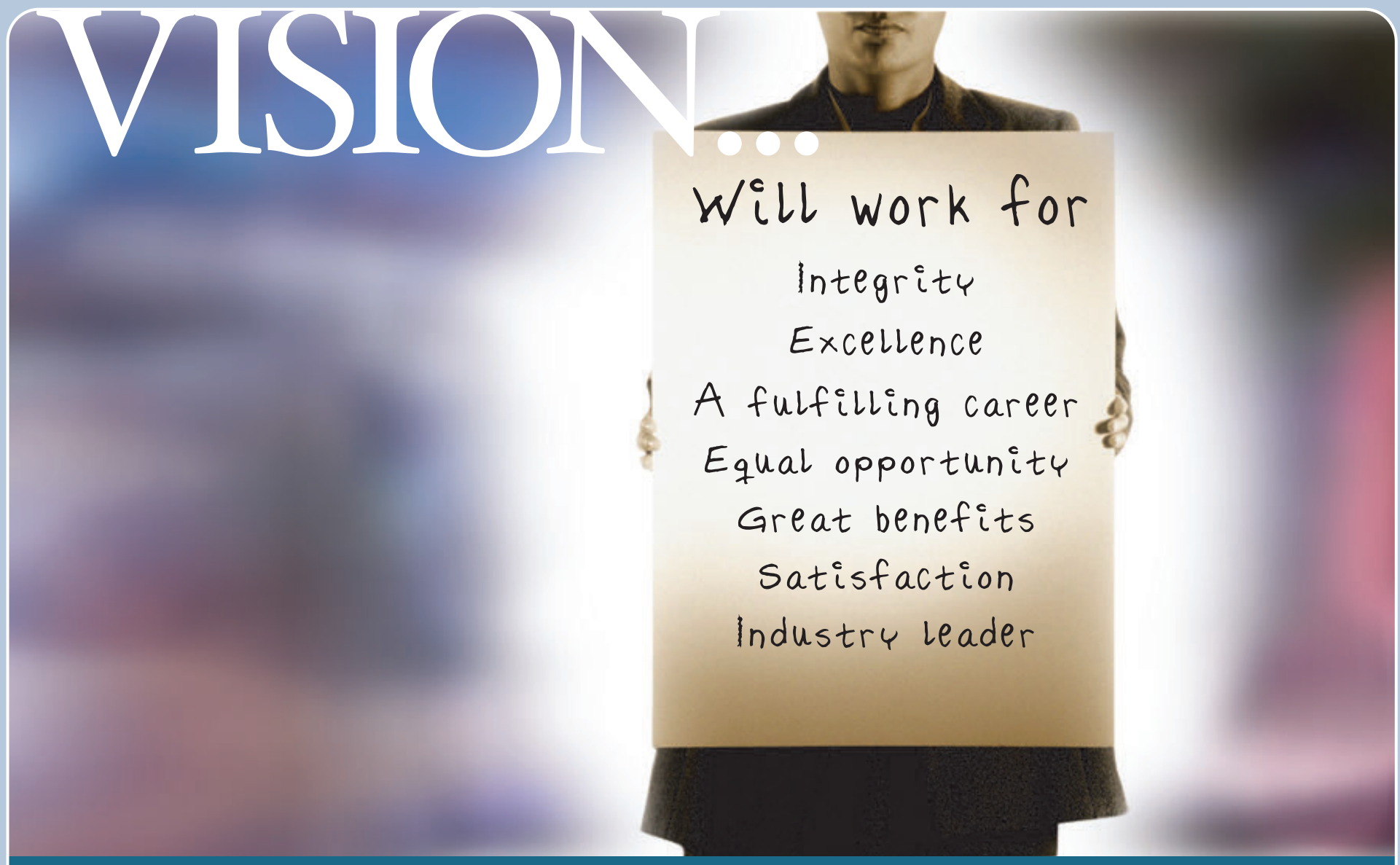

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Comings & Goings


Mr. Gault


Mr. Ealy


Mr. Craig


Ms. Estep


Mr. Spragg

Brokers:

James S. Gault has been named president and chief operating officer of the Brokerage Services Division at Arthur J. Gallagher & Co. of Itasca, Ill. Mr. Gault succeeds **James J. Braniff III**, who will move to Houston as a regional vp. The move is part of a long-planned succession program, the company said.

Two senior appointments were made at Willis Group Holdings Ltd., the London-based global insurance broker:

Tom Ealy will serve as president and chief executive officer of the Chicago office. He joins Willis from San Francisco-based USI Insurance Services, where he served as its Midwest regional CEO based in Chicago.

Richard P. Craig will serve as senior vp and practice group leader in San Francisco. He formerly was a senior vp/environmental practice leader for Marsh Inc. in San Francisco.

Dennis R. Lundgren has been promoted to president of the Dunlap Corp./HRH of Maine. Mr. Lundgren has been with Dunlap/HRH for 13 years, most recently serving as vp. The Dunlap Corp./HRH is one of New England's largest insurance, bonding and claims management agencies with offices in Auburn, Bangor and Gray, Maine, and Manchester, N.H.

Insurers:

Rich Banas will succeed **William Kronenberg III** as CEO of XL Environmental and XL Programs, both of Hamilton, Bermuda. Mr. Kronenberg, who joined XL in 1999 in connection with its acquisition of ECS Inc., is taking early retirement to pursue personal interests. Mr. Banas previously served as executive vp and chief underwriting officer of XL's insurance operations.

Fernando Correa Urquiza was named president of Berkley International L.L.C., an insurance holding company based in Greenwich, Conn. Mr. Correa serves as president of Berkley International Argentina S.A., a subsidiary of Berkley International, a position he has held since 1996.

Cesar C. Zalamea has been named senior vp of investments at American International Group Inc. of New York. Mr. Zalamea, who is based in Hong Kong, will continue to serve as president of AIG Investment Corp. (Asia) Ltd., a position he has held since 1986.

Three senior executive appointments were made at Fireman's Fund Interstate Insurance Group, a Chicago-based excess and surplus lines and professional liability subsidiary of Novato, Calif.-based Fireman's Fund Insurance Co.:

- **Jill Estep** has been named to the new position of distribution management executive. She previously worked for the St. Paul Cos. Inc. as regional president of the Western region's commercial lines.
- **Steve Hastings** has been named regional claims executive. He previously worked as regional claims executive for auto/property/liability claims at Fireman's Fund.
- **Daniel Spragg** has been appointed professional liability executive. Prior to this role, he was an executive of the Southern States region for Fireman's Fund.

Reinsurers:

Anthony J. Kuczinski has been named president of Munich-American RiskPartners, a strategic business unit of American Re-Insurance Co. in Princeton, N.J., providing insurance and risk management products and services to the alternative market. He replaces **William J. Moll**, who is leaving the company to pursue other interests. Mr. Kuczinski is chief corporate resource officer of American Re and president of an affiliated company, Munich-American Global Services Inc. Before assuming his current positions, he was president of insurance company operations.

Rafael Saer was named senior vp responsible for growth, management and the financial performance of Folksamerica Reinsurance Co.'s Canadian operations. Mr. Saer, who is based in Toronto, will continue to manage the company's Latin American and Caribbean businesses.

Other suppliers:

Chris Cavazos was named president of the Employer Solutions Division of ValueOptions, a managed behavioral health care company based in Falls Church, Va. Mr. Cavazos previously was an executive at ValueOptions.

Thomas P. Rogan was named CEO of Hanoun Medical Inc., a medical technology and employer services company specializing in the evaluation and monitoring of human performance. Most recently, Mr. Rogan was CEO of Clearvision Laser Centers Inc. of Lakewood, Colo.

Government aviation coverage attaches above $150 million

U.K. extends aid but tightens cover

By SARAH VEYSEY

LONDON—The U.K. Treasury has again extended its insurance aid package for airlines but has restricted the amount of coverage the program provides for cargo airlines and aviation service providers.

The Treasury announced last Monday that it had agreed to extend its aid package, known as Troika, for a further 60 days until Aug. 29. Coverage had been due to expire June 30.

But, due to the "improving availability of commercial cover for third-party and terrorism risks," cargo airlines and aviation services providers would have to find commercial coverage for the first $150 million of risk if such coverage were available, the Treasury said. The move brings air service providers, such as security firms and fuel companies, in line with passenger airlines. Since May, passenger airlines have also had to find the first $150 million of coverage on their own.

The Troika plan provides limits of up to $2 billion and was put together by the London operations of Aon Group Inc., Marsh Inc. and Willis Group Ltd.

The European Commission currently is studying two plans for retention pools for third-party war and terrorism risks for airlines.

The plans, known as Eurotime and ICAO, are backed by Aon, Marsh and Willis. Eurotime would provide coverage for European airlines, while ICAO—the International Civil Aviation Organization—is an international proposal.

In June, the European Union's Council of Transport Ministers referred the plans to the European

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PHOTO COURTESY OF BRITISH AIRWAYS

The U.K. government says commercial terrorism coverage is becoming more available for airlines such as British Airways.

PHOTO COURTESY OF AIRMIC

David Ireland, right, group insurance director at Liverpool, England-based Vinci P.L.C., succeeded Philip Thomas as chairman of the Assn. of Insurance & Risk Managers at AIRMIC's recent annual conference. Mr. Ireland has chosen "the pursuit of excellence" as the theme for his one-year term. Nick Chown, group risk manager for Consignia P.L.C., was appointed deputy chairman of AIRMIC. At the conference, AIRMIC members adopted a new mission statement for the association: "To develop excellence in business risk management and support the effective use of insurance."

2002 Assn. of Insurance & Risk Managers annual conference

Buybacks can convert old policies into cash

By PAUL D. WINSTON

BIRMINGHAM, England—The practice of insurers buying out their asbestos and environmental exposures under old liability policies—which is expected to increase in the United Kingdom—represents an opportunity for risk managers to convert old policies into current assets, claims specialists say.

Called either buybacks or commutations, the practice is common in North America, where it has been used for some time, but only now is gaining a look from risk managers in the United Kingdom and elsewhere in Europe, said William J. Russell, chief executive officer of Dispute Resolution Management Inc. of Englewood, Colo., which advises policyholders on such negotiations.

The practice of negotiating payment from an insurer in exchange for ending or capping its exposure to potential claims can occur wherever businesses have an ongoing liability risk from historical activities, he explained during a session at the 2002 Assn. of Insurance & Risk Managers conference, held in Birmingham, England, June 16-18. Typical examples of this are pollution or asbestos liabilities, he said. Others include product liability and premises liability arising from bodily injury or a toxic exposure, he added.

Insurers are willing to "buy out" their potential exposure to such claims because they recognize that occurrence-based general liability policies written before the 1980s can potentially be tapped for coverage of activities that took place during policy periods, Mr. Russell said.

The first step for risk managers considering negotiating such a buyout is to engage in "insurance archaeology" and dig up policies from decades earlier.

"If you can get back to the 1940s, you've

See BUYBACK/next page

More AIRMIC coverage on page 17

HIH probe focuses on Adler

FAI chief says insurer wasn't ailing at takeover

By SIMONE ZENONI

SYDNEY, Australia—Rodney Adler, a former director of HIH Insurance Ltd. and former chief executive officer of FAI Insurance Ltd., denied suggestions that FAI was insolvent before its takeover by HIH.

Completing his testimony late last month before the Australian Royal Commission that is investigating the March 2001 collapse of HIH, he also denied that FAI had received other takeover offers.

Mr. Adler told the commission that HIH made "a small profit" on its purchase of FAI. "HIH, in a cash flow sense, got all the money back for the FAI acquisition within the first 12 months."

But, Norman O'Bryan, a senior attorney assisting the commission, said HIH's gap in reserves as of Dec. 31, 1998, had exceeded any profit it may have made. Pretax profits had been overstated by $930 million Australian ($569.4 million).

Mr. O'Bryan also said that Mr. Adler had rejected an early offer by Boston-based Liberty Mutual Insurance Co. for half of his family's share of FAI, but he had expected to receive a revised offer. Liberty Mutual did not enter a formal bid.

Mr. Adler denied he had received the early offer but said he had been "stimulating a number of parties" to take over the company before Sept. 22, 1998, when HIH made its takeover bid.

He further argued that FAI was solvent before its takeover by HIH. Mr. Adler also denied backdating a memo about HIH's takeover bid because the Sydney-based corporate regulator, the Australian Securities and Investments Commission, was investigating the deal.

In its recent hearings, which began in 2001, the Royal Commission reviewed a note prepared by Mr. Adler—dated Sept. 23, 1998, the date of HIH's takeover bid. The note outlined the takeover and the decision to sell half of the Adler

See HIH/next page

World Updates

Broker HLF details plans for July IPO

London-based broker HLF Insurance Holdings Ltd. last week announced the price range and expected timetable for its initial public offering. HLF plans to offer about £250 million ($374.2 million) of shares at 325 pence ($4.86) to 375 pence ($5.61) per share. The pricing of shares is slated for July 11, and the sale is expected to start July 16, HLF said.

Wellington Re gains support

Individual investors underwriting on Wellington Underwriting P.L.C.'s composite syndicate 2020 at Lloyd's of London have agreed to proposals to form a new reinsurance company outside of the Lloyd's market. Wellington has raised £448 million ($670.6 million) to set up a property/casualty reinsurer, to be known as Wellington Re. The new company will likely begin trading within the next few days, a Wellington spokesman said.

XL plans to merge Lloyd's syndicates

XL London Market Ltd., the Lloyd's of London operation of Bermuda-based XL Capital Ltd., announced its intention to merge its two Lloyd's syndicates for the 2003 year. XL London Market is seeking Lloyd's approval to merge nonmarine syndicate 990 into composite syndicate 1209. Syndicate 990, which writes professional indemnity, physical loss, nonmarine liability and property and livestock business, among other lines, has £80 million ($116.5 million) of capacity for the 2002 year. Syndicate 1209, which writes aircraft liability, marine hull and political risks coverage, among other lines, has £360 million ($524.2 million) of capacity for 2002. Both syndicates are 100% backed by XL for the 2002 year.

Lloyd's names Leillard head of Paris unit

Anne-Gaelle Leillard has been appointed general manager of Lloyd's France, the Paris-based operations of Lloyd's of London. Ms. Leillard, formerly operations executive at Lloyd's in Paris, will take the post on July 1 and replace Torquil McLusky, who will return to work at Lloyd's in London.

Watson Wyatt opens office in Budapest

Watson Wyatt Worldwide has opened an office in Budapest, Hungary. The actuarial consulting company said it would use the office to service insurance and other financial services companies across Central and Eastern Europe.

HIH: Adler rejects charge that FAI was insolvent

Continued from previous page
family's 30% share of FAI. Mr. Adler told the commission he "probably started preparing (the note) on the day and finished it the next day or it could have been the day after that."

But Mr. O'Bryan suggested Mr. Adler had written the memo "a week or two later" because ASIC had announced an investigation into whether there had been a breach of Australia's Corporations Law. Mr. Adler rejected that, though, saying, "The reason I prepared this file note is because (FAI Chairman) John Landerer said to me that I should keep a record of what transpired, and, hence, I prepared it."

Mr. Adler told the commission he had met Ray Williams, HIH's managing director, several times in the weeks before the takeover. Mr. Adler had sought cash in exchange for a 15% stake in FAI.

Rodney Adler, the former HIH director, told the Royal Commission that he decided to quit the insurer's board because 'I was unhappy with the quality of information... being presented to me.'

The two could not agree, though, on a level of acceptance for the takeover bid. HIH wanted 90% shareholder acceptance, but Mr. Adler had wanted only 50.1%. The commission was also told that HIH and FAI advisers had argued over legal aspects of the sale of the Adler family shares before the takeover was launched.

Mr. O'Bryan said HIH wanted to offer a mix of shares and cash to ensure the Adler family did not get a better deal than other FAI shareholders. Mr. Adler put the 15% stake up for sale on the open market after an agreement could not be reached, and they were immediately acquired by HIH.

FAI shareholders were offered HIH shares only or a mix of HIH shares and cash.

Mr. Adler also denied knowledge of FAI's alleged "sham" reinsurance contracts, which were used to improve the balance sheet (*BI*, March 4). He said he had first heard of the contracts last year, when preparing for his defense against ASIC charges relating to a loan made to Sydney-based Pacific Eagle Equities Pty. Ltd., a company of which Mr. Adler was a director. "As chief executive, I would never get involved in the detail," he said.

In a New South Wales Supreme Court case, brought by ASIC, Mr. Adler and two other directors were found to have breached their duties under the Corporations Law in relation to a $10 million Australian ($5.75 million) payment made by HIH Casualty & General Insurance Ltd. to Pacific Eagle Equities. Mr. Adler was banned from directing a company for 20 years, and he and Adler Corp. were each fined $450,000 Australian ($258,435).

Mr. Adler told the commission that when he took over FAI, it had "curable cancer," which he treated as a corporate doctor. "Each division, I would take out and repair and graft it back onto the main body."

He decided to quit the HIH board three weeks before the insurer collapsed because "I was unhappy with the quality of information...being presented to me."

Mr. Adler had earlier been granted an adjournment from his Royal Commission testimony to allow him to give evidence in a suit against Rob Porter, former managing director of insurance broker Oamps Ltd., in the Victorian County Court. The pending suit charges that false and misleading information was provided to the Australian Stock Exchange.

The Australian government has given the Royal Commission until Feb. 28, 2003, to report the findings of its investigation.

Airlines: U.K. tightens coverage

Continued from previous page
Commission for a more detailed study to ascertain, among other things, whether the plan breached the European Union's competition law.

Jonathan Palmer-Brown, head of U.K. specialty at Aon Ltd. in London, said that while third-party war and terrorism coverage is available in the commercial market, it still is not affordable.

He said that the government's restriction on the coverage provided by Troika was likely a statement that it would like to see alternative plans pushed forward.

The U.K. government, along with several other E.U. member states, has said it wants to withdraw from the aviation insurance market as soon as possible without disadvantaging airlines.

Mr. Palmer-Brown said that the European Commission had indicated that it would fully evaluate the Eurotime and ICAO proposals by Sept. 18.

He said that he was "quietly hopeful" that the European Commission, at a meeting this week, would approve extending the Troika program until October. This would enable a smoother transition between government-backed coverage and the Eurotime or ICAO plans if either or both were approved.

Tony Medniuk, group chief executive of London-based Global Aerospace Underwriting Managers Ltd., said that many airlines believe there are not yet sufficient limits available in the commercial insurance market for third-party war and terrorism risks.

Mr. Medniuk said that he thought the future of such insurance would be commercial coverage backed up by governments. "We need the government and commercial markets working together," he said.

Both the ICAO and Eurotime plans call for government funding until they build up their own reserves.

Buyback: Old policies may be cashed in

Continued from previous page
done pretty well," said Mr. Russell, who noted that only going back a few decades would be inadequate.

The risk manager must understand what claims and risks might apply to these old policies, he said. Maximizing the value of the potential policy exposure is essential, he explained, to getting the best settlement deal from an insurer.

The insurance industry recognizes that it wrote very broad policies in the past, so it is willing to negotiate such settlements to curb their potential exposure, Mr. Russell explained. For buyers, such deals may be driven by a business need "to turn an idle asset into cash," he said.

For pollution risks, the policies most likely to be involved in such negotiations are general liability policies written in the decades before the early 1970s, when the sudden and accidental pollution exclusion was first broadly adopted in the United States, Mr. Russell said.

Insurers also may be willing to negotiate a settlement of their liability on policies after that point, up to the mid-1980s, when the absolute pollution exclusion was adopted, he said.

"Prior to 1970, it's truly a green light for coverage," he said. "Between then and adoption of the absolute pollution exclusion, it's a yellow light and still subject to negotiation," he added.

But after that point, there is little chance of coverage for pollution, though companies might be able to negotiate a settlement of asbestos exposures under liability policies after the mid-1980s, Mr. Russell said.

Older policies are likely to yield larger offers from insurers, he said, not only because they lacked such exclusions but also because they often had no aggregate limits.

Most insurers are willing to discuss such buybacks, but risk managers should understand their perspective before entering negotiations, Mr. Russell said.

Insurers want to "close the books" on historical policies and release reserves that may have been established, he noted. Such negotiations also can help avoid costly litigation, which can set precedents unfavorable to insurers.

Risk managers must recognize they will be subject to an insurer's due diligence review of the potential liabilities before a settlement is concluded, Mr. Russell said. This is essential for them to justify payment and make reinsurance recoveries.

Buybacks may be driven by a need 'to turn an idle asset into cash.'
William J. Russell
Dispute Resolution Management Inc.

Insurers also vary in their negotiating flexibility.

Some, like Equitas Ltd., may be willing to discuss only the full buyback of all potential risks under old liability policies, whereas other insurers may be willing to buy out only specific risks, but leave coverage otherwise intact, he explained. For example, an insurer might be willing to settle all environmental liabilities or all liabilities arising from one site, he explained.

Richard T. Davies, manager of environmental liability for AIG Europe (U.K.) Ltd. in London, discussed how current insurance policies can help policyholders transfer environmental risks they have reassumed following such buyout settlements.

Environmental impairment liability policies, for example, can cover known contamination, unknown and unforeseen risks and environmental indemnities received or issued, he said.

2002 Assn. of Insurance & Risk Managers conference

Looming threats make continuity planning critical

By PAUL D. WINSTON

BIRMINGHAM, England—Risk managers must make sure their business continuity plans are up to date and sufficient to protect their organizations and employees from terrorism and other threats they face today, risk management experts warn.

Companies that embrace business continuity planning and have trained employees in how to respond to a crisis have a better chance of surviving a catastrophe than ones that have not, the experts said during a workshop at the 2002 Assn. of Insurance & Risk Managers conference in Birmingham, England, June 16-18.

"Before 11 September, enlightened organizations would have regarded continuity planning as a key element of their strategic approach to an active risk management program, but since the previously unimaginable events in New York, even those organizations will have been rapidly reviewing and upgrading their plans," said Nick Chown, group risk manager of Consignia P.L.C. in Chesterfield, England, in a statement announcing the formation of a new AIRMIC special interest group devoted to business continuity planning. This new interest group will ensure that AIRMIC makes "a full contribution to the continuing development of this key element of business risk management," he added.

Mr. Chown, who currently is the deputy chairman of AIRMIC, was a co-presenter of the conference workshop on the topic, which included taking attendees through the process of responding to a mock crisis.

"Sept. 11 is driving many companies to review their continuity plans," he said. But the threat of terrorism is not the only reason that businesses pursue such planning, he added.

Business continuity planning is fundamentally driven by a desire to survive as a going concern after an event disrupts operations, said Mr. Chown. It also is stipulated by various legal and regulatory requirements, including the requirement that publicly traded U.K. companies have a process of assessing and disclosing the risks they face.

It also is driven by customer demand, Mr. Chown said. "Most companies face a demand from customers to have at least a basic commitment to business continuity planning."

Such reviews also offer risk managers an opportunity to gain the ear of top management and of boards of directors to discuss the risks facing their organizations and strategies for controlling them, Mr. Chown said.

While urging businesses to "dust off" and test their business continuity plans in light of ever-changing risks, Mr. Chown also advised against making such plans overly complex.

Such plans should focus on responding to the basic losses that an organization might encounter, such as destruction of facilities or a partial shutdown of operations, rather than on the myriad risks that could produce such losses, Mr. Chown suggested.

Above all, he said, "put the emphasis on making sure your people are all right."

"It's the quality of the paper, not the quantity, which will judge the plan," added Dennis Flynn, managing director of Crisis Solutions Ltd., a Salisbury, England-based consulting firm, and the session's other presenter.

Mr. Flynn stressed the importance of training to the successful execution of business continuity plans.

Risk managers must be aware of critical thresholds for an organization's performance and how they will be affected by a crisis, he said. For example, the highest performance level is the planned performance level. Lower than that is the critical performance level, and lower still is a survival performance level. Where performance falls relative to these benchmarks, which are unique to each organization, dictates whether it thrives or doesn't survive.

After any crisis, Mr. Flynn noted, performance will decline. But teams trained in crisis management are able to respond more quickly than untrained teams and thereby raise performance levels more quickly, he said.

Without training, it is still possible that operational performance will recover, but it is likely to take much longer, he said. And the chances are greater that without proper training, a company will be unable to respond appropriately and performance will fall below survival levels.

2002 Assn. of Insurance & Risk Managers conference

Focus on risk essential

By SARAH VEYSEY
and PAUL D. WINSTON

BIRMINGHAM, England—There has never been a greater need to focus on risk management, according to a panel of six former European risk managers of the year assembled at the Assn. of Insurance & Risk Managers' annual conference in Birmingham last month.

The panel discussion capped a two-day conference filled with two-dozen workshops and lectures. The event, held June 16-18 in Birmingham's International Convention Centre, attracted more than 500 attendees and exhibitors.

Thierry van Santen, corporate risk manager for Paris-based Group Danone and chairman of the Federation of European Risk Management Assns., described the current climate as an "insurance war." He said that, among other challenges, the insurance market for corporate risks is disappearing, some companies will be unable to afford huge rate increases for insurance, and terms and conditions are being severely tightened.

"I think we don't focus enough on risk management today; we are too preoccupied with insurance," he said.

Richard Reddaway, vp of corporate insurance and risk management at London-based GlaxoSmithKline and a director of GlaxoSmithKline Insurance Ltd., agreed that there is a need for a greater focus on risk management. He added that for pharmaceutical companies, such as his own, the spread of litigiousness is a huge concern.

Ray Mattholie, head of risk and insurance solutions at London-based British Telecommunications P.L.C., cited directors and officers liability exposures as a growing threat to risk managers and insurers.

The building and maintenance of long-term relationships is extremely important in such a difficult market as the current one, Mr. Reddaway said. But others on the panel disagreed.

"What happened last year changed long-term relationships," said Pierre Sonigo, vp-environment and industrial risk management for Pechiney Group in Paris. "At renewals I don't think insurers took (long-term relationships) into account."

"Long-term relationships don't make any difference as far as I can see," added Eddie Thompson, risk manager at Amerada Hess Ltd. in London.

Marie-Gemma Dequae, corporate risk and insurance manager for Kortrijk, Belgium-based Bekaert Group, said she believes the nature of long-term relationships between risk managers and insurers is changing. "There are a lot of external factors that influence your relationships," she said, citing a spate of mergers and acquisitions and subsequent personnel changes at insurers.

Delegates at the conference were also treated to the views of a prominent risk manager from across the Atlantic.

Christopher Mandel, president of the Risk & Insurance Management Society Inc., offered attendees of the AIRMIC conference an overview of the current priorities of RIMS and of North American risk managers, as well as his vision for the future.

Mr. Mandel, who is assistant vp of enterprise risk management for USAA in San Antonio, Texas, said he sees a movement to a more progressive view of risk management. This is a shift away from a silo mentality, he said, to a cross-operational approach to managing risks. Such an enterprisewide approach helps his company in numerous ways, he said, including being better able to respond to unexpected risks.

Mr. Mandel also described his principles for "world class risk management" as a way to raise the profile and effectiveness of risk managers (*BI*, May 20).

"In the future, I believe risk managers will have broader accountability and broader credentials and experience," he said. "They'll have greater visibility to management."

AIRMIC's 2003 conference is scheduled for June 16-18 in Manchester, England. For more information, contact AIRMIC at 6 Lloyd's Ave., London EC3N 3AX, England; phone: 207-480-7610; fax: 207-702-3752; e-mail: *equiries@airmic.co.uk*. AIRMIC's Web address is *www.airmic.co.uk*.

2002 Assn. of Insurance & Risk Managers conference

Risk gets public focus

By SARAH VEYSEY

BIRMINGHAM, England—Risk managers have an important role to play in changing public perception of risk in the wake of Sept. 11, according to a new study launched at the Assn. of Insurance & Risk Managers' annual conference in Birmingham.

A widespread belief that some "intentional" risks, such as terrorism, are uninsurable is creating a risk-averse culture that could create opportunities for terrorists and hoaxers to spread panic, states a report conducted by think-tank Global Futures on behalf of AIRMIC and Lloyd's of London.

"Overreaction and speculation about threats are disabling to a reasoned risk management response and inhibit good planning," said the author of the report, Frank Furedi, professor of sociology at the University of Kent. "The risk management sector needs to find ways to discourage speculation. If the ability to cope with and learn from intentional risks is not accepted, there is likely to be a deterioration in the relationships between insurers and risk managers," he added.

Mr. Furedi

"We need to regard insurance as providing a web of protection and security for society," said Mr. Furedi. "We do not need to lose our nerves, not say that things are uninsurable. These are just knee-jerk reactions."

He suggested that the insurance industry should treat some intentional acts as "normal, insurable" events, to "discourage societal preoccupation with the idea that it is exceptionally vulnerable."

The study cited a survey of property managers at 50 of the largest U.K. companies that concluded the future of "prestigious, city center HQ buildings" may be under threat because of fears about terrorist risk. More than half of the property managers surveyed who worked in such buildings said they were worried about their own safety, and more than half said they were unhappy about working in tall buildings.

"The resulting impression, in politics and industry but also across society, is that Sept. 11 represents the emergence of threats beyond the capabilities of traditional risk management, beyond existing systems of insurance and beyond our social resilience," the report says. "The danger is that, in addition to often being untrue, this outlook will limit society's capacity to respond to such risks and will supplant balanced risk management with acting on fears and insecurities. We face a major challenge in learning how communities should now share the risks they face."

Mr. Furedi said that risk managers had an important role to play in educating the public "that we need a resilient response to risk."

David Gamble, executive director of AIRMIC, said he hoped the study would prompt risk managers to "consider how they can best provide leadership on the issues raised."

David Ireland, the new chairman of AIRMIC, pointed out that AIRMIC, in conjunction with the Assn. of British Insurers, was in discussions with the U.K. Treasury about an extension to the remit of Pool Reinsurance Co. Ltd., the government-backed terrorism reinsurance pool.

A spokesman for the ABI said that these discussions were going well, though he said he was reluctant to give any idea of timescales for a government response.

Mr. Furedi invited responses from risk managers, insurers, industry representatives and government agencies to the report. He said Global Futures would publish a commentary on responses to the report at the end of the year.

Copies of the report are available at *www.futureproof.org*.

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LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK
In re:

SEFTON PARK INSURANCE LIMITED
(Petition of Malcolm L. Butterfield)
Case No.: 02-B-12934 (BRL)

PLEASE TAKE NOTICE that on June 14, 2002, Malcolm L. Butterfield (the "Petitioner") commenced a case under 11 U.S.C. §304 with respect to Sefton Park Insurance Limited (the "Company") and the Bankruptcy Court entered an order pending a hearing scheduled for June 18, 2002.

PLEASE TAKE FURTHER NOTICE that on June 18, 2002, the Bankruptcy Court entered a temporary restraining order in connection with the Company's case (the "Order"):

(1) enjoining all persons and entities from (a) transferring, relinquishing or disposing of certain property to third parties; (b) commencing or continuing any action or proceeding; (c) enforcing any judgment, assessment, order, or award against the Company, and taking any action to create, perfect or enforce any lien, setoff or other claim against the Company and certain property; and (d) drawing down any letter of credit or otherwise applying property that is the subject of any trust, escrow agreement or similar arrangement in which the Company has an interest, in excess of amounts expressly authorized by the terms of the contract pursuant to which such arrangement has been established, except that no drawing against any letter of credit, trust, escrow, or similar arrangement shall be made in connection with any commutation unless the amount has been agreed in writing with the Petitioner or permitted by further Order of the Court; and

(2) requiring that all persons and entities that are beneficiaries of letters of credit, any trust, escrow or similar arrangement in which the Company has an interest, provide notice to the Petitioner's United States counsel (at the address set forth below) of any drawdown on any letter of credit or any withdrawal from, setoff against, or other application of property that is the subject of any trust, escrow or similar arrangement in which the Company has an interest, together with information sufficient to permit the Petitioner to assess the propriety of such drawdown, withdrawal, setoff or other application, including, without limitation, the date and amount of such drawdown, withdrawal, setoff or other application and a copy of any agreement pursuant to which such drawdown, withdrawal, setoff, or other application was made and provide such notice and other information contemporaneously therewith.

The Order shall remain in effect pending the conclusion of a hearing scheduled for July 22, 2002 at 10:00 a.m., New York time, before the Honorable Burton R. Lifland, in the Alexander Hamilton Custom House, One Bowling Green, New York, New York, to consider the Petitioner's motion for a preliminary injunction and related relief (the "Motion"). Any person wishing to obtain a copy of the Order, the papers filed in support thereof and the Motion should contact Theresa D'Agostino at (212) 610-6300 or Dagostit@newyork.allenovery.com. Any objection to the Motion must be in writing and filed with the Court and received by counsel for the Petitioner on or before July 15, 2002 at 11:00 a.m., New York time.

ALLEN & OVERY
1221 Avenue of the Americas
New York, New York 10020
Tel: (212) 610-6300
Fax: (212) 610-6399

Attention: Ken Coleman
ken.coleman@newyork.allenovery.com
Stephen Doody
stephen.doody@newyork.allenovery.com

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Fairchild: Compensation of asbestos victim upheld

Continued from page 1

who had previously been exposed to excessive quantities of asbestos dust. Such a result would reflect no credit on the law," wrote Lord Bingham of Cornhill.

But Simon Chandler, a lawyer at CMS Cameron McKenna in London, said "fresh uncertainty is generated and existing uncertainties" are exacerbated by the ruling. The Law Lords' decision undermines "long-established legal concepts, which are used not just by judges, but throughout the legal profession and beyond it by employers, manufacturers and their risk insurers."

Fairchild "increases the unpredictability of litigation, not only for industrial disease cases but also for a wider range of matters where the factual matrix is complex and the evidential basis imperfect," Mr. Chandler said.

In the underlying case, the widow of a building contractor, Arthur Eric Fairchild, sued Leeds, England-based Waddington P.L.C. and the Leeds City Council for negligently exposing Mr. Fairchild to asbestos. He died of mesothelioma in 1996.

The Law Lords ruled that under six conditions met in the case, a claimant is entitled to recover against two defendants, even if he could not explicitly link causation to one particular defendant. The six conditions are:

- C was employed at different times and for differing periods by both A and B.
- A and B were both subject to a duty to take reasonable care or to take all practicable measures to prevent C inhaling asbestos dust because of the known risk that asbestos dust, if inhaled, might cause a mesothelioma.
- Both A and B were in breach of that duty in relation to C during the periods of C's employment by each of them with the result that during both periods C inhaled excessive quantities of asbestos dust.
- C is found to be suffering from a mesothelioma.
- Any cause of C's mesothelioma other than the inhalation of asbestos dust at work can be effectively discounted.
- C cannot prove, because of limits of science, on the balance of probabilities, that his mesothelioma resulted from inhaling asbestos dust during his employment by A or during his employment by B or during his employment by A and B taken together.

Lord Bingham considered that this conclusion is fortified by the "wider jurisprudence reviewed" by the court and that "policy considerations weigh in favor of such a conclusion."

'*Fairchild* increases the unpredictability of litigation, not only for industrial cases but also for a wider range of matters where the factual matrix is complex and the evidential basis imperfect.'

Simon Chandler
CMS Cameron McKenna

Although Lord Bingham stressed that his opinion related only to the conditions laid down and to no other case, he acknowledged that "it would be unrealistic to suppose that the principle here affirmed will not, over time, be the subject of incremental and analogical development. Cases seeking to develop the principle must be decided when and as they arise."

While the Law Lords acknowledged that imposing liability on a former employer without requiring the conventional causal link to be proved may be unjust to one of the employers, it was the least unjust result.

"The concepts of fairness, justice and reason underlie the rules which state the causal requirements of liability," wrote Lord Hoffman, adding that "the purpose of the causal requirement is to produce a just result."

Any other outcome would be "deeply offensive to instinctive notions of what justice requires and fairness demands," wrote Lord Nicholls.

The Law Lords were not asked to rule on apportionment of compensation between the defendants in the case.

"It was not suggested in argument that C's entitlement against either A or B should be for any sum less than the full compensation to which C is entitled, although A and B could of course seek contribution against each other or any other employer liable in respect of the same damage in the ordinary way," ruled Lord Bingham.

CMS Cameron McKenna's Mr. Chandler said "the decision represents a significant change in the law of tort in England and Wales. For cases where an injured claimant has evidential difficulties in proving the necessary causal link between the injury suffered and a breach of duty by more than one former employer, *Fairchild* sets a new precedent by making each of the former employers jointly liable for the entirety of the loss."

The "inevitable consequence of this significant precedent is uncertainty," he said. The ruling "explicitly anticipated further developments and extensions to the law of negligence in the future."

The Assn. of British Insurers, however, welcomed the decision. "Now that the position has cleared, insurance companies will be looking to ensure that relevant claims are paid as soon as possible," said John Parker, head of general insurance at the ABI.

Workers comp: States permit exclusions

Continued from page 6

jected five insurers' filings for terrorism exclusions for excess workers comp policies but subsequently re-evaluated its position after a review, an Illinois Insurance Department spokeswoman said.

Safety National said that the approvals were granted by a dozen states that "had an opportunity to review our exclusionary endorsement."

Despite having obtained permission from self-insurance regulators in those states, "Safety National hasn't imposed the terrorism exclusion on any specific accounts and doesn't know if it will," said Jeffrey Otto, senior vp and general counsel of the insurer, an affiliate of Delphi Financial Group Inc. in New York. Mr. Otto refused to name the 12 states.

Self-insured employers are required to carry excess insurance in at least 27 states, according to a 1996 survey by the Madison, Wis.-based International Assn. of Industrial Accident Boards & Commissions.

Health costs: Midsize squeezed

Continued from page 3

find, employers feel they're probably in a better position to be able to pass along some of those rate increases they've been bearing."

While employers are considering cost-shifting strategies, "the ones that are really trying to impact things long term are looking more seriously at disease management," according to Mr. Edgren.

Disease management programs seek to educate patients to help them adhere to treatment plans that are often neglected, to improve doctor/patient understanding of specific health conditions and to prevent costly complications.

By encouraging proper treatment of the conditions, the programs aim to reduce costs that can be incurred when a condition worsens, such as those for hospitalization.

Midsize employers lag larger employers in adopting disease management. For instance, while 59% of the Fortune 500 companies responding have a disease management program for diabetes, only 24% of midsize employers have such a program.

The study also found that 38% of employers with 500 to 999 employees provide benefits information online. Using a corporate intranet or an Internet site, employees can obtain forms, access summary plan documents or enroll.

Employers 'that are really trying to impact things long term are looking more seriously at disease management.'

Roger Edgren
Marsh Employee Benefit Services

This is a "good news, bad news" situation, said Mr. Edgren. "In the short term, it's more work for benefit managers to assess and analyze those options as to whether or not it can work for them" and to go through the process of determining which companies can provide the services they need.

But in the long term, these approaches can cut down on the number of telephone calls coming into benefits departments, which is helpful because "very few (benefit managers) are having a whole lot of success adding staff to their department," he said.

While health care costs were up overall, the largest increases were in preferred provider organization plans.

The study found the cost of PPO coverage jumped 14.8% to $4,557 per employee on average in 2001. Health maintenance organization costs rose 13.6% to $3,803 per employee, while point-of-service plan costs increased 8% to $4,328 per employee. Traditional indemnity plan costs increased just 4.9%, but remained the most expensive of all plan types with per-employee costs averaging $4,794 in 2001.

The larger the employer, the more likely they are to self-fund their medical plans, the survey showed. For example, while 49% of PPO sponsors with 200 to 999 employees do so, only 17% of PPO sponsors with 10 to 199 employees self-fund.

A copy of the report may be obtained from local Marsh offices or by contacting Sharon Sikkema by e-mail at Sharon.K.Sikkema@marsh.com.

Supreme Court to hear state immunity, FMLA case

By SALLY ROBERTS

WASHINGTON—The U.S. Supreme Court has agreed to decide whether states' sovereign immunity can be pierced by lawsuits brought by state employees alleging violations of the federal Family and Medical Leave Act.

The case, *Nevada Department of Human Resources vs. William Hibbs*, involves William Hibbs, a former employee of the Nevada Department of Human Resources, who sought and was granted 12-weeks leave under the FMLA to care for his wife in April 1997. That June and then again in September, he requested and the department granted him a total of 380 hours of paid leave from the state catastrophic leave program.

According to court papers, the department informed Mr. Hibbs that the catastrophic leave would count against his annual 12-week FMLA leave entitlement. Mr. Hibbs argued that his unpaid FMLA leave should begin after his paid-catastrophic leave ended, not run concurrently.

After Mr. Hibbs took more than the 12 weeks, or 480 hours, of FMLA leave to which he was entitled, the state disciplined and eventually fired him.

Mr. Hibbs sued the department in U.S. District Court for the District of Nevada alleging violations of the FMLA.

The district court ruled that the FMLA claim was barred by Nevada's sovereign immunity under the 11th Amendment. It also held that Mr. Hibbs' 14th Amendment rights of due process had not been violated by the inability to sue the state.

Mr. Hibbs appealed the case to the 9th U.S. Circuit Court of Appeals, which overturned the district court. The appellate court ruled that the FMLA was a valid exercise of Congress' power under Section 5 of the 14th Amendment, which gives it the authority to abrogate state immunity.

The 9th Circuit also held that the FMLA is "expressly aimed" at preventing gender discrimination based on the stereotype that women are the primary care givers. Preventing gender discrimination is a valid use of Congress' Section 5 powers, the court held.

Several other circuit courts, though, have ruled that the FMLA was not a valid exercise of Congress' power to abrogate state immunity.

"State employers should not be immune from liability for damages when they violate employees' rights to care for a seriously ill family member," said Treva J. Hearne, a partner in the law firm of Zeh, Saint-Aubin, Spoo & Hearne in Reno, Nev., who represents Mr. Hibbs. "We believe (the FMLA) squarely fits Congress' authority under Section 5 of the 14th amendment," she said.

"Women are expected to take care of the family and are treated differently in the workforce than when a man goes to take care of his wife," she said. The Nevada Department of Human Resources found "it objectionable" when Mr. Hibbs took leave to take care of his ailing wife "and fired him while he was on his family leave," Ms. Hearne said.

Charles Hilsabeck, the deputy attorney general of Nevada, who is representing the defendant, countered that a three-month leave benefit provided by the FMLA is "substantive in nature" and therefore does not pass a test for valid Section 5 legislation. "That changes the nature of the 14th Amendment and Congress can't change the 14th Amendment," Mr. Hilsabeck said. "Nowhere in the 14th Amendment does it say you have a right to three months of unpaid leave from your job."

The Supreme Court will take up the issue next term, which begins in October.

Tobacco: Companies undeterred by recent defeats

Continued from page 1

Project in Boston.

- A Florida jury ordered tobacco company defendants to pay $37.5 million to John Lukacs, who lost his tongue to oral cancer and suffers from bladder cancer.
- The Oregon Court of Appeals reinstated a $79.5 million punitive damage award against Philip Morris Cos. The family of Jesse Williams won the award after Mr. Williams died of lung cancer following decades of smoking. A lower court had reduced the award to $32 million.
- Lynn French, a flight attendant, was awarded $5.5 million in compensatory damages by a Florida jury in a suit filed against the tobacco industry. The suit claimed her exposure to tobacco smoke in airplane cabins caused her chronic sinusitis. It was the second case to be tried from the so-called Broin class of flight attendants. In a 1997 settlement of the class-action case *Broin vs. Philip Morris Cos. et al.*, flight attendants agreed to the industry's $300 million settlement, which was earmarked for research into diseases suffered by flight attendants. In return, they agreed not to seek punitive damages in individual lawsuits against the industry.

The companies are appealing the losses and have yet to pay plaintiffs in the cases.

Tobacco victories

The industry has also seen some courtroom victories, which they claim receive much less attention than their defeats.

"The ones that get in the news are the ones that go against us," said Michael York, an attorney for Philip Morris with the Washington firm of Wehner & York.

In March, a federal jury in Providence, R.I., ruled against a woman who sought compensatory damages from Philip Morris for the death of her husband, who began smoking as a teen-ager. Philip Morris won a Florida case in May when a state court jury ruled against a man who suffers from laryngeal cancer.

William S. Ohlemeyer, vp and associate general counsel for Philip Morris, said that, "in the history of litigation" against tobacco companies, 15 verdicts have been returned in favor of plaintiffs. Three of those were reversed on appeal, and two were upheld. The rest remain on appeal.

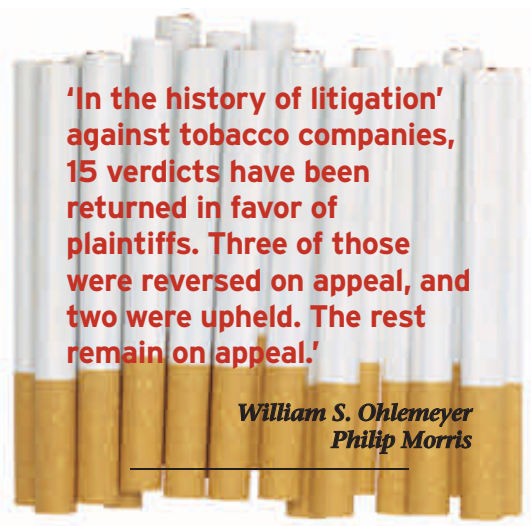
Of the two that were upheld, one was awarded no monetary damages. The other ended with the landmark $750,000 payment in 1996 to Grady Carter, a Florida man who became the first to collect damages from the tobacco industry. A state circuit court jury in Jacksonville, Fla., determined that the Lucky Strike cigarettes Mr. Carter smoked for 44 years until he developed cancer in 1991 were "unreasonably dangerous and defective," according to the verdict.

Charles A. Blixt, executive vp and general counsel at Reynolds, said during a conference call to analysts and reporters last week that there have been 15 smoking cases tried by juries in the last 18 months. The industry has won 10 of those, he said.

Others don't see the tobacco companies' courtroom record as so encouraging for the industry.

"There's the typical Wall Street analyst who will say it's bad luck and bad timing," said Richard Daynard, a law professor at Northeastern University and the chairman of the Tobacco Products Liability Project. "The bad luck is that you have a judge now who actually is deciding a punitive damages verdict and is giving 75 times the compensatory damages."

There is a trend to rule against tobacco companies because judges and juries "are all getting fed up with the industry's stonewalling tactics," Mr. Daynard said. The industry's arguments, he said, have been that though smoking can cause diseases, "it didn't cause this guy's disease."



"We're optimistic that, in fact, the tide may be turning," said Ginny Steiger, a legal assistant who works on tobacco cases for the Jacksonville, Fla., firm of Spohrer, Wilner, Maxwell & Matthews. The firm represented Mr. Carter in his successful claim against the industry.

Juries are reacting with anger when they see tobacco company documents in a trial, Ms. Steiger noted. "I think the general tendency to totally blame the smoker is turning," she said, as jurors learn "what is going on inside the tobacco companies."

Tobacco companies are steadfast in their determination to fight all the cases brought against them and to appeal rulings that are not in their favor. They have spent much of their time in the appeals courts, arguing that punitive damages awarded against them are unconstitutionally large.

The question of the relationship of punitive and compensatory damages is one that, "ultimately, the Supreme Court of the United States will have to answer," said Mr. Ohlemeyer. The court, he said, will have to give guidance to lower courts as to the size of punitive awards as they relate to compensatory damages.

Insurance coverage

Even though tobacco cases often involve the kinds of numbers that make insurance company executives lie awake at night, insurers have largely been able to stay out of the fight. In the two U.S. tobacco cases in which insurers were named, one was dismissed and the other ended in a ruling favorable to the underwriters.

In a decision reached in May, the Delaware Supreme Court ruled that exclusions in coverage written for Liggett Group Inc. meant insurers did not have to fund a defense in smoking-related lawsuits. Liggett sued 33 of its insurers in January 2000, seeking defense coverage for hundreds of liability suits (*BI*, Feb. 14, 2000).

Insurers also were named in an action filed in 1997 by the Louisiana attorney general's office, but that suit was dismissed a year later, after the tobacco industry agreed to pay the states $368.5 billion to settle lawsuits seeking reimbursement for expenses to treat smoking-related illnesses.

Thomas Locke, an attorney with Ross, Dixon & Bell, a Washington law firm that represented insurers in the Liggett case, said it is likely that tobacco companies, in most cases, aren't eager to seek coverage.

"If there were a duty to defend, it would mean insurance companies have the right to control the defense," Mr. Locke pointed out. "I suspect that would be a problem for the tobacco companies, who don't want to turn over documents to the insurance companies."

Turning the defense over to insurers could also create problems with regard to settling or trying cases if underwriters and tobacco companies disagreed on which strategy to use, Mr. Locke suggested.

He said the Liggett decision was a "complete victory for the insurance industry," and the court was decisive about the "unambigous tobacco exclusions in Liggett's general liability policies."

Mr. Ohlemeyer said Philip Morris has chosen to mount its defense in the courtroom as a way to protect against adverse judgments, rather than buy insurance to cover the risk. "Philip Morris is a company that is fundamentally sound. It is a company that has 50% of the market and is the leading brand in the world. Management has decided that it makes sense to devote a level of resources and expertise to defend the cases," he explained, noting that the company regards the strategy as having been successful.

HRAs: IRS approves rollovers

Continued from page 1

going to abate in the near future," said Jan Cohen, managing director of benefits at Budget Group Inc. in Lisle, Ill.

About 12% to 13% of Budget's 7,500 eligible employees are enrolled in a consumer-driven health plan that the company began offering in January, and Mr. Cohen said he already sees changes in employee purchasing behavior.

"I think you'll see more corporations heading in this direction," as a result of the IRS guidance, he said.

"This removes any uncertainty for any prospect that was considering adopting a consumer-driven health plan," said Michael Showalter, vp of product development at Minneapolis-based Definity Health, a pioneer in the plan concept in the late-1990s.

The IRS ruling is "a green light to new plan designs for health plans and employers," said Tom Beauregard, a consultant at Hewitt Associates L.L.C. in Rowayton, Conn.

"We will see many more innovations with how these spending accounts work," said Stephanie Swift, product director in the administrative services division at the Principal Financial Group, which recently launched a defined contribution product.

Many benefit experts were pleased and surprised that the IRS ruling went beyond ensuring the tax-favored status of employer-provided contributions and permitting year-to-year rollovers of funds—which were the two main issues that vendors and supporters of the plans had ask to be resolved. This could allow for more creativity in health plan design, they say.

The IRS ruling also:

- Permits employees to use HRA funds to pay health insurance premiums in addition to other qualified medical expenses.
- Allows former employees, including retirees, continued access to unused contributions.
- Provides that where both plans exist, a Section 125 flexible spending account funded by employee contributions could be the primary source of reimbursement, with an HRA providing secondary funding.
- Designates HRAs as group health plans, subject to COBRA continuation requirements.

All that translates into "portability," said Greg Scandlen, a senior fellow at the National Center for Policy Analysis, a policy research institute in Washington. "One of the uses could be to pay COBRA continuation premiums or post-retirement benefits. And that can be very attractive," he said.

"It shows some creativity and innovation" on the part of the IRS," said Helen Darling, president of the Washington Business Group on Health, an employer coalition that was among those seeking IRS guidance. "It's a very positive signal."

Mary Case, a principal at Buck Consultants L.L.C. in New York, said she was surprised by the IRS's ruling that an employer could require FSA funds to be exhausted before an employee taps his or her HRA.

"I'm surprised that they would give us that level of flexibility," she said.

Many employees have been hesitant to participate in FSAs because any unused funds remaining in the accounts must be forfeited at year-end. With the IRS ruling, the employee could set aside a more conservative sum, knowing that the employer-provided funds would be there after their FSA account is used up for the year.

Jerry Ripperger, product director for insured plans at the Principal Financial Group in Des Moines, Iowa, said the ruling could improve the availability and affordability of coverage for small and midsize employers, which are among those hardest hit by recent health care premium increases.

"Most of the companies that are offering these plans are large," he said. "This could become a replacement plan in the smaller market. We will see employers begin to return to offering catastrophic plans to their employees."

Because the IRS ruling allows employees to use the HRA to pay premiums and does not cap the amounts that employers put into the accounts, it also could potentially open the door to employers giving their employees health care vouchers to buy health insurance, said Mark Tierney, chairman of the board of eBenX, a Minneapolis firm that provides technology to defined contribution plan vendor Benu.

Employers "can take the entire contribution that they normally make for an employee and put it in an HRA" that the employee would use to reimburse his or her purchase of health insurance, he said.

For example, should an employer put $5,000 into an employee's account and the employee buys a plan that's only $4,500, "that $500 if you don't spend it for medical expenses that are outside that plan, that will roll over," he said. "They knew that that's where we've got to go. It (encourages) people to purchase economically."

Age bias: Ruling favors employer

Continued from page 3

administration degree that he sought during his employment.

A jury awarded Mr. Esberg $51,000 in economic damages and $35,000 in noneconomic damages, including emotional distress. The jury found, that because Union Oil had a policy against age discrimination, the company had violated this policy—a contract—by not awarding the benefits.

Union Oil sought reconsideration of the award, and the trial court judge struck down the $35,000 emotional distress award on the grounds that FEHA offers no protections against age discrimination in the awarding of benefits. Both the appellate and Supreme Court agreed. The $51,000 award for the contract violation, though, was allowed to stand.

"We are obviously very pleased that our position was upheld," said a spokesman for El Segundo, Calif.-based Union Oil. "It's our policy not to discriminate against any employee. Age is not a factor in determining benefits."

The spokesman added that "education benefits are based on position and developmental needs," and, in Mr. Esberg's case, "the benefits were denied based on the employee's work performance and how well he did in previous education programs."

Before obtaining his MBA, Mr. Esberg received his bachelor's degree with financial assistance from Union Oil.

Because the decision basically interprets existing law, it is unlikely to have a wide impact on employers in California and will have no impact outside of the state, according to William Emanual, an employer attorney at Jones, Day, Reavis & Pogue in Los Angeles who was not involved in the case.

The ruling "is surprising to a lot of people, but once you read the statute, it is clear that the state's age discrimination law does not apply to benefits," he said.

Mr. Emanual pointed out that employers are more likely to be affected by the passage of A.B. 1599, because the measure would specifically prohibit discrimination against older workers in awarding benefits.

"The state court ruled that on its face the statute is clear," agreed Dale Fiola, the Anaheim, Calif.-based attorney who represented Mr. Esberg.

Under current state law, Mr. Fiola said, "any favoritism (in employee benefits) could actually become incipient in the workplace," pointing to vacation, sick pay and stock options as examples.

Mr. Fiola said he is hopeful that Gov. Davis will sign the legislation, which was introduced after the appellate court ruled in the *Esberg* case.

"The Senate will definitely present the bill to the governor," he said. "Unfortunately, this doesn't help Esberg."

Dan Esberg vs. Union Oil Co. of California, Supreme Court of California; No. S96524; June 24, 2002.

ERISA: Clarification may follow ruling

Continued from page 3

yet to be named to reconcile the differences between the two bills, though, thus making enactment of such legislation in the waning days of this Congress unlikely.

But Mr. Dennett pointed out that provisions in the federal legislation that would require external review of coverage disputes haven't been a major sticking point in the congressional debate. Instead, he said, disagreements have focused on how much liability health plans—and, in some cases, the employers that sponsor those health plans—should face when the plans fail to cover appropriate care.

"The reason that legislation is stalled has virtually nothing to do with disagreements over the structure or operation of independent external review," he said.

"It's really a political question as to whether Congress feels any less pressure to adopt rules about a patients' bill of rights as a result of the decision. Given the current environment, this Congress is likely to look for any reason to procrastinate, because they have so many other things to work on," said Joe Martingale, national leader for health care strategy at Watson Wyatt Worldwide in New York.

Chip Kerby, an attorney with William M. Mercer in Washington, predicted the impact of the decision will be minimal on the patients' bill of rights debate, other than "possibly drawing some attention back to that legislation" for a short time.

But Mr. Kerby said the decision "highlights a growing concern" about how Congress has been "divvying up the ERISA pre-emption."

Congress, he said, has allowed states to adopt more stringent standards for insured health plans regarding such matters as mandated benefits and minimum hospital stays for certain procedures, while maintaining ERISA's pre-emption of imposing such requirements on self-insured plans.

"You get into these very sticky wickets" of when state law applies to health plans and when it doesn't, Mr. Kerby said, particularly given that large employers often offer some combination of self-insured and fully insured plans as part of their benefits packages.

Neil Trautwein, director-employment policy for the National Assn. of Manufacturers in Washington, also stressed that the main concern in the debate over a patients' bill of rights has been liability. Where the decision touched on liability, "it mostly follows our point where it says ERISA should be the exclusive province for remedies, but that language wasn't central to the court's decision," he said.

Mr. Trautwein said that the NAM is "playing with the possibility" of trying to persuade Congress to enact narrow legislation that would affirm ERISA pre-emption of state laws such as the one in Illinois, overturning the court's decision.

"If Congress were to act, they should act on a narrow bill. This absolutely does not bring any employers to the table in support of patients bill of rights" legislation, he said of the decision.

Mr. Dennett said that politics and the resistance of the trial bar to any limits on liability had stalled managed care reform efforts in Congress.

'The reason that (patients rights) legislation is stalled has virtually nothing to do with disagreements over the structure or operation of independent external review.'

Paul Dennett
American Benefits Council

"There's a heavy dose of political calculus" in determining whether the issue would be more potent in the campaign for congressional Democrats than in the enactment of legislation before the November elections, said Mr. Dennett, who added that it appears as though Democratic candidates would prefer an issue to a law.

"We're still looking at the wind-down phase of patients bill of rights, but this is smelling like a political issue," said the NAM's Mr. Trautwein. "Look for it on the campaign trail this fall and again in the next Congress."

For the Record

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P/C underwriting losses decline: ISO

Improved underwriting results at U.S. property/casualty insurers in the first quarter of 2002 were insufficient to offset the poor investment results of insurers, according to the Insurance Services Office Inc. First-quarter 2002 profits for U.S. insurers fell to $5.1 billion, down 7.3% from the same period in 2001. Net underwriting losses fell 38%, to $3.8 billion, in the first quarter, but investment gains fell also, by 26.4%, to $9.3 billion. Insurers' combined ratio improved to 102.3% in the first quarter of 2002.

Blue Shield to measure patient experience

Blue Shield of California, which in April introduced a tiered hospital plan that encourages enrollees to use lower-cost hospitals and providers, is adding quality and patient experience measures to its program. Beginning in October, Blue Shield will use patient experience information derived from the Patients' Evaluation of Performance in California, or PEP-C. Patient safety information will come from the Washington-based Leapfrog Group. Initially, participating hospitals will be credited under Blue Shield's evaluation process just for participating in the PEP-C and the Leapfrog programs. Beginning next year, how they rank under these measures will also be taken into account.

Enron loans a sham, Chubb filing charges

JPMorgan Chase Bank conspired to mask its client Enron Corp.'s deteriorating finances with loans fraudulently disguised as oil and natural gas deals that were guaranteed by surety bonds, one of the surety insurers is charging in a court filing aimed at rescinding the bonds. Chase last year sued Chubb Corp.'s Federal Insurance Co. unit and 10 other insurers to recover more than $1 billion under the bonds after Enron declared bankruptcy and defaulted on oil and natural gas sales contracts with a Jersey, Channel Islands, company called Mahonia Ltd. The insurers have denied liability, though, and Chubb last month filed a counterclaim charging that Chase helped structure the allegedly bogus Mahonia deals and obtain the surety bonds to keep Enron afloat. Under the deals, Mahonia prepaid Enron hundreds of millions of dollars for future deliveries of oil and gas, which it would purportedly resell, the complaint says. But Mahonia, a Chase affiliate, never intended to take delivery or resell any oil and gas; instead, the Jersey company existed merely as a conduit to funnel loan money to Enron, the suit alleges.

California to liquidate comp insurer PAULA

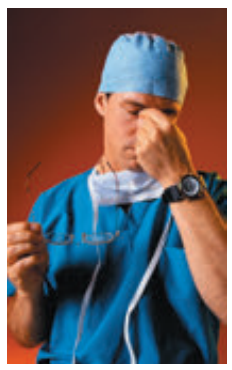
Workers compensation insurer PAULA Insurance Co. was placed in liquidation late last month, four months after it ceased underwriting. The Pasadena, Calif.-based unit of Paula Financial Corp. announced last year that it faced reserving problems for workers comp business written between 1997 and 1999. In the fourth quarter of 2001, PAULA Insurance increased its reserves by $37 million and announced that it no longer met risk-based capital requirements. On Feb. 28, the company said it would cease underwriting workers comp business. The California Insurance Department said last week that the insurer was insolvent by $22 million.

Credit insurers' profits expected to rebound

Credit insurers' fortunes should improve after this year, as global economies recover, a Moody's Investors Service report suggests. The credit insurance industry worldwide experienced profit declines in 2001, amid deteriorating conditions in corporate markets, Moody's noted. The rating agency said credit insurance remains a profitable niche in the nonlife insurance industry and shows significant growth potential. Moody's also cited consolidations—including those of Gerling Kreditversicherung A.G. and NCM Holding N.V., Euler Group and Hermes Kreditversicherungs A.G., and Groupe Coface and Natexis Banques Populaires—as strengthening the market positions of leading global credit insurers.

American Physicians exits med mal market

American Physicians Assurance Corp. is pulling out of the medical professional liability market in Florida. The insurer, a subsidiary of American Physicians Capital Inc., has 2,200 policies in force in Florida. The coverage generated $26.7 million in premiums last year. R. Kevin Clinton, president and chief executive officer of American Physicians Assurance, said in a statement that Florida's "unpredictable and unfavorable legal climate has become an impediment to our ability to write business profitably in Florida." The insurer reported an $18.8 million underwriting loss on the Florida business last year.



Health care premium hikes ahead: Aon

Employers will continue to face double-digit health care premium increases next year, according to a forecast released by Aon Corp. Based on data provided by the nation's largest medical, dental, prescription benefit manager and vision care vendors, health maintenance organization premiums will rise an average of 16.2% for 2003 renewals, point-of-service and preferred provider organization plan premiums will increase by an average of 16.0%, and indemnity plan prices will leap an average of 18.3%. Rate increases for plans that do not provide prescription drug coverage will be slightly lower: 14.6%, on average, for HMOs and POS plans, 14.5% for PPOs, and 17.1% for indemnity plans.

City of Hope awarded $200 million in damages

Genentech Inc. was ordered by a Los Angeles County Superior Court jury to pay the City of Hope National Medical Center $200 million in punitive damages last week in a contract dispute involving royalty payments for biologically engineered drugs. Earlier this month, the jury awarded the City of Hope $300 million in compensatory damages in the dispute, which centered over the interpretation of a 1976 contract. City of Hope researchers had conducted research under an agreement with Genentech that lead to the creation, among other things, of synthetic insulin, according to the medical center. Genentech retained ownership of the patents involved, but the City of Hope contended it should have been paid royalties when it licensed the patents to other companies. Genentech said it would appeal the decision. The company said it will post a one-time charge of about $500 million in the second quarter.

Briefly noted

A.M. Best Co. has placed Philadelphia-based **PMA Capital Corp.**'s A financial strength rating under review with negative implications. Oldwick, N.J.-based Best cited PMA's earnings declines and announcement that it will exit the excess and surplus lines business operated by its Caliber One Indemnity Co. unit. Best also changed its A rating of Caliber One to NR-3....The Pension Benefit Guaranty Corp. announced last week that it will terminate and assume responsibility for two pension plans that cover more than 3,300 employees of Burnham, Pa.-based **Freedom Forge Corp.**, a bankrupt producer of steel products formerly known as Standard Steel. The plans are underfunded by about $37 million, according to the PBGC.

Online Poll [6/24 - 6/28]

Should federal law be modified so employees in phased retirement programs be allowed to receive distributions from their employer's pension plan while working part-time?

Yes 81.3%

No 18.7%

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

BI Stock Index [6/24 - 6/28]

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

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

BI Stock Index	Dow Jones	S&P 500
-0.55	-0.16	0.07
2096.90	9239.25	989.82

Largest gains

Accel International Corp.	47.78%
Trenwick Group Ltd.	17.19%
PMA Capital Corp.	10.60%
AEGON N.V.	8.82%
ING Groep N.V.	8.07%

Largest losses

Gainsco Inc.	-36.25%
EMC Insurance Group	-21.92%
SCPIE Holdings Inc.	-13.27%
Acceptance Insurance	-7.87%
Wellpoint Health Network	-7.65%

Weekly change by market segment

Brokers	-0.34%
Insurers/Reinsurers	-0.85%
Managed Care Organizations	-1.08%

Source: CNET Investor (investor.cnet.com)

Near North: Ex-IT workers sued

Continued from page 3

and April of this year, Mr. Cheley used the insurer's computers to access Near North's systems 20,000 different times, searching for e-mails marked "urgent," "confidential" and "important," the complaint alleges.

Mr. Cheley and the other two defendants have provided the contents of the e-mails—which involved business negotiations, litigation, employee compensation and other matters—to competitors, potential business partners and "actual and potential adverse litigants of Near North," the broker charges. The complaint does not cite any specific instances of stolen information being passed to third parties.

The suit charges Mr. Cheley and Mr. Jongsma with violating federal computer fraud laws and all three defendants with gaining unauthorized access to Near North's systems.

Mr. Jongsma declined to comment on the lawsuit. Messrs. Cheley and Sikora could not be reached.

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