BI 08-01-05 A 1 7/29/05 5:30 PM Page 1

Aug. 1, 2005
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Senate cash balance proposal draws criticism over scope / 3

Bush signs measure that promotes reporting of medical errors / 3

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House approves med mal liability reforms

But Senate support unclear

By MARK A. HOFMANN

WASHINGTON—Medical malpractice liability reform advocates hope the Senate will follow the House's lead and approve medical malpractice liability reform legislation, but they have no illusions that achieving that goal will be easy.

The House passed the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2005 on a largely party-line 234-190 vote last week. The House has passed broad medical liability reform legislation numerous times, but the Senate has never followed suit.

Introduced by Rep. Phil Gingrey, R-Ga., late last month, H.R. 5 would cap noneconomic damages in medical malpractice cases at $250,000 and limit each defendant's damages to a proportion of his or her responsibility.

In addition, the HEALTH Act would establish standards for punitive damage awards.

Punitive damages could be awarded only when "clear and convincing" evidence proves that a defendant acted with malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury. Punitive damages would be limited to the greater of twice economic damages or $250,000. In addition, punitive damages could be awarded only when compensatory damages had also been awarded.

Among other changes called for the bill are:

- Allowing courts to restrict the payment of attorney contingency fees based on the size of the award.
- Setting a statute of limitations of three years after the date of manifestation of injury or one year after the claimant discovers the injury, with certain exceptions, to file a lawsuit.
- Permitting the introduction of collateral source benefits as evidence. Collateral sources cited in the bill include payments from such sources as workers compensation, health or accident insurance or any public or private program.
- Limiting the liability of manufacturers, distributors, suppliers, and providers of medical products that comply with Food and Drug Administration standards.
- Providing for periodic payments of future damage awards.

A recent development in Wisconsin underscores the need for congressional action, said one leading reform advocate.

Sherman Joyce, president of the American Tort Reform Assn. in Washington, pointed to the recent decision by the Wisconsin Supreme Court to

See MED MAL / page 34

SEC probe into RenRe restatement may spur charges against chief exec

By RUPAL PAREKH

PEMBROKE, Bermuda—RenaissanceRe Holdings Ltd.'s top executive could be the next individual to face civil charges as part of a broad probe into finite reinsurance abuses, after the reinsurer disclosed last week that regulators are mulling a civil enforcement action against him for alleged violations of U.S. securities laws.

PHOTO: DAVID SKINNER

RenaissanceRe CEO James N. Stanard has been served with a "Wells" notice.

Pembroke, Bermuda-based RenaissanceRe reported in a statement that the Securities and Exchange Commission had served its chief executive officer, James N. Stanard, with a so-called "Wells" notice, indicating that SEC officials plan to recommend that the agency levy charges against him.

See RENRE / page 34

Backstop supporters seeking alternatives to current TRIA

Lawmakers examine options after Treasury objects to extension

By MARK A. HOFMANN

WASHINGTON—A key lawmaker wants to work with the Treasury Department during the August recess to devise alternatives to the existing federal terrorism insurance backstop provided by the Terrorism Risk Insurance Act.

PHOTO: ZUMA PRESS

Rep. Richard Baker, R-La., made that offer during a hearing about the future of terrorism insurance before the House Financial Services Committee's Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises. Rep. Baker, who chairs the subcommittee, said it is "very clear" that the White House will not accept a simple extension of the current program, which is set to expire on Dec. 31.

A June 30 Treasury Department report said that the administration would oppose extending the current program unless it underwent significant changes.

> "The prime beneficiaries of this legislation are not the insurance companies; they are the insureds."
>
> Rep. Barney Frank, D-Mass.

Among other things, the administration would require that the private insurance market accept a greater share of terrorism risk than it does currently under TRIA.

In addition, the administration wants the trigger that activates the government backstop raised to a minimum aggregate $500 million in insured damage. Under current law, a qualifying terrorist attack causing as little as $5 million in insured

See TRIA / page 35

Late News

Spitzer asks Moody's about reinsurer ratings

New York Attorney General Eliot Spitzer has subpoenaed Moody's Investors Service in connection with its reinsurer ratings.

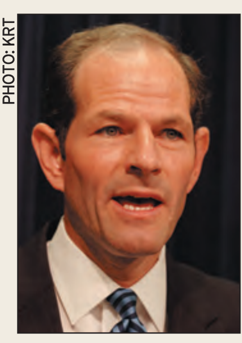

PHOTO: KRT

Mr. Spitzer

Moody's Corp., parent of Moody's Investors Service, said in its quarterly filing with the Securities and Exchange Commission that it received a subpoena from Mr. Spitzer's office on July 13 regarding its reinsurer financial strength and subordinated debt ratings, among other issues. Moody's said it is responding to the subpoenas and intends to continue cooperating with Mr. Spitzer's office. Representatives of rating agencies Standard & Poor's Corp., A.M. Best Co. and Fitch Ratings said their companies have not been subpoenaed.

Wisconsin governor vetoes HSA tax breaks

Wisconsin Gov. Jim Doyle last week vetoed provisions in a broader bill that would have amended Wisconsin law to conform with legislation Congress passed in late 2003 giving federal tax breaks to health savings accounts linked to high-deductible insurance plans. Under the vetoed provisions—included in a budget measure—contributions individuals made to their HSAs would have been tax-deductible, while employer contributions would not have been added to employees' taxable state income. Gov. Doyle said that because HSAs are linked to high-deductible plans, they could

See LATE NEWS/page 35

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NEWSPAPER

SPOTLIGHT
Workers Compensation and Disability Management
PAGE 11

BI RANKS
Safety Consultants and Rehabilitation Service Providers
PAGES 20, 22

Inside

Clinical trials litigation on the increase

Drug makers and others are facing more claims from drug trial participants.
Page 4

AIG faces fraud allegations in workers comp dispute

Insurers charge AIG and Trenwick with inflating claims in fronting arrangement.
Page 4

Railroads face rate hikes for liability coverage

Insurance costs are helping to push some rail companies out of business.
Page 4

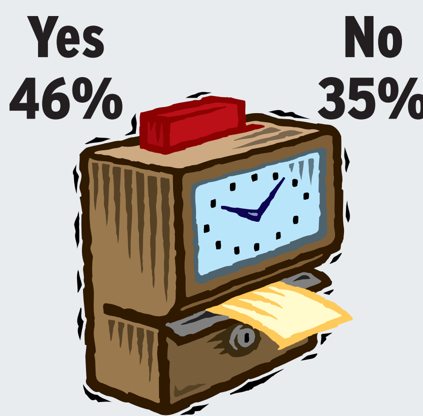
Court ruling could spell end for solvent schemes

Solvent schemes of arrangement will be harder to form following a court ruling.
Page 29

Online poll - [7/25 - 7/29]

Do you think employees are taking time off under the Family and Medical Leave Act for reasons beyond what the law intended?

Yes 46% **No 35%**



Do not know 19%

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Departments

Advertiser Index 34
Business Resources 28
Commentary 28
International 29
Opinions 8
Paul Winston 6
Perspectives 10
Products & Services 28
Professional MarketPlace 30
Ticker 35
World Updates 29

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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Effort to dispel cash balance doubts criticized for ignoring existing plans

By JERRY GEISEL

WASHINGTON—A legislative effort to shield future cash balance plans from age discrimination suits may be worse than lawmakers doing nothing at all, benefit experts say.

The Senate Finance Committee last week passed, as part of a broad pension funding reform bill, a provision designed to eliminate uncertainly about the legal standing of cash balance plans. Under the provision, cash balance plans would not be considered age discriminatory as long as pay-related and interest credits provided do not decrease with employee age.

That is a standard all existing cash balance plans likely would meet. In many of the plans, all participants receive the same pay-related and interest credits, though in some cases, older and longer-service workers receive bigger credits than younger employees. It is unheard of, though, for a cash balance plan to give larger pay and interest credits to younger employees than older employees.

As a result, the legislation would—to a point—put an end to the fear that engulfed cash balance sponsors in the wake of a July 2003 federal court ruling that IBM Corp.'s cash balance plan discriminated against older employees.

That ruling, by U.S. District Court Judge G. Patrick Murphy of the Southern District of Illinois, was a bombshell not only because it was the first of its kind and involved a high-profile company, but also because it was so sweeping that, if applied by other courts, it would invalidate virtually all cash balance plans.

Judge Murphy said IBM's plan was age discriminatory because the benefit credit provided to an older employee would purchase a much smaller benefit—expressed as an annuity payable at age 65—than the same credit provided to a younger employee. IBM will soon formally appeal Judge Murphy's ruling.

While the Finance Committee bill would preclude such rulings involving new cash balance plans, no such protection would be extended to the roughly 1,700 cash balance plans—covering more than 8 million people—that have been set up over the past two decades.

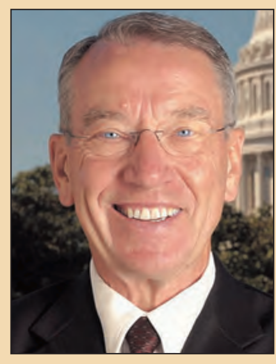
Protecting only future plans makes no sense, benefit lobbyists say.

"You have two identical cash balance plans. One is set up in 2002…the other is set up in 2006. The older plan is exposed to litigation and the other is not. What is the logic of that?" asked Janice Gregory, a senior vp with the ERISA Industry Committee, a Washington-based benefits lobbying organization representing employers.

"This sets up a completely arbitrary system of winners and losers," said Lynn Dudley, vp-

See CASH BALANCE / page 33

Pension plans



Senate Finance Committee Chairman **Charles Grassley, R-Iowa**, is co-sponsoring a pension funding reform bill that would, among other things:

- Shield future cash balance plans from age discrimination charges, as long as certain conditions were met.
- Tie liability valuations to plan demographics.
- Tighten funding rules so that companies would have to fund liabilities faster.
- Raise the base PBGC premium rate.

Pa. court rejects tort reform law

PHILADELPHIA—Pennsylvania's Commonwealth Court ruled last week that a 2002 tort reform measure that limited joint and several liability was unconstitutional.

The court ruled that the so-called Fair Share Act, which business groups favored because it required greater use of proportional liability in awarding damages, violated a state law that each bill should address a single-subject. The tort reform measure was added to a bill related to DNA testing of offenders, according to the court decision.

Pennsylvania Gov. Ed Rendell expressed his concern about the court's rejection of the tort reform measure, a spokeswoman said. The Democratic governor supports the concept of the Fair Share Act and said he will work with legislators to craft an acceptable bill when they return in the fall, she added.

The act stated that a defendant was responsible only for his or her proportion of fault, unless he or she was found at least 60% responsible, the governor's spokeswoman said.

Two leading Pennsylvania Democrats brought the constitutional challenge. Republicans continue to control both chambers of the Legislature, as they did in 2002 when the act was passed.

The Washington-based American Tort Reform Assn. expressed regret at the court's decision, a spokeswoman said.

"This will make it easier for defendants to go after businesses with deep pockets, even though they are minimally at fault," she said.

Since 1983, she said at least 93 civil justice reform statutes have been struck down, in whole or part, in at least 28 states including the District of Columbia.

—By Meg Fletcher

Medical errors database designed to improve care

By JOANNE WOJCIK

WASHINGTON—President Bush last week signed into law landmark legislation that would establish a national patient safety database intended to encourage voluntary reporting of medical errors.

"This bill is a critical step toward our goal of ensuring top-quality, patient-driven health care for all Americans," the president said at a signing ceremony Friday morning at the White House.

The bill, the Patient Safety and Quality Improvement Act of 2005, sponsored by Sen. Jim Jeffords, I-Vt., would authorize the Department of Health and Human Services to certify independent "patient safety organizations" that would compile a national database of medical errors reported by health care providers. The organizations would analyze the findings and make recommendations on ways to reduce the errors.

The data would not identify specific patients, health care providers or individuals who report errors, and disclosure of such information would result in a $10,000 fine per violation. In addition, the information could not be used as evidence in malpractice lawsuits or other litigation, nor could it be used by an accrediting body or regulator to take action against a provider.

The one exception would be if a judge in a criminal proceeding determines the information "contains evidence of a criminal act and that such patient safety work product is material to the proceeding and not reasonably available from any other source."

The bill would not bar patients or their families from using other medical records as evidence in malpractice lawsuits.

The bill also would prohibit employers from taking retaliatory action against employees who report medical errors.

The Washington-based National Business Group on Health, an employer coalition that has been promoting private-sector efforts toward improving patient safety, hailed the legislation.

"This is real breakthrough, game-changing legislation," said Helen Darling, NBGH president. "We can now make substantial progress toward ensuring that the health care system is at least safe."

PHOTO: KRT/GEORGE BRIDGES

President Bush signs legislation that will establish a national patient safety database.

BI 08-01-05 A 4 7/29/05 3:13 PM Page 1

More lawsuits being filed over clinical drug trials

High profile cases, number of tests contribute to increase in litigation

By JUDY GREENWALD

The increased use of clinical drug trials by pharmaceutical companies striving to bring more drugs to market is leading to a growing volume of lawsuits being filed by trial participants, many observers say.

The participants who file the suits frequently charge that they were inadequately warned of potential risks of the trials.

The charges can vary, however, and in at least one instance, participants are suing because they were denied continued access to an experimental drug.

Defendants named in the suits can include pharmaceutical manufacturers, medical device manufacturers, the institutions where the tests are conducted, and the physicians involved, say observers.

Each clinical drug trial must have certain safeguards in place from the start; participants in clinical trials must be provided with an informed consent document that includes details about the study, including its purpose, duration and study procedures, as well as its risks and potential benefits; and every clinical trial in the United States must be approved and monitored by an institutional review board.

But despite measures taken, some observers say there has been an increase in the number of cases filed by unhappy participants or their survivors.

One factor contributing to the increase is the number of highly publicized cases in this area, including that of Jesse Gelsinger, an 18-year old who died at the University of Pennsylvania's medical center in 1999 while participating in a gene therapy study.

"I do see an increased likelihood of litigation," said George Mernick, a defense attorney with Hogan & Hartson in Washington. "There have been enough cases now that have received some measure of publicity that like any trend in litigation, a few cases can tend to spark a lot of cases."

Some observers also believe the sheer number of trials now being conducted has inevitably lead to an increase in litigation. According to Boston-based Thomson Center-Watch, a clinical trials listing service, there are now an estimated 50,000 trials ongoing in the U.S. by both governmental and private institutions.

The number of suits is increasing "because the number of clinical trials is increasing, and the number of people in the world who are impacted by the clinical trials is in-

See TESTING / page 32

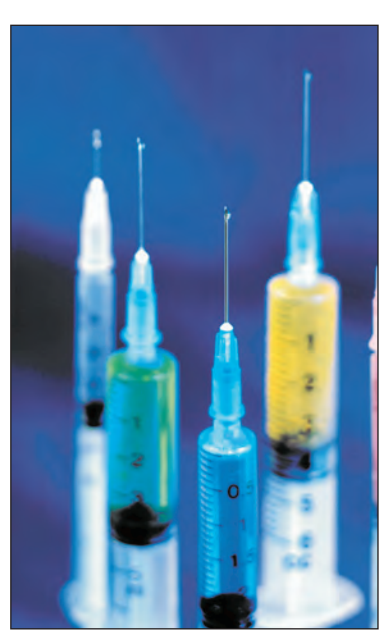


PHOTO: AP PHOTO/ PAUL VERNON

Ohio Attorney General Jim Petro is investigating the state's Bureau of Workers Compensation's investment in rare coins.

Ohio comp fund scandal sidelines reform efforts

By ROBERTO CENICEROS

COLUMBUS, Ohio—Ohio employer groups say the ongoing investment scandal plaguing the state's Bureau of Workers Compensation has indefinitely postponed enactment of employer-backed workers comp reforms.

Several county, state, and federal agencies are investigating the Columbus-based BWC's investments in rare coins. The state-run monopoly insurer first came under fire for those investments in April, when reports revealed that millions of dollars from a $50 million investment in rare coins—managed by a Republican-party donor—were missing.

In a July 21 statement, Ohio Attorney General Jim Petro said evidence shows that rare coin dealer Tom Noe improperly appropriated $4 million of BWC funds for his own use.

The BWC, which has more than $21 billion in assets, provides coverage for 283,000 employers, representing about two-thirds of the state's workers. Self-insured plans cover the rest of Ohio's workers.

Shortly after news of the scandal broke, Ohio Gov. Bob Taft appointed a management review team to study the BWC's $14 billion investment portfolio. Since then, several complications have surfaced, and the governor himself has faced criticism as partisan politics fuel the scandal.

State Sen. Marc Dann, D-Liberty Township, for example, has filed a lawsuit seeking to force Gov. Taft, a Republican, to release memos he claims could show the governor knew about BWC investment losses earlier than he has admitted.

Among other ramifications, George L. Forbes, one of nine members serving on a BWC Oversight Commission, resigned rather than bring more

See SCANDAL / page 32

AIG, Trenwick accused of offloading losses on pool

By ROBERTO CENICEROS

BOSTON—Nineteen insurers have filed a lawsuit alleging that American International Group Inc. and Trenwick America Reinsurance Corp. fraudulently inflated claims and schemed to leave them with $73 million in unsubstantiated reinsurance obligations.

The dispute, detailed in the complaint filed July 6 in Superior Court in Boston, stems from three reinsurance facilities in which Trenwick participated. Among other cedents, the pools reinsured several AIG units that provided coverage for workers compensation, occupational accident, and industrial aid insurance risks, the lawsuit states.

The reinsurers, in a participation agreement, granted Wakefield, Mass.-based LDG Reinsurance Corp. authority to act as managing agent for the three facilities and handle their claims, underwrite reinsurance risks and pay losses on behalf of the participants. LDG is now in runoff, according to a spokesman for its parent company, Houston-based HCC Insurance Holdings Inc.

In 1997, LDG arranged for Chartwell Reinsurance Co. to participate as a member of each of the three facilities. Chartwell also agreed to act as a fronting reinsurer for the pools while ceding risks back to the facilities.

Trenwick acquired Chartwell in 2002 and assumed its responsibilities for the reinsurance pools, including the fronting of reinsurance risks, the lawsuit shows.

Trenwick America Corp.—the parent of Trenwick America Reinsurance, which has ceased writing business—filed for Chapter 11 bankruptcy protection on Aug. 20, 2003. But between December 2002 and August 2003, Trenwick America Reinsurance had issued at least 11 reinsurance contracts to the AIG units.

The lawsuit alleges that AIG manipulated Trenwick's fronting arrangement and formed a strategy to "co-opt Trenwick in the pursuit of unsupportable claims, payments and a restructuring of AIG's reinsurance coverage at the expense of plaintiffs."

See AIG / page 33

Higher liability costs derail small freight, tourist rail lines

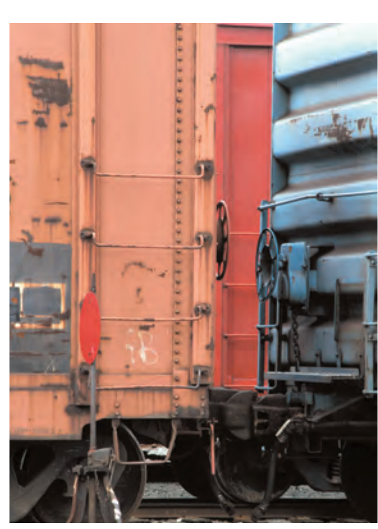
By MICHAEL BRADFORD

Liability insurance costs, coupled with soaring fuel prices, are running some railroads off the tracks.

Even though liability prices have stabilized for some small-to-midsize freight and tourist railroads, costs are way up from those charged before the 2001 terrorist attacks, sources said. The strain is catching up with some of the railroads and it is a factor in their decisions to scale back or abandon operations.

Particularly hard hit are freight and tourist operations that use lines controlled by the nation's largest railroads. The railroads that own or lease the tracks are demanding that smaller users provide proof of liability insurance with hefty limits and burdensome costs.

And while the largest railroads are able to escape premium burdens somewhat by assuming large self-insured retentions, their insurance costs have continued to rise. Large freight haulers—Class 1 railroads—are paying from double to 300% more than they were charged before the terrorist attacks, according to Jim Wolfarth, senior vp and deputy managing director of Aon Corp.'s national rail practice in Baltimore.



Some Class 1 railroads have been able to negotiate flat renewals this year, he said, but others' costs are still rising from 5% to 10%.

Regional railroads have seen premiums rise from 25% to 50% since the 2001 attacks, Mr. Wolfarth said. The regional operations now are seeing flat insurance renewals, or, in some cases, slight premium reductions, he said. Even so, the reductions are off "hard market pricing," Mr. Wolfarth noted.

The Montana Rockies Rail Tour, which operated the Montana Daylight train tour for 10 years, blamed

See RAILROADS / page 33

BI 08-01-05 A 6 7/29/05 4:32 PM Page 1

ERM widely accepted but not widely implemented, study says

By SALLY ROBERTS

While enterprise risk management has gained wide acceptance as a method for analyzing and confronting risks, only a small number of risk managers have actually fully implemented the process within their organizations, a report concludes.

An overwhelming 91% of the 271 risk management executives recently surveyed by The Conference Board and risk management consulting firm Mercer Oliver Wyman, both based in New York, said they are either positively inclined toward accepting ERM or are actively preparing, developing or implementing the practice. Only 11% of the respondents, however, have spread ERM throughout all aspects of their operations.

Having business units determine risk mitigation strategies is the most common basic ERM element, and is used by 22% of the survey respondents. Risk management executives have had less success in implementing two other important elements of ERM: establishing a business risk inventory, reported by 18% of the respondents, and developing a common language for risk exposure, reported by 15%, the survey said.

91% of those surveyed were positively inclined towards accepting or actively preparing their businesses for ERM.

Only 14% of the respondents said they are adequately communicating expectations for risk taking to senior managers, making it the least accepted basic element of ERM.

"Competing priorities" was cited as a "very significant challenge" by 26% of the respondents. Among other impediments to successful ERM implementation, 12% of the respondents reported insufficient resources and 10% of the respondents reported lack of consensus on ERM's benefits and getting their organization to make changes as very significant challenges.

Among the benefits of full ERM implementation, 86% of the small group of risk management executives who have fully implemented ERM ranked "better-informed decisions" as the No. 1 return. Greater management consensus was reported by 83%, and increased management accountability and smoother governance practices were reported by 79% of the respondents, respectively.

Members of The Conference Board can access the report online at *www.conference-board.org/risk-report.htm*. Nonmembers can purchase the report at *www.conference-board.org* or by calling 212-339-0345.

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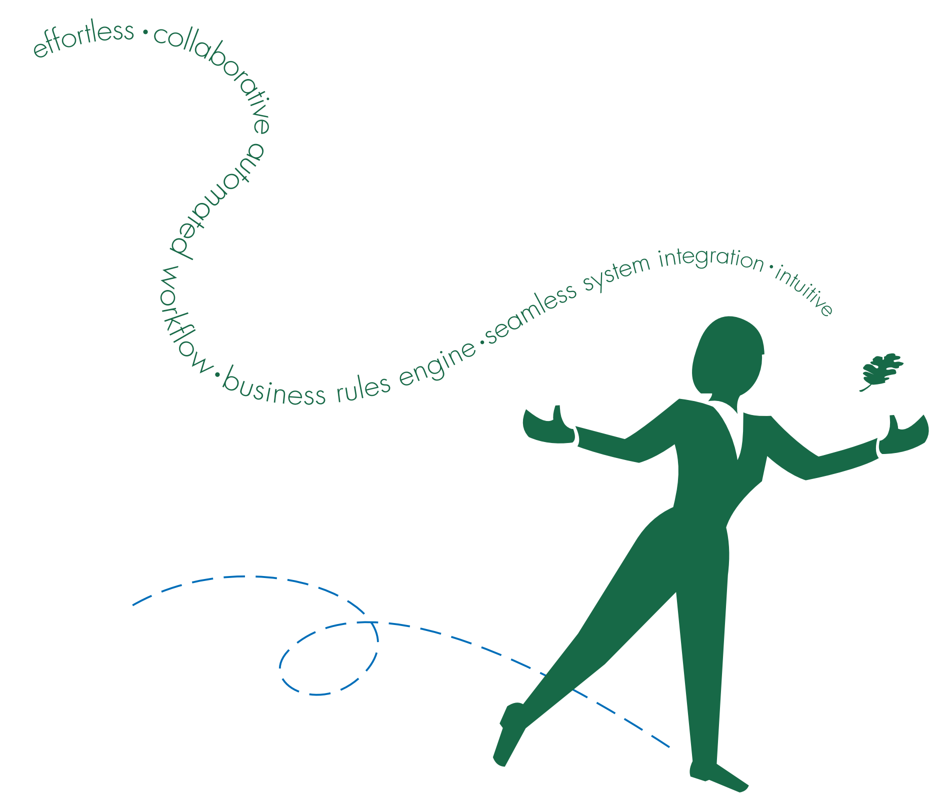

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PAUL WINSTON

Editorial Director

Working with a pro like you is heaven

"Baloney is flattery laid on so thick it cannot be true, and blarney is flattery so thin we love it."

—*Fulton J. Sheen*

You've heard the expression flattery will get you nowhere? A group of scientists with apparently nothing better to do has now proved that to be false.

Dutch researchers studied a group of modern-day lab rats, known as college students, to try to discover why people tend to think highly of anyone who flatters them, according to a report by Amy Norton of Reuters News Service. After a series of experiments, the researchers learned that people like their flatterers not because they believe what is said about them or because they lose their critical faculties in the face of compliments. Rather, they just like anyone who says nice things about them...even if they know the compliments to be untrue.

The scientific conclusion about our species is that we are suckers for sweet talk, no matter how deceitful.

I'm not sure this research breaks any new ground. It just means a lot of time and money was spent to confirm a hypothesis that many of us already have tested through personal experience.

We've all held our noses and winced at hearing someone paid compliments that didn't have any basis in fact, only to be amazed that the subject responded favorably to such hooey.

How many times have you kicked yourself for adhering to the dictum that honesty is the best policy, when some other slimeball used flattery to far greater advantage?

If nothing else, though, this research should provide a helpful reminder of options to anyone trying to influence others or improve their chances of getting what they want—such as lower insurance rates.

Or, if insurers won't budge, maybe you can use this strategy on CFOs and other management to keep your job secure. It's worth a try.

Here are some suggestions to get you started on the road to successful flattery:

- Most insurers are sissies, but I know you have the courage to continue to provide terrorism coverage as part of my property policy with no additional premium.
- Your golf game is really incredible. Have you ever considered trying out for the Tour? I mean it. Now about my workers comp premium...
- I think you are the most brilliant underwriter I know. And, when you agree to lock in my D&O program for five years, you will look like a genius to your managers for all the money you will have made off my account.
- I know that when other risk managers hear me sing the praises of how swiftly, fairly and fully you have handled my liability claim without a reservation of rights, they will be beating a path to your door.
- Have you been training for a triathlon or something? You look marvelous! About this business interruption claim...
- Any insurer could write our program, but I really hope to stay with you because I know that you are the very best. I felt I just had to tell you that.
- Quality people like you are the reason I would never consider forming a captive, because I could never do as good a job as you do in handling our risk.
- What does the home office know? You're so much smarter than those hacks in the back office and understand that we're a good risk.
- You should be proud of not being a lemming like so many others in the industry today. It's so refreshing to encounter an independent thinker like you, who won't jack up my rates just because everyone else is doing so.
- You must make all the other insurers jealous. They have to charge so much more because they have not figured out how to operate as efficiently as you have.
- Few insurers have the expertise to understand a sophisticated risk like mine, but you clearly have what it takes. Why aren't you running the company?
- What does it feel like to be the only smart underwriter in the industry today?
- I think I can die happy now, because working on our claim with a professional like you is heaven.

Even if they don't believe a word you say, the research proves they'll like you anyway. And maybe that's the edge you need.

Editorial Director Paul Winston is on vacation. This Commentary from the BI archives originally was published May 13, 2002.

BI 08-01-05 A 8 7/29/05 3:12 PM Page 1

Editorial

Opportunity knocks for national med mal reform

ADVOCATES OF FEDERAL medical malpractice liability reform have been presented with the best opportunity in years to realize their goal, courtesy of the House of Representatives.

And they should make every effort to take advantage of that opportunity, for it may be the last one they get for quite a while.

The opportunity comes in the form of the Help Efficient, Low-cost, Timely Healthcare—or HEALTH—Act of 2005, which the House passed on a 234-to-190 vote last week. The measure, which is identical to bills the House has passed before, would, among other things, limit noneconomic damage awards in medical malpractice cases to $250,000 and cap punitive damages at the greater of twice economic damages or $250,000. It also would allow future damages to be paid out on a periodic basis under some circumstances.

This is hardly radical stuff. In fact, it incorporates reforms that have already been adopted by many states.

While the states have a valuable role to play in the effort to reform medical malpractice liability, it's long been our position that medical malpractice liability reform is a national issue as well as a state one.

Health care—as the framers of the bill note, and as any employee benefits manager for a multi-state company knows—can constitute interstate commerce. Congress has the right to regulate interstate commerce.

Health care is too big a part of the economy, and the legal treatment of health care is too important to the nation's employers and employees alike to be left to the vagaries of 50 state laws.

And there are vagaries, too. Just last month, the Wisconsin Supreme Court struck down the state's decade-old cap on noneconomic damages awarded in medical malpractice cases. The law had worked as designed for 10 years, and then was rendered invalid.

We're under no illusions that national medical malpractice reform will be any easier to achieve than other federal tort reforms. In fact, doing so may be more difficult. But supporters should remember that the Class Action Fairness Act, first introduced in 2000, didn't become law until this year because of multiple setbacks.

And the House action presents the best opportunity to date to achieve federal medical malpractice liability reform.

The Senate, which has too often been the stumbling block for tort reform efforts of any sort, probably has more pro-reform members than at any other time in at least a generation.

If reform is going to happen, it's most likely to happen with this Senate.

This may be the best—and last—chance because historically, a lame-duck president's party loses seats—often a significant number of seats—in Congress in the last congressional election before a presidential election. The upcoming congressional election is only 15 months away.

This is the opportunity reform advocates have long sought. They must make their case to the Senate now, or risk having this opportunity vanish for quite some time, if it ever reappears at all.

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Schillerstrom

Editorial

Extend litigation protection to all cash plan sponsors

IF THERE IS LOGIC in a legislative proposal that would make it clear that cash balance pension plans set up in the future are not age discriminatory, but would not extend such protection to the roughly 1,700 plans that already have been set up, it escapes us.

But that is exactly what the Senate Finance Committee has done. As part of a broad pension funding reform measure, the panel last week included an amendment that cash balance plans that provide at least the same interest and pay-related credits to older employees as to younger workers do not violate federal age discrimination law.

But that protection only would apply to cash balance plans set up on or after July 26, 2005, the date the committee took action. That explicit legal protection, though, would not be available to plans established before that date.

To judge how irrational the committee's action is, consider this situation: Two employers have identical cash balance plans. One employer set up its plan last year. The other employer sets up its plan after the committee's action.

The second employer is shielded from age discrimination suits. The first employer is exposed. Does that make sense? Hardly. If committee members believe, as they said last week, that cash balance plans are legitimate and also, in some cases, a better design than traditional plans, why shouldn't plans already in existence be protected from age discrimination so long as they meet certain basic standards?

If committee members want to keep cash balance plan sponsors in the defined benefit plan system, which should be among their highest priorities, the litigation protection must be extended to all plans and not just those established after an arbitrary date.

Common sense and good retirement policy dictate no less.

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BI 08-01-05 A 11 7/28/05 12:42 PM Page 1

Spotlight

Workers Compensation and Disability Management

Telephone triage helps employers reduce workers compensation costs / page 24

In fight against illicit drug use, companies battle products designed to beat drug tests / page 26

Employers tuning in to the dangers of noise

By MARK A. HOFMANN

An invisible occupational injury that manifests itself in neither bleeding wound nor broken bone is threatening millions of workers.

This injury comes from no silent threat, though. It is hearing loss brought about by dangerous levels of workplace noise. The problem presents employers with unique challenges as they attempt to protect their workers' hearing.

Simply getting workers to use personal protective equipment can be a challenge in and of itself, experts point out (see story, page 15). That means that attempts must be made to engineer potential problems out of the workplace before they emerge. Employers also must try to differentiate work-related hearing loss from that caused by such factors as loud music or recreational noise.

In addition, state workers compensation systems vary greatly in how they treat hearing loss, both in terms of how they measure the injury and how much compensation they grant.

Meanwhile, the aging of the workforce could mean that hearing loss will become an even greater issue in the future regardless of the steps employers take to prevent it.

The problem of hazardous noise is considerable, as is evident in an estimate by the National Institute for Occupational Safety and Health that about 30 million workers in the United States are exposed to hazardous noise. But the definition of what constitutes dangerous levels of noise varies depending on the industry. The Occupational Safety & Health Administration has crafted two standards.

The first standard, which covers general industry, was promulgated in the 1980s. It requires employers to adopt a hearing conservation

See NOISE / next page

Army mulls using single insurer to reduce workers comp costs

By ROBERTO CENICEROS

With violence in Iraq stretching on, efforts to overhaul the workers compensation system for defense contractors have gained a fresh boost, which is causing concerns among some insurers.

Their concern stems from an ongoing effort that could lead to a requirement that contractors performing overseas work for the U.S. Army Corps of Engineers and, eventually, the entire Department of Defense, acquire their Defense Base Act workers comp insurance from just one centrally managed insurer offering fixed rates.

PHOTO: DARREN MCCOLLESTER/GETTY IMAGES

Civilian contractors adding armor to a military vehicle may soon be covered by workers compensation insurance bought from a single provider.

The Corps of Engineers, a part of the Defense Department, oversees billions of dollars worth of reconstruction contracts for Iraq, Afghanistan and other countries. Currently, employers contracting with the Corps on projects overseas are free to purchase Defense Base Act coverage from several insurers, including New York-based American International Group., Philadelphia-based ACE USA and Chicago-based CNA Financial Corp.

Congress enacted the Defense Base Act in 1941 to provide workers comp coverage for government contractor employees working at U.S. defense bases overseas. The act requires that all contractors and subcontractors secure DBA coverage for their employees, including foreign nationals.

Insurer concerns about the possibility of the Defense Department selecting just one DBA insurer also come amid recent inquiries from Congress and the Government Accountability Office seeking to deter-

See CONTRACTORS / page 19

Health insurers try to bring managed care to workers comp

By SARA HARTY

After an employee sustains a workplace injury, everyone agrees that the goal is to get the injured worker back to good health and on the job as quickly as possible.

Efforts to accomplish this in the most economical way are creating new opportunities for players in the group health markets. As the cost of medical care continues to increase, managed health care providers are trying their hand at containing the cost of medical components of workers compensation claims, which are typically higher than for comparable injuries that do not occur on the job.

Yet group health companies have a history of making unsuccessful forays into the workers comp arena, and at least one consultant questions the wisdom of the current effort as well.

Others argue, however, that circumstances are different this time, and that not only is there a place for managed care companies in the workers comp market, but that employers will benefit from the trend.

"The medical component of workers compensation now accounts for more than 50% of the workers compensation dollar. It is a very significant cost item for employers," said Joe Marlowe, a senior vp of Aon Consulting in Philadelphia.

Most employers with 500 employees or more have either workers comp deductibles or self-insured elements to their coverage and stand to benefit from trimming the medical component of their comp costs, said Anne Ritter, an East Hartford, Conn.-based national practice leader for Aon's Workforce Strategies.

"If I were an employer, I would be asking some very serious questions of my workers compensation

See INSURERS / page 16

RANKINGS: Safety Consultants / 20 and Rehabilitation Service Providers / 22

Warning signs of hazardous noise

- You must raise your voice to be heard.
- You can't hear someone two feet away from you.
- Speech around you sounds muffled or dull after leaving a noisy area .
- You have pain or ringing in your ears (tinnitus) after exposure to noise.

Source: American Speech & Hearing Assn.

Noise: Employers tuning in to noise problems

Continued from previous page

program when average noise levels exceed 85 decibels. The standard describes the elements of a hearing conservation program and includes monitoring and audiometric testing.

OSHA's construction standard, in contrast, is quite simple. It requires an employer that has workers exposed to noise levels in excess of 90 decibels to implement an effective hearing conservation program, but gives no specific requirements for what the program should include.

The impact of occupational hearing loss on the workers compensation system is murky.

"If you lose some of your capacity to hear, it usually doesn't result in lost time," said Keith Lessner, vp-loss control for the Property Casualty Insurers Assn. of America in Des Plaines, Ill. He noted that hearing loss didn't even make the top-10 list of workplace injury types in last year's annual Liberty Mutual Workplace Safety Index, which measures costs associated with workplace injuries.

Still, "it is just about everyplace," said Mr. Lessner. "Just about every work environment presents some sort of noise hazard, including some office environments."

Experts say that employers need to make hearing conservation efforts even before workplaces open for business.

"The most cost-effective thing is to reduce noise at its source, particularly in the design phase," said Joe Capuzzi, a certified industrial hygienist at Philadelphia-based ACE USA's ESIS risk control services. "If you can engineer out the noise before you bring a piece of equipment into the facility, that's the most effective way to do it," Mr. Capuzzi said, adding that doing so can save up to two to five times the cost of retrofitting the noise-generating equipment.

"Although engineering controls can be expensive to implement, they may be more effective than other noise exposure reduction methods, because they address the noise problem at the source instead of relying on behavior modification and hearing protection devices, or HPDs," said Ted Madison, senior technical service representative in 3M's occupational health and environmental safety division in St. Paul, Minn.

"Likewise, use of HPDs is far more effective when it is part of a comprehensive hearing conservation program including noise monitoring, audiometric testing and worker training and education on when and how to wear hearing protection at work and elsewhere, he said. OSHA and the Greenwood Village, Colo.-based National Hearing Conservation Assn. have developed an online hearing conservation tool to help employers understand how to implement effective hearing conservation programs.

But "unlike safety glasses or hard hats, hearing protectors do not have to meet minimum performance standards set by ANSI or other standards bodies," noted 3Ms' Mr. Madison. He explained that HPDs are not "tested and approved" by NIOSH or other government agencies.

Numerous research studies have concluded that the laboratory-derived Noise Reduction Rating—or NRR—printed on packages of hearing protectors significantly overestimates the average noise reduction achieved by groups of employees in the workplace, said Mr. Madison.

"As a result, NIOSH recommends applying a safety factor to the NRR, which varies by hearing protector type. They recommend that employers lower the NRR of earmuffs by 25%, formable earplugs by 50% and all other earplugs by 70% in order to more closely estimate the average noise reduction achieved by groups of workers. Employers may find it helpful to consult the NIOSH online compendium of hearing protectors, which allows them to search for HPDs by type, manufacturer, and noise level," he said.

Still, employers have to be able to separate work-related hearing loss from other exposures.

"A combination of well-documented work and exposure history, as well as a medical history, can provide information to aid in determining whether a hearing loss is re-

See NOISE / page 15

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BI 08-01-05 A 12,15 7/28/05 12:44 PM Page 2

Noise: Employers tuning in to dangers

Continued from page 12

lated to a medical cause or a nonwork noise exposure rather than work-related noise-induced hearing loss," said Christine Dixon-Ernst, manager of industrial hygiene services for Alcoa Corp. in Pittsburgh.

"Controlling and reducing exposure to workplace noise is always the company's primary goal," said Ms. Dixon-Ernst. "Alcoa has metrics for reducing noise exposure and over the past 5 years has substantially reduced workplace noise exposure for the most significant noise-exposed groups. While factory noise may be less, are more workers listening to their music and not hearing safety instructions? The use of (portable music) devices is not permitted in most work environments at Alcoa," said Ms. Dixon-Ernst.

Hearing loss workers compensation claims can be costly, said Laurie Wells, an occupational audiologist with Associates in Acoustics Inc. in Loveland, Colo., and president of the NHCA. The NHCA's mission is to prevent hearing loss due to noise and other environmental factors in all sectors of society.

"Each state has unique workers compensation regulations and procedures; therefore, it is important to consult each state separately for detailed and current information," Ms. Wells said. Many states use a formula, called AAO-79, recommended by the Alexandria, Va.-based American Academy of Otolaryngology - Head & Neck Surgery, she said. Still, Ms. Wells said, about one-third of the states have no formula, depending instead on "medical evidence."

"Monetary compensation is generally derived by applying the impairment rating to a predetermined payment schedule for a one-time payment, or payments over time based on a percentage of the employee's earnings. The maximum awards for total hearing loss vary greatly from state to state, from a low of $9,000 to a high of $150,000," she said.

Hearing loss in the workplace is likely to become a bigger rather than smaller problem in the decades ahead, predicted Alma Jackson, president and chief executive officer of Colorado Safety Works Inc., a Grand Junction, Colo.-based consultant.

Ms. Jackson noted that, as the workforce ages, "even if there are older workers out there that don't have hearing loss problems, they still have problems hearing. It's not just about the damage to the ear; it's also problems with the central auditory nervous system," she said, adding that this age-related diminishment causes problems like the inability to distinguish individual words.

Ms. Jackson said that this means that fellow workers should face their older counterparts when they speak. "One of the things that people do as they get older is they automatically develop the habit of lip reading, whether conscious of doing so or not," she said.

Ms. Jackson said that lower pitches are easier for older workers to hear as well, and this should extend to alarm systems. Currently, most alarms are pitched to higher frequencies and can thus be harder for older workers to heed, she said.

Decibel levels

Sustained decibel levels of 85-90 dB can cause hearing loss

Painful:
150 dB = rock music peak
140 dB = firearms, air raid siren, jet engine
130 dB = jackhammer
120 dB = jet plane take-off, amplified rock music at 4-6 ft., car stereo, band practice

Extremely loud:
110 dB = rock music, model airplane
106 dB = timpani and bass drum rolls
100 dB = snowmobile, chain saw, pneumatic drill
90 dB = lawnmower, shop tools, truck traffic, subway

Very loud:
80 dB = alarm clock, busy street
70 dB = busy traffic, vacuum cleaner
60 dB = conversation, dishwasher

Moderate:
50 dB = moderate rainfall
40 dB = quiet room

Faint:
30 dB = whisper, quiet library

Source: American Speech & Hearing Assn.

Noise safety advice unheeded

Even the best-designed hearing protection devices will fail if workers won't listen to safety advice.

And the construction industry is particularly prone to ignoring advice that could prevent hearing loss, safety experts say.

"In industry, things have gotten better but the biggest problem I see out there is no hearing conservation requirement for construction," said Joe Capuzzi, a certified industrial hygienist at Philadelphia-based ACE USA's ESIS risk control services. "Construction workers are exposed to high noise levels in their jobs. When you go out to a construction site, it's rare to see people wearing ear protection."

In construction, people may be exposed to dangerous noise levels only part of a day, said Mr. Capuzzi, and they are reluctant to use protective gear that they only need for part of the time.

"It is seldom easy to convince workers of the necessity for personal protective equipment of any kind, and hearing protection is no exception," said John A. Neil, practice leader-national market loss prevention for Liberty Mutual Insurance Group in Boston.

"Many workers resist personal protection on general principle. We often hear others having specific arguments with excuses such as; 'Noise doesn't bother me,' 'Ear plugs are uncomfortable,' or 'You can't hear warning signals or a person trying to communicate with you.' These arguments can easily be overcome through good supervisory response and leadership, and involving employees in the risk assessment process. Workers are becoming increasingly aware of the damage that may be done to their hearing by exposure to excessive noise," he said.

Craig Moulton, a senior industrial hygienist at the Occupational Safety and Health Administration in Washington, said the workers often resist using devices. "It varies. It depends on the general attitude toward safety in the workplace." The greater the emphasis on safety in management, the more compliance will be spread throughout the organization, he said.

"Hearing protection is everyone's job and responsibility," said Liberty Mutual's Mr. Neil. "Employers should provide everything possible to protect their workers' hearing. In return, employers should also expect workers to be concerned about their own hearing, both on and off the job. Encourage workers to use hearing protection when they are exposed to loud noise through leisure activities such as rock concerts, hunting or when using common home tools such as chainsaws," he said.

— *By Mark A. Hofmann*

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Insurers: Bringing managed care to the workers comp arena

Continued from page 11

carriers and TPAs," said Ms. Ritter.

"I think that employers have to drive it right now, really dig and find out what their true costs of care are. Are there better discounts available? There should be opportunities to decrease overall costs," she said.

Aetna Inc. is one of the group health insurers betting that they can help trim those costs.

"There is a probability of workers compensation costs skyrocketing, medical costs being unchecked and premiums becoming unacceptable for employers," said Robyn Walsh, president of Aetna Workers' Comp Access in Hartford, Conn.

As large employers move toward self-funding, "they wonder, 'Why can't I bring purchasing power to comp like I have for group health?'" said Ms. Walsh.

Aon's Mr. Marlowe observed "group health networks have a much greater membership base, giving them leverage for more-favorable reimbursement rates, and they have much more information on physicians and hospitals. Better profiling leads to better decisions on which providers to include or exclude."

It's more difficult for workers comp insurers to "determine who the good performers are vs. the bad performers" because of their lower usage rates, he said.

Aetna was drawn to managing workers comp medical care because it played to the company's "existing capabilities and strengths," including strong provider networks and large health databases, Ms. Walsh said.

"Based on interviews with carriers and employers, we saw opportunities to apply cost management, quality management, network development" and access Aetna's stores of data to trim costs, she said.

Aetna's AWCA network is already in Connecticut, New Jersey, Pennsylvania, Texas and Virginia, and soon should be available in six more states.

Cutting costs

The Hartford Financial Services Group Inc. contracted with AWCA in June to provide services to its clients in Pennsylvania.

"We know comp claims, but they are experts in managing the medical world," said Judy Kunisch, vp of medical support and strategy at The Hartford.

"We've traditionally gone outside to traditional occupational health networks for health care; now we're going to the powerhouses, to the people who really know how to do it," said Ms. Kunisch.

Resource allocation is one area where Ms. Walsh expects experience on the group health side to deliver savings on the comp side.

"In group health, 20% of the members are driving 80% of the medical costs. Every patient does not need the same level of case management, and it is a better use of resources if we identify early on, when a person is first injured; if it is an overweight 50-year-old male with diabetes and hypertension who has a broken back or a 30-year-old healthy male with a broken back. We do different things for them, and that has not been done in comp," she said.

WellPoint Inc. is another health plan that sees opportunities to contain costs in workers comp. WellPoint aims to manage "overutilization, inappropriate meds, pharmacy costs and unit costs," said Tim Hoops, the Anaheim, Calif.-based

See INSURERS / page 18

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Insurers: Bring the muscle of managed care into the workers comp arena

Continued from page 16

president of WellPoint's workers compensation business unit.

WellPoint offers managed care comp services in California and Missouri and plans to expand to more states.

"Quality care is the goal, not to deny treatments. We are using evidence-based guidelines on what is appropriate," stressed Mr. Hoops.

Their large databases are another strong point for the group health insurers, Ms. Walsh said, offering an example of a male injured on the job and requiring surgery. "We know from the group health side that a behavioral health/psychiatric consultation before surgery is extremely beneficial in mitigating depression after surgery, leading to a faster recovery and faster return to work."

Yet psychiatric consultations are not typically provided before surgery for comp injuries, Ms. Walsh said. "In the past, workers got what they needed to get back to work but no more. The assumption is that a worker is always trying to get more than is really needed. We're saying that a broken back is a broken back and should be treated appropriately."

'Smitten with databases'

Not all observers think that the group health data amassed by managed care companies is pertinent to workers compensation claims.

Some insurers are "smitten with these large databases and physician results. That's nice, but a lot of the data is not relevant to workers compensation," said Joseph Paduda, principal with Strategy Health Associates in Madison, Conn.

Mr. Paduda noted that much of the data pertains to claims that will never arise in workers comp, such as those involving cancer, pediatrics or obstetrics and gynecology.

More importantly, "functionality is fundamental to workers comp. With workers compensation, you have to resolve the disabling condition," he said. Group health plan data doesn't show how a claim is resolved, he said. "The data shows treatment occurred and the claim ended, but there is no functionality. Did the claimant die, change health plans, go to an acupuncturist? There is no output determining functionality. As a result, the data is not only incomplete, I would say it is inherently misleading," Mr. Paduda said.

Another limitation of group health databases is the very notion of a plan year. "In workers compensation, one-third of medical dollars are paid out more than three years after an injury occurs. In group health, the data tracks plan year to plan year," Mr. Paduda said.

Even the idea of applying managed care cost containment principles to workers comp is flawed, he argued, because of the long-tail inherent in workers comp, the musculoskeletal nature of the injuries and the necessity of a quick return to work. "You fundamentally have to manage care differently," Mr. Paduda said, offering the example of standard treatment for back pain. Because back injuries can drag on, the motivation in workers comp is to immediately verify the extent of the injury and get the worker back to work as soon as possible, he said.

Workers compensation claims certainly have "unique differences," acknowledged Mr. Hoops. At the same time, "with certain types of injuries the outcomes should be very similar," he said. "Workers compensation claims require occupational health care providers, more orthopedists and certain types of clinics that understand return to work," he said. Nevertheless, "all of the ancillary services like labs and hospitals are identical," and these areas provide key opportunities for trimming costs.

"A surgical back should cost the same whether it is a group health claim or a workers compensation claim," Mr. Hoops said.

Ms. Kunisch agreed, saying, "Hartford looked at the injuries, and the injuries are the same. There are more similarities than differences, because we are taking an injury focus."

"The myth is that if you don't have a doctor trained in workers compensation, you won't get a good result. That is true to some extent, but there are no injuries in the workplace that aren't also seen in group health, whether it be carpal tunnel or back injuries," said Ms. Ritter.

That being the case, using the best doctor to treat a particular type of injury can lead to better outcomes, she said.

The trend toward managed care companies entering the workers compensation market may create a sense of déjà vu for some in the industry who remember similar—but short-lived—forays by group health insurers into workers compensation in the 1980s.

"The big difference is that health care is in crisis. And this time, it's not like in the '80s; it's a real crisis," said Ms. Ritter, noting that it's getting much more difficult to figure out how to pay for medical costs.

Another critical difference is that, for the most part, group health insurers are not underwriting compensation claims.

"We're still managing the claims," observed The Hartford's Ms. Kunisch. They don't want to manage the claims; they know they don't know how to do it."

"This business is fee-driven," agreed Ms. Walsh. "Aetna is not incurring any underwriting risks, which is a different scenario from 10 years ago when health insurers did take on risk despite a lack of underwriting expertise."

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BI 08-01-05 A 18,19 7/28/05 5:01 PM Page 2

Contractors: Army mulls using single insurer to reduce workers comp costs

Continued from page 11

mine whether workers compensation costs for contractors working in Iraq are justified. The costs are eventually passed on to the U.S. government.

While the possibility of centralizing all DBA coverage for the Corps contractors has surfaced in past years, the increased scope of contractors' current role in Iraq has given the idea new impetus, a Corps spokesman said. Corps documents also show that the organization wants to ensure small and minority contractors are able to afford DBA coverage.

The Corps now wants to determine whether it is possible to reduce contractors' workers comp insurance costs by centralizing coverage with one large insurer, rather than having many small employers purchasing coverage from a variety of insurers, the Corps spokesman said.

To that end, the Corps of Engineers issued on March 7 a request for proposal in search of a single insurer willing to participate in a temporary pilot program providing DBA coverage for contractors participating in all its overseas operations.

If the project is successful, the effort could be expanded to the entire Defense Department, Corps documents show.

Request for proposal responses were due June 3. The Corps declined to say how many insurers, if any, submitted bids. When an insurer might be selected also remains to be determined.

Meanwhile, the large number of contractors working amid the continuing violence in Iraq has raised congressional concerns over their roles in support of military and civilian operations, including the cost of workers compensation insurance for their participation, states a GAO report released April 29.

The report was inconclusive about whether DBA insurance is being purchased in a cost-effective manner. A lack of reliable information on the numbers of contractors working and the cost of insurance, along with confusion over claims processing and other issues, is problematic, the report states.

Additionally, the report's authors could not reach a conclusion because recent state investigations into insurers and brokers raise questions over the reliability of information the GAO obtained from those sources.

But they noted that the Department of State and the U.S. Agency for International Development for years have had programs in which all their contractors are covered by single commercial insurers—Chicago-based CNA Financial Corp. for the State Department and Philadelphia-based CIGNA Corp. for AID—with fixed rates for their contractors. For DBA coverage, their contractors pay about $2 to $5 for every $100 in payroll. Defense Department contractors, in contrast, pay about $10 to $21 per $100 of payroll, the GAO found.

Rates for DBA coverage have been falling, though, just as other commercial insurance pricing has. DBA coverage rates were flat in 2004, and for 2005 renewals, policyholders have experienced rate decreases averaging about 10%, with some seeing 25% decreases, according to Anita Robinson, a senior vp for Marsh Inc. in Los Angeles.

> "I just think it's extraordinary that, particularly in this administration, they could be talking about a proposal that would create a monopoly market."
>
> **Bruce C. Wood**
> **American Insurance Assn.**

Rates can vary depending on factors such as the concentration of insureds at individual facilities and the facilities' security measurements, Ms. Robinson said.

Under the DBA, though, insurers are not responsible for combat-related deaths or injuries, only those resulting from normal duties. The government reimburses insurers for paid combat injury claims.

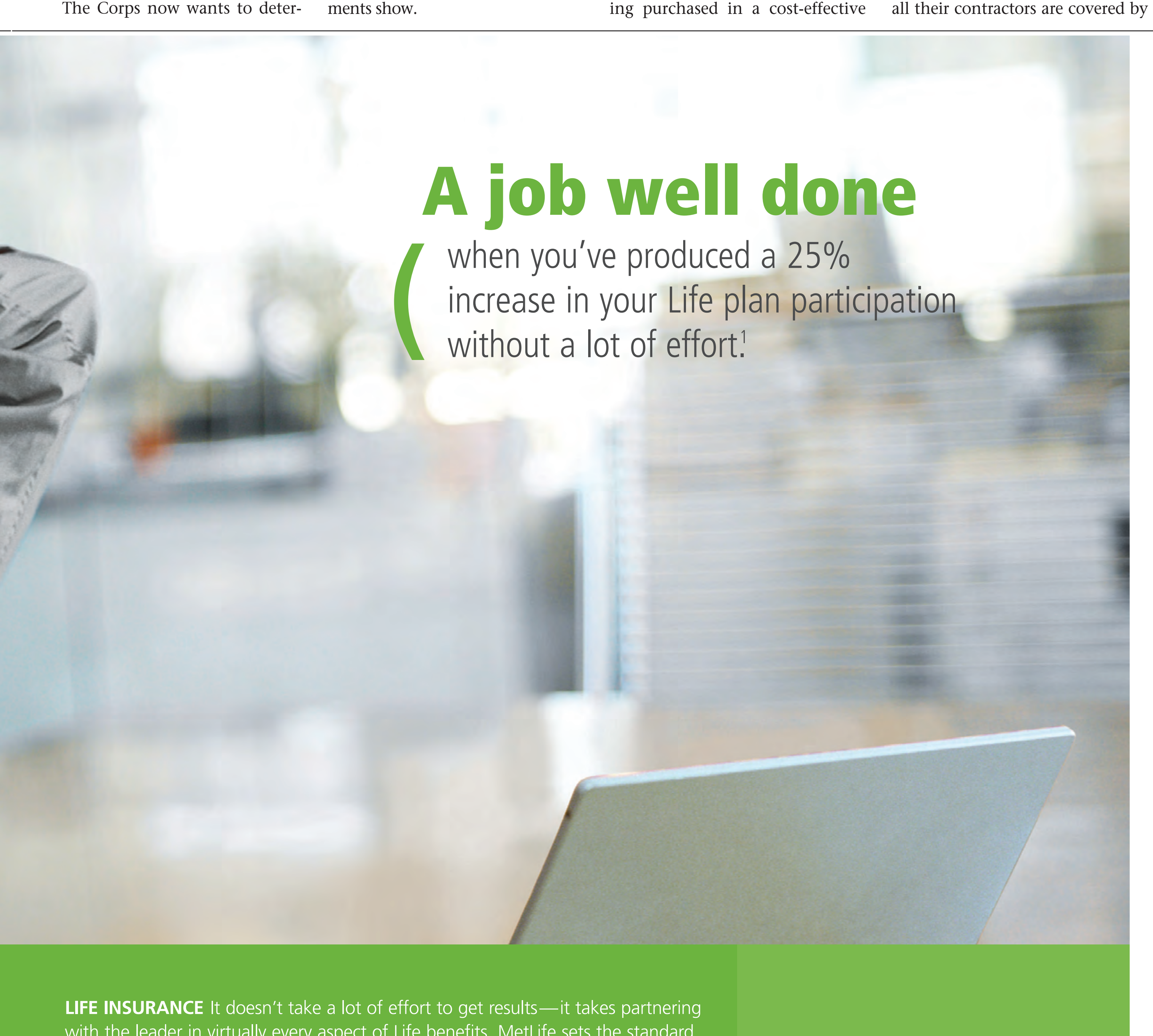
But the nature of jobs in Iraq—truck driving and construction work, for example—are hazardous and tough to insure even in the United States, said Eric Oxfeld, president of UWC-Strategic Services on Unemployment & Workers' Compensation and the National Foundation for Unemployment Compensation & Workers' Compensation. UWC is a Washington-based association of employers, insurers and business associations.

Given the poor quality of the infrastructure in Iraq, the lack of health care and other problems, such jobs are bound to be even more hazardous and, thus, more expensive to cover, Mr. Oxfeld said.

The Corps' search for a single insurer could strip employers' ability to chose whom they conduct business with and disrupt employer relations with their insurers, Mr. Oxfeld added.

Additionally, he noted, the proposal raises considerable risk for employers because, under the DBA, they are responsible for any unpaid claims should the insurer covering their employees become insolvent. And concentrating very unpredictable and extremely hazardous long-tail risks with one insurer puts that insurer at particular risk, Mr.

See CONTRACTORS / page 21

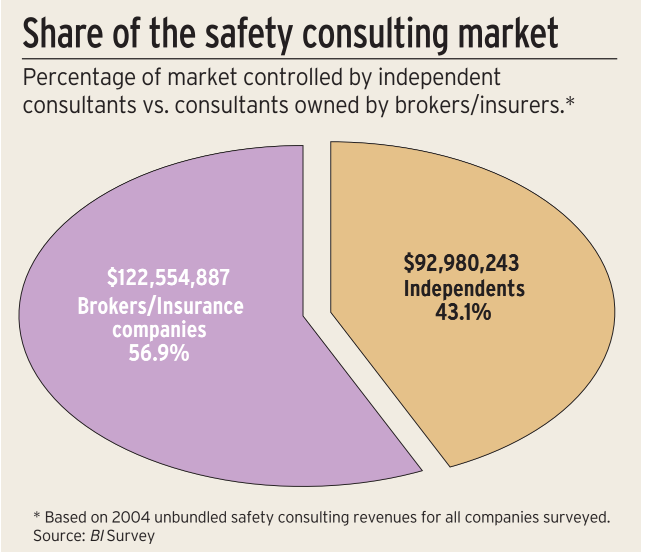


BI 08-01-05 A 20,22 7/28/05 12:40 PM Page 1

BI Ranks

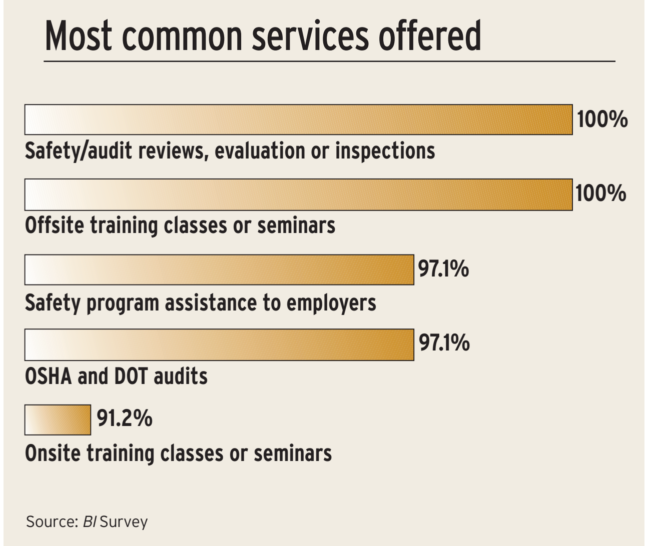
Share of the safety consulting market

Percentage of market controlled by independent consultants vs. consultants owned by brokers/insurers.*



* Based on 2004 unbundled safety consulting revenues for all companies surveyed.
Source: *BI* Survey

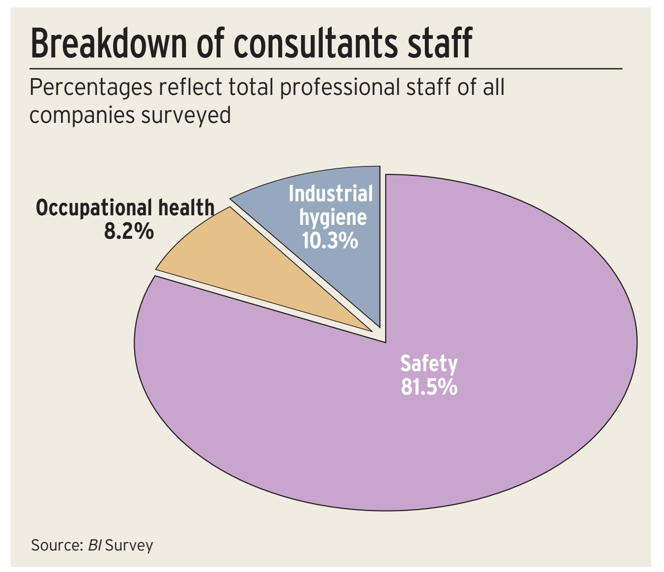
Most common services offered



Source: *BI* Survey

Breakdown of consultants staff

Percentages reflect total professional staff of all companies surveyed



Source: *BI* Survey

Largest independent safety consultants*

Ranked by 2004 revenues from safety consulting services**

Rank	Company/Address	Phone/Fax/Web site	Unbundled safety consulting revenues	Staff	Total unbundled clients	Corporate/ individual clients	Principal officer
1	Clayton Group Services Inc. 45525 Grand River Ave., Suite 200, P.O. Box 8008, Novi, Mich. 48376-8008	248-344-8577 Fax: 248-344-0229 *www.claytongrp.com*	$23,000,000	445	1,475	730	Philip J. Kaszar, president/CEO
2	Safety Resources 239 New Road, Building C, Parsippany, N.J. 07054	973-575-0900 Fax: 973-575-0901 *www.safetyresc.com*	$21,347,000	223	86	86	Jack Leonard, president
3	Broadspire NATLSCO Risk & Safety Services 4 Corporate Drive, Suite 100, Lake Zurich, Ill. 60047	847-719-5376 Fax: 847-719-5271 *www.choosebroadspire.com*	$14,100,000	93	350	320	Dennis Replogle, president/CEO
4	Risk Consultants Inc. 6611 Watson St., Union City, Ga. 30291	770-964-1226 Fax: 770-969-7301 *www.riskcon.com*	$8,878,000	96	452	452	R. Michael Malone, president/CEO
5	F.A. Richard & Associates Inc. dba FARA 1625 W. Causeway Approach, Mandeville, La. 70471	800-259-8388 Fax: 985-624-8489 *www.fara.com*	$6,200,000	120	72	34	M. Todd Richard, president/CEO
6	North American Risk Management Inc. 100 First Ave. S., St. Petersburg, Fla. 33701	888-486-7466 Fax: 727-287-1666 *www.narm.biz*	$4,990,000	86	172	78	Bud Schade, president
7	Regional Reporting Inc. 40 Fulton St., New York, N.Y. 10038	212-964-5973 Fax: 212-608-5074 *www.regionalreporting.com*	$2,250,000	218	236	72	Martin Myers, CEO
8	Bickmore Risk Services 1831 K St., Sacramento, Calif. 95814	800-541-4591 Fax: 916-244-1199 *www.brsrisk.com*	$2,230,000	101	19	19	John Chiquica, CEO
10	Strategic Safety Associates P.O. Box 80161, Portland, Ore. 97280-1161	503-977-2094 Fax: 503-977-3175 *www.masteringsafety.com, www.movesmart.com*	$2,150,000	13	59	59	Robert Pater, managing director

*Includes companies not owned by brokers or insurers. **Reflects safety consulting revenues provided on a direct, unbundled basis to corporate/institutional clients.
Source: *BI* survey

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BI 08-01-05 A 21 7/28/05 12:51 PM Page 1

Contractors: Army mulls using single insurer

Continued from page 19

Oxfeld said.

Insurers that now provide DBA coverage declined to comment. But the American Insurance Assn. also opposes the Corps' proposal to centralize all coverage under one insurer, said Bruce C. Wood, assistant general counsel for the AIA in Washington.

Mr. Wood disputes that the Corps is merely embarking on a pilot project. He sees it as the first step in creating a permanent program.

So far, though, insurer-supported associations have had little luck asking Congress and Secretary of Defense Donald H. Rumsfeld to block the Corps' initiative. They say they are shocked that President Bush's administration would back such an effort.

"I just think it's extraordinary that, particularly in this administration, they could be talking about a proposal that would create a monopoly market," Mr. Wood said. "I thought this was an administration that favored competition in the marketplace, and here they are going in the other direction."

Another potential problem with concentrating coverage under a single insurer stems from the possibility that the arrangement could cause other insurers that lose the business to shed their DBA expertise, said Robert P. Hartwig, senior vp and chief economist of the Insurance Information Institute in New York.

If that happens and the lone insurer chosen to provide coverage were to opt in later years to exit the DBA business, there would be a lack of DBA coverage expertise among potential competitors.

Two years ago, when it was thought that the war in Iraq might last six months or so, that scenario was not as much of a concern, Mr. Hartwig noted. But he pointed out that Secretary Rumsfeld recently stated the insurgencies in Iraq could drag on for as many as 12 years.

"You basically have to look at it as an ongoing operation that could last many, many years, and it probably makes sense to have multiple centers of expertise," Mr. Hartwig said.

PHOTO: ZUMA PRESS

The Corps of Engineers' search for a single workers compensation insurer could eliminate choices for contractors, critics say.

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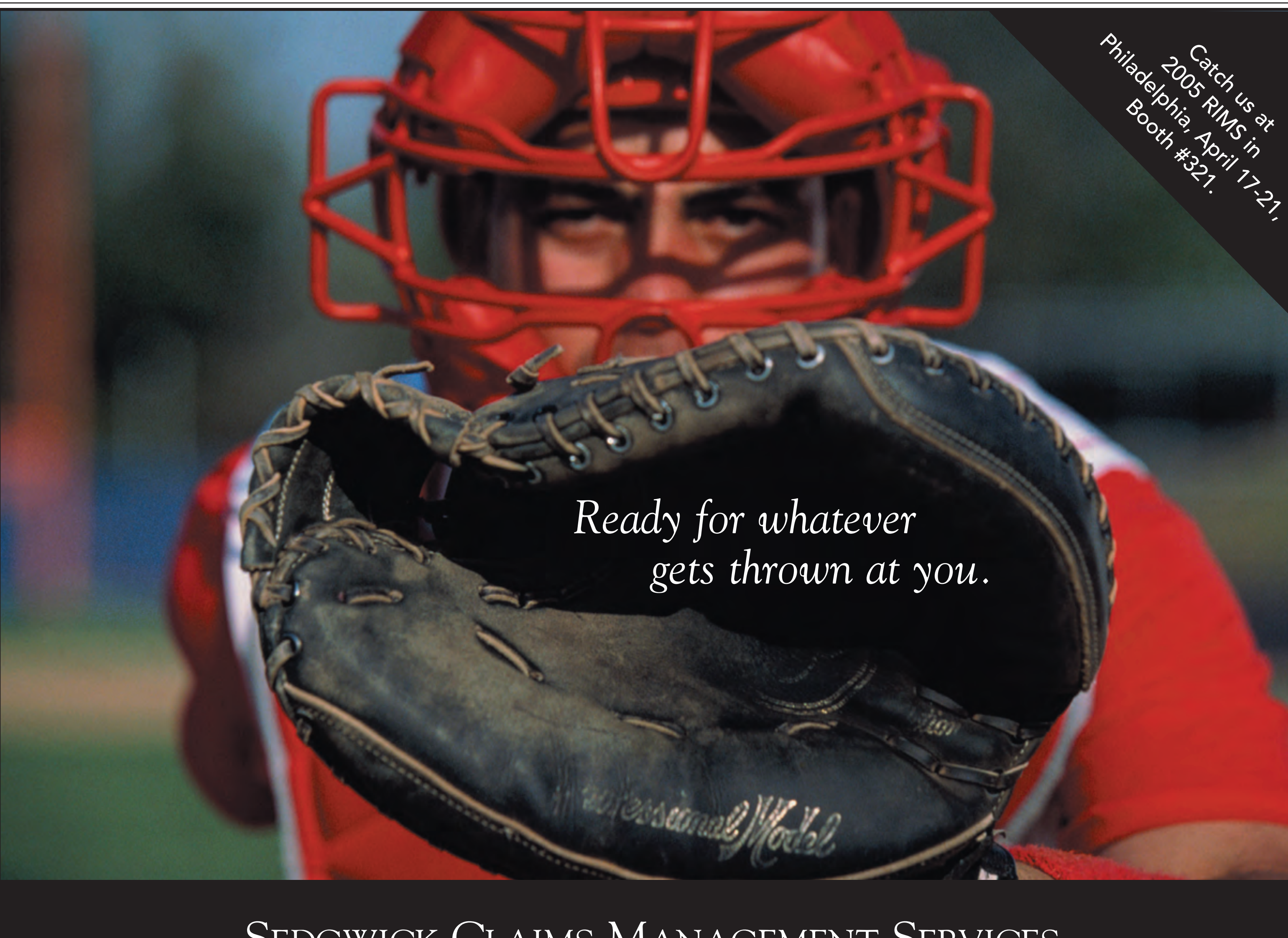

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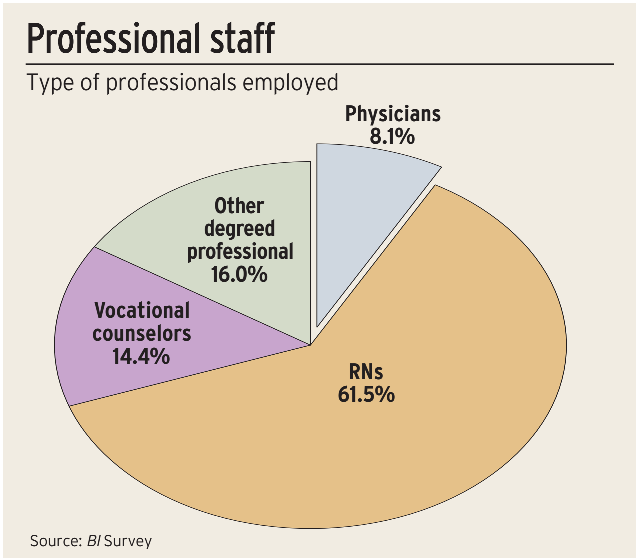
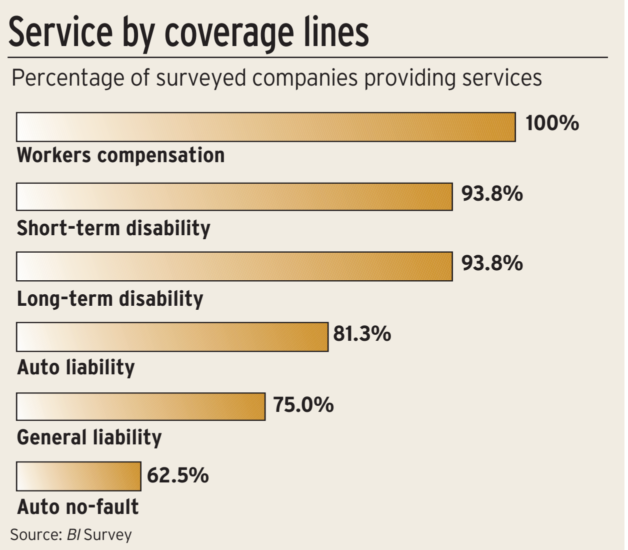
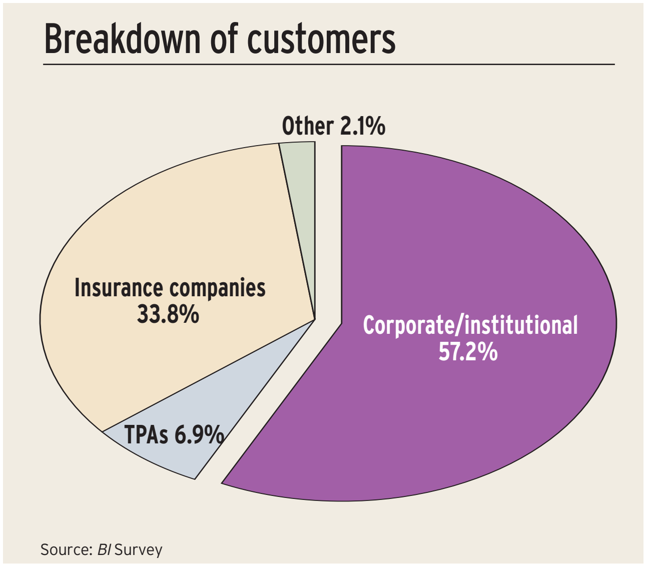
BI 08-01-05 A 20,22 7/28/05 12:40 PM Page 2

BI Ranks







Largest rehabilitation service providers

Ranked by revenues from rehabilitation services provided directly to employers in 2004*

Rank	Company/Address	Phone/Fax/Web site	Revenues from rehabilitation services in 2004	Professional staff	Total clients	Closed cases in 2004	Independent medical exam cases	Expert opinion cases	Officers
1	Concentra Inc. 5080 Spectrum Drive, Suite 1200W, Addison, Texas 75001-4648	800-232-3550 Fax: 972-387-0550 *www.concentra.com*	$188,941,000	3,265	3,700	207,226	91,754	6,748	Dan J. Thomas, CEO
2	Intracorp 1601 Chestnut St., Philadelphia, Pa. 19192	215-761-7100 Fax: 215-761-5538 *www.intracorp.com*	$167,000,000	2,323	1,183	268,386	2,451	247	Fred Scardellette, vp-product management and marketing
3	Corvel Corp. 2010 Main St., Suite 600, Irvine, Calif. 92614	949-851-1473 Fax: 949-851-1469 *www.corvel.com*	$133,000,000	1,200	2,000	55,000	60,000	0	Gordon Clemons, CEO
4	GENEX Services Inc. 440 E. Swedesford Road, Suite 1000, Wayne, Pa. 19087	610-964-5100 Fax: 610-964-1919 *www.genexservices.com*	$120,000,000	1,398	1,100	92,794	10,285	0	Peter C. Madeja, president/CEO
5	Crawford & Co. 5620 Glenridge Drive, Atlanta, Ga. 30342	800-241-2541 Fax: 404-845-3142 *www.crawfordand company.com*	$44,465,227	357	1,385	39,684	4,059	1,190	Tom Crawford, CEO
6	MedInsights Inc. 4360 Chamblee Dunwoody Road, Suite 500, Atlanta, Ga. 30341	770-457-2400 Fax: 770-457-1500 *www.medinsights.com*	$18,500,000	70	262	10,600	100	5	Paul Bode, president
7	GatesMcDonald 215 N. Front St. Columbus, Ohio 43215	800-336-4733 Fax: 866-587-7206 *www.gatesmcdonald.com*	$18,150,000	177	6,733	15,000	8,000	5,000	Bill Evans, president/COO
8	F.A. Richard & Associates dba FARA 1625 W. Causeway Approach, Mandeville, La. 70471	800-259-8388 Fax: 985-624-8489 *www.fara.com*	$9,800,000	75	173	5,461	0	0	M. Todd Richard, president/CEO
9	CareSys 15 River Road, Suite 200, Wilton, Conn. 06897	203-761-7300 Fax: 203-761-7311 *www.mcmcllc.com*	$5,500,000	35	25	14,000	200	10	Michael Lindberg, president/CEO
10	Rising Medical Solutions Inc. 325 N. LaSalle St., Suite 475, Chicago, Ill. 60610	312-559-8445 Fax: 312-559-8450 *www.risingms.com*	$2,500,000	51	120	2,276	3,000	698	Jason F. Beans, president/CEO

*Rehabilitation management services are defined as providing all services included in the medical management or vocational rehabilitation of an injured or ill individual. They do not include the delivery of physical rehabilitation or treatment, or case management for group life and health cases.

Source: *BI* survey

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BI 08-01-05 A 24,25 7/28/05 5:02 PM Page 1

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Telephone triage services help companies save on comp costs

By JOANNE WOJCIK

Telephone triage is helping some employers reduce their workers compensation costs by eliminating unnecessary trips to hospital emergency rooms.

But some critics assert that the service is redundant in states where employers are permitted to direct injured workers to low-cost facilities when they first report an injury. Others expressed concerns that they could become liable if injuries are not handled property.

"There are very few employers with anyone skilled to triage an injury. Typically what happens is that someone without the skill level automatically refers someone to the ER, which is expensive and often unnecessary," said Larry Jolley, risk manager at Ramsey, Krug, Farrell & Lensing, a workers compensation insurance broker in Little Rock, Ark.

But by using telephonic triage, "we've reduced visits to clinics, as well as our reportable losses to claims administrators," said Michael Simmons, director of risk management at restaurant chain El Pollo Loco in Irvine, Calif., which has been using Medcor Inc.'s Medcor On-Line telephone triage service for the past three years.

"As far as our accident frequency and severity numbers, they're dramatically reduced," he said.

McHenry, Ill.-based Medcor, which also provides onsite occupational medicine clinics to employers, recently expanded the telephonic triage service it has been providing for the past five years in response to increasing demand from employers in the retail, restaurant franchise and entertainment industries. The service, which is currently being provided at 13,000 worksites nationwide, is available 24 hours a day, seven days a week.

With the service, employees and/or their supervisors can call a toll-free hot line immediately after an injury occurs. The hot line is staffed with nurses who use Medcor's proprietary software programmed with triage algorithms to determine how serious the injury is and the best course of action. In cases where the employee does not speak English, translation services are provided in more than 100 languages.

"The concept is: Someone gets hurt in the workplace. If no one in the workplace is trained in addressing the injury, sometimes not-so-serious injuries are sent to the emergency room, whereas some serious injuries are not given the level of treatment they require. We have figured out, for the kinds of common workplace injuries, predictive software that can say, based on the symptoms, whether you do or don't need to go to the emergency room, whether it's urgent or can wait until later, etc. For example, a tetanus shot for a laceration can be given the next day," said Curtis Smith, vp at Medcor.

The software was created using a database derived from information Medcor obtained through operating occupational medical clinics.

"We (have) treated more than 1 million people (over the past) 20 years, and we collected all that data in one piece of software that we own," he said.

But Medcor's service goes beyond providing just telephonic triage. It also acts as a tool for creating injury reports. And because every call is recorded, it can provide the proof than an injury was handled promptly and properly in cases where injured employees may claim otherwise.

"We're in an ideal position to do first report of injury; if there's a referral (to a medical facility), to notify the TPA. The system automatically sends reports to whoever the employer wants," Mr. Smith said.

However, "more often than not, the employer wants the injury reports sent directly to them, and then they handle it from there. That's the beauty of the system. We can modify the reporting on a site-by-site basis," he said.

The system also contains all 50 states' reporting requirements and individual employers' pre-selected provider networks in states where employers are permitted to direct claimants' initial medical treatment.

Even in states where employees can select their own provider, 98% of the time they go to the facility recommended by the triage nurse, according to Mr. Smith.

Some critics of the service are concerned that the service might actually add costs to workers compensation claims, particularly in cases of first-aid injuries that can be treated at work rather than at a medical facility.

In response, Medcor's telephonic triage service is billed annually, on a subscription basis.

"We avoid the per-incident pric-

Continued on next page

Workplace injuries

- 4.1 million nonfatal injuries in 2003.
- 2.8 million occurred in the service industry.
- 1.3 million occurred in the goods producing industries.
- Manufacturing sector and the trade sectors have the largest shares of injury cases.

Source: Bureau of Labor, 2003 statistics

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BI 08-01-05 A 25 7/28/05 12:52 PM Page 1

Continued from previous page

ing. People start triaging the triage. They don't want to spend $100 to find out they need to go to the ER, or vice versa," Mr. Smith said.

To determine pricing, Medcor examines each employer's loss history and works with their broker and third-party administrator to agree on a fixed annual fee.

Crisis situations

When presented with the concept of telephonic triage, a lot of employers are skeptical at first, Mr. Smith said.

"We've had to prove it out over and over," he said.

But employers that have used it have become Medcor's greatest word-of-mouth advertisers.

For example, Mr. Simmons learned about the service from another risk manager in the fast-food industry.

"We had a crisis situation with our premium increase one year on workers comp. And she happened to mention to me that there was a service out there that could be used for this purpose. I made contact and we implemented the program five weeks later," he said.

"They've done a really good job for us over the last three and a half years where we're committed to them," Mr. Simmons said. "I have to say it's probably the easiest check for me to write every year."

Because of the crisis in the workers compensation system in California, that state has provided most of Medcor's client base, according to Mr. Smith.

"Employers have been forced to think outside the box there," he said.

In response to some employers' concerns about liability, Medcor provides full indemnification and lists employers as additional insureds on its medical malpractice liability insurance policy, which provides up to $10 million in coverage.

In addition, all calls are digitally recorded, which minimizes litigation, according to Mr. Smith.

"We do not determine compensability, and we do not take sides. We record injury, background noises, what everybody says, etc., and we will provide the tapes to the employers when requested," he said.

> "It's a win-win. The employees like it. It's easy. It's simple. They have someone paying attention to them immediately."
>
> **Larry Jolley**
> **Ramsey, Krug, Farrell & Lensing**

The reports Medcor provides to employers also conceal nonwork-related personal medical information so the company complies with the privacy and confidentiality provisions of the federal Health Insurance Portability and Accountability Act.

In many cases, the availability of telephonic triage has improved employee relations, according to Mr. Jolley, whose brokerage also provides risk management services to its workers compensation clients.

"It really sends a signal of how a company values safety in the workplace, how they value getting employees directed to proper care as soon as they can," he said.

Mr. Simmons agreed.

"This acts as a form of a benefit to our employees," he said. "They like the opportunity to talk to the triage nurse, to have somebody there to confirm that the injury isn't severe, totally independent to them. And they also understand that they're the ones who are in control because the ultimate decision they make at the end of that phone call is the way that it goes."

"It's a win-win," said Mr. Jolley. "The employees like it. It's easy. It's simple. They have someone paying attention to them immediately. They have a resource to call if they have problems. If there's a disagreement on the triage outcome, they have options.

"I think they see value in their employer providing a mechanism that ensures that they don't fall through the cracks in the system when an injury occurs," he said.

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BI 08-01-05 A 26 7/28/05 5:03 PM Page 1

Drug-test cheats frustrate employer screening efforts

By MEG FLETCHER

Employers that use drug-testing programs as part of efforts to improve safety and reduce workers compensation claims increasingly face obstacles as some workers access a plethora of products designed to beat the tests.

More than 400 products are available to help workers cheat tests for illicit drugs. The products are often only a mouse click away on the Internet, observers say.

And the products are constantly being updated, creating constant problems for employers as they try to stamp out accidents related to the use of marijuana, narcotics, as well as the illegal use of prescription and other drugs.

The companies selling drug-testing subversion products are "a significant obstacle" to the effectiveness of drug testing because they present "additional, distracting and unnecessary challenges for employers" and those who help them conduct tests, according to congressional testimony by Josephine Elizabeth Kenney, senior vp of compliance with a unit of Bethesda, Md.-based First Advantage Corp., a provider of testing services.

Rachel Anderson, drug testing administrator for Bethesda, Md.-based Clark Construction Group L.L.C., said drug test subversion "is a concern, but we try to prevent it from happening." For example, the company often uses laboratories with sophisticated collection and processing procedures to conduct urine testing of workers.

Like many employers, Clark's testing program is motivated by a desire to enhance safety. "A person using drugs may not perform the job safely" and can hurt himself or herself and others, she said.

In addition, drug-related accidents also may result in more workers comp claims, higher premiums and additional costs for employers, other sources said.

Workers can easily buy—especially on the Internet—products designed to thwart drug tests, including a life-like prosthetic device that delivers clean urine, which a worker may be able to submit as his own. Other products can dilute or cleanse a drug user's specimen, usually urine. Some are chemical adulterants that are sold in small, easily concealable vials that can be added to a specimen to mask drug use.

The drugs that screeners most commonly test for are marijuana, cocaine, amphetamines, opiates and phencyclidine or PCP, said Curtis Smith, vp-business development for McHenry, Ill.-based Medcor Inc., which provides occupational health services, including drug testing.

The national scope of the problem is emphasized by the federal government's activity in two areas:

- A subcommittee of the House Energy and Commerce Committee, which held a hearing about drug test subversion in May, is currently researching records from three drug test subversion companies that declined to testify at that hearing. A committee spokesman said representatives plan to introduce legislation aimed at controlling the problem, though no details are available.
- The Substance Abuse and Mental Health Services Administration is preparing a final rule to allow federal agencies, which now test only designated employees' urine, to expand the types of specimens tested. Alternatives may include hair and oral fluids, which some experts consider more difficult or impossible to substitute or adulterate.

In addition, "14 states have passed drug falsification legislation to address this threat to effective Drug Free Workplace Programs," but they have "inconsistent language and do not address critical reporting and enforcement issues," Ms. Kenney testified. She supports strong federal law to cope with the problem.

States also vary in the extent to which they regulate the drug test subversion industry's manufacture or distribution of drug masking products, according to testimony by a representative of the Government Accountability Office.

Subversion of drug testing is an important issue for some U.S. businesses. A 2003 SAMHSA survey on drug use and health found 74.3% of current illicit drug users aged 18 and older are employed, according to testimony by Robert L. Stephenson II, director of the division of workplace programs for the U.S. Department of Health and Human Services' federal substance abuse unit.

In addition, some drug users are using masking devices to try to beat drug tests at sensitive facilities, Mr. Stephenson said.

For example, he said that in 2002, the nuclear power plant in Perry, Ohio, discovered several job applicants had used an adulterant product during prescreening employment testing required by the plant owner, Akron, Ohio-based FirstEnergy Corp.

A FirstEnergy spokesman confirmed that the company had discovered seven altered samples in initial testing and then, after discovering discarded packaging for an adulterant, retested all of the applicants and discovered three additional adulterated samples.

When to test?

Employers who support drug testing see it as a way to reduce losses.

"The general consensus is that there are still a lot of workers compensation accidents that are related to illicit drug use," said Keith Lessner, vp-loss control for the Des Plaines, Ill.-based Property Casualty Insurers Assn. of America. In addition, some employers can obtain premium credits for drug-free work sites.

Employers often engage in only limited testing, however.

Long Beach, Calif.-based SCAN Health Plan currently does only "post mishap drug testing for cause," said Deborah Shulman, director of risk and insurance management. She is recommending that the company begin pre-employment testing also, she said.

Most employers that do test require only pre-employment testing. Other employers, though, also require that workers submit to drug tests if there is "reasonable suspicion" that they may be using drugs or if a worker—such as a train conductor—has been involved in an accident.

Despite that, ongoing random testing is generally considered to provide more of a deterrent to drug use by workers, several sources said.

Among the reasons employers do not conduct random drug testing are the costs and administrative burden of such a program as well as concerns that it may invade workers' privacy, sources say.

"The AFL-CIO strongly supports relevant testing requirements to prevent accidents…(but) civil liberties and due process concerns, however, outweigh drug testing concerns when it comes to denying benefits to injured workers who have already been determined eligible for workers compensation," said Robert E. McGarrah Jr., the organization's workers compensation coordinator.

Given the potential for false positives, "in a good program, an employer will make every effort to guarantee the validity of the test results—which often requires lab confirmation—and protect employees" from loss of pay and benefits, he said.

Most employers that test usually rely on urine testing.

Ms. Anderson said Clark Construction, which currently relies on urine testing, also is investigating using "mouth swabs" because they are less invasive, among other factors.

Testing "oral fluids" avoids the "cheating" that can occur with urine specimens, said Peter Cholakis, vp of Canton, Mass.-base Avitar Inc., which manufacturers a digital thermometer-like testing device.

Most sources emphasized the need for confirmatory laboratory tests for all so-called "non-negative" onsite tests. Some vendors also urge that a medical review officer assess initial "non-negative" test results to protect workers who are properly using prescription drugs that might trigger a positive result.

Nearly every state allows for the reduction of workers comp benefits if a worker is found to be under the influence of illicit drugs, although such cases are usually so difficult to win that employers and insurers do not pursue them, Mr. Lessner said. As a result, several states are placing the burden of proof on drug-using workers to show that the accident was caused by something other than their drug use, he said.

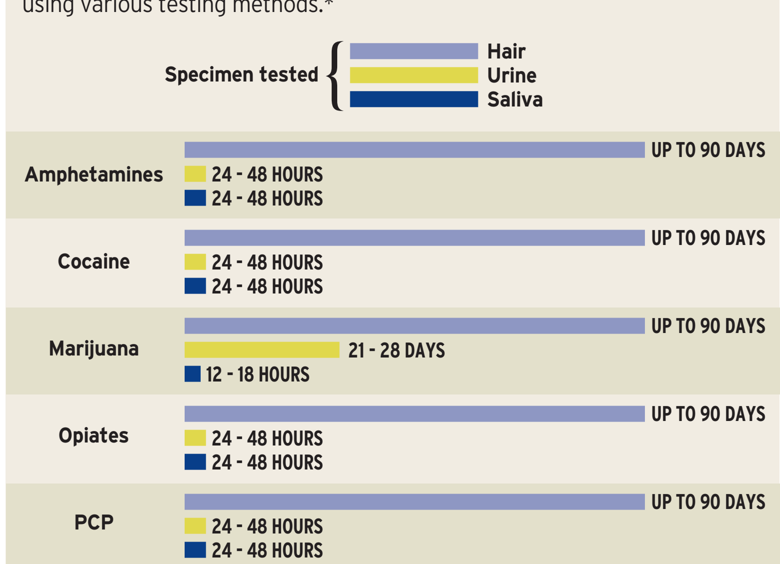
Six-step program

Companies are advised to take these actions in establishing effective drug testing for employees.

1. Research all applicable laws and labor contracts to design an acceptable program.
2. Choose appropriate test criteria that meet the company's goals and operations, including: type of test (e.g., urine, hair or oral fluids); substances to test for (e.g., marijuana, cocaine, amphetamines); when to test (e.g., pre-employment, random or postaccident); who to test (e.g., all workers including executives or only those in safety-sensitive jobs).
3. Integrate the program with the company's employment policies, document it and communicate it to all workers before instituting it.
4. Use responsible testing protocols that ensure privacy and accuracy in collection of specimens, documentation and reporting of results.
5. Require that any so called "non-negative" results from initial on-site tests be checked by a certified lab using definitive gas chromatography/mass spectroscopy tests.
6. Require that a physician medical review officer evaluate lab results in conjunction with a worker's legitimate use of substances such as prescription medications, before making a final determination about whether he or she was using drugs illicitly.

Window of detection

Length of time various drugs can be detected in a person's system by using various testing methods.*



*Actual detection depends on the amount of drug used, the person's metabolism and other conditions of the test.
Source: Medcor Inc.

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BI 08-01-05 A 28 7/28/05 12:54 PM Page 1

COMMENTARY

Senior Editor Mark A. Hofmann

Lawmakers back to old habits after strong start

The long hot summer has descended upon Washington.

Following a time-honored tradition that predates the invention of air conditioning—or the electric fan for that matter—Congress has left town for the month of August, not to return until after Labor Day. In doing so, it's left behind an awful lot of unfinished business of interest to risk managers and insurers alike.

This is the same Congress that got off to a strong start by taking up and passing with all due dispatch the Class Action Fairness Act. This piece of legislation, which previously had passed the House only to die in the Senate, is perhaps the most significant federal tort reform ever to pass.

But after the strong start, lawmakers reverted to old habits. Consider what has happened with two key issues for risk managers—asbestos liability reform and reauthorization of the Terrorism Risk Insurance Act.

The current session started with Senate Judiciary Committee Chairman Arlen Specter, R-Penn., saying that he wanted to move quickly on his controversial bill designed to create a new national trust fund to replace the current lawsuit-based system for compensating victims of asbestos-related diseases. In fact, he said that the bill needed to win Judiciary Committee approval by late January or early February if it were to stand any chance of enactment.

January came and February went, as did March, April and most of May. The Judiciary Committee didn't approve the bill until late May and it has yet to appear on the Senate calendar.

On the other side of Capitol Hill, the only House legislation dealing with asbestos liability specifically eschews the trust fund approach in favor of requiring claimants in asbestos injury suits to establish that they meet specific medical criteria before their cases can proceed. But that bill hasn't gone anywhere yet.

Even without taking into account the relative merits and problems of either approach, asbestos liability reform of any sort appears difficult at best to achieve this year.

The question of whether the federal government should provide a backstop for insurers facing losses from future catastrophic terrorist attacks also remains to be dealt with, although this is due less to lawmakers' actions than to those of the U.S. Treasury. The original Terrorism Risk Insurance Act of 2002 required the Treasury Department to deliver a report on the terrorism insurance marketplace by June 30.

And that's exactly when the report appeared—June 30. The report held that any government role in guaranteeing terrorism insurance should be greatly scaled back. It's up to Congress to determine what the role will be.

The catch, of course, is that the current version of TRIA expires on Dec. 31. Risk managers already report that some insurers are insisting on terrorism exclusions on policies that extend into 2006. While the chairmen of both committees of jurisdiction over terrorism insurance legislation have promised to move on the issue with all due dispatch, the leadership of both Houses have also made it clear that they would like to adjourn for the year in October. That could push consideration of terrorism insurance legislation into next year, leaving risk managers with the choice of buying standalone terrorism coverage—that would no doubt be more expensive than TRIA-backed coverage—or going without.

While determining what role, if any, the federal government will play in guaranteeing terrorism insurance is the most urgent of the issues left undecided, that issue and the asbestos issues are far from the only ones left hanging fire. The House Judiciary Committee has approved several tort reform measures that remain undecided. The fate of federal medical malpractice liability reform remains unclear. Meanwhile, the issue of reforming state insurance regulation via a federal law has received relatively little notice.

When the Senate returns, its time will be devoted to the confirmation of Judge John G. Roberts, nominated to fill Sandra Day O'Connor's seat on the U.S. Supreme Court. This will not be a swift process. Meanwhile, lawmakers are already beginning to think about reelection—if some ever stop doing so.

The long hot summer is upon us, and Congress has left town. Given the amount of legislative work that remains unfinished and the likelihood that it will remain so for the foreseeable future, this long hot summer may well prove to be a prologue for a winter of discontent for risk managers and others.

Feedback from readers are welcome. Please send comments to mhofmann@businessinsurance.com.

PRODUCTS & SERVICES

LIU alliance offers liability coverage for CPAs

DALLAS—Liberty International Underwriters, a division of Boston-based Liberty Mutual Insurance Co., has partnered with ProTexn Inc., a Dallas-based insurance agency, to offer an accountants' professional liability policy.

The CPAEssential program is designed for certified public accountants and CPA firms and it is targeted at companies employing up to 75 accounting professionals.

The definition of professional services offers coverage for those services the CPA is legally qualified to perform for others in his or her capacity as an accountant, consultant, financial planner and notary republic, among a variety of other duties.

The policy is available in 34 states, as well as the District of Columbia on an admitted basis. Limits of up to $10 million are available.

For more information, visit the company Web site at *www.cpaessential.com*.

CIGNA programs designed to cut disability costs

PHILADELPHIA—CIGNA Group Insurance is offering three programs that are intended to reduce disability and medical costs for employers.

Two offerings, Disability Solutions for Chronic Care and Employee Assistance Program, are now available to employers who purchase long-term disability and/or life insurance products from CIGNA.

The chronic care program covers five chronic conditions including diabetes, cardiac disease, asthma, chronic obstructive pulmonary disease and low back pain.

Philadelphia-based CIGNA's EAP consists of a three-tiered program that provides services such as behavioral health counseling, wellness product discounts and lifestyle management programs.

The third product offers onsite disability management services as part of CIGNA's fully insured long-term disability coverage for employers with more than 50,000 lives. These case management services are available through CIGNA's subsidiary, Intracorp.

To learn more, contact Ruth Stoolman, director of public relations, at 215-761-7152 or *ruth.stoolman@cigna.com*. More information can also be found by visiting the company's Web site at *www.cigna.com*.

Betterley issues report on cyber insurance market

STERLING, Mass.—Betterley Risk Consultants has published the 2005 edition of its annual report, "Cyber-Risk Market Survey."

The report issued by the Sterling, Mass.-based consultant evaluates insurance products designed to protect against e-commerce exposures, such as property, theft and liability cover. It examines policies offered by 11 leading carries and wholesalers and includes information on rate and retention trends and market segment growth trends.

To order a copy of the 55-page report, contact Betterley Risk Consultants at 877-422-3366 or visit *www.betterley.com/ordering_information.html*. Also, an executive summary of this report can be found on the company's Web site at *www.betterley.com*.

Book presents insight on executive liability

AUSTIN, Texas—The National Alliance Research Academy has published an executive liability insurance guide, "Three Dimensions of Executive Liability Insurance: D&O, EPL, & Fiduciary Exposures, Coverages, & Market Information," written by Richard Clarke.

The book provides information on the risks and coverages available to insure policyholders clients as well as reduce errors and omissions exposures. Each chapter contains an insurance checklist and risk control suggestions.

Some of the topics discussed in the publication include the Sarbanes-Oxley Act, managing directors and officers liability renewals, employment practices liability coverage extensions, protecting employee pensions and personal liability of fiduciaries.

To purchase the guide, contact the Austin, Texas-based organization at 800-633-2165 or visit the company's Web site at *www.thenationalalliance.com*.

Travis Software releases updated benefit system

HOUSTON—Travis Software Corp. has issued an enhanced version of its employee benefits information system, TravisCobra 7.3.

The software's enhanced features include premium payment systems, the Health Insurance Portability and Accountability Act certification, disbursement and reimbursement processes, among others.

The TravisCert system, which is a separate employee benefits software product, has been made a part of this latest version of TravisCobra. This integration allows the user to enter those who need a HIPAA certificate of continuation coverage.

For more information, contact the Houston-based Travis Software's marketing department at 281-496-3737. More information can also be found by visiting the company's Web site at *www.travisoft.com*.

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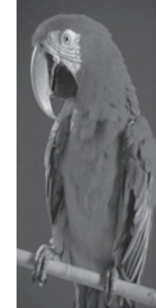

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BI 08-01-05 A 29 7/29/05 4:32 PM Page 1

Ruling could curtail solvent runoff schemes

By BARBARA COCKBURN

LONDON—U.S. policyholder attorneys have welcomed a U.K. court ruling blocking an aviation insurer's proposed solvent scheme of arrangement.

The ruling should end a practice that can be unfair to policyholders with long-tail liability claims, they say.

The proposed solvent scheme by British Aviation Insurance Co. Ltd. was "pernicious and contrary to the whole purpose of liability by closing its book of business just as the claims began to emerge," said William Greaney, a partner at Covington & Burling in Washington, which represented the policyholders.

Advocates of the process, however, say that, with some adjustments, solvent schemes may still be used by insurers to run off individual books of business more efficiently than conventional runoff arrangements.

The ruling, which the judge in the case said may be the first time a solvent scheme has been blocked, will prevent London-based BAIC from rapidly running off the business it sought to have covered by the scheme.

Schemes of arrangement for several years have been used by U.K. insurers as a means of running off business without placing a company in liquidation. Advocates of the process say that schemes of arrangement avoid delays and costs associated with lengthy liquidations.

A U.K. court has blocked a solvent scheme of arrangement for a book of aviation products liability business.

More recently, solvent schemes of arrangement have been used to run off individual books of business so that all liabilities for smaller slices of insurers' business can be ascertained or estimated and paid off more quickly. A key component of the process is the estimation of losses from liabilities that have already occurred but which policyholders have not reported to their insurers.

London-based BAIC was seeking to use a solvent scheme of arrangement to run off mainly long-tail products liability business it had written in the United States and Canada between 1930 and 1991.

BAIC sought court approval to set up the plan after creditors, which include both policyholders with accrued claims and policyholders with incurred-but-not-reported claims, voted against its inception.

The proposed court approval was opposed, however, by several U.S. policyholders, including Goodrich Corp., The Goodyear Tire & Rubber Co. and Textron Inc.

The policyholders argued, among other things, that their incurred-but-not-reported claims should have been placed in a separate class from the accrued claims and that their claims had not been properly valued by the plan.

High Court judge Mr. Justice Lewison ruled that the plan proposed by BAIC, which went into runoff in 2002, was "unfair."

According to the ruling, "the most powerful consideration is that it seems unfair to require manufacturers who have bought insurance policies designed to cast the risk of exposure to asbestos claims on insurers to have that risk compulsorily retransferred to them. BAIC is in the risk business and the policyholders are not."

U.S. policyholder attorneys welcomed the ruling.

Robert Horkovich, a lawyer at New York law firm Anderson Kill & Olick P.C., said that the judge's decision was "hailed as a good thing for policyholders and policyholders that face future IBNR claims."

Laurence Eisenstein, a partner at Washington-based law firm Eisenstein Malanchuk L.L.P., said he would be "happy to see the death" of such plans. "They are a dangerous development and it is entirely speculative to protect long tail exposures in a solvent scheme of arrangement. Potentially it is inappropriate because it impairs the rights of untold numbers of policyholders to recover from an old insurance policy."

Mr. Eisenstein said that if the company is insolvent, then it is appropriate to use conventional run

See RULING/ next page

FSA finds problems in brokers' handling of client funds

LONDON—The U.K. Financial Services Authority said it has found "a large number of failures in the systems and controls" relating to commercial insurance brokers' handling of client funds.

The FSA, which began regulating brokers in January, visited 15 U.K. intermediaries to review "areas of concern" and in a July 20 letter asked brokers to confirm their compliance with client money regulations by Aug. 31.

Regulators discovered an "isolated instance" in which a brokerage firm had a deficit in its client money account and had not notified the Financial Services Authority. The FSA would not provide any further information on the investigation.

FSA regulations require that "all money belonging to clients needs to be held under a trust arrangement" and labeled with the words "client" or "client money," the FSA noted in its recent letter. Some broker bank accounts it reviewed were not clearly labeled with such words.

Julian Adams, head of the FSA's wholesale insurance department, in the letter said, "these findings lead us to believe it would be timely to ask all firms to revisit the systems and controls which they have in place to monitor compliance with our client money rules."

He asked brokers to ensure client money accounts "are not in deficit, have the correct trust status and resource calculations are performed on a regular basis," among other things.

In the letter, Mr. Adams said, "client money rules," which were introduced Jan. 14, "represent a significant change for general insurance intermediaries." But an FSA spokesman said Monday "it is difficult to see any confusion; client money is client money."

"Brokers have to accept that they have to pay promptly into their client money accounts and it is high time they did so," said David Gamble, chairman of the Assn. of Insurance & Risk Managers. "I think it's a small issue but an issue that demonstrates that we operate in a professional marketplace."

Eric Galbraith, the chief executive of the London-based British Insurance Brokers Assn., said, "We are disappointed by the findings of the recent FSA research on the issue of client money. The rules around client money are extremely complex and we are looking at working more closely with the FSA and the broking community to have a better understanding of what they have to do in this area."

Brokers that collect premiums on behalf of insurers have traditionally been allowed to draw interest income from those funds held in trust for a time until they're paid to the insurer. But brokers generally are required to keep fiduciary funds separate from operating accounts, so that they cannot be tapped for other corporate purposes.

—By Barbara Cockburn

Equitas to pay U.S. manufacturer Crane $33 million to settle asbestos, other claims

LONDON—Equitas Ltd. has agreed to pay $33 million to Crane Co. to settle asbestos and other liability claims against the Stamford, Conn.-based manufacturer.

The settlement resolves all claims against pre-1993 policies issued to Crane by certain Lloyd's of London underwriters that are reinsured by Equitas.

Under the agreement, Crane will receive $1.5 million this year. The remainder will be paid into an escrow account for payment of future asbestos claims.

Funds remaining in the escrow will be paid to Crane on Jan. 3, 2007, if no federal U.S. asbestos liability reform law is enacted by then.

If such a law is enacted, the remaining funds in the escrow will be paid back to Equitas, subject to the payment of an additional $1.5 million to Crane and, according to a statement released by Crane, "a hold-back of certain funds in the escrow for the payment of asbestos claims during the year following enactment of asbestos legislation."

The Senate Judiciary Committee approved a bill in late May that would create a national trust fund to replace the current litigation-based system for compensating victims of asbestos-related disease, but the full Senate has not begun to consider the measure.

The Crane settlement is one of several deals that Equitas has entered into with U.S.-based policyholders over asbestos and pollution related liabilities in the past two years.

—By Mark A. Hofmann

Updates

Benfield opens Canadian facultative practice

Benfield Group Ltd. is expanding its global facultative reinsurance practice into Canada. Jim Willis will head the company's new facultative solutions practice and will be based in Benfield's Toronto office. Benfield's global facultative solutions operation includes representatives in Australia, continental Europe, New Zealand, Singapore, South Africa, the United Kingdom and the United States.

Bermuda's OIL names chief exec

Robert D. Stauffer is joining the OIL Group of Cos. as president and chief executive officer. Mr. Stauffer, who will assume his new position at the Bermuda-based energy insurance group on Aug. 15, is succeeding Jack Wesley, who will retire Aug. 30. Mr. Stauffer joins OIL from Oklahoma City-based Kerr-McGee Corp., where he held the position of vp-risk management and real estate operations.

RSA making changes to closed DB plans

Royal & SunAlliance Insurance Group P.L.C. is making changes to its closed defined benefit plans in an attempt to reduce its pension costs from January next year. Under the change, the insurer will convert the four plans, which were closed to new entrants in 2002, to career-average defined benefit plans from final-salary plans. Current retirees collecting benefits and deferred members will not be affected, an RSA spokesman said. The change should reduce RSA's pension funding deficit by £180 million ($313.9 million) gross of tax, the insurer reported.

Markel (UK) expanding regional operations

Markel (UK) Ltd. is expanding its regional underwriting operations by opening three more offices and increasing its specialty product offerings. The new U.K. offices in Cambridge, Edinburgh and Bristol, will supplement the insurer's regional operations in Leeds, Manchester, Birmingham and Reigate.

Towers Perrin sets up pension consultant

Towers Perrin HR Services has launched a consulting service to provide corporate pension advice. Corporate Pensions Solutions is staffed by actuaries and pension consultants. Its services have been developed to "reflect the growing demand of companies for advice separate from the compliance-driven advice received by pension plan trustees," Towers Perrin said.

Ruling: Solvent schemes will be more complex

Continued from previous page

off procedures, whereby insurers assess and pay claims as they arise over time.

Marc Mayerson, an attorney at Washington–based law firm Spriggs & Hollingworth said that "significantly, the ruling invalidates solvent schemes of arrangement because it unfairly forces policyholders to liquidate unknown asbestos and other health hazard claims that may or may not come to fruition."

But Geraldine Quirk, assistant solicitor in the corporate insurance group at London-based law firm Clyde & Co., said that it may be possible to make modifications to solvent schemes to ensure that they obtain court approval.

For example, the plans could be established with a provision that would allow IBNR claimants to vote as a separate class, she said.

In addition, there will likely be a greater focus on the methodologies used to estimate claims, Ms. Quirk said. "Companies may rethink this and give stronger guidelines." The plans could require an independent adjudicator to decide the value of the claims.

To comply with the ruling, future solvent schemes may also need to treat insurance policyholder claimants differently from cedent insurer claimants, because cedents are generally more familiar with actuarial valuations, said John Winter, chief executive of Ruxley Ventures Ltd., a London-based run off specialist.

But the need to treat IBNR claims as a different class of claim from others, and for policyholders to be treated differently from cedent insurance companies, or to be excluded from solvent schemes of arrangement altogether, will make the structuring of future solvent schemes of arrangement more complex, Mr. Winter said.

IBNR claims and accrued claims are inexorably linked so that it is not logical that they should be treated separately, he said.

Dan Schwarzmann, a partner in the London office of PricewaterhouseCoopers L.L.P., the company that arranged the solvent scheme for BAIC, said that schemes are "always evolving."

"We will, going forward, explain in more detail how the various aspects of the schemes benefit the company and its policyholders because the schemes are a useful mechanism and most U.S. policyholders believe that." Mr. Schwarzmann said.

He added, "we must learn from the judgement, and it would be very interesting to see how lawyers interpret the case."

The judge gave BAIC leave to appeal the ruling. BAIC said through its lawyers at Herbert Smith that it is "disappointed" that the High Court refused to sanction the proposed scheme and is "considering its options."

APRA bars former HIH director from holding senior position

SYDNEY, Australia—The Australian Prudential Regulation Authority has barred the former finance director of failed insurer HIH Insurance Ltd. from holding a senior role in an insurance company.

Dominic Fodera, who held several senior positions within HIH, including chief operating officer from 1995 to March 2001, had, in "a number of instances, failed to disclose to HIH's board and auditors material information and advice," APRA said in a statement.

The statement added that "he did so, knowing that, if this information was appropriately assessed and accounted for, it would have resulted in a more accurate but far less favorable financial condition and solvency position for HIH."

Earlier this month, APRA dropped a ban on Ross Eade, formerly operations director in the corporate risks division of HIH, from holding a senior role at an Australian insurance company or as an agent of a foreign insurer in Australia following a review.

HIH's $5.3 billion Australian ($2.72 billion) insolvency in 2001 was Australia's largest corporate failure.

Several former executives at the company have been disqualified by APRA, and some have been jailed for their roles in the company's failure.

—By Barbara Cockburn

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Request for Proposal

The West Virginia Public Employees Insurance Agency (PEIA) will release a Request for Proposal for its Group Life Insurance and Accidental Death and Dismemberment Insurance program on August 1, 2005. The Agency provides life insurance to approximately 119,000 active and retired employees of various West Virginia public employers. The coverage will become effective July 1, 2006.

A mandatory bidder's conference will be held at the office of the PEIA on August 16, 2005 at 1:00 p.m.

A copy of the RFP is available on the PEIA website at **www.wvpeia.com.** Direct further questions to:

Thomas J. Marchio, Policy Specialist
West Virginia Public Employees Agency
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AND IN THE MATTER OF
SECTION 99 OF THE COMPANIES ACT 1981

TAKE NOTICE that the Liquidators of Aneco Reinsurance Underwriting Limited - in Liquidation have declared a Second and Final Dividend payable to Scheme Creditors, whose claims have been agreed, pursuant to the Scheme of Arrangement that became effective on 28th June, 2002.

It is expected that the final dividend cheques will be dispatched to Scheme Creditors during August, 2005.

Any enquiries regarding the above should be addressed to:-

The Joint Liquidators
Aneco Reinsurance Underwriting Limited - in Liquidation
PricewaterhouseCoopers
PO Box HM 1171
Hamilton
Bermuda HM EX
Telephone: 441-295-2000
Fax: 441-295-1242
PETER C.B. MITCHELL *Joint Liquidator*
Dated this 27th Day of July, 2005

LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re: Petition of Catherine Geraldine Regan, as Foreign Representative of **RIVERSTONE INSURANCE (UK) LIMITED**, Subject of a Foreign Proceeding.	) In a Proceeding Under Section 304 of the Bankruptcy Code
In re: Petition of Catherine Geraldine Regan, as Foreign Representative of **SPHERE DRAKE INSURANCE LIMITED**, formerly Odyssey Re (London) Limited, Subject of a Foreign Proceeding.	) Case No. 05-12678 (RDD) (Jointly Administered)

NOTICE OF ENTRY OF ORDER GIVING FULL FORCE AND EFFECT TO U.K. SCHEME

PLEASE TAKE NOTICE THAT, on July 26, 2005, the Honorable Robert D. Drain, United States Bankruptcy Judge for the United States Bankruptcy Court for the Southern District of New York, entered an Order Giving Full Force and Effect to U.K. Scheme under Section 304(b) of the Bankruptcy Code in the above-captioned cases. Parties in interest may obtain a copy of such Order and the referenced U.K. Scheme by making a written request to the undersigned attorneys for the Petitioner.

Dated: New York, New York • July 26, 2005

DREIER LLP
By: /s/ Norman N. Kinel
Norman N. Kinel (NK0474)
Jonathan F. Linker (JL8894)
499 Park Avenue, New York, New York 10022
Tel.: (212) 328-6100, Fax: (212) 328-6101
Attorneys for Petitioner Catherine Geraldine Regan, as Foreign Representative of RiverStone Insurance (UK) Limited and Sphere Drake Insurance Limited (f/k/a Odyssey Re (London) Limited)

BI 08-01-05 A 32 7/29/05 4:33 PM Page 1

Clinical trails: High profile of cases, large volume of tests lead to increased litigation

Continued from page 4

creasing," said Nancy Sher Cohen, an attorney with Heller Ehrman in Los Angeles. "We have an aging population, and companies are putting a lot of funds into research and development for new drugs," and testing a new drug on people is the only way to get it to market.

Mark Wood, assistant vp of underwriting at CNA Financial Corp in Chicago, said, "It may be a function of how much clinical research is going on, but we are seeing an increase in exposure."

CNA is one of several insurers that offer clinical drug trial coverage to pharmaceutical and medical device manufacturers. Others include Boston-based Lexington Insurance Co., a unit of New York-based American International Group Inc. and Warren, N.J.-based Chubb Group. Physicians and hospitals are often covered under their medical malpractice policies.

Richard Bucilla, executive vp at Lexington, said, "I think there's an increase in clinical trial claim activity, but that's an increase over a very small level of historic activity."

Clinical trial risks

The basic claim being made by patients in litigation is "they didn't truly understand the risks of the clinical trial," said Ms. Cohen.

In a survey of trial participants conducted by CenterWatch this year and last, 15% disagreed with the statement that they understood their trial would carry additional risks, while 9% said they were not sure.

Jan Murray, an attorney with Squire, Sanders & Dempsey in Cleveland, said, "I think a lot of litigation has focused on people not being fully advised of the risks involved in a trial, people not being informed of potential conflicts of interest with the people conducting the trial, people not understanding what the course of the trial would be."

Dr. Greg Koski, senior scientist at the Institute for Health Policy at Massachusetts General Hospital in Boston said the fact that issues of informed consent are often foremost among the causes of litigation reflects "that we've not done a very good job in the process of obtaining consent properly, and that's something that everybody in research has to pay very close attention to."

Dr. Koski said the best way to avoid potential litigation "is to look at the process for what it really is, one of informed decision making, rather than one of just informed consent," where the attitude is that it is an unpleasant, but necessary, step toward getting people to enroll in the trial.

Another problem is that many trial sponsors "see protections for participants as sort of a necessary administrative burden, rather than part of the science itself, and by simply changing that attitude" the likelihood of litigation can be greatly reduced, said Dr. Koski.

Dr. Michael Para, associate dean for clinical research in the College of Medicine and Public Health at Ohio State University in Columbus, Ohio, said one factor in the increase is "the studies are getting significantly more complicated, and maybe people's expectations are higher as well."

There may also be cases where physicians "bend the rules just a little bit" in terms of accepting participants, which may eventually attract the attention of plaintiff attorneys if there is a bad outcome, said Dr. Para.

Clinical trials are likely to remain "a potential hotbed of litigation if those trials aren't managed appropriately and appropriate attention is not given" to fulfilling the ongoing duty to provide informed consent information to the patients, said Linda Pissott Reig, an attorney with Porzio, Bromberg & Newman in Morristown, N.J.

> The best way to avoid potential litigation "is to look at the process for what it really is, one of informed decision making, rather than one of just informed consent."
>
> **Dr. Greg Koski**
> **Institute for Health Policy, Massachusetts General Hospital**

People also have to realize how success is measured in clinical research, said Mr. Mernick. If there is a disease where only 20% of patients survive, and a clinical trial increases that percentage to 26% among those in the test, those six percentage points are an improvement, "but it still means 74% of the people who are participating are dying," which can lead to increased litigation, he said.

However, Alan C. Milstein, a plaintiff attorney with Sherman, Silverstein, Kohn, Rose & Podolsky in Pennsauken, N.J., said, "I think the reason for the increase is that there are more trials going on with less supervision, so there's more things going wrong."

Mr. Milstein represented patients in a clinical trial who sued Thousand Oaks, Calif.-based Amgen Inc. because they were denied continued access to an experimental drug, GDNF, to treat Parkinson's disease. Courts in New York and Kentucky ruled in favor of the pharmaceutical manufacturer.

Amgen had discontinued the drug after it concluded it was neither safe nor effective and ran the risk of worsening the patients' condition, while the patients contended it helped them. In both cases, the courts ruled Amgen was under no obligation to continue to dispense the medication.

Litigation is continuing in connection with negligence charges that have been made in both cases, said Mr. Milstein.

In another case, a jury last year cleared Fred Hutchinson Cancer Research Center of alleged negligence in the deaths of four patients who participated in a medical experiment in the 1980s, but found the center negligent in the death of a fifth patient and awarded more than $1 million to his family.

The leukemia patients were being treated with donated bone marrow with antibodies to try to prevent a common and often fatal complication from bone marrow transplants, said Mr. Mernick, who represented the cancer center.

Plaintiffs charged that the center knew, or should have known, the procedure would be unsuccessful, and that they were not told the center and doctors involved had a financial stake in the company that licensed the antibodies used in the procedure. Both sides are appealing the verdict.

"It's a little hard to say" what the success rate has been in deciding these cases because many are settled early, particularly "the most notorious ones," such as the Gelsinger case, said Ms. Murray. In that case, the family reached an undisclosed settlement while the University and the Washington-based Children's' National Medical Center paid more than $1 million in a civil settlement to the federal government.

Scandal: Controversy sidelines reform efforts

Continued from page 4

controversy, Mr. Forbes said in a retirement letter. Mr. Forbes' daughter works for Pittsburgh-based MDL Capital Management, which the attorney general is suing to collect $215 million in BWC investment fund losses.

On July 25 Gov. Taft announced the appointment of Michael C. Taft, a retired vp and chief investment officer for Indianapolis Ind.-based Wellpoint Inc., to replace Mr. Forbes.

Even some of the state's Supreme Court justices have declined to weigh in on a related lawsuit that sought release of BWC information on its coin investments because they received campaign contributions from the coin dealer involved in the scandal.

The BWC, meanwhile, has terminated arrangements with several investment managers because their funds were underperforming, the BWC says.

Although employer groups generally stand behind the BWC, they have expressed concerns that the scandal has sidelined efforts to reform the state's workers comp system.

"The unfortunate piece of all of this is some very needed reforms…are now on hold and quite frankly are probably on hold for quite some time because of the investment scandal," said a spokesman for the Ohio Manufacturers' Assn. in Columbus.

For example, one pending measure would have required injured workers to provide objective evidence, such as X-rays, to receive indemnity and medical benefits for a work-caused aggravation of a pre-existing injury.

The measure, Senate Bill 7, would have required injured workers to show "substantial aggravation" of the pre-existing injury. Currently, workers need only claim increased pain caused by a "mere aggravation." Among the other changes, the bill also would have shortened the time an inactive claim could remain open from the date medical or indemnity benefits were last provided.

The bill—sponsored Gary Cates, R-West Chester, and largely drawn up by the Ohio Chamber of Commerce—passed the Senate on July 1. But its timing was unfortunate, as its passage came as news of the investment scandal continued to build, said Anthonio Fiore, director of labor and human resources policy for the Columbus-based Ohio Chamber of Commerce.

In trying to win passage of the bill, employers had already garnered neutral positions by labor and claimant attorneys, Mr. Fiore said. The bill was poised to pass the state Assembly and be signed by Gov. Taft, who made workers comp reform one of his top priorities for this year.

But the scandal put the bill on lawmakers' back burner, and it may remain there next year, as several legislators will be facing reelection campaigns, the Ohio Manufacturer's Assn. spokesman said.

Employers want the issue resolved soon, Mr. Fiore said. "The sooner we get back to focusing on what the bureau is there for, the better the system is going to be."

Overall, the BWC has a good track record, he said.

Through the late 1990s and into 2003, the BWC's investment returns, coupled with efficiencies, allowed it to provide substantial premium discounts for employers that maintained a good loss history, Mr. Fiore said.

After 2003, with investment opportunities less lucrative, the discounts have not been as steep. But BWC rates have remained reasonable while it maintains a conservative reserving approach, Mr. Fiore added.

More recently, the BWC has focused on programs that reduce costs. About three years ago, it gathered medical providers, employers and other stakeholders to find areas where it could reduce costs. That resulted in plans to reduce pharmacy utilization and cut hospital and doctor reimbursements, Mr. Fiore said.

AIG: Offloading of losses on pool, Trenwick deals alleged

Continued from page 4

Among other measures, the plaintiffs are seeking compensatory, punitive and exemplary damages.

Trenwick, because of its deteriorating financial position, colluded with AIG "to hijack LDG's rightful gatekeeper role in handling claims for the LDG facilities and to give an unfair advantage to AIG in passing off inflated loss reports in workers compensation and other books of business," the suit states.

The complaint alleges that AIG co-opted Trenwick by threatening its solvency. To do that, AIG demanded that Trenwick pay for $130 million in "grossly inflated" losses at a time when Trenwick was facing a financial crisis, the suit alleges.

The $130 million in alleged losses had an actual present value of more than $81 million, according to the lawsuit. The plaintiffs also allege that AIG and Trenwick entered into secret negotiations while Trenwick intentionally excluded LDG and prevented it from acting as a gatekeeper for the facilities.

LDG had already notified Trenwick that it was in negotiations with AIG on behalf of the reinsurance facilities. LDG had also notified Trenwick that Trenwick was required to defer authority to LDG and that facility members would not be bound by any settlement between AIG and Trenwick.

But the plaintiffs allege that AIG induced Trenwick to usurp LDG's role as managing agent by providing Trenwick funding for a $73 million promissory note to cover much of AIG's claims. In exchange, Trenwick agreed to assist AIG in pressuring plaintiffs to meet the insurer's demands, the plaintiffs allege.

Court records show that AIG and Trenwick eventually entered a commutation agreement under which LDG would pass AIG losses through to the three facilities. On Nov. 23, 2004, AIG sent each plaintiff a demand for payment of its alleged proportional share of the $73 million promissory note, the plaintiffs say in their lawsuit.

Arbitration over commutation has commenced in Massachusetts, court records indicate. The plaintiffs, meanwhile, allege in their lawsuit that AIG has consistently refused to provide LDG with records of its losses.

Several of the plaintiffs declined to comment, as did AIG.

The plaintiffs listed in the lawsuit include American Reinsurance Co., American United Life Insurance Co., Dorinco Reinsurance Co., First Allmerica Financial Life Insurance Co., Guardian Life Insurance Co. of America, Hartford Life Insurance Co., Houston Casualty Co., Insurance Corp. of Hannover, John Hancock Life Insurance Co., Monumental Life Insurance Co., Pan American Life Insurance Co., Phoenix Life Insurance Co., Reliance Standard Life Insurance Co., ReliaStar Life Insurance Co., Sun Life Assurance Co. of Canada, Swiss Re Life & Health America Inc. and Transamerica Occidental Life Insurance Co.

BI 08-01-05 A 33 7/29/05 4:33 PM Page 1

Cash balance: Provision covers future plans

Continued from page 3

retirement policy at the American Benefits Council in Washington.

The prospective cash balance provision, if enacted by Congress, could actually increase the likelihood of more rulings like Judge Murphy's, benefit experts say.

Plaintiffs attorneys undoubtedly would argue that since Congress only applied the age discrimination protection for new plans, different rules apply to existing plans, some say.

"Plaintiffs' attorney would argue that cash balance plans were age discriminatory on the basis that Congress had to change the law. Accordingly, many in the field believe that no legislation would be better than prospective only," said Ethan Kra, chief actuary with Mercer Human Resource Consulting in New York.

"It is worse than nothing. Judges could say that if these are new rules then there must be different rules for existing plans," said Kyle Brown, an attorney with Watson Wyatt Worldwide in Arlington, Va.

A simpler and far better approach, cash balance plan supporters say, would be for federal legislators to clarify current law by saying that cash balance plans providing at least equal pay and interest credits to older employees are not age discriminatory.

The likelihood of Congress taking that approach is not clear. The House Education and the Workforce Committee also included prospective-only cash balance plan age discrimination protections as part of the pension funding reform measure it passed in June.

The chairman of that committee, Rep. John Boehner, R-Ohio, though, says he will press to make the age discrimination language retroactive as the measure moves through Congress.

Additionally, some say there is support in the Senate Health, Education and Labor and Pensions Committee—to which the Finance Committee bill is now headed—for making the provision retroactive.

Some members of that committee believe a comprehensive approach would be a better one, said Anne Waidmann, a manager in the human resources unit of PricewaterhouseCoopers L.L.P. in Washington.

And congressional attitudes could change once members become more aware of the potential ramifications of protecting only prospective plans from age discrimination suits.

"Hopefully, continuing to talk to legislators will make a difference. Legislators may not have had time to get into the details" of what they were proposing, said Scott Macey, a senior vp with Aon Consulting in Somerset, N.J.

Past rulings on cash balance plans

Courts have offered contradictory rulings on the cash balance plan age discrimination issue

September 2000: In the first ruling on the issue, a federal judge in Indianapolis rules that the design of cash balance plans does not discriminate against older employees.

December 2002: U.S. Treasury Department proposes rules to make clear that the core of cash balance plans—crediting employees' accounts with interest and pay-related credits—does not violate federal age discrimination law.

July 2003: U.S. District Court Judge G. Patrick Murphy in southern Illinois rules that IBM Corp.'s cash balance plan is age discriminatory because the benefit credit provided to an older employee would purchase a much smaller benefit—expressed as a monthly annuity payable at age 65—than the same credit provided to a younger employee.

June 2004: Under pressure from Congress, the Treasury Department shelves its proposed rules for cash balance plans.

June 2004: A second federal judge rules cash balance plans are not age discriminatory. Calculating accrued benefits in terms of an age-65 annuity is not the only option under ERISA, said Judge Catherine Blake in rejecting the reasoning of Judge Murphy in the IBM case.

September 2004: IBM and plaintiffs agree to a partial settlement—subject to final court approval—of the cash balance plan age discrimination suit in which IBM agrees to pay a maximum of $1.4 billion if it loses its appeal of the ruling.

January 2005: IBM freezes its cash balance plan, with new employees receiving retirement benefits through an enhanced 401(k) plan.

June, July 2005: Congressional committees pass legislation to make clear that cash balance plans do not violate age discrimination law, but the measures do not apply to existing plans.

Measure offers options for pension calculations

WASHINGTON—A new way of calculating pension liabilities would be available to employers under legislation approved last week by the Senate Finance Committee.

Under current law—set to expire at the end of this year—employers use a four-year weighted average of the yield on an index of long-term corporate bonds to determine the size of plan liabilities. That calculation drives the amount they must contribute to the plans.

The Finance Committee bill, though, would change this methodology in two key ways.

Employers would use rates on corporate bonds of varying maturities to reflect the demographics of their pension plan. For example, yields on shorter-term bonds would be used to value liabilities of older workers and retirees, while yields on longer-term bonds would be used to measure liabilities of younger employees. The mechanics of this so-called "yield curve" would be developed by the Treasury Department.

In addition, the rates to be used would be based on near-current market conditions—yields on bonds averaged over a 90-day period. Currently, the rate used to value liabilities is a four-year weighted average of corporate bond yields.

Backers of these changes say they are needed for several reasons. For example, Finance Committee Chairman Charles Grassley, R-Iowa, notes that "smoothing" techniques can mask a pension plan's true financial condition, a reference to allowing employers to use an interest rate to value liabilities that is based on rates averaged over four years.

But benefit lobbying groups say smoothing of interest rates makes it easier for employers to predict how much to contribute to their pension plans.

The inability to make such predictions will be an impediment to employers' ability to remain in the defined benefit plan system, according to lobbying group the ERISA Industry Committee.

Other provisions in the Finance Committee bill include:

- Employers whose pension plans were less than 80% funded could not boost benefits, while plans less than 60% funded would be frozen—meaning no new benefits would be earned—until the plan was again 60% funded.
- Employers—with one exception—would have to amortize pension liabilities over seven years. The exception would be commercial airlines, who could fund liabilities over a 14-year period.
- The base annual premium employers pay to the Pension Benefit Guaranty Corp. would be raised to $30 per plan participant from the current $19.
- Employers would be allowed to fund plans to up to 180% of plan liabilities; now, companies generally can't make new contributions once their plans are fully funded.
- Employers with 401(k) plans would have to allow participants to sell company stock contributed as a match after three years of service.

—By Jerry Geisel

Statute clears the trail for converted railroad corridors

SACO, Maine—A small legislative change is expected to mean big savings on insurance costs for a group that wants to develop a recreational trail along a railroad corridor.

Maine legislators earlier this year revised the state's landowner recreational immunity statute to clarify that the act applies to railroads and utility companies. The act now clearly states that those companies will not be held liable if a person is injured on a recreational trail developed on rail or utility corridors.

The Eastern Trail Alliance, a Saco, Maine-based group that develops trails in the northeast, pushed for the change. The group is interested in having a trail run along railroad property in Saco and South Portland.

A stumbling block for the trail work has been the liability issue and the expense of insurance that would have been required without clarification of the law.

"Before the law was passed, our insurance would have jumped from $350 per year to $60,000," said Helen McCain, the ETA's administrative director. "It might go up" if the group moves ahead to develop the trail along railroad property, "but not to that extent" now that the law clearly states railroads are immune from liability for injuries on recreational trails, she said.

The ETA contends that having trails along rail lines makes the area safer. Controlled access to those areas cuts down on or eliminates dangerous trespassing and helps guide hikers and bikers away from the tracks, the group says.

—By Michael Bradford

Railroads: Rising premiums derail smaller lines

Continued from page 4

insurance as one of the reasons for its shutdown earlier this year.

It was unreasonable to expect an "enormous increase in revenue needed to offset our fixed costs," said Marcia Pilgeram, president of Montana Rockies Rail Tour, in a statement on the railroad's Web site. "The industry is just too lean to support the Montana Daylight operation," she said.

Along with increasing insurance premiums, rising fuel costs helped derail the operation, according to Ms. Pilgeram's statement.

In northern California, McCloud Railway Co. has initiated abandonment proceedings with the federal Surface Transportation Department to discontinue freight operations along about 80 miles of track it uses in three counties, according to a filing with the department earlier this month.

The railway's president, Jeff Forbis, said the decision to discontinue the service was based on rapidly rising insurance premiums and fuel costs, among other items.

Small-to-midsize freight and tourist railroads have a particularly hard time with high insurance costs partly because it is much harder for them to fund significant portions of their risk, sources said.

"The small-to-medium-sized railroads don't self-insure," said Ann Fraser, Los Angeles-based vp of Railroad Services L.L.P., a Stamford, Conn. wholesale broker. "The liability markets will quote over a retention" for those operators, she said, but it is uncommon for those operators to fund their exposures. Instead, they generally have contractual arrangements with the railroads that control the lines to carry certain limits of liability, she said.

Robert D. McCarthy, president of retail broker McCarthy Rail Insurance Managers Inc. in New Bethlehem, Pa., said some railroads experience a form of sticker shock when they realize how much coverage they will need before being granted access to tracks.

Large railroads have asked for coverage limits as high as $500 million, he said. Coverage limits above $10 million mean "big costs" for railroads struggling with other expenses, Mr. McCarthy noted.

As for closures or abandonments, "we see it once in a while," he said of the smaller tourist and freight operators. Some tourist operations have found themselves in "locations where they are not able to generate enough revenue" to offset the high insurance costs and therefore had to shut down, Mr. McCarthy said.

Mr. Wolfarth said railroads other than the Class 1 operators are especially vulnerable to shifting insurance market conditions.

Smaller railroads "can't handle the volatility of the insurance cycle," he said. "Any small operation that had to go through the hard market" has not been rewarded with a softening that has lowered insurance prices, Mr. Wolfarth said.

The tourist operations need terrorism coverage, he said, and that insurance has become prohibitively expensive for some.

BI 08-01-05 A 34 7/29/05 5:33 PM Page 1

Med mal: Reform measure passes the House

Continued from page 1

declare unconstitutional the state's decade-old inflation adjusted cap on noneconomic damages in medical malpractice cases as justifying congressional involvement.

"Whatever question there was over whether Congress should act has been answered."

"Obviously, the challenge will be" in the Senate, said Mr. Joyce. "The House has a commendable record of passing comprehensive medical liability reform."

Lawrence Smarr, president of the Physician Insurance Assn. of America in Rockville, Md., was guarded in his assessment of what might happen to medical malpractice reform in the Senate.

"Something may happen, but I don't know that we'll get a cloture vote," he said, referring to a Senate parliamentary maneuver that cuts off filibusters and allows a bill to come to a vote on the floor.

Mr. Smarr noted that S. 4, a comprehensive health care reform bill introduced last week by Senate Majority Leader Bill Frist, R-Tenn., contains medical malpractice reform provisions that resemble those of the HEALTH Act in some regards. But he said that the Senate bill's treatment of collateral source benefits did not go as far as the House bill's. "We much prefer the House language," he said.

The outlook in the Senate "is going to be better, but it's still going to be very difficult," said Mr. Joyce.

"We hope the Senate sees, as the House did, that the way to fix the current health care liability system is by reforming medical liability," said a spokesman for the American Insurance Assn. in Washington.

President Bush also called for the Senate to follow the House's lead.

In a statement, the president said: "The nation's medical liability system is badly broken, as frivolous lawsuits are threatening access to quality health care and raising health care costs for all Americans…This is a national problem that deserves a national solution. For the sake of all Americans, it is time for the Senate to pass meaningful medical liability reform legislation."

A prominent opponent of the measure, however, branded it as nothing more than a giveaway to insurers and drug companies.

"Today, the Congress showed once again where its true priorities lie—with the big insurance and pharmaceutical companies and their well-heeled CEOs," Ken Suggs, president of the Assn. of Trial Lawyers of America, said in a statement released after the vote.

"The insurance industry is price-gouging doctors and lying to the public—all to justify limiting the rights of victims so that the industry can add to its already record-setting bottom line," said Mr. Suggs, who is also a member of Baltimore-based law firm Janet, Jenner & Suggs L.L.C. in the firm's Columbia, S.C., office.

Nevada commissioner appoints captive regulator

CARSON CITY, Nev.—Nevada has named its first regulator exclusively in charge of captive insurance companies.

Nevada Insurance Commissioner Alice Molasky-Arman has appointed W. Randy Peppers, the former lead property and casualty actuary with the Kentucky Department of Insurance, to the newly created position of executive director of captive programs.

Last year, Nevada was one of the nation's fastest-growing domiciles, licensing 24 captives and bringing its year-end total to 38.

The state currently has 42 captives, and state officials hope the passage of legislation earlier this year will attract more. That measure, signed into law last month by Gov. Kenny Guinn, caps at $175,000 the maximum annual premium tax a captive would pay and permits protected cell captives.

The measure also dramatically reduced fees—once the nation's highest—on risk retention groups licensed in other states that provide coverage to Nevada policyholders, as well as premium taxes paid by out-of-state RRGs on coverage written for Nevada policyholders.

—By Jerry Geisel

RenRe: SEC investigation may lead to charges against chief executive officer

Continued from page 1

In its statement, RenaissanceRe also said the SEC separately issued a Wells notice to Michael W. Cash, formerly senior vp-specialty reinsurance. Mr. Cash resigned last month, after refusing to comply with an SEC subpoena requesting his testimony in an investigation into the three-year restatement of earnings announced by RenaissanceRe in February (*BI,* Feb. 28, 2005).

Wells notices allow recipients to explain alleged improprieties and argue that civil charges are unwarranted.

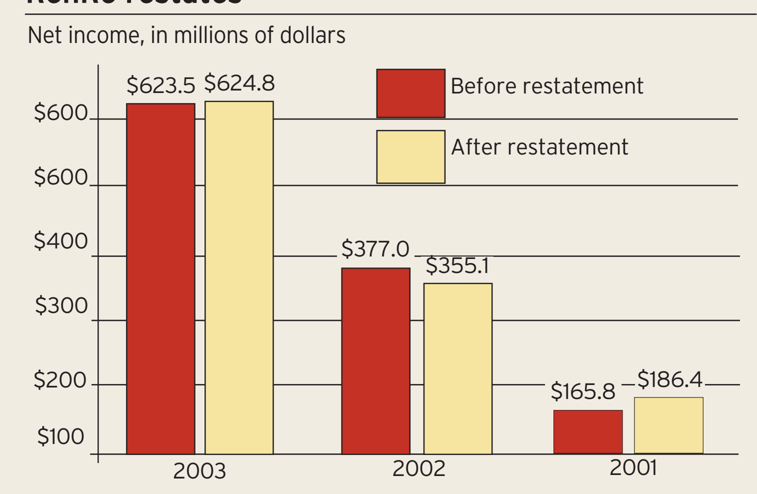
A spokesman for the enforcement division of the SEC declined to comment on the potential actions against RenaissanceRe and its executives.

In a statement, Jim Mathias, an attorney for Mr. Stanard with the law firm of Chicago-based DLA Piper Rudnick Gray Cary, said Mr. Stanard "is cooperating with the SEC and plans to continue to cooperate."

Martin J. Perschetz, a New York-based attorney for Mr. Cash, said: "Mr. Cash denies that he engaged in violations of the securities laws."

The possible SEC enforcement actions are connected to an "ongoing investigation into the restatement of the company's financial statements," RenaissanceRe said in its statement.

The company's decision to restate earnings for three years was largely related to transactions it entered into in 2001 with Inter-Ocean Holdings Ltd., a Bermuda-based finite risk reinsurer that entered runoff earlier this year (*BI*, April 7).



RenaissanceRe acknowledged in its 2004 10-K filing that two transactions that were accounted for as insurance failed to transfer enough risk to meet accounting standards. One was an aggregate excess-of-loss reinsurance agreement under which RenaissanceRe ceded business to Inter-Ocean; the other, an agreement to sell reinsurance recoverables to Inter-Ocean, RenaissanceRe said.

The effect of the restatement was to lift RenaissanceRe's 2001 and 2003 net income by $20.6 million and $1.3 million, respectively, and lower its 2002 net income by $21.9 million, the company reported.

RenaissanceRe, like many insurance industry companies, has been subpoenaed in recent months by state and federal regulators investigating whether companies have used finite risk products to manipulate their results.

Amid those inquiries, many companies have placed their books under scrutiny, causing some to acknowledge improper accounting for certain finite transactions. In addition to RenaissanceRe, companies that have restated earnings to correct their accounting for finite transactions include New York-based American International Group Inc., Chicago-based CNA Financial Corp., and most recently, Hamilton, Bermuda-based ACE Ltd.

At the center of the probes has been a $500 million retrocessional loss portfolio transfer between New York-based AIG and Stamford, Conn.-based General Reinsurance Corp. That transaction, which AIG acknowledged should not have been treated as insurance, forms part of New York Attorney General Eliot Spitzer's fraud suit against AIG and led to the criminal indictment of two former General Re executives—John Houldsworth, former CEO of Gen Re unit Cologne Re Dublin, and Richard Napier, former senior vp of Gen Re in Stamford, Conn. Both men also settled civil charges with the SEC.

Whether RenaissanceRe will itself face charges from the SEC will likely depend largely on its level of cooperation with the investigation, according to a former SEC enforcement lawyer.

In cases where charges are brought against an individual employee of the company, "typically, the SEC will charge the company" as well, said Jacob A. Frankel, who is now a partner at Shulman, Rogers, Gandal, Pordy & Ecker PA in Rockville, Md.

However, if the company being investigated has consistently "met all the criteria for cooperation" with regulators, "then there is a chance that the company will not be charged," Mr. Frankel said. "One of the most important factors in the decision for enforcement is the level and speed of cooperation."

RenaissanceRe previously announced that it "continues to cooperate with the SEC and other governmental agencies in their investigations."

Ratings, legal actions

A.M. Best Co. of Oldwick, N.J., last week affirmed its ratings for RenaissanceRe and maintained a stable outlook for the company, saying that it "believes that RenaissanceRe has a strong and seasoned management team capable of maintaining the group's leading market position in the event that Mr. Stanard should no longer remain in his current position."

But three other ratings agencies—Standard & Poor's Corp., Moody's Investors Service and Fitch Ratings—all placed their ratings under review.

In a statement, Fitch noted that "it is uncertain if further Wells notices will be issued to other members of management."

As part of its 2004 10-K filing with the SEC, RenaissanceRe's outside directors named five of the company's top executives as being responsible for "mistakes" and, in some cases, a lack of "due care" in connection with the original accounting for the Inter-Ocean transactions that led to the restatement. The five executives include Messrs. Stanard and Cash; as well as William I. Riker, president; John M. Lummis, chief operating officer; and Martin J. Merritt, controller.

With the exception of Mr. Cash, all of the executives are currently employed by RenaissanceRe.

Those same five executives, along with the company, were named last week in a shareholder lawsuit filed in a U.S. district court in New York on behalf of investors who allege they were misled about the firm's true financial condition and suffered damages as a result.

The complaint, which was filed jointly by the law firms of Goodkind Labaton Rudoff & Sucharow L.L.P. in New York and Goldman Scarlato & Karon P.C. in Philadelphia, cited the proposed class of plaintiffs as investors who purchased RenaissanceRe securities between Jan. 24, 2002, and July 25, 2005.

The shareholder suit alleges that the company and the five individuals violated federal securities laws by knowingly issuing false and misleading statements regarding the company's financial state, which had the effect of artificially inflating the reinsurer's share price.

On July 25, the day of the announcement noting the Wells notices, the company's share price fell $4.25 a share, closing at $42.98, from its closing price on July 22, the last trading day before the announcement, the lawsuit states.

A spokesman for RenaissanceRe said, "the company has a policy of not commenting on pending litigation."

ADVERTISER INDEX

Issue of August 1

ADVERTISER	PAGE #
Aetna Corporate	13
AIG	36
Aon Corporation	2
Applied Underwriters	10
Broadspire	17
BTE Technologies	16
Burnham System	28
Business Insurance	23, 27, 31
Carvill	35
CCMSI	12
CNA	5
Havensure	28
ISO	25
MetLife	7, 18/19
MHN, Inc.	24
SCRMA, Inc.	23R
Sedgwick CMS	21
Specialty Risk Services LLC	16
Standard Insurance	14, 15
Travis Software	26
Valley Oak Systems, Inc.	6
VPA, Inc.	24
Wachovia	9

MH 08-01-05 A 35 7/29/05 5:42 PM Page 1

TRIA: Lawmaker searches for alternatives

Continued from page 1

damage could trigger the backstop under certain circumstances.

The administration also wants to remove certain lines of coverage, such as general liability and commercial auto, from the backstop's protection and to use any backstop extension legislation as a vehicle for tort reform.

But last week's hearing made clear that even some Republican members would rather expand the existing program to cover group life insurance as well as property casualty lines rather than scale it back.

And the subcommittee's Democrats continue to push for a bill that would add group life to TRIA's protection while extending the current program for two years.

Rep. Barney Frank, D-Mass., who co-sponsored the Democratic TRIA extension bill, stressed that TRIA was not just to benefit insurers. "The prime beneficiaries of this legislation are not the insurance companies; they are the insureds," he said.

One witness representing policyholders called for another extension of the program. James E. Maurin, president of Covington, La.-based Stirling Properties Inc., speaking on behalf of the Washington-based Coalition to Insure Against Terrorism, said that the government backstop should apply to acts perpetrated by domestic terrorists as well as foreign terrorists.

He also called for swift congressional action on the terrorism insurance question.

"When the current program expires, so does our coverage," said Mr. Maurin.

During the hearing, how to provide a long-term answer to the question of the terrorism insurance market's future was on the minds of both witnesses and lawmakers.

> "When the current program expires, so does our coverage."
>
> **James E. Maurin**
> **Stirling Properties Inc.**

Several witnesses, notably District of Columbia Insurance Commissioner Lawrence Mirel, proposed creating a privately funded terrorism risk pool along the general lines of government-created pools in the United Kingdom, Germany, France and Spain.

Congress would have to enact legislation creating such a pool, said Mr. Mirel. While the federal government would remain the ultimate guarantor, its role would steadily diminish as the pool grew, he said. Mr. Mirel suggested that the pool could be funded by "a very small charge" on policies backed by the pool.

Mr. Mirel said that he believes that if Congress would establish a pool, the insurance industry would do a good job of putting it together, and doing it quickly.

Rep. Baker noted, however, that Congress is on a tight timetable to act on terrorism insurance legislation before its proposed October adjournment. He said that he intended to consider alternatives over the current recess. But any alternative would have to meet three aims, said Rep. Baker.

The first aim would be to provide market stability with less taxpayer exposure by requiring private insurers to assume an increasing amount of the terrorism exposure, just as the Treasury report advocated.

Rep. Baker's second aim would require insurers to repay over time any money they had received from the federal government to pay for losses arising from a future catastrophic terrorist attack. Under current law, repayment of funds would be at the discretion of the Treasury secretary.

The third aim would be replacing the minimum $500 million aggregate trigger that the Treasury report held was necessary for White House backing with some sort of "relative trigger."

Rep. Baker said he believes the proposed $500 million trigger would be too high to provide relief in the event of any attack that could occur outside of a major metropolitan area. He suggested instead a trigger based on some measure of commercial property valuation in the attack area that would be adjusted upward over time.

BI Stock Index [7/25 - 7/29]

Up-to-the-minute data for all 85 companies that comprise the *BI* Stock Index can be found at *www.businessinsurance.com*

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

Indicator	Value	Change
BI Stock Index	2624.03	0.99
Dow Jones	10640.91	-0.10
S&P 500	1234.18	0.04

Largest gains

Company	Change
Gainsco Inc.	23.49%
SCPIE Holdings Inc.	9.32%
St. Paul Travelers	7.13%
HCC Insurance Holdings	7.11%
Tower Group Inc.	6.44%

Largest losses

Company	Change
RenaissanceRe Holdings	-4.85%
Sierra Health Services	-3.56%
United Fire & Casualty	-3.05%
Philadelphia Consolidated	-2.70%
EMC Insurance Group Inc.	-2.49%

Weekly change by market segment

Segment	Change
Brokers	0.87%
Insurers/Reinsurers	1.45%
Managed Care Organizations	1.44%

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

Late News

Continued from page 1

decrease employer-sponsored insurance coverage.

Reserve boosts hit XL profits

XL Capital Ltd., in reporting a 29.1% drop in first-half net income to $578.8 million, blamed two reserve increases during the second quarter as the drag on its results. One, an aftertax charge of $63.3 million, was related to an increase in future policy benefit reserves and a write-off of deferred acquisition costs on novated blocks of U.S.-based term-life mortality business. The six-month results also include a reserve strengthening of $186.3 million aftertax for the company's North American reinsurance operations. XL's gross premiums written dropped 4.9% to $5.29 billion in the half.

USA Risk Group forms Cayman operation

USA Risk Group is opening a captive management office in the Cayman Islands. Rob Leadbetter will serve as vp and manager of USA Risk Group (Cayman) Ltd., which will be located in Grand Cayman. The Cayman operation will offer a full range of captive management services, USA Risk Group said in a statement. USA Risk Group, based in Montpelier, Vt., also operates captive management offices in Bermuda, the British Virgin Islands and six U.S. domiciles.

AHP measure clears House

Legislation passed last week by the House of Representatives would allow small employers to band together through trade associations to purchase health insurance plans that would be subject to federal rather than state regulation. Through this change in oversight, association health plans would, among other things, be exempt from state benefit mandates or state financial requirements that commercial insurers now must meet. The House has passed similar measures in prior sessions, but the Senate has yet to act favorably.

PCS estimates Dennis losses at $900 million

Hurricane Dennis caused an estimated $900 million in insured property damage, the Insurance Services Office Inc.'s Property Claim Service unit said. Florida, where Dennis made landfall on July 10, suffered the largest losses, with estimated insured damage at $640 million. Alabama sustained an estimated $115 million in insured property damage, Georgia $85 million, and Mississippi $60 million.

Safety National acquires ERC excess comp renewals

Safety National Casualty Corp. has acquired the renewal rights to Employers Reinsurance Corp.'s excess workers compensation business. The renewal rights represent between $50 million and $60 million in premiums, according to a spokesman for Safety National's parent, Delphi Financial Group Inc. Terms were not disclosed, but Delphi said no reserves or liabilities were transferred. General Electric Co., the parent of GE Insurance Solutions, previously said that it is seeking to reduce its insurance holdings.

P/C industry's profits up 29% in first quarter

The U.S. property/casualty industry's net underwriting gain was $7.1 billion in the first quarter of 2005, up 34.8% over the prior-year period, according to estimates by the Insurance Services Office Inc. and the Property Casualty Insurers Assn. of America. The industry's combined ratio was 91.9% for the quarter, compared with 93.3% recorded during the first quarter of 2004. Net income rose 29.4% to $17.3 billion, while the rate of net written premium growth dropped to 2.4% during the first three months of this year from the first-quarter 2004 rate of 4.6%.

Many employees take 401(k) cash in job moves

According to a study by Hewitt Associates Inc., 45% of 401(k) plan participants terminating employment in 2004 took at least half of their account balance in cash—despite stiff tax penalties—while 32% kept their savings in their former employers' 401(k) plan. The remaining 23% either rolled the money over to an individual retirement account or to another retirement plan, such as one sponsored by their new employer. Younger terminating employees were most likely to take their 401(k) account balances in cash. For example, 66% of participants aged 20-29 took at least half their account balance in cash compared with 42% of those aged 40-49, Hewitt found.

At *BusinessInsurance.com*

New **Online Poll**: Will the Senate follow the House's lead and pass medical malpractice liability reform this year?

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