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Business Insurance

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\$4

New fronts in 9/11 litigation battles

Victims' suits clear hurdle; insurers target conspirators

By DOUGLAS McLEOD

NEW YORK—The tangle of litigation that grew out of the Sept. 11, 2001, terrorist attacks is developing new twists on the second anniversary of the assault.

A federal judge in New York last week cleared the way for victims of the attacks to sue airlines, the World Trade Center's owner and operator and other defendants. Victims have until Dec. 22 to decide whether to sue or participate in the federal Sept. 11 Victim Compensation Fund.

Meanwhile, five large insurance groups have filed what is believed to be the first insurance industry lawsuit against parties allegedly respon-

sible for the attacks, ranging from the al Qaeda terrorist organization to the governments of Saudi Arabia and Iran and several hundred individuals, corporations and Islamic charities.

And, in its latest legal effort to recover on a \$1.05 billion total loss claim for its former New York headquarters building, Deutsche Bank A.G. has sued the state of New York, charging that the state prevented the bank from containing damage to the gutted building in the weeks after the terrorist attacks.

While many lawsuits filed by Sept. 11 victims remain on hold while families decide whether to tap the Victim Compensation Fund, **See SEPT. 11/page 34**



PHOTO: ZUMA

Relatives of victims of the Sept. 11, 2001, terrorist attacks attend a memorial service at the former site of the World Trade Center. Many victims' families still are pursuing lawsuits over the attacks.

Late News

SCOR's Best rating lowered to B++

A.M. Best Co. downgraded SCOR S.A.'s financial strength rating to B++ from A- Wednesday, a move the Paris-based reinsurer called "unfounded." Best said its action followed "deterioration in SCOR's risk-adjusted capitalization as a result of slower-than-anticipated improvement in performance despite the positive action taken to curtail underwriting in certain areas." Best noted SCOR's plan to sell Bermuda-based alternative risk transfer unit Commercial Risk Partners and launch a new life reinsurance unit would strengthen SCOR's capitalization. SCOR said it "regrets A.M. Best's decision to lower the rating of the group at a time when the group's fundamentals are improving."

Health care cost increase lower: Survey

Health care claims costs are projected to rise in 2004 at a slightly lower rate than this year, according to New York-based benefit consultant The Segal Co. The survey of 60 health care organizations, third-party administrators and prescription benefit managers shows that medical claims costs for 2004 are projected to rise, on average, between 12.5% and 15.0%, depending on the type of health plan. The increase is about 0.4 to 1.1 percentage points lower than comparable plans saw in 2003. Among preferred provider organizations, costs are projected to rise by 13.5% on average in 2004, compared with a 13.2% increase this year. Prescription drug costs are projected to rise by an average of 18.2% next year, compared with 19.5% for 2003, the survey states.

Quicker action needed in insolvency: Study

The harm to consumers caused by insolvent insurance companies can be minimized if regulators move quickly to shut down dying companies, suggests a survey prepared for the Foundation for Agency Management Excellence, a nonprofit foundation of the Council of Insurance Agents & Brokers, by Stewart Economics Inc. "Failed companies are being kept alive, so the industry is less sound," FAME's report says. The **See LATE NEWS/page 35**

Wide range in loss estimates Bermuda tallies storm damage

By MICHAEL BRADFORD

HAMILTON, Bermuda—Bermudan insurers facing claims from Hurricane Fabian expect their losses to be far less than had originally been feared.

The deadly storm that pounded Bermuda on Sept. 5 is expected to produce around \$100 million in insured damages, the island's insurers say, not the \$300 million to \$350 million initially estimated by catastrophe modeler AIR Worldwide Corp.

"The \$350 million figure is way wrong," said Larry Osborne, vp-property/casualty at Argus Insurance Co. Ltd. in Bermuda.

"In reality, it will probably be more like \$100 million," he said.

"I wouldn't have thought it would be anywhere near that, to be honest," Glenn Titterton, president and chief executive officer of Bermuda-based insurer BF&M Ltd., said of the \$350 million estimate. But, he cautioned, "we don't know what the business interruption claims are going to be."

AIR's estimate does include business interruption losses, but a spokesman for the Boston-based company pointed out that the \$300 million to \$350 million figure is for "insurable" property

See FABIAN/page 31

Bill would block Treasury rules on cash balance

By JERRY GEISEL

WASHINGTON—Employers are gearing up to fight legislation that would effectively prevent the Treasury Department from finalizing cash balance plan regulations that would give plan sponsors some protection from age-bias claims.

Last week, the House approved on a 258-160 vote an amendment to a broader appropriations bill that would prevent the Treasury Department from taking any action that would "assist in overturning" a recent federal court ruling that IBM Corp.'s cash balance pension plan discriminated against older employees. Rep. Bernard Sanders, I-Vt., a

longtime opponent of the plans, proposed the amendment.

If enacted, the cash balance provision would apply through Sept. 30, 2004. During that period, the Treasury Department could not do anything that would have the effect of undoing a July 31 decision by U.S. District Court Judge G. Patrick Murphy, who ruled that IBM's cash balance plan was discriminatory (*BI*, Aug. 4). IBM is appealing that decision.

The practical effect of the amendment, benefit lobbyists say, would be to prevent the Treasury Department from finalizing—for at least the next year—regulations it

See CASH BALANCE/page 32

International

GERMAN AVIATION POOL TO CLOSE

Begins on page 29



California comp reforms would trim billions in costs

By **ROBERTO CENICEROS**

SACRAMENTO, Calif.—California Gov. Gray Davis is expected to sign into law a package of workers compensation reform measures once it clears the state's Legislature.

A conference committee of California lawmakers last week adopted the package of reforms, which they said would slash more than \$5 billion annually from the state's beleaguered system.

The reforms, which target soaring medical costs in the state's workers compensation system, were sent out of committee to the state Assembly and Senate, where they are

expected to win approval, and Gov. Davis said he would sign them into law. The legislative session was set to end at midnight on Friday.

Risk managers and insurers generally support the reform proposals, but added that the California workers comp system will still require additional reform, such as changes in how permanent disabilities are rated and compensated.

Among other things, the reform proposals call for:

- Adopting a fee schedule for outpatient surgical centers. The centers would be paid based on 120% of the current Medicare reimbursement rate for the facilities. Current-

ly in California there is no limit on what surgical centers charge for treating workplace injuries, which some have blamed as a key factor behind soaring costs.

- Adopting a fee schedule for drugs prescribed for workers comp claimants. Payments made to pharmacies for prescription drugs would be set at the current reimbursement schedule for the Medi-Cal system, the state's Medicaid program.

- Cutting current reimbursement levels for hospitals and physicians by 5%, unless their rates are already below Medicare rates.

- Capping at 24 the number of

See **COMP**/page 6

Buyers to see rate hikes ease

Market conditions still ripe for insurer profitability

By **JUDY GREENWALD**

Although insurance buyers can expect to see some moderation in rate increases, U.S. property/casualty insurers continue to post strong results on the back of existing rates, continued pricing discipline and an improving interest rate environment.

While some market observers say that the hard market may be at or near its peak, most commercial property/casualty companies reported a profitable first half and are expected to do likewise for the remainder of the year.

Factors that could prolong firmer rates include the planned withdrawal of Royal & SunAlliance Insurance Group P.L.C. from the U.S. market, additional reserving activity by insurers and unpredictable catastrophe losses from hurricanes and other events, observers say.

Excluding the Hartford Financial Services Group Inc., the remaining 14 property/casualty insurers that

reported net income in *Business Insurance's* survey reported a profitable first half. As a group, the 14 saw a 35.9% increase in net income,

Property/Casualty Insurers FIRST-HALF RESULTS

to \$7.5 billion. The Hartford recorded an \$888 million first-half loss, reflecting a \$3.91 billion pretax charge for asbestos reserves in the first quarter.

Other first-half results from the *BI* survey of 16 major property/casualty insurers include:

- All 16 insurers reported a weighted average combined ratio of 98.1% vs. 101.4% for the comparable period a year ago. Combined ra-

tio figures are weighted by premium volume.

- Net premiums written increased 14.3% to \$61.08 billion.

- Policyholder surplus for the 15 insurers that reported this data increased 10.5% to \$57.55 billion.

Analysts generally applauded the first-half results.

"I think the industry did fantastic, and my expectation is that we'll see more of the same in the second half," said Chris Winans, senior property/casualty analyst with Lehman Bros. in New York.

"Broadly speaking, the results were as good as we would have hoped," said James Inglis, managing director at Stamford, Conn.-based Philo Smith & Co., a boutique investment bank that specializes in the insurance industry.

"All things being equal, the companies are clearly realizing the benefits of all the rate increases they have put in place and, equally importantly, all the underwriting

See **RESULTS**/page 20



Buyers tolerant of big brokers' varying styles

By **SALLY ROBERTS**

LONDON—Willis Group Holdings Ltd. plans to bring marketing expertise to all of its local brokerage offices worldwide to bring clients closer to the person representing them in the insurance marketplace.

That closer relationship will give the placing brokers more intimate knowledge of the client's risks, which, in turn, should lead to better-negotiated terms and conditions in the market, the London-based broker contends.

This localized model, which Willis says is a more formal version of the approach it has always used, contrasts with the approach taken by competitors Marsh & McLennan Cos. Inc. and Aon Corp. Marsh uses a more centralized approach to its marketing function, while Aon Corp. combines localized and

centralized models.

For their part, risk managers say they are indifferent to the brokers' various marketing strategies, as long as the approach doesn't interfere with the buyer's relationships with underwriters, gives risk managers some choice and provides them with the best team possible.

That perspective is far different from the one expressed in 1997, when Marsh's Global Broking Centers became a center of controversy after it was revealed that the broker planned to channel property/casualty insurance placed with Chubb Corp. through these regional—rather than local—brokerage offices.

At the time, risk managers complained that the centers would circumvent their established relationships with insur-

See **BROKERS**/page 32

Inside Business Insurance

Unpleasant side-effect of OTC drug cost claims

The IRS' recent ruling permitting reimbursement of over-the-counter drug costs could overwhelm employers, some warn. **Page 4**

AIG to pay SEC penalty over retroactive policy

American International Group Inc. has agreed to settle SEC charges related to a policy it wrote. **Page 4**

California considering pay-or-play measure

California legislators were expected late Friday to approve legislation that would mandate health care coverage. **Page 6**

Cash balance plans still useful option

A move to make cash balance plans less attractive is a bad idea, one of this week's editorials says. **Page 8**



China preparing to lower capital requirement

Foreign insurers operating in China would benefit under a proposal to reduce the minimum capital required for a license. **Page 29**

Online

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

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

- New **Opinion Poll** for readers: Would buyers be better protected if regulators shut down insolvent insurers more quickly?

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REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS.

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HMOs leaving Medicare will affect fewer lives

By MICHAEL PRINCE

WASHINGTON—Next year will see a marked decrease in the number of people affected by the withdrawal of health maintenance organizations from the Medicare program, but plans are continuing to cut benefits and hike premiums.

The plan changes will further reduce the appeal of a managed care approach employers have turned to in an effort to curb rising retiree health care costs.

The latest round of pullouts of managed care plans from the Medicare program will affect about 40,000 beneficiaries starting Jan. 1,

according to a survey of 57 managed care plans conducted by the Washington-based American Assn. of Health Plans.

Those pullouts are the smallest in the past six years. This year, for example, market withdrawals affected more than 200,000 beneficiaries, while last year 536,000 beneficiaries were affected by HMO withdrawals from what is known as the Medicare+Choice program.

Currently, about 11% of Medicare's 40 million enrollees—or about 4.6 million people—are enrolled in Medicare+Choice plans, down from the highpoint of 1999,

when enrollment peaked at 6.2 million.

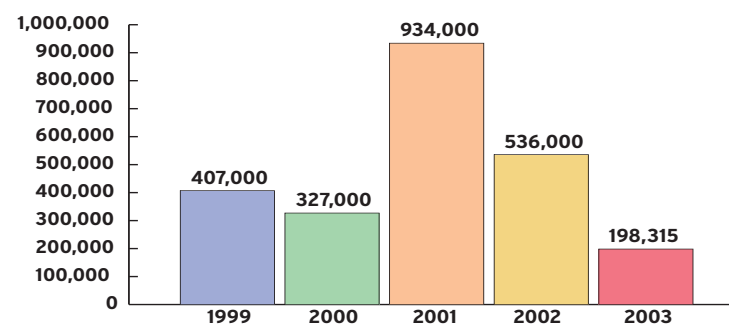
Since then, though, many large Medicare HMO providers, including PacifiCare Health Systems Inc., Humana Inc. and Aetna Inc., have withdrawn from certain Medicare markets, saying that government reimbursement rates are inadequate to cover their costs in those areas.

This year's withdrawal tally is lower because plans "got out of most of the markets that were unprofitable already," said Joe Martingale, national leader for health care strategy at Watson Wyatt World-

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MEDICARE +CHOICE WITHDRAWALS

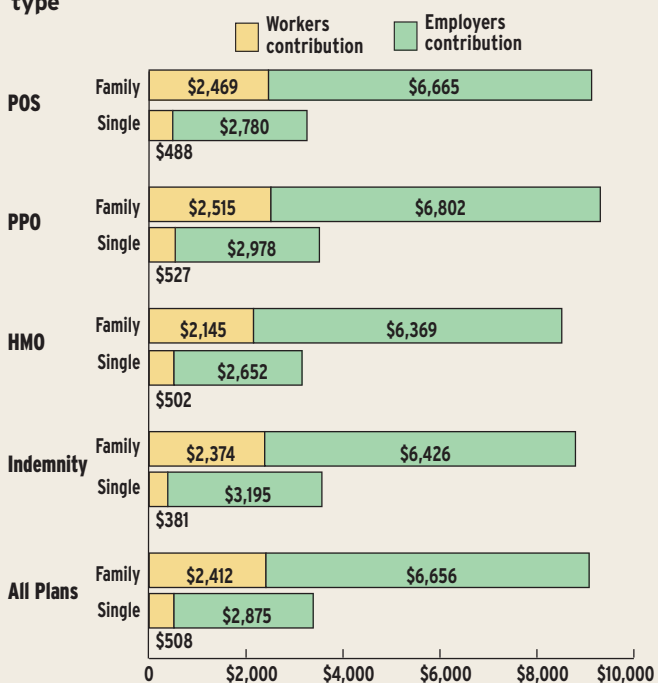
Medicare +Choice enrollees affected by non-renewal or service area reductions



Source: AAHP

2003 HEALTH CARE COSTS

Average annual premium cost for covered workers, by plan type



Source: Kaiser/HRET Survey

Employers attempt to keep health care costs under control

By MARK A. HOFMANN

The cost of employer-provided health care benefits continues to rise at a double-digit rate, and employers are making changes in their plans to keep these costs in check, a new study finds.

The survey, conducted by the Henry J. Kaiser Family Foundation and the Health Research & Educational Trust, found "no let up in the rate of increase in health insurance premiums this year," said Drew Altman, president and chief executive officer of the Palo Alto, Calif.-based Kaiser Foundation, at a Sept. 9 news conference in Washington.

Mr. Altman called the rising costs "obviously bad news" for employers and employees alike.

As a result of the rising costs,

employers are not only absorbing premium increases themselves but also shifting more costs to employees, according to the "2003 Annual Employer Benefits Survey." But, Mr. Altman said, the cost increases generally are not prompting employers to drop their health care coverage plans.

The report was based on the responses of 1,856 public and private employers, ranging in size from three employees to more than 300,000. Among the survey's findings are that:

- Premiums for employer-provided health insurance increased 13.9% between spring 2002 and spring 2003. That followed annual increases of more than 10% in each of the two prior years.

See **BENEFITS**/page 28

Over-the-counter drug ruling should boost FSA participation

By JERRY GEISEL

WASHINGTON—New federal tax guidance that nonprescription drugs can be reimbursed through flexible spending accounts is likely to boost employee participation in such programs.

Any increase in administration fees resulting from the growth in participation likely would be offset by payroll tax reductions stemming from employees' contributions, benefit experts say.

Under Revenue Ruling 2003-102, which is effective immediately, employees' purchase of over-the-counter drugs—such as nonprescription pain relievers, cold medicines, antacids and allergy medications—can be reimbursed

See **DRUGS**/page 35



OPHOTO: GETTY/TIM BOYLE

An IRS ruling that allows nonprescription drugs to be reimbursed through flexible spending accounts could increase employee participation in such programs.

AIG, Brightpoint settle charge that policy defrauded investors

By DOUGLAS McLEOD

NEW YORK—American International Group Inc. has agreed to pay \$10 million to settle Securities and Exchange Commission charges that it helped defraud a telecommunications company's investors by issuing a retroactive insurance policy to conceal the company's losses.

The SEC announced the settlement simultaneously with its filing of a lawsuit in U.S. District Court in New York against AIG; Brightpoint Inc., a Plainfield, Ind.-based distributor of mobile phones; and former Brightpoint Chief Financial Officer Phillip Bounsall, former Chief Accounting Officer John Delaney and former Director of Risk Management Timothy Harcharik.

According to the complaint, Brightpoint officials discovered in late 1998 that the company faced \$29 million in losses from a division in the United Kingdom, far exceeding its publicly announced estimate of \$13 million to \$18 million. Brightpoint then approached AIG's

National Union Fire Insurance Co. of Pittsburgh, Pa., subsidiary to provide \$15 million in retroactive coverage that would allow it to report an insurance receivable in its financial statements, offsetting the additional losses. As a result, Brightpoint's 1998 net income was overstated by 61%, the SEC charges.

The policy did not represent actual insurance, though, since AIG bore no risk and Brightpoint's \$15 million premium simply made a "round trip," deposited with the insurer and repaid to the telecom company, the SEC alleges.

AIG and Brightpoint officials disguised the nature of the transaction by backdating the policy, concealing the large premium and combining the retroactive coverage with standard fidelity coverage, the suit charges.

After being subpoenaed by the SEC in late 2001, Brightpoint restated its financial results to reflect its payment of the full premium in 1998 rather than in installments

over three years, as it had earlier claimed. The telecommunications company restated its results again in early 2002 to account for the entire transaction as a deposit rather than insurance.

Along with AIG, all of the defendants except Mr. Harcharik have agreed to settle the complaint, with Brightpoint paying a \$450,000 fine and Mr. Bounsall a \$45,000 fine. Without admitting or denying the charges, the settling defendants have also agreed not to violate securities laws in the future. Louis Lucullo, an AIG assistant vp involved in the transaction but not named in the lawsuit, also agreed not to violate securities laws.

"AIG acknowledges that mistakes were made in the underwriting of this policy," the insurer said in a statement. "Consistent with its longstanding commitment to ensure that it has sound and effective internal controls, AIG has taken steps to correct those mistakes. AIG's profit from this policy was less than \$100,000."

California closes in on health insurance mandate

By JOANNE WOJCIK

SACRAMENTO, Calif.—A “play or pay” bill that would force employers to offer health care coverage to workers or pay into a fund that would provide it for them had a good chance of passing the California Legislature in the final hours of this year’s session on Friday, sources say.

If passed, it would make California the first state since the passage of the Employee Retirement Income Security Act in 1974, which pre-empts state laws or regulations that relate to employee benefits, to require employers to offer and pay for health insurance. While Massachusetts enacted a similar law in 1988, it later was repealed amid stiff employer opposition. The only other state with such a mandate is Hawaii, whose law predates ERISA.

The California Chamber of Commerce asserts the play-or-pay man-

date would force some employers to leave the state or go out of business. The Chamber cites a Los Angeles Economic Development Corp. study issued last week that estimated S.B. 2 would cost more than \$7.2 billion annually, including \$5.7 billion from business and \$1.5 billion from their employees.

As of Friday morning, the contribution for employers would be 75% of the premium, with employees paying the rest, sources said. Details on how much employers would have to pay into the fund were still being worked out.

“Businesses in California are already being hammered by high workers compensation costs, and electricity rates that are double the national average,” said a spokesman for the California Manufacturing & Technology Assn. in Sacramento, which opposes the legislation.

But the bill, which has popular support in a state where nearly 7 million people are uninsured, was expected to pass by midnight Friday.

While some observers say ERISA pre-empts the bill, others disagree.

“For the businesses that currently do not offer coverage to be mandated into offering it, there is no ERISA pre-emption,” said Dallas Salisbury, chief executive officer of the Employee Benefit Research Institute in Washington.

“The only impact would be if there is a coverage requirement on existing self-funded plans,” he said. “It just looks like they’re trying to get something passed and they’ll work out the details later.”

“It’s just not part of the discussion in California,” said Peter Warren, vp-communications of the California Medical Assn. in Sacramen-

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Comp: Passage close

Continued from page 4

chiropractor visits for which the workers comp system would pay.

Currently, there are no caps on chiropractic care, and workers in California average 37 visits per injury compared to 15 nationally, said a spokeswoman in Sacramento for the American Insurance Assn.

“California is way out of whack,” she said.

• Introducing a new system for reviewing medical treatment for injured workers.

The bulk of the reform measures adopted by the conference committee last week are contained in two pieces of legislation. Sen. Richard Alarcon, D-San Fernando, introduced S.B. 228 and Assemblyman Juan Vargas, D-San Diego, introduced A.B. 227.

“Our initial impressions are that these are good reforms and this is a good start in a process where there is certainly more work to be done,” said Tim East, chairman of the Sacramento-based California Coalition on Workers’ Compensation. Mr. East also is director of risk management for the Walt Disney Co. in Burbank, Calif.

Conference committee lawmakers estimated the reforms would cut \$5.3 billion from the system the first full year after enactment and \$4.8 billion to \$5.3 billion annually in following years.

But some are skeptical about the extent of potential savings.

While the AIA supports the legislation and is optimistic about its chances, “we are very concerned that the expectation based on cost savings is overoptimistic and won’t be realized and people will be frustrated,” said Mark Sektnan, AIA Western region assistant vp in Sacramento.

He said the AIA is waiting for the San Francisco-based Workers Compensation Insurance Rating Bureau of California to assess the potential savings under the proposed reforms. The WCIRB is a licensed rating organization and the designated statistical agent of California’s insurance commissioner, whose office indicated an assessment of the measures might take several weeks.

The proposed medical utilization review system also might not be as effective as suggested, Mr. Sektnan said.

The review process called for under the legislation would not require a “true, independent” examination of claims, such as under group health plans, he said. Instead, it would resemble more of a second opinion, in which another qualified medical examiner would see a patient, Mr. Sektnan said.

Under the proposal, the California Workers Compensation Appeals Board would be the final arbitrator of disputed claims, Mr. Sektnan said. But the WCAB also suffers from a notorious backlog of claims, he noted.

Insurance Commissioner John Garamendi, testifying in support of the reforms, told the conference committee on Sept. 5 that, “Overall, workers compensation costs in this state have risen from \$9 billion in 1995 to \$29 billion in 2003.”

That is a daunting amount for employers that are shouldering the costs, Mr. Garamendi testified.

The number of workers hired in California by Costco Wholesale Corp., for example, account for 36% of the Issaquah, Wash.-based retailer’s total workforce, Mr. Garamendi said. But claims by California workers account for 70% of Costco’s total workers comp costs, the commissioner said.

Meanwhile, some reforms supported by employers are absent from this package.

Changing the way permanent disabilities are rated in California could provide considerable financial relief to the current system, they contend.

Assessing permanent disabilities now relies on subjective criteria, such as a claimant telling a doctor that an injury causes him or her great pain, explained Willie Washington, legislative director for the California Manufacturers & Technology Assn. in Sacramento.

There is no requirement that the extent of injuries be proved through established medical procedures, Mr. Washington complained.

“It’s being done just on the basis of people describing pain,” he said. “There are so many soft tissue issues in the body that you can generally say you hurt at some point. If you just say, ‘My back hurts’ and that is good enough to get compensated, guess what? It is going to happen. People are going to say, ‘My back hurts,’” he said.

Employers would like to see doctors apply more objective protocols for specific injuries when rating a disability and when determining a treatment regimen, Mr. Washington said.

The permanent disability rating system needs thorough examination to insure fairness and benefit consistency for workers, Mr. East said.

“Somebody with a really serious injury needs to be adequately compensated,” said Mr. East. “But at the same time, someone with an injury where they lose no time from work should not receive the same compensation as somebody who loses the ability to compete in the market.”

The current permanent disability system encourages the involvement of attorneys, who woo clients by claiming that they can win them a higher disability rating than the worker could otherwise obtain without representation, Mr. Washington said.

To bump up an employee’s permanent disability injury rating, attorneys encourage workers to miss work and increase the number of doctor visits they make, he added.

Improving that system could eliminate many claims and account for a “huge amount of savings,” Mr. Washington said. But some of the state’s lawmakers are unwilling to make such improvements because of special interest groups that benefit from the current system, he added. “There is no interest on the part of attorneys and labor to visit that area,” Mr. Washington said.

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Editorial

Wake up to pension bill dangers

CONGRESS MUST REALIZE that if it makes cash balance plans undesirable—as a recent House vote is sure to help do—there is no guarantee that employers will embrace other defined benefit pension plans as a replacement.

The defined benefit plan system is struggling, with many plan sponsors facing challenges in meeting their liabilities amid a tough economy, and a vote last week by the House of Representatives will only encourage more employers to abandon that system.

As we report on page 1, the House last week approved an amendment by Rep. Bernard Sanders, I-Vt., that would bar the Treasury Department from any activity that would assist in overturning a recent federal district court ruling that held that IBM Corp.'s cash balance plan violates age dis-

crimination laws.

While there is debate about the scope of the amendment, we believe the practical impact is clear: the Treasury Department would not be able to complete long-awaited rules, proposed last year, that would make clear that the basic design of cash balance plans does not discriminate against older employees. In other words, employers that offer the plans would continue to face the threat of age-bias lawsuits.

It is beyond us why a majority of House members would want to elevate to law a single federal judge's ruling—even before it is reviewed on appeal. Legislators, through their vote, are saying that a ruling by one judge in southern Illinois should pre-empt the collective wisdom of Treasury Department regulators who have been studying the issue for years.

While many members voting for the amendment likely had no idea of the practical impact of the Sanders amendment, there should be no doubt about the true motives of Rep. Sanders and his allies: They want to kill cash balance plans.

And they may well succeed, unless members of Congress wake up to the disastrous consequences to plan participants that would result from this proposal.

Most employers that convert traditional final-average-pay plans to cash balance plans do so because their old plans were ill-suited to provide meaningful benefits to the majority of today's workforce. The old defined benefit model was most attractive to long-service career employees—today, a dwindling percentage of the workforce—but offered limited benefits to shorter-service employees.

Lawmakers must understand that killing cash balance plans would not result in a large number of employers restoring their old plans. If those plans did not make sense from the standpoint of delivering benefits when they were dropped, they still won't make sense today.

Instead, we believe employers would exit the defined benefit plan system and funnel their pension dollars into defined contribution plans. While those plans are valuable retirement savings vehicles, they are hardly the equal of defined benefit plans in terms of beneficiary protection.

We hope Congress, once it understands the implications of the Sanders amendment, will decisively defeat the proposal and let regulators proceed in finishing reasonable and fair rules for cash balance plans.

Litigation adds to 9/11 woe

TWO YEARS AFTER the Sept. 11 terrorist attacks shook the global insurance industry, it's evident that claims from that horrible day are far from settled.

Even as plans proceed to rebuild on the site where the World Trade Center stood, with space devoted to a memorial for the thousands who perished in the attacks, a new wave of litigation is just beginning.

As we report on page 1, in recent days, a federal judge has allowed lawsuits to proceed against not only the owners of the trade center but

also the owners of the hijacked planes and the aircraft's manufacturer. Last week, dozens of insurers filed a suit seeking to recover billions of dollars from the supporters of terrorism. In addition, the owner of a now-vacant building it claims was contaminated after the attacks is suing New York state after its failed efforts to sue New York City.

Given the immensity of the human losses and property damage caused on Sept. 11, 2001, it's no surprise that insurers and others are seeking indemnification. We hope,

however, that the industry doesn't lose sight of some of the lessons from the tragedy.

The costliest insured event in history redefined risk and showed the need for catastrophe planning. We think what's also needed is clear communication between policyholders and insurers, and a deeper understanding of their contracts.

Wounds are beginning to heal for many who suffered that fateful day in 2001. We hope that the wave of recovery litigation doesn't create new ones.

Schillerstrom



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Directors depend more on risk managers

By Roger Kenny

Both the best and the worst things that happen to a company begin with its board of directors.

Because of recent events, corporate risk managers are beginning to examine carefully the scope of the risk associated with their directors and officers liability. D&O cases are so potentially crippling that a company may never recover from an onslaught of D&O suits.



At a recent panel discussion on corporate governance that I monitored, some experts cautioned that the first time the independent directors of a

public company are found guilty of failing in their duty of care or their duty of loyalty and the D&O insurer asserts that there was a fraud or malfeasance—and, therefore, no coverage—we could see a mass exodus of directors of public companies.

Now, more than ever, directors and director candidates rely on corporate risk managers to identify and monitor enterprise risk—that is, uncontrollable factors such as

Potentially crippling D&O lawsuits mandate extra attention to risk management

competition, political uncertainty and economic conditions. Last year, a survey in The McKinsey Quarterly of 200 directors on 500 boards revealed that 36% of the directors questioned did not understand the company's major risks.

In the spirit of good, proactive risk management, it is not enough simply to abide by new federal and industry mandates. The risk management professional will play a key role in the development of a series of best-practice guidelines on how to implement good corporate governance.

We laud the professional risk management community for seeking to analyze and discuss how to better coordinate the intersection of risk management and corporate governance. We still have a ways to go, though, before we can say we have developed a consensus from which a defined set of best practices can be drawn. A survey conducted by Allianz Global Risks of 115 respondents who attended the annual Risk & Insurance Management Society Inc. conference, revealed that although 39% believe that the Sarbanes-Oxley Act will significantly reduce corporate malfeasance,

another 33% don't think so, and 28% don't know whether the legislation will be effective. The respondents represented a broad range of industries; 87% are from North America, and 65% work at companies with more than \$500 million in annual revenues.

Risk managers need to review and understand their company's overall corporate governance function. Indeed, they need to ensure that corporate governance is, in fact, performing its function: truly governing the company's behavior and influencing its culture, from the very top down to the line workers.

Risk managers of companies of all size and across all industries need to fully engage their boards and come up with best practices that make sense for them. A thorough assessment of corporate governance can serve to lessen the risk of D&O litigation.

For many reasons, we believe there are real benefits from working with an independent consultant that specializes in corporate governance to develop a program that best suits your needs. Below, though, are some basic guidelines for undertaking a review of your company's corporate

governance:

- Focus on the board's role and effectiveness. Design an assessment that evaluates the spirit of the board's independence, what it focuses its attention on and how. This will ensure that directors are spending time on the most important issues and on the value of the board's contributions. The outcome is a plan for improvement.

- Communicate governance standards to stakeholders. Publish governance standards on the corporate Web site and publicize them wherever possible.

- Ensure greater transparency of accounting information. Help directors and management better understand the need for recordkeeping, transparency, disclosure and accountability regarding their own function.

- Analyze the process for the review of compliance efforts, including provisions for establishing a whistle-blower process. Sarbanes-Oxley provides plaintiffs attorneys with a guideline to examine whether directors paid proper heed to compliance efforts.

If directorship was a high risk before, it's a super high risk now. The best insurance against that risk is strong governance

Roger Kenny is co-founder and managing partner of Boardroom Consultants, a New York-based management consulting firm.

'First call' system saves workers comp dollars

Nurse case managers get workers back on the job faster

By Karen L. Andalman

Workers compensation—it's a term that alarms many employers. And it's no wonder. Consider these statistics:

On an average day in the United States, 17,000 workers are injured, with work-related injuries costing the economy more than \$110 billion a year.

A total of 5.2 million injuries and illnesses were reported in private industry workplaces during 2001, resulting in a rate of 5.7 cases per 100 equivalent full-time workers, according to a survey by the Bureau of Labor Statistics. Of the 5.2 million total injuries and illnesses, roughly 2.6 million required recuperation away from work or restricted duties.

Average workers compensation insurance premiums and other costs run 2% to 3% of payroll, and in extreme cases they can equal as much as 80% of payroll.

While these statistics may be alarming, taking control of your workers compensation program can cut annual direct costs by 25% to 50%. The most effective way to take control of your program is to implement a "first call" claims management reporting system, which directs employees to appropriate care at the start of the claim. A first-call system:

- Promotes communication among all parties involved.

This is really the key to a successful program. A first-call system promotes communication among all parties: the injured employee, the employer, the provider of the medical services and the nurse case manager. As soon as the injured employee makes this first call to the nurse case manager, the case manager becomes the hub

of the three-point contact, coordinating services and communication.

- Directs the injured worker to the appropriate provider of services.

From the initial call, the nurse case manager directs the injured employee to quality providers and often negotiates discounts for services. This avoids situations where a patient first sees an internist or general practitioner, instead directing him or

The most effective way to take control of your workers compensation program is to implement a 'first call' claims management reporting system, which directs employees to appropriate care at the start of the claim.

her to the proper specialist from the start. Expediting expert treatment cuts costs by making sure the injury isn't worsened and by eliminating unnecessary doctor visits.

- Gives the injured worker a nurse advocate.

The assigned nurse case manager works one-on-one with the injured employee throughout the case—from first call through return to work—to make sure he or she is getting the best care possible. Throughout the case, the case manager continually follows-up with the injured employee to make sure he or she is following the treatment plan, observing physician orders, taking prescribed medications and going to physical therapy, if ordered. The nurse case manager can also interpret the physician's orders to the patient.

- Assures parties involved that the process is positive.

Because there is a nurse advocate assigned to the case, adversarial relationships among

the employer, injured employee and physicians do not arise. The employer is assured that the employee is doing everything to take care of the injury and return to work as soon as possible. The employee feels that the employer cares and that he or she is receiving appropriate care. And physicians get a timely response for approval to render services.

- Guarantees a quicker return to

work, thus saving money on disability payments.

We have found that a first-call program closes cases 50% to 75% sooner. A nurse advocate, with his or her ongoing positive relationship with the employer, continually works on creative back-to-work or light-duty alternatives for the injured worker. Employers are usually more amenable to partial or light duty when they are assured by the nurse case manager that the patient is complying with treatment orders.

- Promotes successful outcomes and limits costly litigation down the road.

The ability to sue an employer varies on a state-by-state basis. In general, there are three reasons injured employees sue their employer: they feel they are not being treated fairly; they feel they are not getting appropriate medical treatment; or they are not receiving their disability payments. However, if a patient thinks the employer is providing appropriate quality medical care,

the case is less likely to go into litigation. Most employees do want to get better and return to work.

Here's how the first-call program works. When the employee is injured, either the employee or the employer places a call to the company's first-call number. The case manager, who is always a registered nurse, obtains the demographics and details of the injury, makes a medical assessment and then refers the injured worker to the most appropriate network provider.

It is during this first call that the registered nurse initiates the management of the claim and early intervention.

Working with the medical provider, the nurse case manager obtains and certifies an acceptable treatment plan, outlining specifically the medical outcome expectations, practice protocols and utilization criteria. The nurse case manager then notifies the claims payer of the treatment plan. All referrals to specialists or hospitals—as well as second opinions, home health care and rehabilitation—are coordinated and approved by the first-call registered nurse. This case manager manages the claim for its duration, making sure the injured employee adheres to the treatment plan, that proper medical protocols are followed and that medical improvement is reviewed regularly.

A well-designed and properly monitored first-call management program will undoubtedly produce cost savings for employers. Aggressive claims management, coupled with well-designed loss control programs, go hand in hand with controlling costs.

Karen L. Andalman is president of Managed Care Concepts Inc., a Chicago-based provider of utilization review, medical large case management and workers compensation claims management programs.

D&O market troubles not likely to end soon

By Megan G. Colwell

Despite faint glimmers of relief on the horizon, the troubles plaguing the directors and officers liability insurance market will linger for a while.

Solutions are emerging, but customer satisfaction with those solutions may lie in redefining the problem.

Driven largely by stock market volatility, initial public offerings and corporate governance scandals, the frequency and severity of D&O claims have increased,



particularly claims arising from securities class-action lawsuits. The increase in claims has been accompanied by a constricting D&O market. Departing D&O insurers, stiffer terms and conditions, narrower contracts, soaring premiums, and a

good deal more underwriting skepticism—particularly for public companies—are all evidence of the constricting market.

Since 1999, several significant D&O markets have ceased providing capacity, although their outstanding loss portfolios are alive and kicking. The remaining insurers—those that haven't gone under or sold off their book—fall into basically two categories of players.

First, there are those that have been in the market for some time, typified by American

International Group Inc. and Chubb Corp. These companies have good ratings, experienced underwriting and claims staff, significant books and significant loss portfolios. Although they're here for the long haul, it is evident that "long haul" will be based on their need to fund for today's outstanding losses along with tomorrow's predicted loss costs.

The other category of D&O insurer is a new entrant, with no prior corporate track record in this arena but with new management, underwriters and claim staff who individually bring their experience to the insurer. These companies have new capital but no loss portfolio, enabling them to attract a book of business, priced competitively with broader terms and conditions than may be available elsewhere. This provides a counterbalance to the other insurers, but it also breeds resentment, resistance and skepticism as to whether the newer players will be around over the long term.

A challenging dynamic of this market is that clients may want the absolute best paper—as provided by the long-term D&O insurers—but may not be willing or able to pay what the insurer perceives its program to be worth.

Further evidence of a constricted market can be found in terms and conditions, which involve a narrower scope of coverage, additional exclusions, mandatory coinsurance and the elimination of coverage for the corporate entity for securities class-action lawsuits.

There are other issues. Certain classes of business remain problematic, such as technology, health care and more recently,

the energy sector. Broker Woodruff-Sawyer & Co.'s proprietary securities litigation database shows that 20% of the companies going public in the past decade have experienced securities class-action lawsuits.

Insurers also have made flawed assumptions, including believing that geography is a long-term predictor of claim activity; that industry in the Midwest is less problematic than the same industry in other states; and that bigger companies are safer than smaller, newer companies. The recent scandals have taught us that good corporate governance comes down to the integrity of the people running the companies and the decisions they make.

These developments proceed, of course, with the tumult over corporate governance. The Sarbanes-Oxley Act has resulted in broad changes to D&O underwriting, requiring more information. Clients now need to share their corporate governance practices, revenue recognition procedures and information on additional, ancillary issues. They must anticipate questions on the company's mission, strategic position and customer pipeline; the composition and expertise of its board, management team and audit committee; and the procedures and processes that guide them.

At present, buyers need to regain the trust of insurers. The underwriters are saying, in effect, "Help me understand why I should want to insure these directors and officers." In the softer market, underwriters said, "Let's just make sure there are no red flags here that prevent me from insuring this customer."

Looking ahead, we'll see another unsettled year in which insurers will continue to redefine their products and costs. Unsettled

for the carrier, however, doesn't need to mean unpredictable and prohibitive for the buyer, as risk managers can mitigate the effect of the market on their D&O renewal.

To obtain favorable pricing, underwriters must understand the risks and issues surrounding an operation, so buyers must spend time with their brokers long before the policy expiration, to analyze risks and highlight strengths. Together, they should develop their story on "what makes them different from other companies in their industry." This can be key when determining the ultimate pricing.

Developing trust between insurers and buyers starts with open communications. Building relationships with the underwriters and demonstrating that the buyer has instituted sound policies and procedures is the first step in this process. It might be an exaggeration to call this a "silver lining," but the return to sound business practices, solid management and open communications can generate a solid, less prohibitive D&O renewal.

From a broader perspective, the return to a more balanced relationship between D&O sellers and buyers will be affected by factors outside insurance. The return of a viable stock market, some semblance of an IPO market, more confidence in corporate governance and the investment community all have to work in concert to create a more predictable environment for D&O insurance.

Megan G. Colwell is a principal with San Francisco-based broker Woodruff-Sawyer, an Assurex Global Partner.

Injury at ballpark not covered under workers comp

The Court of Appeals of North Carolina ruled that an employee on a business trip for his employer deviated from that trip when he was injured while exiting a ballpark where he attended a ballgame.

Sara Lee Corp. employed Tim Jacobs as a salesman. His job duties consisted mainly of outside sales activities that involved traveling to the places of business of customers and prospective customers. Sara Lee offered trips to food shows as an incentive to its sales force.

Mr. Jacobs had taken about 20 such trips during his Sara Lee employment. Sara Lee provided transportation and spending money for the employees and the employees were paid their normal salaries.

In May 1999, while Mr. Jacobs was in Chicago on one such trip, he bought a ticket to the White Sox-Yankees baseball game. While exiting the ballpark, he slipped and fell, twisting and rupturing a tendon in his right knee. His claim for workers compensation was denied, and he appealed.

The appellate court said the test of eligibility for workers comp benefits in such cases is whether Mr. Jacobs was on a substantial personal deviation from his business trip or whether he had returned to his business route. The court concluded that Mr. Jacobs was still at the stadium, on a deviation from his business trip, at the time of the injury. Thus, the court affirmed the denial of workers compensation benefits.

Jacobs vs. Sara Lee Corp., Court of Appeals of North Carolina, April 1, 2003 (BI/01/O.-\$10)

Legal briefs

ERISA determines beneficiary

The Employee Retirement Income Security Act pre-empted Illinois law with respect to determining the rightful beneficiary of a deceased employee's ERISA-regulated group term life insurance proceeds, according to the 7th U.S. Circuit Court of Appeals.

Alexandria Melton is the 14-year-old daughter of Richard Melton, who died in 2001, and Judy Melton, who was married to Richard from 1986 until their divorce in 1989. The couple's divorce agreement required Mr. Melton to maintain all then-existing life insurance policies in the names of Alexandria and his two other minor children from a previous marriage for "so long as he owes the duty of support for each of the minor children." Mr. Melton married Peggy Melton in 1993. During their marriage, Peggy Melton was named as the primary beneficiary of his employee benefits plan, which included group term life insurance benefits. The Meltons divorced in May 2001. Their divorce agreement contained a blanket revocation of their interests in all financial and property rights arising by reason of their marital relation. Although the couple divorced six months before Mr. Melton died, Peggy Melton was still the named beneficiary of his group term life policy. Alexandria sued in the Illinois courts seeking to impose a trust upon the proceeds of group life insurance payable to Peggy Melton as the named beneficiary. The case was removed to federal

court, where a federal trial court ruled for Peggy Melton and dismissed Alexandria's suit.

The appellate court said ERISA pre-empted Illinois state law with respect to determining the rightful beneficiary of ERISA-regulated group life insurance policy. Because Mr. Melton's ERISA-regulated benefits plan determines beneficiary status according to the persons named in plan documents, the court found that Peggy Melton was the proper beneficiary of the policy. The trial court decision was affirmed.

Melton vs. Melton, 7th U.S. Circuit Court of Appeals, April 8, 2003 (BI/02/O.-\$10)

Exception to dishonesty exclusion

A dishonesty exclusion in a special property insurance policy did not apply to preclude coverage of losses arising from the erasure of the policyholder's vital computer files and databases by a former employee, the 4th U.S. Circuit Court of Appeals ruled.

NMS Services Inc. is a software development company whose operations are computerized. Hartford Insurance Co., under a special property coverage form that provided basic property coverage and a computer and media endorsement, insured NMS' property. The policy contained an exclusion for loss or damage caused by employee dishonesty, but the exclusion did not apply to acts of destruction by employees.

In July 2000, NMS discovered that its computer systems had sustained considerable damage, including the erasure of vital computer files and databases. It was learned

that a hacker, John Powell, who had been employed by NMS as a technical systems administrator until he was terminated on May 30, 2000, caused the damage. Mr. Powell had installed two hacking programs on NMS' network while he was still employed at the company. Hartford denied NMS' claim for recovery under the policy, and NMS sued Hartford in state court. The case was removed to federal court, where a trial court found that the employee dishonesty exclusion precluded coverage because Mr. Powell was entrusted with NMS' property while still employed at NMS.

The appellate court said that if the trial court's reasoning was correct, then any dishonest or criminal act committed by an employee (or former employee) that damaged property would preclude coverage if the employee had also been entrusted with the property. Such exclusion, the court said, would render the exception meaningless. The court emphasized that NMS' property was destroyed by an employee, which triggered the exception to the dishonesty exclusion of the special property form. Under the exception, the court said, acts of destruction by employees do not preclude coverage. The trial court decision was reversed.

NMS Services Inc. vs. Hartford, 4th U.S. Circuit Court of Appeals, April 21, 2003 (BI/03/O.-\$10)

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

California regulator cuts SCPIE med mal rate hike

Investigation prompts commissioner's denial of 15.6% proposed increase

By MICHAEL ROMANO

SANTA MONICA, Calif.—A California consumer group has successfully mounted a challenge to a malpractice insurance rate increase, reinforcing its assertion that tough oversight by state regulators—not caps on damages—is the best way to limit rate increases for struggling physicians.

State Insurance Commissioner John Garamendi ordered SCPIE Indemnity, California's second-

biggest malpractice insurer, to roll back its proposed rate increase for doctors by 36% after conducting an eight-month investigation triggered by a formal objection from the Santa Monica, Calif.-based Foundation for Taxpayer and Consumer Rights.

In September 2002, SCPIE, which insures about 9,000 California doctors, asked for a 15.6% rate hike to take effect Jan. 1, 2003. The increase was postponed pending the outcome of the investigation, and instead, the insurance commissioner

allowed the company to increase premiums by only 9.9%, effective Sept. 22, a reduction that will save the state's doctors almost \$24 million, the consumer group estimated.

"We challenged this proposed rate hike because we believe SCPIE was trying to charge excessive premiums," said Douglas Heller, the FTCR's senior consumer advocate. "They were just out of line."

The insurance commissioner, acting on the recommendations of an

administrative law judge, based the recent ruling in part on the fact that SCPIE posted a profit in the quarter ended June 30 despite being forced to postpone any rate increase during the lengthy investigation, Mr. Heller said.

But Donald Zuk, the insurance company's president and chief executive officer, said SCPIE's second-quarter profit was modest—it posted net income of \$612,000 compared with a \$12 million loss in the year-ago quarter—and was fully jus-

tified in its rate request.

"The FTCR alludes to the fact that SCPIE made a profit in the 2003 second quarter without a rate increase," Mr. Zuk said. "This profit, if annualized, would represent approximately a 1% return on equity, hardly overwhelming evidence that the requested rate increase was not justified."

Mr. Heller called the rollback a tribute to Proposition 103, a 15-year-old initiative that requires insurance companies to justify any premium increases with the state insurance commissioner while pro-

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'We challenged this proposed rate hike because we believe SCPIE was trying to charge excessive premiums.'

*Douglas Heller
 Foundation for Taxpayer
 and Consumer Rights*

viding consumers with the right to challenge rate increases. That law is primarily responsible for California's relatively stable insurance rates, said Mr. Heller, who rejected claims by the American Medical Assn. that doctors' premiums would be far higher if not for a 1975 state law that places a \$250,000 limit on noneconomic damages in malpractice rates.

In fact, he noted, James Robertson, SCPIE's actuary and assistant vp, provided written testimony to the insurance commissioner that the Medical Injury Compensation Reform Act of 1975 has not played a key role in holding the line on insurance costs.

"While MICRA was the Legislature's attempt at remedying the medical malpractice crisis in California in 1975," Mr. Robertson's statement read, "it did not substantially reduce the relative risk of medical malpractice insurance in California."

Said Mr. Heller: "Insurance companies tell doctors and lawmakers that caps will reduce rates, but under the spotlight of regulation SCPIE admitted that California's caps do not keep physicians' rates down. This is the big lesson: It's not caps that keep rates down—it's regulations."

Mr. Garamendi was not available for comment.

SCPIE's Mr. Zuk said that the insurer would not appeal the decision.

"We are moving forward to implement the approved rate increase in the fourth quarter of 2003," Mr. Zuk said.

"We will apply strict but fair underwriting standards to our existing insureds and new applicants for insurance," he said.

Michael Romano is a reporter for Modern Healthcare, a sister publication of Business Insurance.

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Two Pennsylvania insurers face lawsuits over practices

By LAURA B. BENKO

Even as one Pennsylvania-based health insurer settles its legal woes, two others may be heading to court to defend themselves against allegations of illegally hoarding money—one from consumers, the other from providers.

CIGNA Corp. of Philadelphia agreed earlier this month to pay at least \$540 million to settle its portion of a federal class-action lawsuit

filed on behalf of 700,000 doctors who charged that the nation's largest health maintenance organization routinely shortchanged them for their services (*BI*, Sept. 8). CIGNA has earmarked \$70 million in cash to pay previously disputed claims up to 12 years old, \$55 million to cover attorneys' fees and \$15 million to create a health care foundation. The 12 million-member insurer also will spend about \$400 million to modify its claims-pro-

cessing system.

"CIGNA is to be commended for agreeing to change its business practices and improve its relationships with practicing physicians and their patients," said Donald Palmisano, president of the American Medical Assn.

The CIGNA agreement builds on a \$470 million settlement reached by Aetna Inc. of Hartford, Conn., in May. The remaining defendants, all major insurers, hope to win an appeal in Atlanta next week challenging the lawsuit's class-action status. The case, first filed in 1999, is being heard by U.S. District Judge Federico Moreno in Miami.

Meanwhile, Independence Blue Cross was dealt a setback when the Pennsylvania Supreme Court agreed to review a class-action lawsuit seeking to force the Philadelphia-based insurer to "disgorge" a portion of its \$707 million surplus to reduce premiums for its 2.8 million members. The lawsuit, originally filed by a group of lawyers in 2001, had been dismissed by a lower court late last year.

The plaintiffs charge that Independence violated state not-for-profit laws by "stockpiling" \$300 million, or 42%, more in reserves than regulators require. Independence argues that an ample surplus is crucial to ensure that money will be available to pay claims in the event of a financial or public health crisis and is needed to satisfy requirements of the Blue Cross & Blue Shield Assn.

An Independence spokesman said a five-judge Commonwealth Court unanimously ruled in December 2002 that any dispute over the reserves fell to the Pennsylvania Insurance Department, not the courts. Independence "is confident that upon review, the Supreme Court will uphold that decision and put to rest this important jurisdictional question," he said.

Separately, AmeriChoice of Pennsylvania and its parent company, UnitedHealth Group of Minneapolis, face a lawsuit filed by Radnor, Pa.-based Jefferson Health System, charging that they failed to reimburse the eight-hospital chain for more than \$9 million in care provided to AmeriChoice enrollees since 2000.

According to the lawsuit, filed Aug. 22, AmeriChoice refused to fully pay for services involving hundreds of Medicare and Medicaid patients. Jefferson is seeking \$90 million in damages. An AmeriChoice spokesman said the company remains hopeful the matter can be resolved outside of court. AmeriChoice covers 1.2 million people, mostly Medicare and Medicaid beneficiaries in 13 states, including 117,000 in Pennsylvania. UnitedHealth acquired the insurer last year for \$560 million.

Laura B. Benko is a reporter for *Modern Healthcare*, a sister publication of *Business Insurance*.

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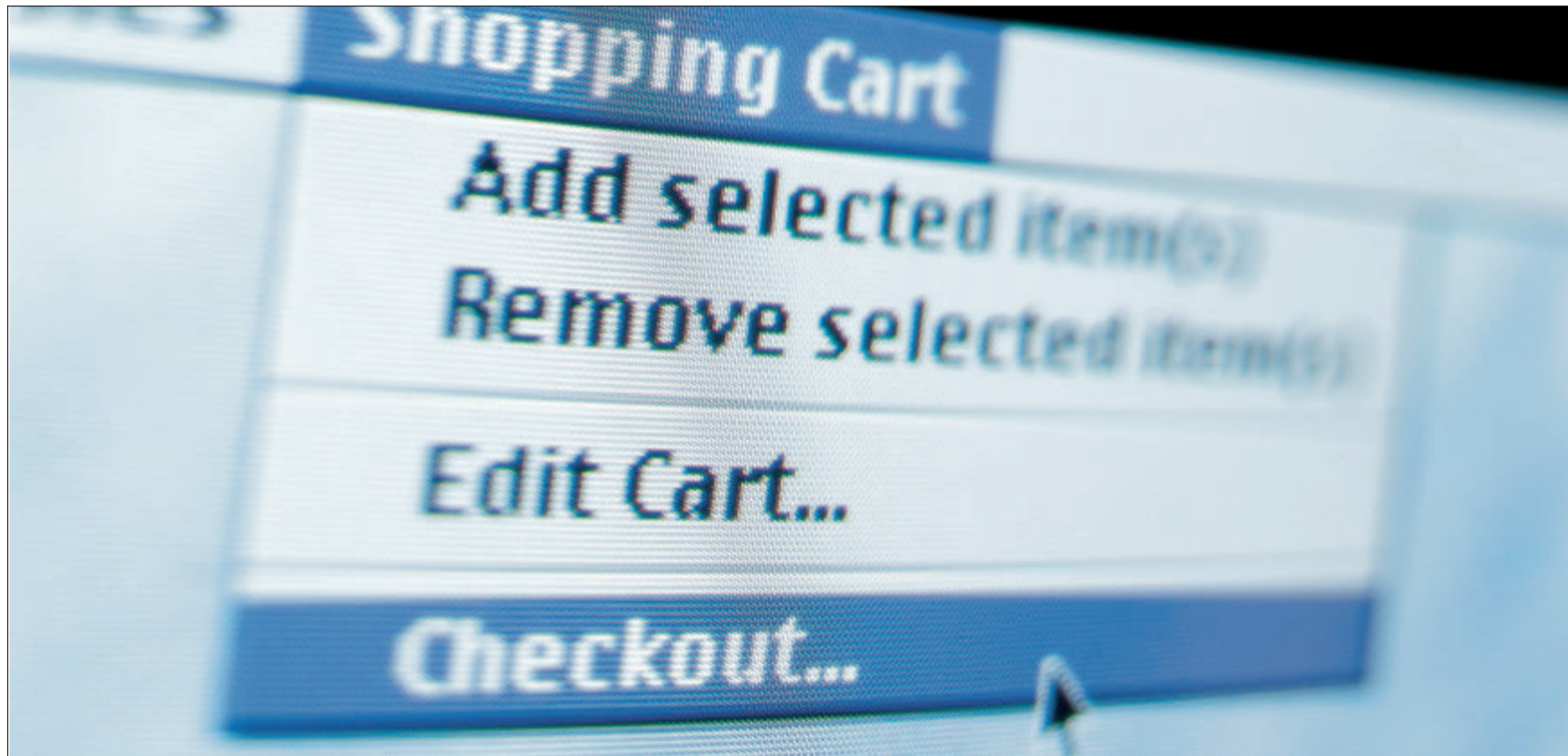
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INSURER TOPICS

A MONTHLY EDITORIAL SECTION SENT EXCLUSIVELY TO INSURERS AND REINSURERS

Customer Service



Interest in online self-service tools growing

By **MICHAEL PRINCE**
and **RODD ZOLKOS**

For many in the insurance industry, the Internet is seen as an ideal vehicle for improving customer service.

Many insurers are using Web-based platforms as a way to give buyers direct access to policy and claims information, or to provide agents and brokers with instant access to those details so they can better serve their clients.

But despite the advantages afforded by technology, many producers have been slow to embrace self-service systems.

Providing self-service tools to agents and brokers is proving particularly useful for some insurers in their small-business areas.

"We've had some efforts for a while," said Mark Korsgaard, managing director and senior vp at Chubb & Son Inc. in Warren, N.J.

Chubb's online initiatives, such as its recently introduced ClaimVista tool, are seen as a way to streamline communication among company, agent and buyer about issues such as claims status, he said. Such tools allow "the agent to better serve the customer (and) to reduce the inquiries they have to make to us."

"It's a combination of customer service and selfishness, I suppose," Mr. Korsgaard said.

ClaimVista gives agents and brokers

online access to real-time information about customers' claims through a password-protected Web site. The system applies to personal lines, commercial property, workers compensation, business auto and general liability accounts.

"Clearly, the Internet offers a better platform for this," Mr. Korsgaard said.

The ClaimVista system is an offshoot of the ClaimView system Chubb makes available to its larger risk management accounts, giving them direct access to the insurer for various kinds of policy information. "That was the predecessor to this," Mr. Korsgaard said.

To date, 73 agents have enrolled with Chubb to use the ClaimVista system. "We're looking to do another 30 this month," Mr. Korsgaard said.

Those who have signed on to ClaimVista have been using it to varying degrees, he said. "Some of them are very heavy users, and some poke in once or twice."

In rolling out the new system, Mr. Korsgaard said Chubb has sought to make sure it is truly benefiting the agents and brokers using it. "We have to make sure we're supporting them and not bogging down anybody's system," he said.

Zurich North America is another insurer that has been using Web-based tools to help agents and brokers enhance customer service.

An online underwriting system, for example, allows agents to submit

applications, get quotes and bind policies. "If there's a transaction needed to process the business, it's available at the fingertips of the agent," said Darryl Catts, vp of small business technology at Zurich in Baltimore.

And a direct-bill Web feature gives agents and brokers instant access to customer billing information from the insurer, enabling them to quickly resolve customers' payment questions. In some lines, policy forms can actually be delivered online, and Zurich is working to accomplish that with additional product offerings.

"Our entire focus is pretty much giving access to our customers through the independent agents and brokers," Mr. Catts said.

The insurer also has opened its online Zurich Data Warehouse to agents, offering online access to policy information, loss runs and a variety of other information. "We want to give the agent the common tools that are needed to service the client," he said.

"By putting a lot of stuff at the agents' fingertips, we've taken processes that have historically taken days for the independent agent...down to minutes," Mr. Catts said.

Often, that added efficiency can help an agent make a profit from a small-business account that otherwise might not have been cost-effective, he said.

But despite the widespread use of the Internet for customer self-service throughout the financial world, insurance intermediaries

have been very reluctant to adopt the technology for themselves.

In addition to being intimidated by the Internet in general, observers say, some agents are concerned that giving customers direct access to services via the Internet will take away some of the value of the services they offer.

But customer demand may force many intermediaries to offer Web-based customer self-service. Those that have implemented self-service technology are finding themselves reaping the rewards.

"It is catching on slowly," said Jeff Yates, executive director of the Agents Council on Technology in Alexandria, Va.

Although it has been available for several years, customer self-service "is still in its infancy," said Laura Nettles, president and chief executive officer of Nettles Consulting Network in Atlanta.

"I think this thing is just getting started," said Richard Roy, chairman and CEO of idNET Inc., a developer of customer self-service software in Simsbury, Conn.

Generally, agencies have two ways to obtain the technology. Either an agency management system provider can buy software to add the capability as an added feature to their Web site, or agencies can turn to an outside vendor that links an existing system to the Internet.

Using either method allows an agency's clients to access detailed policy information

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**Industry groups
oppose 'no-fax' rule / 18D**

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**Dealing with a 'wild card'
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INSURER TOPICS

Self-service: Popularity of approach growing with industry

Continued from previous page

from Web-connected computers. In addition, systems generally allow policyholders to print certificates of insurance and identification cards and to make minor changes to policies.

Despite the numerous advantages self-service offers, agencies have been slow to adopt the new technology.

In general, insurance agencies are conservative when it comes to new technology and are slow to implement it, said Kevin Wheeler, president of Cardinal Insurance Services Inc., a four-employee

agency in Indianapolis.

"We move at a snail's pace with anything that involves the word 'change,'" Mr. Wheeler said.

So far, only agencies that have a high degree of technological savvy and are open to new ventures have been willing to take this step, said Mark Parrish, president of Ajasent Inc., an application service provider in West Monroe, La.

"The early adopters now are adopting it," Mr. Parrish said.

Adoption has been especially slow by agencies in rural areas, Mr. Yates said. But with agents that have large blocks of commercial

business, especially with clients in the trucking or construction industries, the adoption has been more brisk, he said. These businesses often need quick access to certificates of insurance, and a Web site is a great way for them to obtain them, Mr. Yates explained.

Many agencies have adopted the technology in response to customer demand, observers say.

Around-the-clock Internet access is common for so many other businesses that policyholders are wondering why they can't also have it for their insurance needs, Mr. Roy said. This attitude has been

forcing agencies to respond, he said.

"I think the customers will drive it faster than the agencies," he said.

It's becoming harder for agencies to ignore the movement toward self-service, said Steve Anderson, president of The Anderson Network, an agency consulting firm in Nashville, Tenn.

"Consumers are going to demand it," he said.

Another roadblock to wider adoption is policyholders' performance of administrative tasks, which strikes at the heart of what many agencies believe is their

role, Ms. Nettles said.

"They are very threatened by the new technology that takes away the processing," she said.

Too often, Ms. Nettles said, agencies define their relationship by pushing paper, so that when the paper goes away, "the agency does not know where they fit." These agencies need to focus on serving their clients as insurance experts and consultants, she said.

Agencies can see a number of significant advantages to implementing online customer self-service systems.

Such systems provide a unique customer service arrangement. Policyholders can access their policy information 24 hours a day, print out their own insurance certificates and identification cards and perform numerous transactions. Insurance customers are no longer restricted to doing business only when their insurance agencies are open.

Customers can use the Web site "to do their own thing at their own pace," Mr. Wheeler said.

Online self-service also cuts down on the mundane administrative tasks and allows agencies to focus more on their customers, Ms. Nettles said.

"The misconception is that self-service takes the agency out of the picture," she said. Ms. Nettles explained that self-service merely lets customers handle the tasks they can perform on their own.

With a system in place, an agency can market itself as having around-the-clock customer service, giving it a significant advantage over its rivals, said Donna Wilson, senior vp at Bowen, Miclette & Britt, an agency in Houston. The 170-employee agency has had a system in place for about three years, Ms. Wilson said.

"It's a value-added service to our clients," she said.

A few years ago, Mr. Wheeler's agency started using the popular system sold by idNET called CSR24. The system connects the agency's existing management system to the Internet and provides customers access to policy information and transactions.

"It's been huge. It sets us apart from some of our competitors," Mr. Wheeler said.

Another advantage has been the 24-hour telephone backup service offered along with CSR24, he said.

The benefit of the phone backup was proven last year, when the agency lost electricity for five days after a tornado struck the area. The agency's offices lacked phone service but customers were still able to transact business over the Internet and file claims through the backup phone service, Mr. Wheeler said.

One concern, though, is that some customers might need to be convinced that the online access benefits them and gives them greater freedom rather than just requiring them to do more work, Ms. Wilson said.

"We don't want our customers to think we're trying to get them to do the work," she said.



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INSURER TOPICS

Insurance industry groups irate about 'no-fax' rule

By JOANNE WOJCIK

The federal government's decision last month to postpone implementation of a "no-fax" rule doesn't mean that insurers and producers can rest easy, industry sources warn, though some say that reversal of the regulation is likely.

The rule on faxes, issued June 26 by the Federal Communications Commission as part of a "no-call list" law, requires businesses, organizations and individuals to obtain written permission from recipients before sending them unsolicited faxes that can be considered advertising.

Such a restriction, which eliminates an exception in previous FCC rules that had allowed businesses to communicate by fax with individuals with whom they have an existing business relationship, could hamper the ability of agents and brokers to provide effective customer service, according to Pat Borowski, senior vp of the National Assn. of Professional Insurance Agents in Washington.

"PIA absolutely understands that everybody in this country is fed up with getting calls and stuff from people you don't even know. If I get one more call from an aluminum siding company, I'm going to blow my stack," she said. "But our guys don't do what one would reasonably recognize as either junk faxes or unsolicited advertising."

"If you have an established business relationship with someone, it doesn't seem to make sense that you wouldn't be able

to...send them faxes, that you would have to get constant approval," said Gary Karr, director of federal media relations for the American Insurance Assn., a Washington-based trade organization for property/casualty insurers.

"This is the collision of the privacy issue with just pure business efficiencies," said Joel Wood, senior vp of government affairs at the Washington-based Council of Insurance Agents & Brokers.

But even though the FCC has postponed implementation of the new rules until Jan. 1, 2005, the PIA's Ms. Borowski is not letting up on the offensive.

"This doesn't mean they're backing away from the order," she said. In fact, one of the reasons for postponement cited in the FCC stay order is that the delay gives businesses and others affected more time to obtain permission to send unsolicited faxes, she pointed out.

Although the rule is vague on the subject of how often permission must be obtained, Ms. Borowski said it could be as often as every six months, depending on how frequently an organization sends faxes.

A spokeswoman for the FCC said that the PIA, like other organizations, now has "14 months to notify the members and get some kind of authorization from them to continue sending faxes," adding that the rule also applies to the trade group's members individually in their communications with customers.

"The rules as we adopted them haven't

changed," the FCC spokeswoman said. "After Jan. 1, 2005, you will have to get their approval to send faxes, even though you have a business relationship."

Indeed, the FCC's Aug. 18 stay order states: "Section 64.1200(a)(3)(i), as amended, requires the sender of a facsimile advertisement to first obtain from the recipient a signed, written statement that includes the facsimile number to which any advertisements may be sent and clearly indicates the recipient's consent to receive such facsimile advertisements from the sender."

"The comments filed after the release of the 'Report and Order' indicate that many organizations may need additional time to secure this written permission from individuals and businesses to whom they fax advertisements. We believe that, in light of this new information, the public interest would best be served by allowing senders of such advertisements additional time to obtain such express permission before the new rules become effective."

Both Mr. Karr and Mr. Wood say the FCC's decision to postpone implementation of the new rule and accept additional comments means that the rule likely will be reversed.

"It's a moot point," said Mr. Karr of the controversial rule.

"It was just causing a groundswell of



opposition and real outrage," said Mr. Wood. "I'd be shocked if this rule weren't substantially altered. It actually was unnerving to me how many of our members were contacting us spontaneously about this, and we were only one sector of the entire economy."

"Let's put it this way: There will be plenty of faxes going in to Capitol Hill over the course of the next year or two, whether the senator or representative gave them express authorization to do so or not," Mr. Wood said.



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INSURER TOPICS

Customer service key to client loyalty, report finds

By ALLISON REYNOLDS

A new study linking customer loyalty with customer service indicates it may be increasingly important for insurers and brokers to add value to the servicing side of their relationships with clients.

The "Walker Loyalty Report for Financial Services and Insurance," released in July by Indianapolis-based Walker Information, shows that 66% of financial services and insurance customers are not truly loyal to their suppliers. And, according to the report, the key driver of loyalty is customer focus.

Walker's report measured customers' attitudes and experiences with vendors in four industry sectors: health and medical insurance, retirement/investment plans, property/casualty insurance and commercial banking.

The study surveyed a panel of senior-level executives whose responsibilities include purchasing financial services and insurance

products for organizations with 50 or more employees. The findings are based on 2,278 observations gathered from 767 questionnaires completed during 2003.

"While satisfaction with insurance providers measures specific experiences, only loyalty provides an understanding of the relationship and future customer behaviors," according to the study.

The top five drivers of loyalty include customer focus, overall quality of the company, value for the money, brand and quality of the products or services, Walker found.

"In terms of the overall findings, one of the strongest drivers of loyalty is customer focus," said Marc Drizin, vp and loyalty specialist for Walker Information. "It's the No. 1 driver in all areas of the market."

Specifically, 75% of those surveyed indicated at least some satisfaction with their current vendor, but a large percentage were not pleased with the overall relationship or have low intentions

of continuing it, according to the report.

Customer loyalty levels were split into three categories: "high risk," those with low intentions of continuing with the provider;

'I think most customers would be OK with paying a little more if they know they would be getting better service.'

Marc Drizin
Walker Information

"trapped," those likely to continue business with the company but not pleased with the relationship; and "truly loyal," those who plan to maintain the relationship with the provider.

Those described as "high risk" make up 31% of those surveyed, while those categorized as "trapped" make up 33%. With another 2% as "accessible," meaning they may not continue

doing business despite being pleased with the relationship, just 34% were "truly loyal."

Moreover, just one in four of those surveyed say that they would not consider offers from other insurance vendors. Nearly 39% of the survey respondents said that they are very open to considering competitive offerings, but only one-third said they plan to increase their business with existing suppliers.

Only half of those surveyed have positive perceptions of customer service, the enrollment/renewal process, and the relationship with their agent or broker, according to the study.

Mr. Drizin suggests that, in today's market, when customers have trouble differentiating the products of insurance companies, distinguishing good customer service is needed to create more "truly loyal" customers.

Mr. Drizin said that a lot of the trouble in the industry is caused by the focus on the acquisition of new customers and not the retention of

existing customers.

"The initial sale is easy," Mr. Drizin said. "It's not just talking the talk but walking the walk."

Traditionally, insurers have won customers through competitive fees and rates while building relationships with customers. But it may be important for insurers to realize that it's not just low prices that count but the customer service provided that determines customer loyalty.

"I think most customers would be OK with paying a little more if they know they would be getting better service," Mr. Drizin said.

The research suggests that increased customer focus, followed by improvements in quality, brand and reputation, are all needed for turning "trapped" and "high-risk" customers into "truly loyal" ones.

Information about the "Walker Loyalty Report on Financial Services and Insurance" is available on the Internet at www.walkerinfo.com/resources/reports.

Looming asbestos liabilities raise coverage questions

Nonproduct liability issues adding to uncertainty for insurers

By Lloyd Gura
and Barry Bassis

In the movie "Jurassic Park," there is a scene where someone in an open field is suddenly covered by a shadow, whereupon he looks up to discover that he is facing a tyrannosaurus. The insurance industry is like that at the moment, and the monster with the big jaws is asbestos.

And, just when the would-be victim thinks he has reached safe ground, another dinosaur appears, this one a vicious raptor. For the industry, that dangerous creature is asbestos nonproduct liability.

Asbestos claims have flooded the courts, bankrupting more than 60 companies. A Rand Institute for Civil Justice study in September 2002 found there were more than 600,000 asbestos-related lawsuits currently in the courts—in addition to more than 600,000 previously litigated claims—and estimated that the claims could cost businesses more than \$210 billion.

Consequently, insurers have been adding massive amounts to their reserves. For example, Travelers Property Casualty Corp. recently announced it added \$2.45 billion to its asbestos reserves, and ACE Ltd. boosted its gross reserves by \$1.91 billion. In October 2002, Chubb Corp. announced it was adding \$625 million to its asbestos reserves.

Many believe these efforts were not enough. A Feb. 3 editorial in *Business Insurance*, titled "Come Clean on Reserves," observed: "It's time for insurers to clear the air on their true financial exposure to

IT Perspective

asbestos liabilities."

Standard & Poor's Corp. has noted that there is a looming problem for reinsurers, who, for the most part, have not followed their cedents in raising reserves. And after 30 years of asbestos lawsuits, Congress has finally lurched into action, but because of powerful interest groups pushing conflicting agendas, passage of any legislation is far from certain.

The asbestos 'wild card'

What are asbestos nonproduct liabilities, and why did the president of claims at a large property/casualty insurer recently refer to them as the "wild card" in insurance liabilities?

Generally, nonproduct claims arise out of the installation of asbestos-containing materials and involve incidents that occurred before the manufacturer completed operations and departed from the covered premises. They include premises liability claims by individuals not employed by an asbestos defendant company who were exposed to asbestos while working on the premises, as well as claims from spouses who come in contact with asbestos-laden clothing and so-called "downwind" claims from people living near affected plants and mines.

Other potential defendants are manufacturers and distributors of asbestos, subsidiaries that installed

asbestos and trade associations that failed to warn workers about dangers then known about asbestos.

Earlier this year, the U.S. Supreme Court observed that the majority of courts hold that those who suffer from asbestosis may also be able to recover damages for fear of asbestos-related cancer, and the high court applied that rule to railroad workers.

Unlike products or completed-operations provisions, which usually have aggregate limits, nonproduct liability coverage was mostly written on a per occurrence basis and without aggregate limits. Now that the products aggregates in many policies have been exhausted, policyholders are seeking additional coverage by submitting or reallocating asbestos claims as nonproduct claims.

As stated by a principal at Peterson Asbestos Claims Enterprise, policyholders have been billing their asbestos claims under their product-liability limits, but now they are realizing that their liability policies "have a separate no-aggregate limit for nonproducts. So even though you've consumed \$2 million, you actually have another \$2 million available for some other type of liability that's coming in your door."

Rising nonproduct claims were a major factor in the decision by ratings agency A.M. Best Co. to

increase its estimate of the asbestos liability of U.S. insurance companies to \$65 billion last year from \$40 billion.

Nonproduct liability

Some of the issues arising from nonproduct coverage are similar to those in products coverage. For example, how many limits apply in multiyear policies?

This issue is also important in the reinsurance context. A recent Massachusetts federal district court decision dealt with an environmental loss in which the cedent's policies with its insured had annual limits. The reinsurer, however, had issued three-year facultative certificates with "following form" language. The court held that the per occurrence and aggregate limits of the certificates prevailed as between the reinsurer and the cedent and thus there was a single limit for each three-year period for reinsurance purposes, even though the insured received three separate annual limits.

Another significant issue is the number of occurrences. If the parties agree on the number of occurrences or if a court holds that all nonproduct claims with respect to a particular defendant arose out of a single occurrence, coverage would be capped even if there were no aggregate limits. An aggregate extension clause may also affect reinsurers, depending on the wording of the clause and the course of performance of the parties.

Reinsurers often become involved in disputes concerning

allocation of settlements. The cedent has a duty to act in a good-faith, businesslike manner and is not to settle a case solely to maximize its reinsurance recovery.

One area of contention in allocation is how to distinguish between product and nonproduct exposures. Policyholders generally prefer nonproduct classification to avoid application of aggregate limits. An alternative dispute resolution decision involving Armstrong World Industries Inc. held that a policyholder can classify a claim as nonproduct even if a claim is 1% nonproduct and 99% product. The rationale was that allocation between the two was impossible and would not further the "dominant purpose" of a policy to indemnify.

The 1985 Wellington Agreement, which provided a framework for the resolution of asbestos claims and coverage disputes, may also have an impact in this area. Although the vast majority of claims under the agreement involved products liability coverage, the agreement states that it applies to "all asbestos-related" bodily claims and expressly refers to nonproduct coverage. The imposition of artificial aggregate limits for nonproduct claims has the potential, under certain circumstances, to exhaust primary limits, creating possible exposures for excess insurers and reinsurers that might not otherwise have been at risk.

Both cedents and reinsurers should be aware of the possible impact of nonproduct claims on commutations. Like the unwary

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INSURER TOPICS

Perspective: Insurers, reinsurers facing nonproduct claims

Continued from page 18F

visitor in "Jurassic Park," a reinsurer might believe it has reached safety and ended its asbestos liability, only to discover that it still faces possibly limitless nonproduct claims. Thus, cedents and reinsurers must be careful about the language of their commutations, the former to reserve their rights to pursue nonproduct claims and the latter to end their liability for all

asbestos-related losses.

Difficulties for reinsurers

While most uses of asbestos stopped in the early 1970s, some asbestos-related diseases have a latency period of more than 40 years. Identification of coverage at risk is more difficult for a reinsurer than for a direct insurer.

While a direct writer can search

underwriting files to identify policies issued to possible asbestos defendants, treaty reinsurers normally cannot perform this type of search for potential exposure. Facultative reinsurers are in a somewhat better position than treaty reinsurers, since they typically have access to more information about the risk.

Even when a reinsurer identifies coverage at risk, it is still not easy to

estimate whether coverage will be triggered. Reinsurers have less access than direct insurers to claim filings and settlement information, which can be used to determine which policies will likely be affected.

Reinsurers are also hampered by the delay between the time claims are reported to direct insurers and when they are transmitted to reinsurers. Thus, the asbestos

nonproduct dilemma is likely to continue to create as much havoc for insurers and reinsurers as the unruly "Jurassic Park" dinosaurs that refused to die.

Lloyd Gura and Barry Bassis are partner and special counsel, respectively, with the New York law firm of Mound Cotton Wollan & Greengrass.

IT briefs

NAMIC salary survey now on Internet

INDIANAPOLIS—The National Assn. of Mutual Insurance Cos. has put its survey of property/casualty industry salary information online.



Covering more than 50 positions, the NAMIC Online Salary Survey offers participants the ability to retrieve custom reports and allows them to submit data electronically via the Internet.

Survey Research Associates of Madison, Wis., developed the secure Web-based service for NAMIC.

NAMIC said that providing year-round, immediate access to the most current salary information available will help its members attract and retain quality employees.

Participants can submit position and salary data at any time and purchase the reports when they are ready. NAMIC will still produce an annual paper survey report for those companies that do not wish to take advantage of the online service.

Participating companies will receive a significant discount on both the purchase of online access to the survey data and the survey report. Companies that are not members of NAMIC are invited to participate but will pay higher fees for the survey reports and access to the online data.

Companies wishing to participate in the NAMIC Online

Salary Survey can learn more by visiting www.namic.org/salarysurvey. Direct access to the NAMIC Online Salary Survey is available at <http://namic.salaries.com>.

AIG opens facility for data recovery

NEW YORK—American International Group Data Center Inc. has opened a data center facility in Fort Worth, Texas, that will provide data recovery capabilities to AIG member companies.

In addition to providing enhanced data recovery and business continuity capabilities for New York-based AIG's companies, the data center also features an extensive telecommunications infrastructure to support the companies' business operations.

Through the new data center, applications are recoverable to the last business day, within 24 hours. The new center also increases the capacity of AIG's American

International Technology Enterprises Inc. company to provide data management services to third-party clients.



Chubb, LoJack sign marketing pact

WARREN, N.J.—Chubb & Son Inc. has entered into a marketing agreement with stolen vehicle recovery technology company LoJack Corp.

Under the arrangement, LoJack will provide Chubb customers who have contractors equipment commercial inland marine insurance with a free extended warranty and other benefits on LoJack's Stolen Vehicle Recovery System. Warren, N.J.-based Chubb will waive deductibles of up to \$10,000 for unrecovered stolen contractors' equipment protected by Westwood, Mass.-based LoJack's system.

Nearly \$1 billion of construction equipment and tools is lost annually in the United States due to theft, according to the National Insurance Crime Bureau. In 2002, some 87% of LoJack-equipped construction equipment was recovered within 24 hours of being reported stolen, and 95% of that equipment was undamaged.

Chubb customers will be able to purchase LoJack's Stolen Vehicle Recovery System for construction equipment at a special rate. They will also receive an extended warranty on the LoJack unit of seven years including parts and labor and a replacement guarantee.

AIA expands partner program

WASHINGTON—The American Insurance Assn. has added three new organizations to its Corporate Partnership Program: Alliance Consulting, Percussion Software Inc. and SurfControl P.L.C.

Washington-based AIA's partnership program allows noninsurer companies to reach key decision-makers within the property/casualty insurance industry to showcase company expertise and establish business

partnerships in a high-profile, highly targeted environment. The program has drawn increasing attention and a steady stream of new participants since its inception in 2002.

Philadelphia-based Alliance Consulting's products and services include data warehousing and integration, application development and integration, infrastructure and application maintenance outsourcing, industry standard packaged software and strategy services for outsourcing and business/information technology alignment.

Boston-based Percussion Software's flagship product, Rhythmyx, is an enterprise content management system that enables organizations to easily manage all of their enterprise content, including documents, Web content, digital assets and images.

SurfControl, with a global headquarters in Congleton, England, and a U.S. base in Scotts Valley, Calif., provides Web and e-mail filtering, as well as a total content security product.

CIMS reaches deal with eBenefitManager

DALLAS—Comprehensive Integrated Marketing Services, an employee benefits general agency and subsidiary of WellPoint Health Networks Inc. of Thousand Oaks, Calif., has entered into a joint marketing agreement with eBenefitManager, an employee self-service technology provider based in Dallas.

Under the agreement, CIMS consultants and eBenefitManager sales personnel will offer the eBenefitManager ESS program for resale through the independent agent and brokerage community. The program will provide access over the Internet for enrollment, participant communication and benefit program administrative features to employee groups of 100 lives and larger.

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ING Re	18B
Ingenix	18C

Results: P/C insurers post first-half profits

Continued from page 3

changes," such as changes in terms and conditions and exclusions, Mr. Inglis said. "Everything's going in the right direction," excluding the possibility of hurricanes.

It was a very positive quarter, said Stephan Petersen, an analyst with Cochran, Caronia & Co. in Chicago. In addition to seeing the impact of past rate increases in insurers' income statements, there also have been some "amazing cash flow numbers" because of the higher rates and increased business volume. Expense ratios have also improved, said Mr. Petersen.

"The second quarter in particular was a strong quarter for the property/casualty segment," said John Ward, chairman of the Cincinnati-based Ward Group. Strong investment returns, "particularly on the realized capital gains side," were one factor, he said. "And while the catastrophe situation in the second quarter was a little bit worse than usual, most companies, by and large, were able to deal with that and actually turn in positive results for the quarter."

In addition, companies are continuing to get very solid rate increases, so that helped as well,

he added.

"There continues to be a little bit of reserve strengthening issues coming through the segment, but on a fairly isolated basis, and not big enough to have a noticeable impact on the segment's results overall," Mr. Ward said.

Results "were quite good, both in terms of premium growth and underwriting margins," said Jay Cohen, an analyst with Merrill Lynch & Co. in New York. "There were some negative surprises, but on balance more positive surprises relative to our expectations."

Some observers say the hard mar-

ket has peaked, at least for property lines, if not necessarily also casualty lines.

"The premium growth was very good for a lot of the specialty commercial writers," including American International Group Inc. and ACE Ltd., said Gary Ransom, senior vp at Hartford, Conn.-based Conning Research & Consulting Inc.

However, "as you got more into the general and middle-market and smaller commercial lines, the rate increases were not as large, nor were the premium growth numbers as large," he noted.

"But even though you had those

varying rates of premium growth, the one consistent theme across every one was that rates, in fact, were decelerating," Mr. Ransom said. "If you piece together all the quarterly results, it seems the peak results were in the second or third quarter of '02," he said.

Rates will continue to increase, but at a slower pace, predicted Merrill Lynch's Mr. Cohen. "Underwriting margins should remain good and, in fact, likely improve modestly because price increases have been exceeding claims inflation for the most part."

Next year, "We would expect to see a reasonable pricing environment, or a rational pricing environment, and that does mean further deceleration (in rate hikes), but at this point, at least in the next two to four quarters we're not expecting any intense price competition," said Mr. Cohen.

Royal & SunAlliance's exit from the U.S. market may act as a brake on the pace at which rate increases shrink, say some observers.

As part of its restructuring plan, Royal & SunAlliance is selling the renewal rights to a large part of its U.S. commercial insurance business—which accounted for \$1.17 billion in net premiums—to The Travelers Indemnity Co., a subsidiary of Hartford, Conn.-based Travelers Property Casualty Corp. (BI, Sept. 8).

We have seen insurers leave the market over the last three years for various reasons, including parents' retrenching, insolvencies and companies shifting their business mix, said James B. Auden, senior director at rating agency Fitch Ratings in Chicago. "I think it helps to support the hardening market" when marginal competition leaves, he said.

Although its exit will not have a dramatic impact, "any time you eliminate a less disciplined competitor, that's always good for the market," said Michael Paisan, an analyst with Legg Mason Inc. in New York.

Conning's Mr. Ransom said the Royal & SunAlliance move is "another example of the broader trend of some companies just in essence giving up and saying, 'We don't have capital to keep doing this, so we'll start selling off books of business.' We could see more sales of a similar nature to what we just saw with Royal and Travelers."

Karen Horvath, vp at Oldwick, N.J.-based A.M. Best Co., said Royal thought it could not take care of losses that stemmed from the soft market. "While we are in the hard market, Royal is a casualty of the soft market. Those aren't over."

Reserve deficiency is a consideration for some observers.

"I think we will still see some reserve charges among the weaker companies," said Mr. Ransom. Some companies have come through this cycle in good shape and have been able to capitalize on the growth opportunities that have presented themselves, he said. However, others "didn't quite get through the balance sheet cleanup process," Mr. Ransom said. Most of the rate increases are behind them, "and yet they still have some more

See RESULTS/page 22

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Property/casualty insurers' 2003 first-half results

Ranked by net income. All amounts in thousands of dollars

	Corporate			Combined		Property/casualty operations		Policyholder	
	Net income 2003	Percent increase (decrease) 2002-2003	Consolidated revenues 2003	ratio 2003 ¹	ratio 2002 ¹	Net Premiums written 2003	Percent increase (decrease) 2002-2003	surplus 2003	Percent increase (decrease) 2002-2003
American International Group Inc.	\$4,230,000	11.9%	38,818,000	92.7% ²	94.9% ²	\$17,087,000 ²	30.3%	N/A	N/A
Travelers P/C Corp.	781,200	80.0	7,351,700	97.2 ²	100.2 ²	6,435,800 ²	10.6	\$8,122,100	6.2%
ACE Ltd.	617,912	104.8	4,857,527	91.1 ²	92.2 ²	5,336,045 ²	38.2	8,178,104	28.1
Chubb Corp.	476,700	16.7	5,454,400	95.3	97.0	5,292,000	22.9	5,850,000	46.8
The St. Paul Cos. Inc.	395,000	N/M ³	4,285,000	97.8 ²	116.0 ²	3,771,000 ²	(4.8)	5,605,000	15.0
Old Republic International	225,959	11.3	1,553,740	94.0	99.4	723,344	20.6	1,798,202	14.4
SAFECO Corp.	201,000	19.6	3,633,300	99.6	107.9	2,522,300	11.0	2,600,000	20.2
CNA Financial Corp.	153,000	300.0	5,940,000	119.3 ²	108.3 ²	3,890,000 ²	(21.2)	6,990,000	10.3
Cincinnati Financial Corp.	141,102	28.1	1,505,446	96.8	103.6	1,412,782	13.4	3,002,698	3.6
Royal & SunAlliance USA	107,000	67.2	N/A	109.7	107.2	1,546,000	2.3	1,723,000	(32.1)
American Financial Group	55,600	311.9	1,619,600	101.5	101.4	1,025,500	(20.0)	1,431,800	(14.6)
Argonaut Group Inc.	53,330	292.5	359,592	106.1	105.7	277,800	37.3	429,269	(6.5)
Ohio Casualty Corp.	30,922	(22.6)	831,235	107.5 ²	107.8 ²	728,088 ²	(2.9)	782,713	2.6
RLI Corp.	29,828	56.5 ⁴	246,674	92.3 ²	96.7 ²	225,764 ²	19.7	511,414	51.1
Hartford Financial Services Group Inc.	(888,000)	N/M	9,013,000	98.7	100.4	4,568,000	8.7	4,986,000	2.4
Liberty Mutual Insurance Co. ²	N/A	N/A	N/A	104.3	107.0	6,241,000	17.5	5,538,000	(0.3)
Cumulative	\$6,610,553	10.3%*	\$85,469,214	98.1%	101.4%	\$61,082,423	14.3%	\$57,548,300	10.5%

1. Includes dividends. 2. Statutory. 3. Comparison not meaningful due to first-half 2002 loss. 4. Comparison not meaningful due to first-half 2003 loss. N/A Company did not provide data. *Excluding Hartford, total net income rose 35.9%

Source: BI survey

Results

Continued from page 20

reserve charges to take," he noted.

"We still think that reserves are short overall," said Mr. Auden. Insurers "tend to take reserve actions later in the year. There'll probably be some in the second half."

Ms. Horvath agreed. "There will be additional adverse development reported in the second half. Whether it be from the asbestos and environmental exposures" or other areas, "there will be development. It's just a question of how much," she said.

However, Todd Bault, a research analyst at Sanford Bernstein & Co. in New York, said that while he is not sure the industry is fully reserved, "we might be at the point where current earnings are strong enough they can absorb any remaining inadequacies, and so we may be getting towards the end of reserve charges."

Other observers are generally optimistic about the industry's near-term outlook.

"On balance, rates will remain strong for the next 12 to 18 months, and it looks like the investment side may be a bigger contributor to overall results than it has been over the last couple of years," Mr. Ward predicted.

"I think it's going to continue to get better. I don't see any clouds on the horizon," said Mr. Inglis.



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Medicare: HMO withdrawals will affect fewer people

Continued from page 4
wide in New York.

Several large health plans said they would make no changes to their coverage areas for 2004. For example, Hartford, Conn.-based Aetna; Boston-based Blue Cross & Blue Shield of Massachusetts; Harvard Pilgrim Health Care in Wellesley, Mass.; Health Net Inc. in Los Angeles; Humana of Louisville, Ky.; Oxford Health Plans Inc. in Trumbull, Conn.; and UnitedHealthcare in Minneapolis all announced they will maintain the same coverage areas next year.

Some Medicare+Choice pullouts will be seen in 2004, though.

Perhaps the largest withdrawal involves Blue Cross & Blue Shield of Georgia, which last week said it will exit the program entirely next year. The move, which the Blues plan blamed on inadequate federal reim-

bursements, affects 19,000 people in eight counties in the Atlanta area.

And many HMOs, while continuing to offer coverage in their Medicare+Choice markets, are raising premiums and copayments. For example, Harvard Pilgrim, which has 36,000 Medicare HMO members, is raising its monthly premium in Massachusetts by 16.7% to \$140 per month. Premiums in New Hampshire will rise by 20% to \$120 per month. In addition, Harvard Pilgrim next year will launch a plan that does not include prescription drug coverage. Monthly premiums for that plan will be \$99 in Massachusetts and \$95 in New Hampshire. The HMO also is imposing a \$300 hospital inpatient copayment next year.

BC/BS of Massachusetts, which has 35,000 Medicare+Choice enrollees, is raising premiums by \$36 per month—an increase ranging from 27.7% to 29.5% depending on the county. In addition, the company said it is increasing copayments for certain services.

Other companies also plan to raise premiums and cut benefits but did not provide details. For example, Oxford, which has 71,000 Medicare+Choice members, plans to hike premiums for its point of service plan and to slightly reduce the benefits for all Medicare+Choice plans, said Pete Haytaian, vp of government programs and specialty businesses at Oxford in White Plains, N.Y.

The combination of higher premiums and reduced benefits could prompt enrollees to quit Medicare+Choice plans and rejoin employer retiree health plans. Most people who join Medicare+Choice plans do so because of their richer benefits, in particular the drug cov-

erage. But if those benefits are cut, the incentive to join the plans is lost, Mr. Martingale said.

Many employers have found it less costly to pay the premiums Medicare HMOs charge retirees than to provide coverage in their own indemnity plans that supplement Medicare. But, as the plans become more costly and the benefits less generous, their utility as a way for employers to cut costs erodes.

Still, the slowdown in Medicare+Choice withdrawals in 2004 is of some comfort to employers, as it will mean fewer retirees returning

to employer plans, Mr. Martingale said.

"It's the lack of bad news, so it's good news," he said.

Indeed, compared with previous years, next year should see fewer retirees heading back to employers' retiree health plans, said Oxford's Mr. Haytaian.

"With a lot less exiting, there will be less walking back to employers' plans," he said.

Although market withdrawals are slowing, health plan executives say that better funding is needed to maintain the program over the long term.

Increases in the federal reimbursements for Medicare+Choice plans are generally limited to between 2% and 3% a year, a range the plans say is often too low to cover their ever-rising medical costs.

"With rising health care costs and dwindling reimbursements, it has become increasingly challenging to maintain the Medicare+Choice business," Dr. John W. Rowe, Aetna's chairman and CEO, said in a statement.

Both houses of Congress this year have passed Medicare reform bills that would boost funding for the

program, with the House measure providing the larger increase, Mr. Haytaian explained. House and Senate conferees are working to reconcile the bills (*BI*, July 7). If the funding provision becomes law, Oxford is poised to offer Medicare HMOs in additional counties, he said.

Mr. Martingale agreed that the funding levels are still too low, making it unattractive for plans to offer these programs.

"So long as plan costs are rising more rapidly than Medicare contributes to the plans, we're still in crisis," he said.

'So long as plan costs are rising more rapidly than Medicare contributes to the plans, we're still in crisis.'

Joe Martingale
Watson Wyatt Worldwide

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Products & Services

Screening for mold without harming property

MOUNT PLEASANT, Mich.—Prism Analytical Technologies Inc. has developed technology that it says allows for the testing of mold growth without harming property.

The company's MoldScan technology screens the air for microbial compounds that can indicate the presence of active mold, which could lead to "sick building syndrome," a condition in which the air inside a building creates health problems for some occupants.



PATI, an analytical laboratory in Mount Pleasant, Mich., sought to enable testing of mold samples without having to cut into walls or cause other disruptions to property.

Instead, air is collected in a tube that is sent to the company for analysis.

More information is available from PATI at 989-772-5088.

Anthem expands site for Spanish speakers

INDIANAPOLIS—Anthem Blue Cross & Blue Shield has expanded MiSalud@Anthem, its Spanish-language health and wellness Web site and added an online provider directory in Spanish to its Anthem.com en Espanol portal.

MiSalud@Anthem now offers daily health news as well as a searchable library of hundreds of articles, reports and news stories on a range of health and wellness themes. In-

teractive tools, animated guides, fitness and nutrition information, children's and seniors' health topics are among the features available at the site.

A provider directory added to the Spanish portal of Anthem.com allows users to find a doctor, hospital or specialist within certain geographical areas. It lists a variety of information about the provider, including languages spoken, whether he or she is accepting new patients and more.

Additional information is available at www.anthem.com.

Wausau offers new excess/umbrella policy

WAUSAU, Wis.—Wausau Insur-

ance Cos. has introduced a new excess/umbrella liability policy.

The policy includes worldwide coverage for non-employment-related discrimination and vicarious liability arising from intentional acts.

"In a litigious world, insufficient coverage and the financial vulnerability of business pose a bigger risk than ever before," said Joe Gilles, Wausau's president and chief operating officer, in a statement.

"Our excess/umbrella can help manage these risks through our personal approach of expertise and decisiveness," he said.

More information on the excess/umbrella liability coverage is available from Wausau at 800-435-4401.



New liability form for universities

CHEVY CHASE, Md.—A new insurance program for colleges and universities is available from underwriting manager Victor O. Schinnerer & Co.

The EdChoice policy, written by CNA Insurance Cos., provides coverage for employment practices, errors and omissions and management liability on one form. Faculty, officers, employees, volunteers, student interns and graduate students are eligible for coverage. Limits are written to \$1 million, with a \$5 million aggregate.

Schinnerer, based in Chevy Chase, Md., is targeting as policyholders public and private nonprofit universities with enrollments up to 10,000.

The nonadmitted coverage is available in Connecticut, Florida, Illinois, Maine, Massachusetts, Michigan, Missouri, New Hampshire, North Carolina, Ohio, Pennsylvania, Tennessee, Vermont and Virginia.

Additional information is available from Schinnerer at 301-951-9745.

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Hundreds of hazard-alert letters issued

Highly hazardous industries focus of new OSHA program

By MEG FLETCHER

CHICAGO—The Occupational Safety and Health Administration is focusing its efforts on a handful of high-hazard industries.

John Henshaw, who heads OSHA as assistant secretary of the U.S. Department of Labor, discussed the agency's plans last week at the National Safety Council's 90th birthday celebration in Chicago.

While noting that OSHA's goal of "strong, fair and effective enforcement" applies to all industries and hazards, Mr. Henshaw said the safety agency is focusing on specific industries because "we believe this is where we can have the greatest impact in reducing injuries, illnesses and deaths—because these industries experience many severe injuries."

Over the past 18 months, OSHA has conducted 1,332 inspections, which have resulted in hundreds of hazard alert letters and 11 ergonomics-related citations under the agency's general duty clause.

The seven high-hazard industries OSHA has identified are: landscape/horticultural services; oil and gas field services; fruit and vegetable processing; concrete and concrete products; blast furnace and basic steel products; ship and boat building and repair; and public warehousing and storage.

As part of OSHA's five-year plan, the agency's activities in high hazard workplaces will include data collection, "site-specific targeting programs as well as outreach, partnerships and cooperative programs," he said.

Across all industries, ergonomics remains another area of concern for OSHA.

Over the past 18 months, the agency has conducted 1,332 inspections, which resulted in hundreds of hazard-alert letters and 11 ergonomics-related citations under OSHA's general duty clause, Mr. Henshaw said.

Mr. Henshaw added, though, that OSHA has followed its policy of not targeting facilities that are making "a good faith effort" to address ergonomics-related issues.

The general duty clause requires companies to provide safe work-sites. It is much less specific than ergonomics rules that were approved in the waning days of the Clinton administration but were subsequently repealed by Congress—under the Bush administration—in favor of voluntary guidelines (*BI*, March 12, 2001).

Mr. Henshaw said that OSHA has instituted an enhanced enforcement program to address "recalcitrant employers—those who've been repeatedly cited but haven't corrected their problems."

In addition, "in the last 18 months, a few of our ergo citations and letters have gone to facilities in corporations with very good ergonomics programs," he said. "The

citations are based on the fact that the programs were not effectively implemented in the specific facility. This is a critical point: The corporate commitment must be translated to positive action at the individual facilities," he said.

In related activities, OSHA has issued a final ergonomics guideline for nursing homes and has pro-

Continued on next page

COMPANIES FACING ERGONOMICS CITATIONS

OSHA cited these employers in 2003 for ergonomics violations

Company	Location	No. of violations
Alpha Health Services	Post Falls and Rathdrum, Idaho	3
Brown Printing	East Greenville, Pa.	1
Coca-Cola Bottling Co.	Cincinnati, Ohio	1
Madonna Manor	North Attleboro, Mass.	1
Mariner Health Care	Palisade and Fort Collins, Colo.	2
Regency Senior Services	Glendale, Wis.	1
Security Metals	Clinton, Okla.	1
Supervalu Inc.	Hazelwood, Mo.	1

Source: OSHA



Continued from previous page

posed guidelines for retail grocery stores and poultry processing. It also has addressed such issues as silica exposures in construction, scrap metal recycling, hazard communication and perchlorethylene exposure in dry cleaning.

In the most recent development, OSHA has expanded its Voluntary Protection Program in hopes of increasing participation to 8,000 sites from the current 1,000. The program is open to companies that meet certain safety-related criteria, including having overall lost work-day rates that are 50% below the industry average.

The new VPP initiatives include three pilot programs:

- VPP Challenge allows a phased

entry to VPP for sites that have the commitment to excellence but

A new coal dust monitoring tool 'looks very promising' and could help a miner keep his or her exposure to coal dust, which can cause black lung disease, below hazardous levels.

*Dave D. Lauriski
Mine Safety
and Health Administration*

need a strategy to achieve it.

- VPP Corporate creates a stream-

lined application and entry process for corporations that are seeking to bring a significant number of sites into the program.

- VPP Construction includes separate criteria for construction sites to address that industry's needs.

The NSC event also featured a presentation by Dave D. Lauriski, assistant secretary of the Labor Department's Mine Safety and Health Administration.

Mr. Lauriski noted that mine safety inspections are being completed "at the highest rate in many years," and that, as a result, "serious violations are decreasing, along with serious injuries."

The MSHA also is developing special programs to help companies learn about safe operations and

ways to reduce worker injuries and illnesses. For example, it declared the first anniversary of last year's July 28 mine inundation in Quecreek, Pa., as "National Coal Mine Safety Awareness Day" and used the event as a springboard to visit many smaller mines.

Also, because many inexperienced miners were being injured, the agency launched its "Speak Out and Make A Difference" initiative to urge experienced miners to warn others about hazardous situations.

The mine safety agency also is testing a coal dust monitoring tool. The device "looks very promising" and could help a miner keep his or her exposure to coal dust, which can cause black lung disease, below hazardous levels, Mr. Lauriski said.

Survey finds privacy rules not disrupting comp systems

By MEG FLETCHER

The privacy rules of the Health Insurance Portability and Accountability Act are not causing serious problems for state workers compensation agencies, a survey has found.

None of the 15 agencies responding to the survey, which sought to determine the effects the federal rules have had on workers compensation claims handling, reported "serious" disruptions to their operations from the regulations. The survey was conducted jointly by the International Assn. of Industrial Accident Boards & Commissions and the National Governors' Assn.

"The majority (of respondents) indicated that they did not need to

'The majority (of respondents) indicated that they did not need to take special measures to repair problems or prepare for the rule.'

*Gregory Krohm
International Assn. of Industrial
Accident Boards & Commissions*

take special measures to repair problems or prepare for the rule," IA-IABC Executive Director Gregory Krohm said during a presentation at the organization's annual conference last week in San Francisco.

Several states did report, however, that they had handled a large volume of calls from people with questions about the application of the rules to workers comp.

Before the rules took effect in April, claims handlers expressed concerns about possible disruptions to the flow of medical information, and there was "considerable confusion" among medical providers and claims handlers on how the HIPAA rule would modify or eliminate claims-handling practices, according to an IA-IABC statement.

According to the IA-IABC, the most serious problem reported by state agencies was that "some clinics were insisting on the use of their own form for the worker to sign for the authorization of release of medical records."

Mona Carter, a regulatory analyst and policymaker with the National Council on Compensation Insurance, said that actuaries and claims managers also should be concerned about delays in the resolution of claim settlements. She suggested that the IA-IABC conduct another survey later this year to monitor claim delays.



*Gary Bridgeford, Director-Corporate Risk Management
Johnson Controls, Inc.*

In a just-in-time world, "downtime" can mean "time's up."

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Between the Lines

Compiled by Joanne Wojcik



Injured worker seeks publicity to pay the bills

An uninsured electrician who accidentally drove a drill bit through his head has hired a public relations firm and is appearing on TV talk shows with his X-ray, trying to scare up funds to pay his medical bills.



Switchback Public Relations & Marketing has even programmed a Web site, www.ron-huntmedicalfund.com, to accept donations online.

"We've had everybody from Ripley's Believe It or Not to the

National Enquirer calling us," said Brinn Wellise, president of the firm hired by Ron Hunt of Truckee, Calif., to solicit media attention to help him raise the "hundreds of thousands of dollars" needed to pay the costs of removing the bit and obtaining a prosthetic eye.

Mr. Hunt lost his right eye and suffered permanent nerve damage last month when he fell from a six-foot ladder while drilling and fell face-down on the bit. Despite the horrifying image, he joked about the mishap with doctors and suffered no brain damage. Mr. Hunt has no health insurance and was not covered by workers compensation because, as an independent contractor, such coverage was not required under California law.

Wired into workplace privacy

In next month's issue, Wired magazine is having privacy experts rank the best and worst publicly traded employers for workplace privacy. Burlington Northern Santa Fe Corp. was slammed by the magazine for attempting to fight workers comp claims with genetic testing, while International Business Machines Corp. got high marks.

Burlington Northern paid \$2.2 million to settle charges that it violated the Americans with Disabilities Act by testing employees without their knowledge. In 2001, the Equal Employment Opportunity Commission sued BNSF, when workers complained they were required to take blood tests after filing work-related injury claims. The EEOC suit was the first such case challenging genetic testing under the ADA (*BI*, May 13, 2002).

By contrast, "Big Blue set the standard in employee privacy in the '60s with the first formal corporate policy. Still in the vanguard, IBM now compels its health care partners to eliminate Social Security numbers as patient identifiers," Wired reports.

Terrorism less scary than losing coverage?



Americans are more afraid of losing their health insurance than of being a victim of a terrorist attack, according to the results of a new nationwide poll.

According to the Kaiser Family Foundation, 33% of the insured population worries that their income might not keep up with health premiums, while only 8% said they fear being a victim of a terrorist attack.

Mental health claims lower than expected

Long-term disability claims for depression and anxiety-related disorders dropped by one-third in the 18 months following the Sept. 11, 2001, terrorist attacks compared with claims for the 18 months prior, a disability income insurer has found.

"No doubt, the terrorists wanted to send waves of fear and depression through the American public with these shocking acts of violence," said Dr. Polly Galbraith, vp and medical director Kansas City, Mo.-based Fortis Benefits Insurance Co. "Instead, this claims experience suggests that Americans responded with confidence and a strong sense of resolve."

The 33% decline in the number of disability claims for depression, stress, panic, anxiety and similar conditions even held true in the Eastern Seaboard states where the terrorist attacks occurred, according to Fortis.

Tips and feedback from readers are welcomed. Please send information to joajcik@crain.com.

Benefits: Double-digit increases

Continued from page 4

• Health maintenance organizations were the least costly plans, while preferred provider organizations were the most costly. Average annual premiums for family coverage in HMO plans ran \$8,514, compared with the PPO average of \$9,317 for family coverage.

• The average family health care policy, including all plan types, cost \$9,068, with employers paying 73% of the cost on average and employees funding the rest. Employers on average paid 84% of the cost of single coverage, which averaged \$3,383 for all types of plans.

• Employers said they are considering various changes to their plans in the next year, the most common of which was increasing employees' share of health benefits costs. Yet none of the small firms—defined as those with 199 or fewer workers—and only 1% of the larger firms said they were "very likely" to drop coverage altogether.

Other strategies employers said that they were likely to follow in the next year to handle rising costs included increasing the amount employees pay for prescription

In 1989, when premiums also rose in the double-digit range, employers felt some optimism that tools such as managed care would be able to hold costs down. Now, though, 'there is a relative sense of helplessness.'

Drew Altman

Henry J. Kaiser Family Foundation

drugs, increasing employee-paid deductibles and increasing physician office co-pays.

• Firms with more than 5,000

employees are increasingly experimenting with high-deductible plans, which generally involve a deductible of at least \$1,000 for single coverage. Seventeen percent of firms of that size surveyed this year said that they already offered such plans with or without employer-funded health savings accounts. Another 16% of firms with more than 5,000 employees said they are "very likely" to do so in the next year.

Mr. Altman said that employers' response to the rising health care costs differs markedly from that exhibited in 1989, when premiums also rose in the double-digit range. Then, employers felt some optimism that tools such as managed care would be able to hold costs down. Now, though, "there is a relative sense of helplessness," he said.

The survey is available from the Kaiser Family Foundation at www.kff.org.

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Members opt to ground aviation pool

German insurers to feel loss most

By NEIL HODGE

MUNICH, Germany—German aviation reinsurance pool Deutsche Luftpool will cease writing new business after several large members withdrew from the facility because of new European Union laws governing competition.

Although some airlines and aviation insurers say that other companies and pools will serve their reinsurance coverage needs, smaller German insurers that participated in the facility are likely to withdraw from writing aviation risks altogether rather than go it alone.

After Jan. 1, Deutsche Luftpool will operate only as a service entity, running off current contracts, handling claims and providing consulting on technical and legal aviation questions.

Wolfgang Schatz, Deutsche Luftpool's managing director in Mu-

nich, said in a statement that "insurers lacking their own aviation departments will thereby continue to be able to offer their customers the service they need in case of claims."

Deutsche Luftpool, which was established in 1924, provides aviation hull and liability and space reinsurance for its 59 member insurance companies, which write a variety of such risks. Since its formation, the pool has been managed by Munich-based Allianz A.G. Holding, which holds a 20% stake in the reinsurance facility.

In 2002, the pool wrote gross premiums of 450 million euros (\$490.5 million), of which roughly half was retroceded to international reinsurance markets.

The decision to cease underwriting was made at a Sept. 10 extraordinary meeting of pool members in Munich. The move was prompted

by the adoption earlier this year of new E.U. laws that seek to avoid cartel-building by, among other things, barring insurers from belonging to more than one pool.

After the E.U. laws took effect,

some large insurer members of Deutsche Luftpool indicated they would terminate their membership at the end of this year in favor of remaining with other aviation pools.

See **POOLS/next page**



PHOTO: EPA

Lufthansa airlines, which previously met 60% of its reinsurance needs through the pool, does not expect difficulty in locating other sources of coverage, its risk manager says.

China plans to ease capital requirement for branch offices

By ELIZABETH FRY

BEIJING—China's Insurance Regulatory Commission will introduce legislation that would reduce the minimum capital requirement for foreign nonlife insurance companies with nationwide licenses, allowing them to expand their operations without committing more capital.

The proposed rule would set a

senior executive from an international brokerage in China, who asked not to be identified, predicts that if this draft becomes final, big international insurers like American International Group Inc. and Allianz A.G. Holding would establish nationwide offices overnight.

Insurers would no longer be hampered by the current rule that requires them to maintain

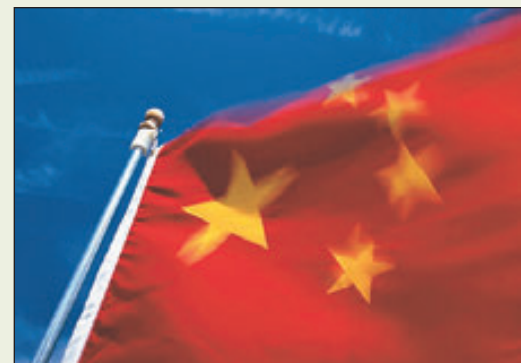
capital adequacy levels of 200 million yuan (\$24.2 million) for each subsidiary established. Nor would they have to fork out an additional 50 million yuan (\$6 million) or more of paid-up capital to establish branches outside the province where their subsidiary is licensed, the brokerage executive said.

Joerg-Michael Luther, general representative at Allianz's representative office in Beijing, agrees that the proposed legislation would make expanding in China cheaper and simpler.

Right now, expanding operations is complicated—there are variations in licenses throughout the country, he said.

"If you had a license in Guangzhou, for example, you

See **CHINA/next page**



minimum capital requirement of 500 million yuan (\$60.4 million) for a nationwide license, bringing foreign insurers into line with the regulations that currently govern local insurers in China. Because of WTO agreements, under which foreign insurers as of December 2004 will be able to sell insurance anywhere in the People's Republic of China, it is expected that the draft rule, "Administrative Regulation China Insurance," would be passed this year.

Equitas execs review U.S. liability threats

Asbestos reform a 'long shot'

By SARAH VEYSEY

LONDON—Equitas Ltd. is holding discussions with U.S. lawmakers on asbestos liability reform proposals but considers passage of such legislation a "long shot," one of the reinsurer's top executives says.

"Congress has made enormous progress in fashioning legislation to establish an asbestos trust to deal with all asbestos claims, but much work remains to be done. The votes aren't there to pass a bill yet," said Scott Moser, managing director of Equitas, which is the runoff reinsurer for Lloyd's of London syndicates' pre-1993 long-tail liabilities.

The Senate Judiciary Committee approved an asbestos liability reform bill in July, but insurers and some other former backers of the measure withdrew their support because of last-minute amendments that would increase their costs (BI, July 14). The bill would create a national trust for asbestos claims, with defendant companies and their insurers providing most of the funding.

"Achieving fair and affordable reform legislation in the coming year will be very difficult, and prospects are distinctly uncertain. But we will continue working intensely on efforts for congressional reform, so long as those efforts offer any reasonable prospects for success," Mr. Moser said in a presentation at the company's annual meeting in London Friday.

Glenn Brace, claims director at Equitas, echoed Mr. Moser's support for U.S. liability reform efforts.

"The dysfunction of the asbestos litigation industry is now at the center of a national debate (in the United States). Many opinion-makers are convinced that this industry harms asbestos victims, the economy and the legal system itself," he said.

"Equitas would celebrate fair and comprehensive reform, as would the victims, employees, policyholders and insurers affected by the asbestos crisis," he said. "Yet, there is a chance that the pressures of politics may cause Congress to replace a bad system with one that is even worse."

Mr. Brace also noted that if the current U.S. asbestos litigation system were dismantled, there is a risk that "the American litigation industry will look for new targets—silica, mobile phones, diet pills—you name it."

While much of Equitas' attention has been focused on asbestos, the company also monitors other potential areas of liability, he said. "So far, we have not identified any emerging claim types that threaten to seriously affect Equitas," he said.

In answering a question from the floor about the potential of silicosis to become the "next bandwagon for lawyers," Mr. Brace said the company is closely watching developments in that area. "We keep a very close eye on silicosis. We do not think it will become the new asbestos, or anywhere close."

Silicosis, a chronic lung disease caused by the continued inhalation of silica dust, typically affects sandblasters, rock cutters, and miners.

World Updates

Illium Insurance buys managing agency

Omni Whittington Group is selling a majority stake in its Lloyd's of London managing agency to Illium Insurance Group Ltd., a new Lloyd's startup. The managing agency will be renamed Illium Managing Agency Ltd. and will manage a syndicate 4040, a new specialty liability syndicate that will start underwriting next year. Omni Whittington will retain a 9.9% stake in the agency.

OPRA names trustee for Maersk U.K. plan

The U.K. pension regulator has appointed an independent trustee for the underfunded pension plan that Danish shipping company Maersk & Co. terminated last year. The Occupational Pensions Regulatory Authority's move stems from Maersk's announcement in October 2002 that it would wind up the defined benefit pension plan of a British subsidiary, Sea-Land Services, without making good the plan's £3.5 million (\$5.4 million) shortfall. OPRA also ordered Maersk to pay the fees and expenses of the OPRA-appointed trustee, London-based Law Debenture Pension Trust Corp. P.L.C.

Trenwick Lloyd's unit renamed Talisman

The management team acquiring the Lloyd's of London interests of Bermuda-based Trenwick Group Ltd. will adopt the name Talisman on completion of the management buyout. Under the deal's terms, the management team of Trenwick Managing Agents Ltd. will take over the interests of the managing agency and its two syndicates under management for the 2004 year. The capacity of the syndicates—composite syndicate 839 and life syndicate 44—is expected to be £250 million (\$397.5 million) and £3.5 million (\$5.6 million), respectively.

London's Aspen enters E&S lines

London-based reinsurer Aspen Insurance Holdings Ltd. is entering the U.S. excess and surplus lines business through its acquisition of Dakota Specialty Insurance Co. from The Insurance Corp. of New York. The new company, Boston-based Aspen Specialty Insurance Co., will write property/casualty business and will be headed by Peter Coghlan, president and chief executive officer.

Briefly noted

London-based loss adjuster **Cunningham Lindsey International Ltd.** has opened an office in Buenos Aires, Argentina.

Pools: Aviation pool grounded

Continued from previous page

Munich, Germany-based insurer Munich Reinsurance Co., for example, said at the beginning of September before the meeting that it would withdraw from the German aviation pool.

Munich Re opted instead to stay with the sector's largest aviation pool, London-based Global Aerospace Underwriting Managers Ltd., which was created in 2001 through the merger of the British Aviation Insurance Group and Associated Aviation Underwriters in the United States.

A spokeswoman for Munich Re said that the E.U. laws "left us with little choice but to choose to remain in the Global Aerospace pool, because it is the largest international pool for reinsuring aviation risk."

Allianz, despite managing the pool, had earlier said that it, too, would likely opt to leave the Deutsche Luftpool in favor of another pool, though it declined to elaborate.

The risk manager for one of Germany's major airlines said that the dissolution of the pool "will not significantly impair" its reinsurance arrangements.

Ralf Oelssner, director of corporate insurance at Lufthansa A.G. in Cologne, said that the dissolution of the pool will not pose a major problem for the airline, despite the fact that Lufthansa's captive had, until this year, placed around 60% of the

airline's fleet reinsurance with the pool.

"From Jan. 1 this year, Deutsche Luftpool announced that it would be capping its maximum liability capacity to just \$500 million for the 2003 renewal season, which was due to take place around now. We wanted the maximum liability capacity to be \$2 billion, so the pool was not going to meet our requirements anyway, and we had decided from the beginning of the year that we would have to make alternative reinsurance arrangements," Mr. Oelssner explained.

In general, though, Mr. Oelssner acknowledged that the dissolution of the pool would make it more complicated for German cedents to reinsure their aviation risks.

He noted that Lufthansa's options also are limited by U.S. prohibitions against companies that trade with "rogue states," which might include some countries to which it flies.

Mr. Oelssner explained that "the U.S. prohibits trade with those states that are either promoting terrorism or pose a threat to U.S. national security, such as Iraq. Since Lufthansa may have plans to resume flights to some of these countries, we would not be able to find appropriate reinsurance cover from a U.S.-based reinsurer, so we have to look to the European reinsurance market." Otherwise, the German airline might be barred from U.S. airports.

Mr. Oelssner said he believes that

only a few of the 59 members of the Deutsche Luftpool will have the capacity and professional capability to continue to reinsure large amounts of aviation risk on their own.

Many of the pool's members will not continue to actively pursue aviation reinsurance contracts because "they don't have the expertise and they probably don't need the business," he said.

"The attraction of the pool for smaller members was that they would get a commission for any aviation reinsurance business they ceded to the pool and a commensurate share of the profits if there were any, as well as pick up expertise from the larger, more experienced players. But I doubt that this would have made a large impact on their revenues," added Mr. Oelssner.

According to one broker who did not wish to be identified, the Luftpool played a "significant role" in the German market, as it retained 40% of the business it wrote, a large part of which was German domestic business.

"I think that the major participants will continue to write their aviation business through the other avenues they currently enjoy," said the broker. "The smaller companies may cease to write aviation but this will most likely have an impact in Germany only. The impact on the aviation market will not be significant, certainly not for the major programs."

China: Easing capital requirements

Continued from previous page

are theoretically allowed to open other branch offices in the province for free, whereas a license in Shanghai, which is a municipality, does not extend to the rest of the province. The 500 million yuan minimum capital level means foreign nonlife insurers can start outbranching for free in the whole country," Mr. Luther said.

But, "while corporate risk managers will be happy to see rules for

jects," he said.

Wrix Gaston, chief executive officer of Singapore-based industrial packaging company Hong Leong Asia, which derives 80% of its profits from business in China, looks forward to the easing of insurance regulations.

Dealing with a single insurer operating throughout the whole of China would be far easier than using an insurer that has an office in Shanghai and in one out of 30 provinces, as most foreign companies do now, Mr. Gaston said.

But Mr. Gaston said he does not believe that companies operating in China would rush to abandon local domestic insurers for foreign-owned ones.

"Maybe we would switch to a foreign insurer, but it will take a fair bit of time before foreigners get comfortable with businesses. Eventually, they will have established a local cost base (which they are not able to do now) as well as develop a proper distribution system," Mr. Gaston said.

"But right now, if something goes wrong and we have a factory fire, we need to know how quickly we can get an assessor in, how they are going to arrange the cover—there's lots of homework to be done by the big foreign insurance companies," he said.

'There's lots of homework to be done by the big foreign insurance companies.'

Wrix Gaston
Hong Leong Asia

foreigners brought in line with local operators, practical implementation issues need to be addressed," the brokerage executive said. "The challenge will be whether the foreign insurers can provide an equivalent network across the whole country. They might have a national license, but the question is the length of time it will take before they will be able to provide the kind of service their clients require—especially with the major commercial risk pro-

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Fabian: Bermuda tallies losses

Continued from page 1

and business interruption risks, some of which may not be covered. That could mean the actual insured losses could be lower than the estimate.

Property damage is "not insignificant," said Pat Donahue, senior vp at AIR.

She said that Fabian losses will be several times more costly than damage caused by Hurricane Emily in 1987, which was the last major hurricane to strike the island. AIR's model uses data on storm tracking, intensity and other information, which it compares with property values across the affected area, she explained.

Fabian, which has been blamed for four deaths, hit Bermuda as the weekend began, raking the island with winds up to 120 mph, according to the National Weather Service. That made it a Category 3 hurricane, which has wind speeds from 111 mph to 130 mph, according to the Saffir-Simpson intensity scale, which ranks such storms from 1 to 5.

Storm surges reached as high as 30 feet, by some accounts, and much of the damage on the island was from seawater, according to Mr. Osborne. The water caused the four largest claims recorded by the insurer, loss of contents and business in-

terruption to two seaside restaurants and damage to two homes, which totaled just under \$2 million.

Seawater forced Café Lido, one of the restaurants insured by Argus, off of its foundation, and structural engineers are assessing the damage, Mr. Osborne said. The biggest loss for the restaurant, though, will be the loss of contents and business interruption, he said.

The Carriage House, another oceanside restaurant, sustained much heavier damage and practically "doesn't exist anymore," Mr. Osborne said.

Among the largest commercial claims is for damage at the Southampton Princess. The hotel, owned by Toronto-based Fairmont Hotels & Resorts Inc., is closed until at least Nov. 1, as roof damage and guestrooms are repaired. The facility's public areas also sustained water damage, the owner said in a statement.

Fairmont reopened its other Bermuda property, the Hamilton Princess, a few days after the hurricane, and is booking around 75% of its rooms, according to a spokeswoman for the parent company. Approximately 25% of the guestrooms have sustained water damage and are currently out of service, the company reported on its

Web site.

The spokeswoman could not provide insurance coverage details for the hotels except to say that insurance is in place, and that the parent company expects its retained share of business interruption and property losses at the hotels will amount to \$5 million to \$10 million after insurance recoveries.

The Bermuda International Airport was "battered, but not down," after reopening early last week, according to James Howes, the facility's general manager.

"Virtually every building sustained roof damage," he said, and the "storm surge sent several feet of water into the first floor of the terminal," ruining equipment and furniture. Damage figures were unavailable.

Wind and water destroyed a chunk of the Castle Harbour Causeway that connects the airport with other parts of Bermuda. Repair crews had a single lane of traffic open not long after the storm had passed.

Homes on the island sustained varying degrees of wreckage, ranging from broken windows to major structural damage.

In Hamilton, the city's Front Street shopping area was littered with broken glass, and some roofs were damaged.

Mr. Osborne expressed surprise that the retail district wasn't in worse shape. "When I came in Saturday morning, around Front Street, I expected it to be in tatters." But, apart from the mess left by broken glass, water and debris, the area appeared to be in pretty good shape, he said.

"Commercial losses in Hamilton seem to be pretty small," said Paul Bailie, deputy chairman at JLT Risk Solutions Management (Bermuda) Ltd. Parts of the island look "absolutely dreadful," he pointed out last week, while in other parts life appeared to be close to normal.

Strict building codes may have helped to mitigate damage, suggested Atul Khanduri, manager of wind engineering at AIR. Bermuda buildings, many of which are made of stone block with heavy timber and slate roofs, "are pretty robust and sturdy," because the island has some of the world's most stringent construction requirements, he explained.

While waiting for a true picture of the damages, A.M. Best Co. placed under review with negative implications the financial strength ratings of the island's three local insurers: Argus, BF&M and Colonial Group International Ltd. The Oldwick, N.J.-based rating agency said the action was based on uncertainty surrounding the ultimate net exposure for the three local insurers.

"I would consider that to be normal procedure for them," said Mr.

Titterton of BF&M. After Best has reviewed the amount of losses and the insurers' reinsurance arrangements, there likely will be no change to the insurers' ratings, he predicted.

Meanwhile, insurance conferences scheduled in Bermuda are still on, at least for now. No cancellations have been announced for either the 17th International Reinsurance Congress at the Hamilton Princess Oct. 8-10 or the World Insurance Forum, which is scheduled for Feb. 17-20 at the Southampton Princess.



PHOTO: REUTERS

Bermuda's Sonesta Beach Hotel was among the properties damaged by Fabian's strong winds.

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Opening Workshops
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Track 2: Employee Benefits in Captives: The Opportunities and the Imperatives

6:00 PM - 7:30 PM
Welcome Reception with Exhibitors
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7:30 AM - 9:00 AM
Breakfast in the Exhibit Hall
Sponsored by Dempsey Myers & Co.

7:45 AM - 9:00 AM
Domicile Info Breakfast
Network with domicile representatives at informational breakout sessions scheduled during breakfast

9:00 AM - 10:30 AM
Keynote Address:
What's Driving the Insurance Markets?
Featuring Dr. Sean F. Mooney, Sr. Vice President and Chief Economist for Guy Carpenter & Co.

10:30 AM - 11:00 AM
Cookies & Milk Break

11:00 AM - 12:15 PM
Breakout Sessions
Track 1: Cell Captives: Uses and Developments
Track 2: The Health Care Crisis

12:15 PM - 1:45 PM
Buffet Luncheon with Exhibitors

1:45 PM - 3:00 PM
Breakout Sessions:
Track 1: New Cell Captive Strategies
Track 2: The How and Where of Reinsurance Markets

3:00 PM - 5:00 PM
Networking Poolside Break
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7:00 PM - 10:00 PM
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7:30 AM - 9:00 AM
Breakfast in the Exhibit Hall
Sponsored by Barbados Investment & Development Corporation

7:30 AM - 8:45 AM
Contingent Capital - The Basic Alternatives

9:00 AM - 10:30 AM
Captive Case Studies

10:30 AM - 11:00 AM
Beverage Break in Exhibit Hall

11 AM - 12:30 PM
Tax and Legal Developments

12:30 PM - 1:30 PM
Box Lunch and Prize Drawing

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Cash balance: Employers to fight measure

Continued from page 1

proposed late last year. Those regulations say that the basic design of cash benefit plans—giving employees benefit credits based on a percentage of pay and adding interest to accrued benefits—does not violate age discrimination law (BI, Dec. 16, 2002).

Rep. Sanders' effort marks the second time in a year that he has attempted to interfere with the Treasury Department's cash balance plan rulemaking. Last year, he proposed an amendment to a Treasury Department appropriations bill to bar the department from develop-

ing certain rules.

The 2002 amendment would have blocked the Treasury from using appropriated funds to develop rules that would have contravened earlier informal guidance that it circulated—but never formally proposed—on how employers were to calculate the value of cash balance plan accounts for terminating employees. A conference committee later stripped that amendment, which was not in the Senate version of the Treasury Department appropriations bill, from the broader bill.

This time around, though, the amendment's fortunes could be different. Benefit lobbyists expect an attempt to be made on the floor of the Senate, when that body takes up the Treasury Department appropriations bill to add an amendment comparable, if not identical, to the one proposed by Rep. Sanders.

Employer groups say they are ready to challenge such an action.

"We will fight it with everything we have got," said Janice Gregory, a vp with The ERISA Industry Committee, a Washington-based benefits lobbying organization representing large employers.

Few, though, are willing to pre-

dict the outcome of the coming battle.

Ms. Gregory, for example, notes that Rep. Sanders' latest anti-cash balance plan amendment won about 50 fewer votes than last year's proposal, which she said is an encouraging sign.

'We will fight it with everything we have got.'

Janice Gregory
ERISA Industry Committee

On the other hand, a very effective public relations campaign by cash balance plan opponents has led to an enormous misunderstanding of the plans, Ms. Gregory said. That led many "members of Congress to assume something is amiss when they hear the words cash balance. That is what we are fighting against," she said.

"While Congress using does not like to interfere with pending litigation, it is difficult to predict how the Senate will act," said Frank McArdle, a consultant with Hewitt

Associates Inc. in Washington.

Historically, though, the Senate has displayed less interest in the cash balance plan controversy than the House, according to Kyle Brown, an attorney with Watson Wyatt Worldwide in Washington. Critics of cash balance plans say they harm older employees—when compared to the traditional defined benefit plans they replace—by cutting the benefits those individuals expected to receive at retirement. Supporters counter that the plans are more in tune with today's mobile workforce and are designed so that shorter-service employees receive greater benefits compared to the plans they typically replace.

The true motive of the Sanders amendment is to create enough controversy that the Treasury Department, which many expected to finalize its proposed regulations by the end of year, will feel that it is unwise to proceed, said Lynn Dudley, vp and senior counsel with the American Benefits Council in Washington.

Already, the legal attacks and lack of regulatory certainty is taking its toll on the plans.

Larry Sher, a principal and direc-

tor of research at Buck Consultants Inc. in New York, said he has several employer clients who intend to freeze their traditional pension plans and not convert them to cash balance plans due to the "poisonous" legal and political climate.

If those attacks continue, the losers could be employees. That is because employers, fearful that there will be no letup on the attacks, likely would exit the defined benefit plan system entirely, some say.

"You can prohibit employers from having these plans, but you can't force employers to adopt their own designs. Employers have a simple alternative: they can get rid of their defined benefit plans and only offer defined contribution plans," said Ethan Kra, chief actuary of Mercer Human Resource Consulting in New York.

If cash balance plans are not an option, few employers will be going back to their old plans and employees will lose protections unique to defined benefit plans, including a shield from investment risk and federal insurance for their basic benefits, Mr. Kra said.

"Something very valuable will have been killed and that is something congressional leaders should understand," he added.

Brokers: Buyers tolerant of varying styles

Continued from page 3

ers, to the client's disadvantage.

Marsh, which has maintained a centralized marketing model since the early 1990s, channels all of its business—except primary casualty risks for larger clients, which often are self-insured—through the centralized centers, explained Chris Treanor, head of global broking worldwide for Marsh in New York.

"One thing we've never done, nor would we advocate, is to distribute our brokers into 63 offices" throughout the United States, Mr. Treanor said, noting that brokers are instead located in 18 locations around the country. "We think there's an advantage to aggregating people into larger groups," he said. "It allows for a freer information exchange, it allows more access to senior leaders of the insurance companies and it allows for better workflow distribution," he said. "If you've got one to two marketing people in an office, then that office is entirely dependent upon the quality of that person, the accessibility of that person, the knowledge of that person and the experience and relationships of that person."

Although at Marsh a placing broker may not be located near a client, Mr. Treanor said the brokerage's model and philosophy promotes active customer engagement in the entire process, which means face-to-face meetings with the brokers.

Willis, however, contends that a local approach is a better way to serve clients, especially in today's tough market conditions.

"At the end of the day, it's an underwriter and a broker talking to each other about the qualities of a risk," said Mario Vitale, chief execu-

tive officer of Willis North America in New York. "If that person is somebody a thousand miles away who has never met the client, never felt in touch with the business and never felt what differentiates them from others in their class of business, how can they really differentiate them?"

"The difference with our model



Placing brokers 'can tell the markets firsthand why the client is different and what is it about their risk that makes them special.'

Mario Vitale
Willis Group Holdings Ltd.

is...we use all the same leverage and advantages of a global broking operation, but...(placing brokers) can tell the markets firsthand why the client is different and what is it about their risk that makes them special," Mr. Vitale said. "That's a very big advantage, and that is what clients are telling us that they want."

According to Willis, some of its recently acquired high-profile accounts said Willis' brokering model was a key factor in their decision to award the brokerage their business.

While Willis and Marsh remain on opposite ends of the spectrum, Aon's marketing model borrows from both approaches.

As part of the Chicago-based broker's much-touted transformation plan announced in late 2000, Aon created national product-specific

"Centers of Excellence" around the country to support its retail offices.

But while it has centralized some of its marketing functions, Aon still does a lot of local brokerage work, said Bob Needle, managing principal of syndication for Aon Risk Services in New York.

"We feel particularly that on the larger business the broker needs to

be very involved with the client, that there needs to be a lot of client-facing activity, both with the broker and with the underwriters," Mr. Needle said. "But we've kept a lot of regional and national flexibility. Because without having that kind of national platform, we can't leverage who we are. We end up being who we are in an individual city."

"We have taken geographic barriers out of the equation as much as possible, and we've built enough local flexibility that if that's what the clients want and that's what they'll have," he said.

While the world's largest brokers may argue over who has the best model, risk managers today do not have strong opinions on the subject.

"I don't care all that much as

long as it doesn't interfere with my interests in a direct relationship with my underwriters," said Chris Mandel, assistant vp-enterprise risk management for United Services Automobile Assn. in San Antonio. "Currently, I use Marsh and Summit (Global Partners), and their different models work equally well for us. I do prefer much of the old (Johnson & Higgins) model, but if there is leverage to be had in deals as a result of centralization, and it reduces intermediary frictional costs that get passed on to buyers, then I think it is supportable."

"What I've always said about global broking was that, to the extent that the individual client cared, there ought to be flexibility to it," said Mark A. DeLillo, North American risk manager of Taylor Woodrow Inc. in Bradenton, Fla. "Not all square pegs fit into round holes," he said. Whether global broking is the most effective way to market accounts "really has to be answered on a case-by-case basis," he said.

Jeffrey W. Pettegrew, vp-risk management for Westaff Inc. in Walnut Creek, Calif., said that he counts on his local account executive to not only know his business inside and out, but to also build an insurance team with the right experts—including marketing experts—regardless of where they are located.

"I can't expect that my whole team is all going to be domiciled in San Francisco," he said. "In today's world, it's important that we use any and all resources that we can, and it's highly unlikely that those experts are going to be close to us."

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Sept. 11: New litigation battles

Continued from page 1

U.S. District Judge Alvin K. Hellerstein last week threw out motions to dismiss suits that are being actively pursued by about 70 victims or victim family members and 10 property damage claimants.

The suits name multiple defendants, including United Airlines Inc. and American Airlines Inc., whose planes were hijacked on Sept. 11; WTC owner The Port Authority of New York & New Jersey and leaseholder World Trade Center Properties L.L.C.; and Boeing Co., which manufactured the hijacked jets.

In a series of consolidated lawsuits, the victims charge that the airlines failed to stop the hijackers from boarding the planes, that the Port Authority failed to provide safe escape routes and adequate fireproofing in the WTC and that Boeing failed to design secure cockpit doors on its aircraft.

The defendants filed motions to dismiss, contending that they owed no duty to the plaintiffs because they could not have reasonably foreseen the Sept. 11 attacks. Judge Hellerstein rejected this argument, though, in ruling that the suits may go forward.

The airlines, he wrote, had long experience with hijackings, while the Port Authority considered the possibility that an aircraft could hit the WTC towers and was aware that the towers were a terrorist target after the 1993 bombing in the Trade Center's garage, the judge wrote.

Trial evidence will determine defendants' ultimate liability on various counts in the complaints, the ruling notes. "This is a very early point in the litigation," Judge Hellerstein wrote regarding claims against the Port Authority and WTC Properties. "Plaintiffs should not be

foreclosed from being able to prove that defendants failed to exercise reasonable care to provide a safe environment...with respect to reasonably foreseeable risks."

'Plaintiffs should not be foreclosed from being able to prove that defendants failed to exercise reasonable care to provide a safe environment.'

Judge Alvin K. Hellerstein
U.S. District Court

James Kreindler, a lawyer representing numerous victims, said he did not expect the ruling to produce a rush of new court cases, noting that those who were "on the fence" about participating in the Victim Compensation Fund before the ruling are still undecided and will be making their choices soon.

Mr. Kreindler, of the New York firm Kreindler & Kreindler, said he expects at least 80% of potential claimants ultimately to opt for the fund. Litigation will be attractive only in cases where a victim's earnings were too high for the fund to provide full compensation, or where fund recoveries would be cut by large "collateral source deductions" for such things as life insurance payouts, he said.

Last week also brought a massive, multibillion-dollar lawsuit by five insurance groups to recover Sept. 11-related losses from more than 500 defendants that allegedly had a hand in the attacks.

The complaint was filed in U.S. District Court in New York by units of Chubb Corp., Zurich Financial Services Group, OneBeacon Insurance Group, Crum & Forster Corp.

and Munich Re Group. So far, these insurers have paid \$2.23 billion in property losses and about \$500 million in workers compensation losses stemming from the terrorist attacks, according to the suit and Sean P. Carter, a lawyer with Cozen O'Connor in Philadelphia, who represents the insurers.

In addition to al Qaeda and its leader, Osama bin Laden, defendants include:

- A dozen groups designated by the U.S. government as foreign terrorist organizations.
- The governments of Iran, Iraq, Sudan and Syria, which have been designated state sponsors of terrorism.
- The Kingdom of Saudi Arabia, which allegedly funneled money to al Qaeda through purported Islamic charities.
- 191 individuals, companies and charitable groups that have been designated terrorists or supporters of terrorism under a September 2001 executive order signed by President Bush that seized the designees' assets.
- Scores of additional individuals and organizations that the insurers charge have been "credibly linked" to terrorism.

The insurers charge that all of the defendants either conspired or aided a conspiracy to commit terrorist acts against U.S. interests. In addition to seeking \$4 billion in damages for Sept. 11 property losses, the insurers cite New York workers compensation law in bringing wrongful death and other charges on behalf of insured victims. Damages on these counts range from \$15 million to \$50 million per victim, adding up to tens of billions of dollars.

The complaint also alleges violations of federal racketeering law, entitling the insurers to treble dam-

ages, and seeks an additional \$200 billion in punitive damages.

If they win their case, the insurers could recover damages from the more than \$2 billion pool of assets of foreign states and allegedly terrorist-linked organizations that the U.S. government has already frozen, Mr. Carter said. Defendant governments and wealthy individual and corporate defendants may also prove viable sources of recoveries, he said.

Two similar suits against al Qaeda and other allegedly responsible parties have already been filed by victims of the attacks and are pending in federal courts in New York and Washington. The insurers' complaint, which has been in the works for two years, may ultimately be consolidated with one of both of these, Mr. Carter said.

Meanwhile, the parent company of Deutsche Bank last week filed suit against New York state, alleging that the state prevented workers from mitigating extensive damage to its 41-story headquarters building adjacent to the World Trade Center site. The bank sued because its "insurance policies require it to preserve any claims the firm might have against third parties," a spokeswoman said.

Judge Hellerstein dismissed a similar Deutsche Bank complaint against New York City in August, finding that the city is immune to negligence claims unless the bank can show that it had a "special relationship" that imposed specific duties on the city. The judge gave Deutsche Bank until Sept. 19 to refile the suit.

The bank is currently suing two of its property insurers, Allianz Insurance Co. and AXA S.A., for refusing to pay their shares of a negotiated \$1.05 billion total-loss claim on the building. The building's two other insurers, a Chubb Corp. unit and Zurich American Insurance Co., have already paid their shares, totaling \$525 million.

Property losses paid by insurer plaintiffs

CHUBB GROUP	
Federal	\$929,593,306
Pacific Indemnity	8,214,399
Chubb Custom	612,585
Chubb Indemnity	3,688,161
Chubb Canada	32,876,547
Chubb NJ	218,692
Great Northern	470,547,313
Vigilant	29,310,073
Subtotal	\$1,475,061,076

ZURICH GROUP	
Zurich	426,947,392
American Guarantee	42,208,222
American Zurich	2,181,146
Assurance of America	1,993,308
Colonial American	20,000
Fidelity & Deposit	1,559,298
Maryland Casualty	420,000
Northern	1,036,068
Steadfast	237,432
Valiant	0
Subtotal	\$476,602,866

ONEBEACON GROUP	
OneBeacon	\$161,874,055

CRUM & FORSTER GROUP	
Crum & Forster	44,300
North River	3,407,432
U.S. Fire	64,885,487
Subtotal	\$68,337,219

MUNICH RE GROUP	
American Alternative	2,119,967
Great Lakes	48,112,347
Princeton Excess	925,925
Subtotal	\$51,158,239

TOTAL	\$2,233,033,455
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Source: Federal Insurance Co. vs. Al Qaeda, filed Sept. 10, 2003, in U.S. District Court for the Southern District of New York

Multibillion loss estimates remain firm

By RODD ZOLKOS

The Jersey City, N.J.-based Insurance Services Office Inc. is sticking to its estimate that losses from the Sept. 11, 2001, attacks will range between \$30 billion and \$50 billion on a direct basis for all insurers worldwide.

ISO noted that U.S. insurers' and reinsurers' 2002 results reflected approximately \$9 billion of losses on a net basis, based on information included in their annual statements.

ISO's Property Claim Services unit has not revised its last estimate, issued Oct. 22, 2002, of \$20.35 billion in insured property damage related to the attacks. "We haven't issued anything since then because there are so many lawsuits pending that would significantly change the numbers," an ISO spokesman said.

The current PCS property loss estimate includes just over \$20 billion in commercial property losses, \$301.5 million in personal property losses and \$43 million in

auto losses.

Similarly, the New York-based Insurance Information Institute has not revised a \$40.2 billion estimate of insured Sept. 11 losses the III released last September.

The III estimate includes:

- \$11 billion in business interruption claims.
- \$10 billion in liability claims.
- \$6 billion in property claims for damage to property, including vehicles, other than World Trade Center buildings One and Two.
- \$3.5 billion in property claims for the twin towers.
- \$3.5 billion for aviation liability.
- \$2.7 billion in life insurance claims.
- \$2 billion for workers compensation claims.
- \$1 billion in claims for event cancellation.
- \$500 million in hull claims for the loss of four commercial aircraft.

Five insurers that are plaintiffs in the *Federal Insurance Co. vs. Al Qaeda* lawsuit filed Sept. 10 in U.S.

District Court for the Southern District of New York say they have paid more than \$2.23 billion in property claims to date, in addition to \$500 million in workers compensation claims related to Sept. 11 (see related chart).

An analysis of property/casualty insurers' 2002 financial statements by Palm Beach Gardens, Fla.-based Weiss Ratings Inc. showed \$9.3 billion in net claims related to the Sept. 11 attacks. Insurers reporting the largest dollar amounts of net claims were: General Reinsurance Corp., \$1.42 billion; Allianz Insurance Co., \$625.0 million; St. Paul Fire & Marine Insurance Co., \$554.8 million; National Indemnity Co., \$499.8 million; and American Re-

Insurance Co., \$451.7 million.

Weiss noted that the combined loss of General Re and National Indemnity, both Berkshire Hathaway Inc. companies, represented 20.6% of the total losses reported.



PHOTO: GETTY

Industry estimates of insured losses from the Sept. 11, 2001, terrorist attacks in New York, Pennsylvania and Washington have changed little since last year.

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Late News

Continued from page 1

report notes that competition itself will eliminate insurers. Delaying recognition of insolvency is an "inefficient" way to protect consumers and could actually be harmful, according to the report, because whatever financial assets a company might have would be depleted by delay. The report also predicts "a lot of exits" among property/casualty insurers in the next few years.

Revised airline liability standard to take effect

A standard worldwide system of compensating victims and their families for injuries and deaths resulting from crashes of international passenger jet flights is scheduled to go into effect Nov. 4. The United States deposited its instrument of ratification of the system—spelled out in the Montreal Convention—with the International Civil Aviation Organization on Sept. 5. The convention, an international treaty that the U.S. Senate ratified on July 31, updates the 84-year-old Warsaw Convention by imposing strict liability of 100,000 Special Drawing Rights (\$137,300) on airlines for passengers' deaths and injuries and by allowing passengers and their families to sue airlines for additional damages, if warranted, in the claimants' local courts.

Lucent to make cuts in retiree benefits

Lucent Technologies Inc. plans to reduce health care benefits for

50,000 of its management retirees starting in 2004. Murray Hill, N.J.-based Lucent said the cuts, which are expected to save the company about \$75 million annually, are necessary to control rising costs in its retiree health care program. The reductions include stopping reimbursement of management retirees for the cost of Medicare Part B premiums, eliminating dental coverage and ending certain retiree subsidies. Lucent said it expects to make further cuts in retiree benefits. The company said it expects to spend \$850 million in 2003 on retiree health care coverage, more than three times what it expects to spend on active-employee coverage.



PHOTO: KYODO NEWS

A Bridgestone tire plant in Japan smolders after a Sept. 8 fire at the facility.

Bridgestone aims to minimize fire losses

Bridgestone Corp. is cleaning up after extinguishing a fire at a tire factory north of Tokyo and is trying to minimize disruptions to its automobile industry customers. The blaze erupted at Bridgestone's Tochigi plant in Kuroiso City on Sept. 8. The cause of the fire, which began in the area of a rubber mixing process, had not been determined. No injuries were immediately reported. A Bridgestone executive said the blaze occurred "despite the

top priority that we have given to fire and workplace safety."

Rate hikes inch down in August: Survey

Property/casualty insurance rates increased on average by about 16% in August, down from 17% in July, online insurance exchange MarketScout.com reports. "Rates continue to adjust downward, with the exception of the tough lines such as (directors and officers), medical malpractice and insurance agents' (errors and omissions). In fact, the pricing and deductibles for insurance agents' E&O are increasing from 25% to 40%," Richard Kerr, Dallas-based MarketScout's chairman and chief executive officer, said. In March, overall rate increases averaged 28%.



Schwarzenegger favors workers comp reforms

The California Chamber of Commerce has endorsed Republican gubernatorial candidate Arnold Schwarzenegger because his agenda includes reforming the workers compensation system and "laws that encourage frivolous lawsuits against California's job creators." Mr. Schwarzenegger is running for governor as part of a recall election scheduled for Oct. 7. His workers comp reform principles include

adopting an independent medical review process to help rein in costly litigation, auditing the State Compensation Insurance Fund to identify waste, fraud and other fiscal problems, and appointing a new management team to the Division of Workers Compensation.

Briefly noted

The Senate voted last week to block President Bush's plan to change the definition of who is eligible for overtime pay. Proponents said the proposed change to the 1938 regulations under the Fair Labor Standards Act would have clarified some of the uncertainty behind the federal exemption tests, which should eventually reduce the number of wage-and-hour lawsuits against employers. However, critics said the change would strip as many as 8 million workers of their right to overtime pay....San Francisco-based private equity firm Fox Paine & Co. L.L.C. has completed its previously announced acquisition of an 80% stake in Bala Cynwyd, Pa.-based **United National Group**. As part of the deal, Fox Paine contributed \$120 million in capital to United National and to a new offshore affiliate. United National writes both surplus lines and specialty risks on an admitted basis.

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Online Poll

[9/8 - 9/12]

Do you think federal pension funding rules need to be strengthened?



Yes 90.8% **No** 6.2%
Undecided 3.0%

BI Stock Index

[9/8 - 9/12]

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

Percentage change of BI Stock Index vs. key indicators

Index	Value	Change
BI Stock Index	1997.55	.007
Dow Jones	9471.55	-0.33
S&P 500	1018.63	-0.27

Largest gains

Acceptance Insurance	10.00%
Baldwin & Lyons Inc.	6.99%
USI Holdings Corp.	6.54%
Selective Insurance Group	6.06%
Hilb, Rogal & Hamilton	6.02%

Largest losses

Fairfax Financial Holdings	-7.60%
Vesta Insurance Co.	-5.42%
American Safety Ins.	-5.25%
Navigators Group	-5.07%
SCPIE Holdings Inc.	-4.37%

Weekly change by market segment

Brokers	1.50%
Insurers/Reinsurers	-0.70%
Managed Care Organizations	0.97%

Source: FinancialContent Inc. (<http://financialcontent.com>)

Drugs: Ruling a boon to FSAs

Continued from page 4 through their FSAs.

The Internal Revenue Service ruling "is a huge benefit to employees," said Karen Frost, a consultant with Hewitt Associates Inc. in Lincolnshire, Ill. "During the cold and flu season," for example, expenses for nonprescription medications can add up quickly, she said. "The ability to get pretax reimbursement for those expenses will be very attractive to employees," Ms. Frost said.

This expansion of FSAs is certain to boost the low participation rate in health care FSAs, consultants say. The current rate—which averages between 10% and 15% of eligible employees—is largely the result of

the IRS "use it or lose it" rule, under which employees' unused account balances are forfeited at the end of the year.

FSA participation is likely to rise because employee fears of forfeiting balances will be offset by the expansion of expenses that can be funded through the accounts.

"The participation rate should improve if employees know there are regular expenses that can be" reimbursed by the FSA, Ms. Frost said.

Increased participation in FSAs, which nearly always are funded by employees' pretax contributions, will cut employers' payroll taxes. With the payroll tax rate now 7.65% of employees' wages, every \$100 in

FSA contributions will cut the amount of payroll taxes paid by employers by \$7.65.

FSA administrators' fees could rise if there is a significant increase in the number of expense receipts submitted by employees.

However, employers that already allowed FSA reimbursement of nonprescription drugs have seen no significant difference in fees charged by their FSA administrators compared with those that did not allow reimbursement, Ms. Frost said.

Benefits debit card providers say the cards will be able to handle over-the-counter drug costs similar to how they pay for other reimbursable expenses, such as prescription drugs and copayments for physician office

visits.

The only additional paperwork requirement would be for employees to submit over-the-counter receipts to FSA administrators, said Rob Butler, vp of sales and marketing for mbi, a debit card provider in Waltham, Mass.

The IRS ruling does not require employers to expand their FSAs to cover nonprescription drugs, nor does it set any deadline on those that choose to do so.

"There is nothing to say you can't wait, for example, until mid-2004," said Tom Billet, a consultant with Watson Wyatt Worldwide in Stamford, Conn.

Indeed, employers that opt to allow the use of FSA funds for nonprescription drugs will need time to change plan documents and to communicate those changes to employees.

Health care: Mandate has popular support

Continued from page 6

to, which co-sponsored the bill with the California Labor Federation.

Even moderate Democrats, once on the fence, say the bill is likely to pass.

And because it wouldn't take effect until 2007, when initially employers with 200 or more employees would have to provide

coverage to workers and their dependents, "there's time to work on the next phase," said Craig Reynolds, chief of staff for Assemblywoman Lois Wolk, D-Vacaville.

Furthermore, "some large businesses are very interested in it," said Mr. Warren.

The "beginning point was, they

were paying 15% more than they need to pay" to cover the cost of uncompensated care for the uninsured, he said.

The legislation, introduced by Senate President Pro Tem John Burton, D-San Francisco, in December 2002, gained momentum when efforts to recall Gov. Gray Davis picked up steam.

"There was some concern that if it passed and Davis or a Democrat were not in office, it might not be signed," explained Mr. Warren.

The bill was still being tweaked by lawmakers on Thursday and Friday.

"It's like watching a tax bill in Washington. It changes every minute," quipped Mr. Warren.